



HONORING THE FEDERAL TRUST RESPONSIBILITY: A NEW PARTNERSHIP TO  
PROVIDE QUALITY HEALTHCARE TO AMERICA'S FIRST CITIZENS

# THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2019 BUDGET

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*March 2017*

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# EXECUTIVE SUMMARY

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Tribal Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 16-17, 2017, to develop the national Indian Health Service budget recommendations for the FY 2017 budget year. The budget priorities are highlighted below:

- Fully fund IHS at \$32 billion phased in over 12 years
- Increase the President's FY 2019 Budget Request for the IHS by a minimum of 33% (**proposed FY 2019 IHS Budget totaling \$6.4 billion**):
  - +\$169.1 million for full funding of current services
  - +\$252.1 million for binding fiscal obligations
  - +\$1.17 billion for program expansion increases
- Support the Preservation of the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable care Act (P.L. 111-148)
- Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficiency of federal dollars at the local level
- Advocate that Tribes and Tribal programs be permanently exempt from sequestration
- Support Advance Appropriations for the Indian Health Service

President Nixon, in his July 8th, 1970, special message to Congress laid out his new national policy concerning American Indians, which stated that “(t)he special relationship between Indians and the Federal government is the result...of solemn obligations which have been entered into by the United States Government. Down through the years, through written treaties and through formal and informal agreements, our government has made specific commitments to the Indian people. For their part, the Indians have often surrendered claims to vast tracts of land and have accepted life on government reservations. In exchange, the government has agreed to provide community services such as health, education and public safety, services which would presumably allow Indian communities to enjoy a standard of living comparable to that of other Americans.”

Today, Tribes value the federal Indian trust responsibility for health care as a sacred promise, made with our ancestral Tribal leaders in exchange for land and peaceful co-existence. American Indians and Alaska Natives (AI/ANs) were promised access to

benefits, including healthcare on the lands the United States set aside for them as reserves. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. As part of upholding its responsibility, the federal government created the IHS, moving Tribal Health Care away from the War Department, and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to try to fulfill the federal promise to provide health care to Native people; however, over the six decades that IHS has been in existence, the agency's progress has never been commensurate with the promise. Appropriations for the IHS has never been adequate to meet basic patient needs, and as a result, health care is delivered in mostly third world conditions. Safety and quality issues have recently once again risen to the level requiring Congressional oversight. The lack of investment in the IHS health delivery infrastructure including accreditable facilities, a capable and qualified workforce and an up-to-date data and information system, means little has changed since 1970. American Indians and Alaska Natives continue to suffer from a multitude of health disparities, and the average American Indian and Alaska Native can expect a life expectancy 4.5 years less than other Americans.

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*“We, the citizens of America, are now joined in a great national effort to rebuild our country and restore its promise for all of our people.”*

PRESIDENT DONALD J. TRUMP,  
INAUGURAL ADDRESS JAN. 20, 2017

As we begin a new chapter with a new President and Administration, one which speaks of restoring promises for all Americans, Tribal leaders look forward to revitalizing the promise made to our forefathers for Indian healthcare. As federal budgets grow tighter, we call on our new President to lead us into an era that finally and *fully* honors the treaties and the trust responsibility for healthcare. This will mean that this Administration must advance a comprehensive budget which fully funds IHS and other Tribal health programs at the Department of Health and Human Services (HHS). It is time for our great nation to rightfully demonstrate measurable progress towards improving the safety and quality of Indian healthcare. America's First Peoples justly deserve healthcare equal to that enjoyed by our fellow American citizens. It is a legal trust responsibility. It is said that great nations, like great men, must live up to their word. This Administration has in its power to fulfill its sacred promise to all American Indians and Alaska Natives and be great again.

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## FY 2019 NATIONAL TRIBAL RECOMMENDATION

|  |                        |
|--|------------------------|
| Planning Base - FY 2016 Enacted                          | \$4,807,589,000        |
| <b>Current Services &amp; Binding Obligations</b>        | <b>\$421,157,000</b>   |
| <b>Current Services</b>                                  | <b>\$169,074,000</b>   |
| Federal Pay Costs  | 7,964,000              |
| Tribal Pay Costs   | 11,946,000             |
| Inflation (non-medical)                                  | 10,385,000             |
| Inflation (medical)                                      | 70,068,000             |
| Population Growth  | 68,711,000             |
| <b>Binding Obligations</b>                               | <b>\$252,083,000</b>   |
| New Staffing for New & Replacement Facilities (estimate) | 68,750,000             |
| Contract Support Costs - Estimated Need                  | 100,000,000            |
| Health Care Facilities Construction (planned)            | 83,333,000             |
| <b>Program Expansion - Services</b>                      | <b>\$985,131,526</b>   |
| Hospitals & Health Clinics                               | 295,549,023            |
| Dental Services  | 67,168,312             |
| Mental Health  | 122,592,753            |
| Alcohol and Substance Abuse                              | 114,762,394            |
| Purchased / Referred Care (formerly CHS)                 | 278,594,524            |
| Public Health Nursing                                    | 24,533,658             |
| Health Education   | 16,662,830             |
| Community Health Representatives                         | 29,531,279             |
| Alaska Immunization                                      | 0                      |
| Urban Indian Health                                      | 20,177,628             |
| Indian Health Professions                                | 13,301,447             |
| Tribal Management Grants                                 | 0                      |
| Direct Operations  | 2,253,411              |
| Self-Governance  | 4,267                  |
| <b>Program Expansion - Contract Support Costs</b>        | <b>\$0</b>             |
| Contract Support Costs - New and Expanded                | 0                      |
| <b>Program Expansion - Facilities</b>                    | <b>\$180,215,767</b>   |
| Maintenance & Improvement                                | 30,720,693             |
| Sanitation Facilities Construction                       | 44,839,660             |
| Health Care Facilities Construction-Other Authorities    | 59,301,676             |
| Facilities & Environmental Health Support                | 12,988,643             |
| Equipment  | 32,365,095             |
| <b>GRAND TOTAL</b>                                       | <b>\$6,394,093,293</b> |

\$ Change over Planning Base

\$1,586,504,293

% Change over Planning Base

33.0%

## DETAIL OF CHANGES — FY 2019 NATIONAL TRIBAL RECOMMENDATION

(Dollars in Thousands) • Feb 21, 2017

| Program                                   | FY 2016       | CURRENT SERVICES |            |              |             |         |                    |  |
|---|---------------|------------------|------------|--------------|-------------|---------|--------------------|--|
|   | Enacted Level | Pay              |            |              | Inflation   |         |                    |  |
|   |               | Federal Pay      | Tribal Pay | Pay Subtotal | Non-Medical | Medical | Inflation Subtotal |  |
| SERVICES                                  |               |                  |            |              |             |         |                    |  |
| Hospitals & Health Clinics                | 1,857,225     | 5,050            | 7,777      | 12,827       | 2,317       | 21,358  | 23,675             |  |
| Dental Services                           | 178,286       | 678              | 722        | 1,400        | 53          | 1,816   | 1,869              |  |
| Mental Health                             | 82,100        | 243              | 373        | 616          | 26          | 980     | 1,006              |  |
| Alcohol & Substance Abuse                 | 205,305       | 177              | 1,157      | 1,334        | 34          | 2,835   | 2,869              |  |
| Purchased/Referred Care                   | 914,139       | 0                | 0          | 0            | 0           | 35,249  | 35,249             |  |
| Total, Clinical Services                  | 3,237,055     | 6,148            | 10,029     | 16,177       | 2,430       | 62,238  | 64,668             |  |
| Public Health Nursing                     | 76,623        | 282              | 323        | 605          | 22          | 1,733   | 1,755              |  |
| Health Education                          | 18,255        | 33               | 100        | 133          | 2           | 545     | 547                |  |
| Community Health Representatives          | 58,906        | 6                | 431        | 437          | 0           | 2,223   | 2,223              |  |
| Immunization AK                           | 1,950         | 0                | 15         | 15           | 0           | 70      | 70                 |  |
| Total, Preventive Health                  | 155,734       | 321              | 869        | 1,190        | 24          | 4,571   | 4,595              |  |
| Urban Health                              | 44,741        | 16               | 196        | 212          | 73          | 1,372   | 1,445              |  |
| Indian Health Professions                 | 48,342        | 15               | 0          | 15           | 778         | 0       | 778                |  |
| Tribal Management Grants                  | 2,442         | 0                | 0          | 0            | 46          | 0       | 46                 |  |
| Direct Operations                         | 72,338        | 423              | 121        | 544          | 527         | 0       | 527                |  |
| Self-Governance                           | 5,735         | 15               | 0          | 15           | 71          | 0       | 71                 |  |
| Total, Other Services                     | 173,598       | 469              | 317        | 786          | 1,495       | 1,372   | 2,867              |  |
| TOTAL, SERVICES                           | 3,566,387     | 6,938            | 11,215     | 18,153       | 3,949       | 68,181  | 72,130             |  |
| CONTRACT SUPPORT COSTS                    |               |                  |            |              |             |         |                    |  |
| Contract Support Cost                     | 717,970       | 0                | 0          | 0            | 0           | 0       | 0                  |  |
| Contract Support Cost- Estimated Need     | 0             | 0                | 0          | 0            | 0           | 0       | 0                  |  |
| Contract Support Costs - New and Expanded | 0             | 0                | 0          | 0            | 0           | 0       | 0                  |  |
| TOTAL, CONTRACT SUPPORT COSTS             | 717,970       | 0                | 0          | 0            | 0           | 0       | 0                  |  |
| FACILITIES                                |               |                  |            |              |             |         |                    |  |
| Maintenance & Improvement                 | 73,614        | 0                | 0          | 0            | 1,126       | 0       | 1,126              |  |
| Sanitation Facilities Construction        | 99,423        | 0                | 0          | 0            | 1,583       | 0       | 1,583              |  |
| Health Care Facilities Construction       | 105,048       | 0                | 0          | 0            | 1,787       | 0       | 1,787              |  |
| Facilities & Environmental Health Support | 222,610       | 1,026            | 731        | 1,757        | 1,907       | 1,062   | 2,969              |  |
| Equipment                                 | 22,537        | 0                | 0          | 0            | 33          | 825     | 858                |  |
| TOTAL, FACILITIES                         | 523,232       | 1,026            | 731        | 1,757        | 6,436       | 1,887   | 8,323              |  |
| TOTAL, BUDGET AUTHORITY                   | 4,807,589     | 7,964            | 11,946     | 19,910       | 10,385      | 70,068  | 80,453             |  |

|  | Pop Growth    | Current Services Subtotal | Binding Obligations         |                |                |                              | Program Increases | 2019 National Recomm. | FY 2019 +/- FY 2016 Enacted | % Change over Plng Base |
|--|---------------|---------------------------|-----------------------------|----------------|----------------|------------------------------|-------------------|-----------------------|-----------------------------|-------------------------|
|  |               |                           | Staffing for New Facilities | CSC            | HCFC (Planned) | Binding Obligations Subtotal |                   |                       |                             |                         |
|  | 33,525        | 70,027                    | 68,750                      | 0              | 0              | 68,750                       | 295,549           | 2,291,551             | 434,326                     | 23.4%                   |
|  | 3,162         | 6,431                     | 0                           | 0              | 0              | 0                            | 67,168            | 251,885               | 73,599                      | 41.3%                   |
|  | 1,476         | 3,098                     | 0                           | 0              | 0              | 0                            | 122,593           | 207,791               | 125,691                     | 153.1%                  |
|  | 3,489         | 7,692                     | 0                           | 0              | 0              | 0                            | 114,762           | 327,759               | 122,454                     | 59.6%                   |
|  | 16,723        | 51,972                    | 0                           | 0              | 0              | 0                            | 278,595           | 1,244,706             | 330,567                     | 36.2%                   |
|  | <b>58,375</b> | <b>139,220</b>            | <b>68,750</b>               | <b>0</b>       | <b>0</b>       | <b>68,750</b>                | <b>878,667</b>    | <b>4,323,692</b>      | <b>1,086,637</b>            | <b>33.6%</b>            |
|  | 1,374         | 3,734                     | 0                           | 0              | 0              | 0                            | 24,534            | 104,891               | 28,268                      | 36.9%                   |
|  | 329           | 1,009                     | 0                           | 0              | 0              | 0                            | 16,663            | 35,927                | 17,672                      | 96.8%                   |
|  | 1,069         | 3,729                     | 0                           | 0              | 0              | 0                            | 29,531            | 92,166                | 33,260                      | 56.5%                   |
|  | 33            | 118                       | 0                           | 0              | 0              | 0                            | 0                 | 2,068                 | 118                         | 6.1%                    |
|  | <b>2,805</b>  | <b>8,590</b>              | <b>0</b>                    | <b>0</b>       | <b>0</b>       | <b>0</b>                     | <b>70,728</b>     | <b>235,052</b>        | <b>79,318</b>               | <b>50.9%</b>            |
|  | 745           | 2,402                     | 0                           | 0              | 0              | 0                            | 20,178            | 67,321                | 22,580                      | 50.5%                   |
|  | 0             | 793                       | 0                           | 0              | 0              | 0                            | 13,301            | 62,436                | 14,094                      | 29.2%                   |
|  | 0             | 46                        | 0                           | 0              | 0              | 0                            | 0                 | 2,488                 | 46                          | 1.9%                    |
|  | 0             | 1,071                     | 0                           | 0              | 0              | 0                            | 2,253             | 75,662                | 3,324                       | 4.6%                    |
|  | 0             | 86                        | 0                           | 0              | 0              | 0                            | 4                 | 5,825                 | 90                          | 1.6%                    |
|  | <b>745</b>    | <b>4,398</b>              | <b>0</b>                    | <b>0</b>       | <b>0</b>       | <b>0</b>                     | <b>35,737</b>     | <b>213,733</b>        | <b>40,135</b>               | <b>23.1%</b>            |
|  | <b>61,925</b> | <b>152,208</b>            | <b>68,750</b>               | <b>0</b>       | <b>0</b>       | <b>68,750</b>                | <b>985,132</b>    | <b>4,772,477</b>      | <b>1,206,090</b>            | <b>33.8%</b>            |
|  | 0             | 0                         | 0                           | 0              | 0              | 0                            | 0                 | 717,970               | 0                           | 0.0%                    |
|  | 0             | 0                         | 0                           | 100,000        | 0              | 100,000                      | 0                 | 100,000               | 100,000                     | 0.0%                    |
|  | 0             | 0                         | 0                           | 0              | 0              | 0                            | 0                 | 0                     | 0                           | 0.0%                    |
|  | <b>0</b>      | <b>0</b>                  | <b>0</b>                    | <b>100,000</b> | <b>0</b>       | <b>100,000</b>               | <b>0</b>          | <b>817,970</b>        | <b>100,000</b>              | <b>13.9%</b>            |
|  | 965           | 2,091                     | 0                           | 0              | 0              | 0                            | 30,721            | 106,426               | 32,812                      | 44.6%                   |
|  | 1,430         | 3,013                     | 0                           | 0              | 0              | 0                            | 44,840            | 147,276               | 47,853                      | 48.1%                   |
|  | 0             | 1,787                     | 0                           | 0              | 83,333         | 83,333                       | 59,302            | 249,470               | 144,422                     | 137.5%                  |
|  | 3,971         | 8,697                     | 0                           | 0              | 0              | 0                            | 12,989            | 244,296               | 21,686                      | 9.7%                    |
|  | 420           | 1,278                     | 0                           | 0              | 0              | 0                            | 32,365            | 56,180                | 33,643                      | 149.3%                  |
|  | <b>6,786</b>  | <b>16,866</b>             | <b>0</b>                    | <b>0</b>       | <b>83,333</b>  | <b>83,333</b>                | <b>180,216</b>    | <b>803,647</b>        | <b>280,415</b>              | <b>53.6%</b>            |
|  | <b>68,711</b> | <b>169,074</b>            | <b>68,750</b>               | <b>100,000</b> | <b>83,333</b>  | <b>252,083</b>               | <b>1,165,347</b>  | <b>6,394,093</b>      | <b>1,586,504</b>            | <b>33.0%</b>            |





# INTRODUCTION

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## *Honoring the Federal Trust Responsibility: A New Partnership to Provide Quality Health Care to America's First Citizens*

Tribal Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 16-17, 2017, to develop the national Indian Health Service budget recommendations for the FY 2017 budget year. The national budget priorities are highlighted below:

- Commit to fully fund IHS at \$32 billion phased in over 12 years
- Increase the Enacted budget for the IHS by a minimum of 33% in FY 2019:
  - +\$169.1 million for full funding of current services
  - +\$252.1 million for binding fiscal obligations
  - +\$1.17 billion for program expansion increases. Top priorities for program expansion include:
    1. Hospitals & Health Clinics..... +\$295.5 million
    2. Purchased / Referred Care ..... +\$278.6 million
    3. Mental Health..... +\$122.6 million
    4. Alcohol & Substance Abuse ..... +\$114.8 million
    5. Dental Health ..... +\$ 67.2 million
    6. Health Care Facilities Construction ..... +\$ 59.3 million
    7. Sanitation Facilities Construction... +\$ 44.8 million
    8. Equipment ..... +\$ 32.4 million
    9. Maintenance & Improvement ..... +\$ 30.7 million
    10. Community Health Reps. .... +\$ 29.5 million
    11. Public Health Nursing..... +\$ 24.5 million
    12. Urban Indian Health..... +\$ 20.2 million
    13. Health Education ..... +\$ 16.7 million
    14. Indian Health Professions..... +\$ 13.3 million
    15. Facilities & Env. Health Support..... +\$ 12.0 million
- Support the Preservation of the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable care Act (P.L. 111-148) including:
  - **Section 2901** which states that any IHS/Tribal/ or Urban (I/T/U) health provider should remain the payer of last resort the payer of last resort for services provided by such notwithstanding any Federal, State, or local law to the contrary.
  - **Section 2902** which grants I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.
  - **Section 9021** ensures that any health benefits provided by a Tribe to its members are not included as taxable income.
- Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficiency and effective use of federal dollars at the local level.
- Advocate that Tribes and Tribal programs be permanently exempt from sequestration
- Support Advance Appropriations for the Indian Health Service



# FY2019 TRIBAL BUDGET

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## *Recommendations and Priorities*

The federal promise to provide Indian health services was received in good faith by our ancestral Tribal leaders to lay the foundation for peaceful co-existence of our great nations. By giving up Tribal lands, the United States were able to prosper and build great wealth, leaving First Americans to try to build a life as domesticated nations in land reserves carved out by the President. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. To facilitate upholding its responsibility, the federal government created the Indian Health Service (IHS), removing responsibility for tribal healthcare from the War Department, and tasked the agency with providing health services to American Indians and Alaska Natives. Since its creation in 1955, IHS has worked with limited means to fulfill the federal promise to provide health care to Native people; however, over the six decades that IHS has been in existence, the agency's progress has never been commensurate with the promise. Appropriations for the IHS has never been adequate to meet basic patient needs, and health care is delivered in mostly third world conditions. Safety and quality issues have risen to the level requiring Congressional oversight. The lack of investment in the IHS health delivery infrastructure, a capable and qualified workforce and up-to-date data and information systems, means little has changed since President Nixon rolled out his new national health policy for Indians in 1970. National comparative reports repeatedly show that American Indians and Alaska Natives (AI/ANs) continue to suffer from a multitude of preventable health disparities, with a life expectancy 4.5 years less than other Americans.

### PROGRESS IS SLOW...

In the 1970 address to Congress, the Nixon Administration wrote of the need for more appropriations for Indian Health. They cited even then that “(d)espite significant improvements in the past decade and a half, the health of Indian people still lags 20 to 25 years behind that of the general population. The average age at death among Indians is 44 years, about one-third less than the national average. Infant mortality is nearly 50% higher for Indians and Alaska natives than for the population at large; the tuberculosis rate is eight times as high and the suicide rate is twice that of the general population. Many infectious diseases such as trachoma and dysentery that have all but disappeared among other Americans continue to afflict the Indian people.” Further, the administration noted that a “strengthened Federal effort will enable us to address ourselves more effectively to those health problems which are particularly important to the Indian community...

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*“The U.S. Senate has a duty to support tribal communities in their work to build sustainable economies and good schools, provide quality health care, maintain access to clean air and water, and protect the deep Native American connection to culture and tradition. Native Americans have faced, and continue to face, great challenges and injustices – and while we have made progress, it is abundantly clear that we have much work to do to improve government-to-government consultation with tribes and to ensure environmental justice.”*

SENATOR TOM UDALL, JAN. 5, 2017

for example, that areas of greatest concern to Indians include the prevention and control of alcoholism, the promotion of mental health and the control of middle ear disease.” On workforce, President Nixon noted that “(t)hese and other Indian health programs will be most effective if more Indians are involved in running them. Yet-almost unbelievably — we are presently able

to identify in this country only 30 physicians and fewer than 400 nurses of Indian descent. To meet this situation, we will expand our efforts to train Indians for health careers.”

The truth is that funds necessary to eliminate the overwhelming health disparities of American Indian and Alaska Native people has never been properly appropriated. The IHS, and the Tribes administering their own health programs, are forced to operate within a base budget which is historically inadequate. The true needs-based budget, which would bring health resources to parity with the rest of the nation, is now at \$32 billion. Compare this to an actual appropriation of less than \$5 billion. While the IHS has received marginal increases in more recent years, these certainly have not been enough to effectively target chronically underfunded health priorities. This decision, intentional or not, which fails to resource even basic services for Indian people, has created the crisis situation we now see in almost all Tribal communities and reservations. The failing infrastructure creates unsafe and unsanitary living conditions and severely compromises the quality of care which can be provided. While controlling TB was a successful effort in the 70’s and 80’s; it is now creeping back up again as a public health concern associated with rampant substance abuse and related behavioral health issues. Infant mortality, suicides and preventable deaths plague our Indian communities. Treatment of chronic diseases like diabetes, auto-immune deficiencies, cancer and heart disease quickly erode our limited resources leaving few dollars for prevention. Aging facilities and the lack of resources to modernize equipment and health information technology, has created a dire need for large investments in basic infrastructure, including housing for health professionals who want to work in our communities but have no place to stay.

## BROKEN PROMISES, POOR RESULTS

In 2010, Congress reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). In renewing the IHCIA, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives, declaring that “it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians — to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”<sup>1</sup>

Yet, IHS has never received sufficient appropriation to fully honor the new authorities promised within the IHCIA, and AI/ANs continue to live with health disparities that are far worse than the rest of the U.S. population. One only has to visit an Indian reservation in heartland America, or a remote village of Alaska, like President

Obama did during his term as President, to see that American Indians and Alaska Natives suffer from a variety of third world health disparities, unlike those seen in other parts of the country. While some statistics have improved in areas where targeted funding has been received from either federal sources or tribal, American Indian and Alaska Native health

disparities are still alarming and not improving fast enough or consistently to be considered a success. In 2003, it was reported that AI/ANs have a lower life expectancy of almost 6 years less than any other racial/ethnic group. While this has improved to 4.8 year, AI/ANs still holds the grim statistic of having a lower life expectancy than any other group. In some IHS Service Areas, it is even lower. For instance, “white men in Montana lived 19 years longer than American Indian men, and white women lived 20 years longer than American Indian women.”<sup>2</sup> In South Dakota, in 2014, “for white residents the median age was 81, compared to 58 for American Indians.”<sup>3</sup> Twenty-five percent of AI/AN deaths were for those with ages under 45. This compared with fifteen percent of black decedents and seven percent of white decedents in 2008 who were under 45 years of age.<sup>4</sup> The quality of care for elderly AI/ANs is far from equal; many tribal communities do

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*“We need to do much better on healthcare. And there is much we can do with the Indian Health Services... It should provide the best care and services possible and ensure that patients are treated with dignity and respect. They should be well cared for during their time of healing... There are many unmet Tribal healthcare needs.”*

SENATOR JOHN HOEVEN (R-ND),  
CHAIRMAN, SENATE COMMITTEE ON  
INDIAN AFFAIRS, FEB. 14, 2017

<sup>1</sup> Indian Health Care Improvement Act, §103(2009).

<sup>2</sup> “The State of the State’s Health: A Report on the Health of Montanans.” Montana Department of Public Health and Human Services. 2013. p. 11.

<sup>3</sup> “2014 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators.” South Dakota Department of Health. 2014. P. 62.

<sup>4</sup> Trends in Indian Health 2014 Edition.” U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health Support, Division of Program Statistics. 2014. p 63.



not have assisted living homes, home care services, or nursing care to provide a dignified end of life experience for their elders.

Across almost all diseases, AI/ANs are at greater risk of death, injury, or chronic conditions than other Americans. For example, AI/ANs are 520 percent more likely to suffer from alcohol-related deaths; 450 percent more likely to die from tuberculosis; 368 percent more likely to die from chronic liver disease and cirrhosis; 207 percent greater to die in motor vehicle crashes; and 177 percent more likely to die from complications due to diabetes.<sup>5</sup> Infant mortality rates for AI/ANs is 8.3 per 1,000 live births, a decrease of 67 percent since 1974. However, AI/ANs still have a higher rate compared to the U.S. all rate of 6.6. Cancer rates in Indian Country are 12% higher than the rest of the country, and AI/AN cancer patients are 26% more likely to die from cancer than the rest of the population. Most statistics have shown no improvement over the last decade, to the detriment of American Indian and Alaska Native people. In 2003, AI/ANs were 204 percent more likely to suffer accidental death than other groups, and it has now risen to 240 percent. Our youth continue to be 2.5 times more likely to die from suicide than other Americans.<sup>6</sup> Suicide rates are nearly 50 percent higher compared to non-Hispanic whites, and are more frequent among males and people under the age of 25.

According to CDC data, 45.4 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. AI/AN children have an average of six decayed teeth, when other US children have only one.<sup>7</sup> There must be a comprehensive change to prevent another decade from going by and countless American Indians and Alaska Natives being subjected to a broken, under resourced health system.

Tribal leaders ask, why, in this great country, which has been quick to help other countries who are equally disparate, has these atrocities been allowed to exist for so many years? Perhaps these statistics are not surprising when looking at the budgets for IHS compared to other health programs. In 2016, national health spending per capita was \$9,990 while IHS spending was only \$2,834!

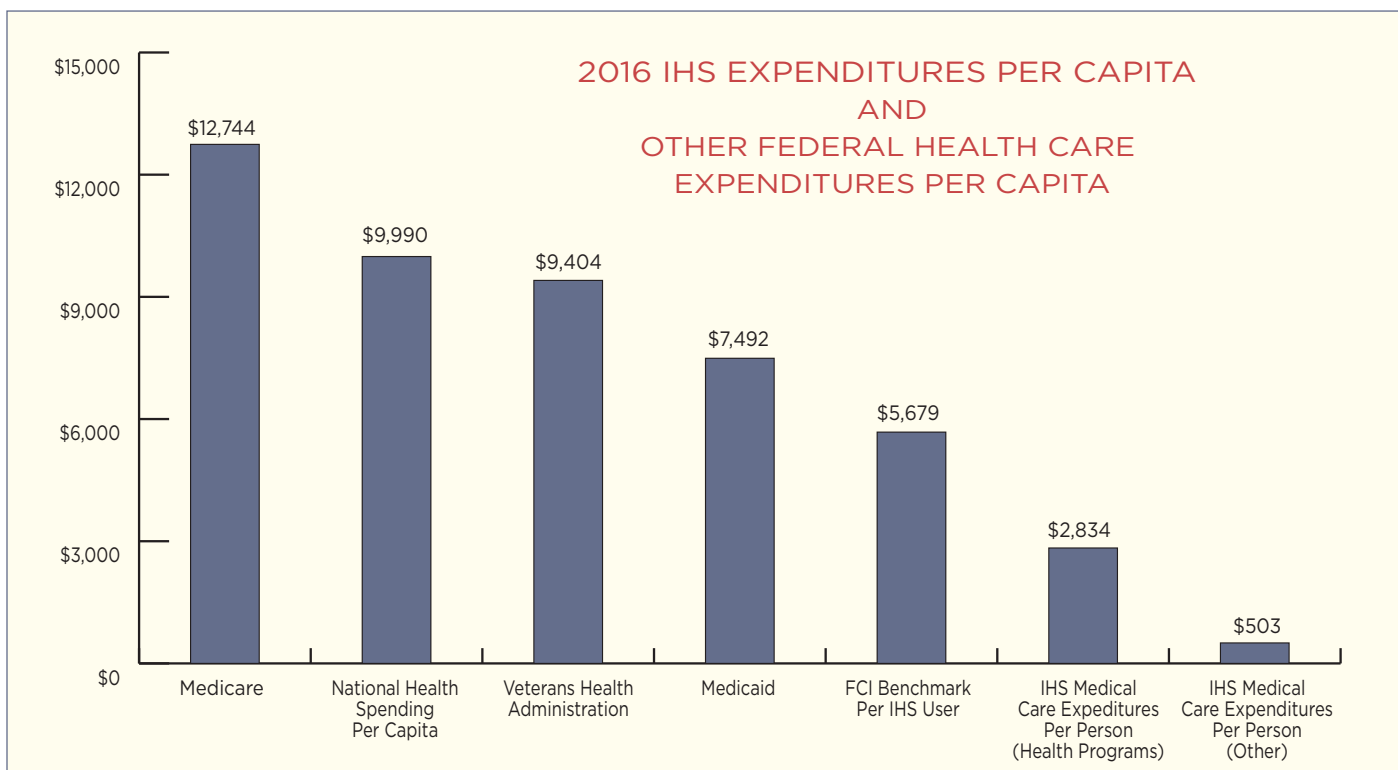
*“If we’re serious about helping Native youth overcome the odds – as they experience the impact of post-traumatic stress at rates similar to newly returning veterans from Iraq and Afghanistan, face tragically high suicide rates, and are far less likely to graduate from high school than any other group – we must change the current trajectory of the federal programs meant to assist them.”*

SENATOR HEIDI HEITKAMP, MAY 19, 2016

<sup>5</sup> Ibid, p 5

<sup>6</sup> Ibid, p 5

<sup>7</sup> Indian Health Service FY 2016 Budget Request to Congress, p. 78.



## A NEW PARTNERSHIP FOR QUALITY AND SAFE CARE

Today, the IHS is an agency with dual objectives. On the one hand, IHS continues to provide direct healthcare services for AI/ANs through the operation of 28 hospitals and 125 outpatient facilities in 9 of 12 IHS Service Areas. On the other hand, IHS also serves as a funder to Tribes who choose to operate Self Governance Compacts or Contracts under Self Determination policies and authorities legislated in 1970. While several Tribal health organizations have taken advantage of ISDEAA to leverage IHS funding to supplement health programs, are now exemplary

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*“One thing we should all agree on is that the challenges facing Indian country cannot be addressed when Indian programs are severely underfunded. It is vital that we address the deficit and I am committed to doing that but I also strongly believe we can’t balance the budget on the back of the Indian country. We must fund tribal programs adequately.”*

SENATOR JON TESTER  
MAR 9, 2016

models of 21st Century healthcare delivery, IHS sites which are operated by the federal government, as well as Tribal sites who struggle with alternative resources, continue to experience serious gaps in patient care. Recent reports by the HHS Office of Inspector General (OIG); Centers for Medicare and Medicaid Services (CMS); and the Government Accountability Office (GAO) has found that the care provided in many IHS hospitals poses direct threats to patients and is outside the standards expected in the United States. This must change. Our new leadership in Washington must insist on changing the status quo at IHS. America is too great a nation to sit idly by while the First Americans live with these unconscionable health realities.

## HONORING THE TRUST RESPONSIBILITY IN A TIME OF REFORM

As this new Administration looks to repair and reform the U.S. health system, it is critical that Indian Country not be left behind. First, Tribes emphatically support keeping the IHCA (which was passed as an unrelated rider as part of the Affordable Care Act (ACA) fully intact. To reverse this law now would not improve health outcomes, but jeopardize a health system on which 2.2 million AI/ANs rely. The ACA recognized the Indian health system as a critical component of healthcare reform and included many Indian-specific provisions to help the IHS and Tribes leverage health reform to improve federal and Tribal health services and outcomes, like premium subsidies, cost sharing exemptions, and monthly enrollment for Indians. These provisions have helped to increase revenues for I/T/U programs to begin to address the historic underfunding of these programs. As health reform continues to evolve, the importance of these programs to the federal health care system must not be forgotten.

Furthermore, the Administration should also insist, along with Congress, that any changes to Medicaid preserve the U.S. policy of the last 40 years by providing 100 percent of the Federal Medical Assistance Percentages (FMAP) for AI/ANs and that AI/ANs are not subject to barriers to the Medicaid program that states may adopt. This policy recognizes that the federal government, not the states, are responsible to provide health care to American Indians and Alaska Natives. Until such time as the tribal Medicaid and Medicare programs

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*“Tribal self-governance is a model that must be supported and expanded. We cannot as a country fulfill a federal trust relationship based on failed economic policies, stifled by bureaucratic regulation and broken promises...”*

SENATOR LISA MURKOWSKI  
MAY 25, 2015

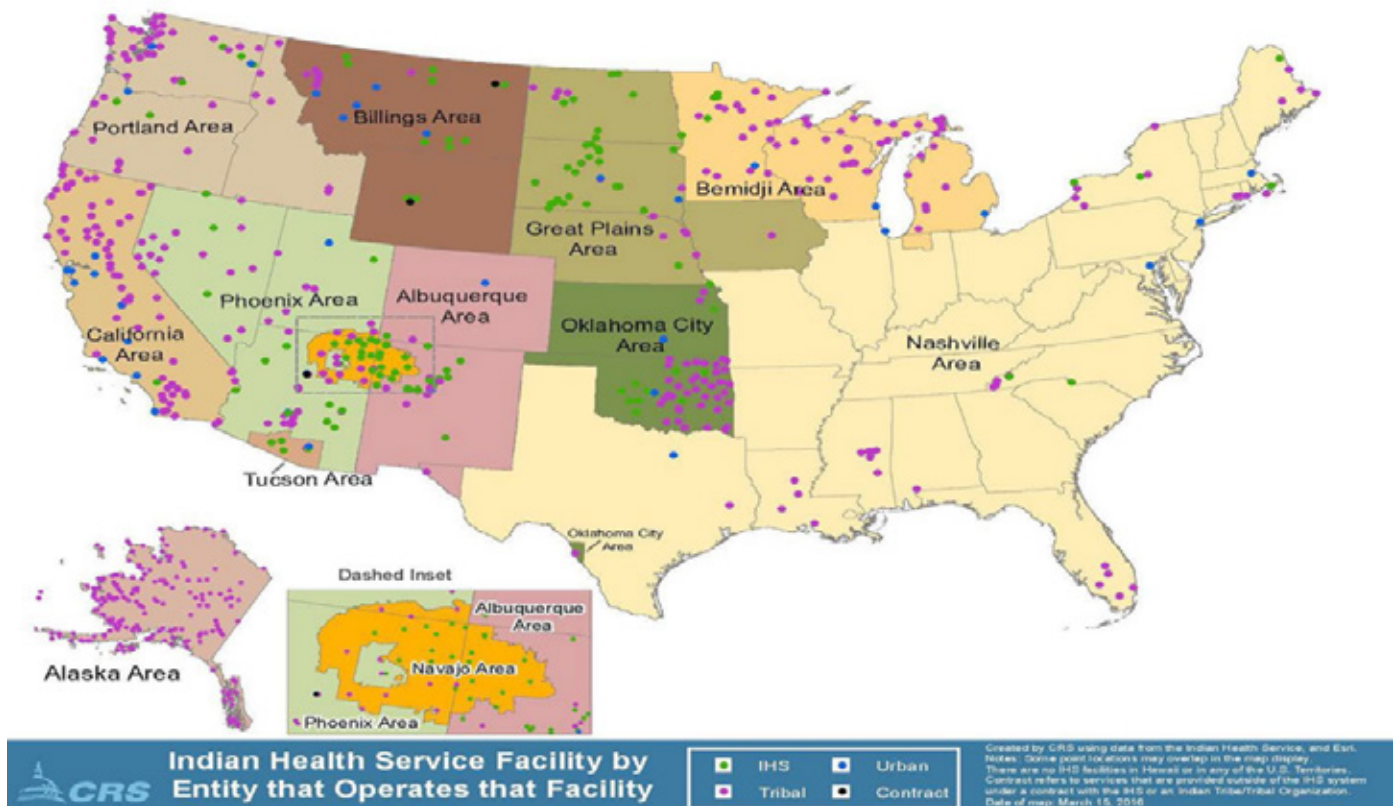
are administered directly by the federal government, the states must be held harmless from any federal obligation for providing trust services to AI/ANs. State imposed barriers which restrict state-defined plan benefits for AI/ANs do not bring down state costs, but only put unnecessary pressure on the already underfunded IHS. We call on the new leaders of CMS to ensure that any state Medicaid plans are only approved if Tribes in that state are also in agreement.

The following thoughtful recommendations for the FY 2019 federal budget request for IHS are designed to make strategic, common-sense investments in the Indian health system infrastructure and patient care outcomes. For too long, AI/ANs have suffered with an afterthought health system that is under-resourced, therefore inadequately and inconsistently managed. As we embark on the next four years together, we look forward

to working as nation to nation partners to ensure that Tribal nations finally receive the appropriated resources necessary to operate a first-class health system. The recommended 33% increase will not fully fund IHS, but rather represents a common-sense, moderate adjustment that will put IHS on the path to full funding within the next 12 years. We encourage you to thoroughly read this document to learn about the IHS system and the challenges facing Tribal communities' health delivery systems. While we understand the overall federal budget is under serious constraints, the treaties negotiated by our ancestors are not discretionary, and should remain a foremost priority for this Administration's budget. It is but a small investment when one compares to the HHS expenditure plan, and even smaller when compared to the national earnings from the land first occupied by America's indigenous peoples. But it is a huge in terms of

returning the trust penned by the forefathers of this country's first immigrants who are now the leaders of our great country.

The TBFWG stands ready to serve as a resource for this administration as you map out your FY 2019 budget strategy to fulfil the promise of this great country to all its citizens, including its first domestic nations.





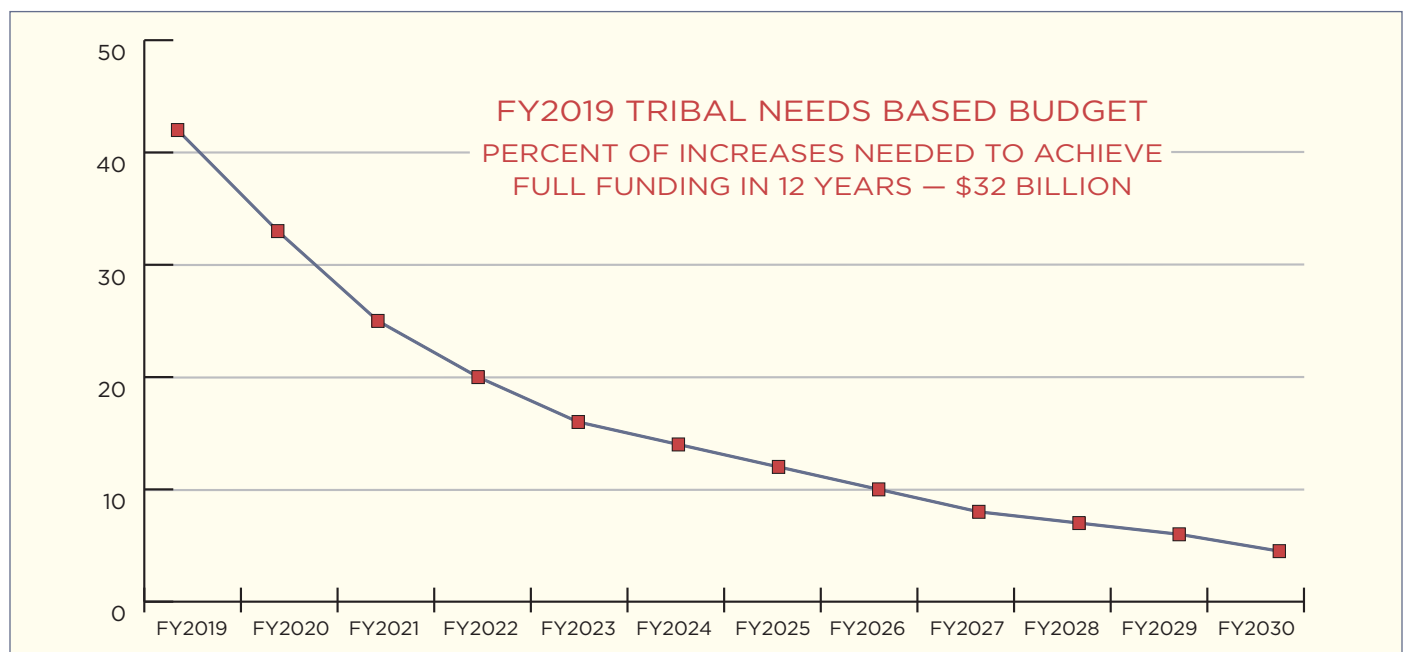
# 1ST RECOMMENDATION

## *Fully Fund IHS at \$32 Billion Phased In Over 12 Years*

Early in 2003, the Workgroup met to evaluate its true funding needs as part of the formulation of the national Tribal budget recommendations for FY 2005. Tribal leaders were dismayed that the planning base for the IHS budget was \$2.85 billion, less than 15% of the total funding required to meeting the health care needs for AI/ANs. This historical level of appropriations was not even sufficient to maintain current services in the face of inflation and increases in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and IHS's efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribal and Urban programs worked together to develop the first true Needs Based Budget (NBB) for FY 2005, utilizing economic actuarial experts. After an extensive analysis and intense consultation with Tribes, this analysis resulted for the first time in

an actuarial-based proposed IHS Needs Based Budget (NBB) totaling \$19.5 billion. This NBB model included amounts for personal healthcare medical services, wrap-around community health services (i.e. prevention and public health) and facility infrastructure investments (i.e. sanitation, safe water and adequate healthcare facilities).

The FY 2005 Budget Formulation Workgroup, recognizing that such an investment could not be implemented immediately, responsibly proposed a 10-year phase-in plan, with substantial increases in the first two years to build facilities and start-up services, with more moderate increases in the following years. The Workgroup also understood that meeting the NBB of \$19.5 billion in one fiscal year was unlikely, due to the importance of balancing the Federal budget and respecting other national



priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at one time. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and Administration to improve the health status of American Indians and Alaska Natives.

That work was done fourteen years ago. Over the years and with failure to produce necessary appropriations to fulfill the initial 10-year plan, the per capita health funding and health disparities between AI/ANs and other populations have continued to

widen, and the cost and amount of time required to close this widening funding disparity gap has grown. The NBB has been updated every year, using the most current available population and per capita health care cost information. The *IHS need-based funding aggregate cost estimate for FY 2019* is now **\$32 billion**, based on the FY 2015 estimate of [2.2 million eligible] AI/ANs served by IHS, Tribal, and Urban health programs. Given the lack of adequate budget increases over the past fourteen years, the amount of time to reasonably phase-in the NBB of \$32 billion has been extended to twelve years.

## FY 2019 AI/AN NEEDS BASED FUNDING • AGGREGATE COST ESTIMATE

| GROSS COST ESTIMATES<br>Source of Funding is not estimated  |   | Need Based on<br>FY 2016 Existing<br>Users at I/T Sites | Need based on FY<br>2016 Expanded for<br>Eligible AIAN at<br>I/T/U Sites* |
|---|---|---|---|
|   |   | 1,618,142   | 2,751,556   |
| SERVICES  | \$ Per Capita   | Billions  | Billions  |
| <b>Medical Services</b>   | <b>\$6,312</b>  | <b>-</b>  | <b>\$17.37</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 2016 @4% per year                                   | \$ Per Capita * Users                                   | \$ Per Capita* Eligible AIAN  |
| <b>Dental &amp; Vision Services</b>   | <b>\$660</b>  | <b>\$1.07</b>   | <b>\$1.82</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>  | <b>\$1,481</b>  | <b>\$2.40</b>   | <b>\$4.07</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, \$1,306 per capita = (.19/.81*\$5,611). |   |   |
| <b>Total Annualized Services</b>  | <b>\$8,453</b>  | <b>\$13.68</b>  | <b>\$23.26</b>  |
| FACILITIES  | \$ Per Capita   | Billions  | Billions  |
| <b>Facility Upgrades Upfront Costs</b>  |   | <b>\$6.51</b>   | <b>\$8.77</b>   |
| <b>Annualized for 30 year useful Life</b>   |   | <b>\$0.38</b>   | <b>\$0.51</b>   |
| IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of \$6.5b to upgrade and modernize. A 30 year useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.  |   |   |   |
| TOTAL   |   |   |   |
| <b>Total Annualized Services + One-time Upfront Facilities Upgrades</b>   |   | <b>\$20.19</b>  | <b>\$32.03</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.

## 2ND RECOMMENDATION

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### *Increase the President's FY 2019 Budget Request for the Indian Health Service by a Minimum of 33% over FY 2016 Enacted Levels (\$6.4 billion total funding in FY 2019)*

#### CURRENT SERVICES & BINDING AGREEMENTS

Tribal Leaders are adamant that the FY 2019 budget request, as a starting point, provides an increase of \$421.2 million over the FY 2016 enacted amount to cover Current Services and all other binding obligated requirements. Tribes have long insisted that the annual request must transparently disclose all known expected cost obligations in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. Deliberately understating the amount necessary to meet the entire fiscal obligation for binding agreements beyond Current Services creates a false expectation that a slight funding increase is available to expand needed program services. In fact, in past years, a 2-3% funding increase has not even been sufficient to maintain the status quo, effectively resulting in an actual decrease from the prior year. These real cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population increases, planned increases in staffing for new and replacement facilities, facilities construction project requirements, and all expected off-the-top mandatory assessments. The workgroup strongly recommends that full funding for Current Services and other "binding" fiscal requirements at the true projected costs of \$421 million be requested as reflected in this section.

#### CURRENT SERVICES (FIXED COSTS) +\$169.1 MILLION

The FY 2017 President's Budget request included an increase of \$159 million for direct and tribally provided health care services to cover increased costs associated with population growth, pay cost increases for workers, medical and non-medical inflation, and ensure continued levels of health care services. Unfortunately, the proposed \$159 million falls short of actual need, specifically in population growth, only covering \$43.2 million of the total population growth need of \$73.3 million. Population growth estimates reflect a 1.8% increase in eligible tribal users.

The FY 2019 Tribal Budget Request for Current Services of \$169.1 million includes an increase of \$7.9 million for Federal Pay Costs and \$11.9 million for Tribal Pay Costs. Tribal and federal facilities cannot continue to offer salaries below the competitive market. As demonstrated most recently in testimony heard from the Great Plains Area, the ability to provide safe, quality care at Indian Health facilities is severely compromised when the IHS and Tribes are unable to fill vacancies or retain qualified staff. Indeed, as testified, it is a matter of life and death. Further, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal pay freeze that may be imposed in FY 2019. We cannot allow pay scales for our health professional to be so substandard that they are forced to look elsewhere to seek a fair wage.



The Current Services request also includes \$10.4 million for Non-Medical Inflation and \$70 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services as the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), the index for all items less food and energy increased 2.3% over the past 12 months, a figure that has been slowly rising since it was 1.7% for the 12 months ending May 2015. The medical care index has increased 3.5 %, its largest rise since October 2012. The Workgroup asserts that the rates of inflation applied to H&C, Dental Health, Mental Health, and PRC in developing the IHS budget should correspond to the appropriate components in the CPI to reflect the true level of funding needed to maintain current services. Another \$68.7 million in Current Services funding is requested for Population Growth to address increased services needs arising from the increase in the AI/AN population, which in recent years has been growing at an average rate of 1.8% annually.

While the budget has received upward adjustments since 2008, these increases have done little to address the huge disparities in funding for Tribal health care compared to similar expenditures for the rest of the U. S. population. With the total funding need now estimated at \$30.8 billion, the Indian Health system remains severely underfunded at \$5 billion. The FY 2013 sequestration cuts were pure disaster for hospitals and clinics across Indian Country. Losing dollars to this as well as the 2014 federal government shutdown, has effectively nullified many of the funding gains of the last seven years. When compounded with rising medical inflation and population growth, and new unfunded mandates resulting from the CMS Meaningful Use and ICD-10 conversion requirements, Indian Health budgets are, in real dollars, trending backwards.

## BINDING AGREEMENTS (FIXED COSTS) +\$152.1 MILLION

**Health Care Facilities Construction (Planned)** +\$83.3 million  
In FY 2019, \$83.3 million is the minimum requested amount to fund priority health facility construction projects which are next in line on the approved IHS health care facilities 5-year plan. With an average investment in health facilities infrastructure of only \$80M per year, the reality is that it will be decades before the IHS catches up on its backlog of planned health facility construction projects. If you look at the Facilities Appropriations Advisory Board's recent report on the funding gap for projects on the construction queue, you readily conclude that the HCFC budget line has been historically underfunded. The current

HCFC priority list totals \$2.27 billion. It includes three inpatient facilities and nine outpatient facilities. A program increase of \$83.3 million affords the advancement or possible completion of only four projects on the list that are already started. These projects are in the past President's FY2017 budget request that provided \$132.377 million in this budget line. As the FY2017 appropriation makes its way through Congress, Tribes remain hopeful that these necessary investments in health facilities infrastructure will be supported by the new Administration and Congress. This \$83.3 million for the FY2019 budget supports the projects in the FY2017-18 requests. Along with funds for staffing and quarters, an increase of \$83.3 million would at least move the following projects towards completion and provide the needed level of quality of care that these tribal communities so desperately need:

- Phoenix Indian Medical Center (PIMC) Northeast Ambulatory Care Center, Salt River Pima-Maricopa Indian Community
- Whiteriver Hospital, Whiteriver, AZ
- Rapid City Health Center, Rapid City, SD
- Dilkon Alternative Rural Health Center, Dilkon, AZ

The tremendous backlog of current construction projects and the overall need in all IHS regions is a major concern of the Tribal Leaders nationwide.

## TOTAL FY 2019 REQUEST FOR FIXED COSTS:

|                           |               |
|---------------------------|---------------|
| Current Services          | \$169,074,000 |
| ● Federal Pay Costs       | \$7,964,000   |
| ● Tribal Pay Costs        | \$11,946,000  |
| ● Inflation (non-medical) | \$10,385,000  |
| ● Inflation (medical)     | \$70,068,000  |
| ● Population Growth       | \$68,711,000  |

|   |               |
|---|---------------|
| Binding Agreements                              | \$152,083,000 |
| ● New Staffing for New & Replacement Facilities | \$68,750,000* |
| ● Health Care Facilities Construction (Planned) | \$83,333,000  |
| ● Newly Recognized Tribe Funding                | \$ 0*         |

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

## BINDING AGREEMENTS — CONTRACT SUPPORT COSTS (ESTIMATE) +\$100 MILLION

The Work group has identified an estimated budget increase of \$100 million over the FY2016 enacted budget will be required as a program increase to address legally obligated Contract Support Cost (CSC) for new and expanded programs. The workgroup recognizes that this amount is subject to change based on the actual CSC obligation to be estimated based on the new CSC policy. This policy references CSC Budget Projections as follows: Each Area Director or his or her designee shall survey Tribes and Tribal organizations within that Area to develop accurate projections of CSC need at the end of the second and fourth quarter. This will include identification of the amounts required for any new and expanded projects as well as projections for the total ongoing CSC requirement for the following FY and estimates for the next two FYs. The information will be consolidated by the IHS Headquarters OFA and provided to Tribes and Tribal organizations as expeditiously as possible. The information will also be generated in the “Contract Support Costs Budget Projections (for the appropriate FY),” and submitted to the Director, Headquarters OFA, on or before September 30 of each FY and will be used by the IHS in conjunction with the Agency’s budget formulation process.

In FY 2016, Congress instituted an indefinite appropriation for Contract Support Costs, authorizing “such sums as may

be necessary” to be expended. The estimated \$28.532 million increase over the FY2017 President’s budget of \$800 million, is requested for reasonable costs for activities that Tribes/Tribal Organizations must carry out to support health programs and for which resources were not otherwise provided.<sup>8</sup>

The total FY2018 CSC request is estimated to be \$818 million. The Indian Self-Determination and Education Assistance Act requires that 100% of these costs be paid, and therefore this budget line is considered to be a legally mandated requirement. In FY2016, over 60 percent of the IHS budget was operated by tribes with authority provided by the Indian Self-Determination and Education Assistance Act, under which tribes may assume the administration of programs and functions previously carried out by the federal government. IHS transfers operational costs for administering health programs to tribes through the “Secretarial amount,” which is the amount IHS would otherwise have spent to administer the health programs. In addition, tribes are authorized to receive an amount for Contract Support Costs that meet the statutory definition and criteria.

The Tribes universally support the Administration’s proposal to reclassify Contract Support Costs as a mandatory, three-year appropriation with sufficient increases year over year to fully fund the estimated need for such costs.



<sup>8</sup> After the Tribal Budget Formulation Workgroup completed its national Budget Recommendations for IHS, the President’s Budget was submitted for Fiscal Year 2016, identifying CSC requirements for a three-year period, FY 2017-2019. In doing so, the IHS identified \$800 million as required to fund all CSC requirements in FY 2017. As this line item is identified as a Binding Agreement, and notwithstanding the estimated funding level by IHS, the appropriation should include such sums that are necessary to fully fund this contractual requirement, realizing that the exact amount will not be known until closer to the appropriated fiscal year.

## PROGRAM EXPANSION INCREASES – SERVICES BUDGET

### HOSPITALS & CLINICS +295.5 MILLION

The Workgroup recommends the FY 2019 Budget Program Increases outlined in this section, totaling a minimum \$295.5 million increase. These national priorities agreed to by Tribal leaders reflect a conservative approach to funding to advance a good faith effort to fulfil the Federal Trust Responsibility negotiated to provide health care. The Hospitals & Clinics (H&C) line item is the core budget line item which makes available appropriations to fund basic medical care services to AI/ANs.

Adequate funding for H&C is the top priority for FY 2019, as this budget line provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations and Tribal communities, predominantly in rural and frontier settings. IHS and Tribal managed facilities continue to grapple with chronic and inadequate funding. Increasing H&C funding critically supports the following; all primary medical care services, including inpatient care, routine ambulatory care, and medical support services, such as laboratory, pharmacy, medical

records, information technology, and other ancillary services and expenditures such as provider/staff housing. In addition, H&C funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, morbidity and mortality relating to maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis.

Tribes have supported the IHS requests for program increases in the H&C line item to address Health Information Technology (HIT), hepatitis C virus (HCV) treatment funds, the Domestic Violence Prevention Program, Quality Improvement, Tribal Clinic Leases, Operations & Maintenance and Tribal Epidemiology Centers. These efforts will require continued support in FY 2019.

The demands on the IHS H&C are continuously challenged. All facilities experience constant and increased demand for services due to the significant population growth, increase in users who

### INDIAN HEALTHCARE IMPROVEMENT FUND

The Indian health system faces significant funding disparities when compared to other Federal health care programs. This disparity continued to grow in 2016, with IHS per capita spending at just \$2,834 per person, while the national average per capita spending was \$9,990 per person. Additionally, the historic allocations of resources appropriated to the IHS have created significant disparities throughout the system as well. Over the years, allocation methodologies have created a disparity of available resources by line items when reflected in a per capita amount.

The IHCIA established the IHCIF to eliminate the deficiencies in health status and health resources and requires a report to Congress to address the current health status and resource deficiency for each IHS Service Unit, Indian Tribe, or Tribal organization. Despite the AI/AN health disparities and a legislative mechanism to address resource deficiencies, little to no funding has been used to expand services

necessary to bring health parity for AI/AN people. Unless funds are targeted to address funding disparities, they will not only continue to exist, but grow wider. We recommend that these funds be targeted to all locations below the national average for IHS funding, as well as locations above the average to be determined through Tribal Consultation.

The funding requested in FY 2019 could begin to reduce disparities for the most underfunded units and promote greater equity in health care funding. While youth trauma, suicide, and substance abuse treatment is a priority, so are elders with heart disease and dementia, children who need vaccinations or suffer a routine infection, as well as adults with type 2 diabetes or bipolar disorder. In short, quality health services remain a priority for all our citizens.

#### REQUEST:

A portion of any H&HC increase should be directed to the Indian Health Care Improvement Fund

- IHS establish a Tribal/Federal Workgroup to update, review and analyze the Indian Health Care Improvement Fund
  - Update existing data in the IHCIF analysis
  - Identify statistical/technical staff as point of contact for IHCIF data
  - In the course of its' work, the Workgroup could re-open the technical evaluation of the Indian Health Care Improvement Fund Methodology completed in 2010 and re-evaluate the recommendations received from Tribes at that time.
  - Then, through Tribal consultation, IHS can explore whether changes to the existing approach are necessary for better articulation of the IHCIF need in the future.

Such an increase and equitable distribution of the IHCIF will ensure greater access to high quality, culturally appropriate care and services across the I/T/U system.



had not come to for services before because they knew services were not available, and the increased rate of chronic diseases. All these factors increase demands on already overworked staff. Add rising medical inflation, difficulty in recruiting and retaining providers in rural and frontier health care settings, and the lack of adequate facilities and equipment, these resources are overwhelmingly stretched. As a result, any underfunding of H&C equates to limited health care access, especially for patients that are not eligible for or who do not meet the administrative policy criteria for referrals through Purchased/Referred Care that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the care provided directly at an IHS or Tribal administered facility. In a lot of cases, that means no access to care.

Tribes are determined to seek the commitment from IHS and the Secretary of HHS to provide resources, from whatever source, to provide meaningful improved health outcomes. This will be impossible to achieve if IHS continues to receive limited resources to address even just the basic primary and urgent care needs. Tribal communities clearly suffer from significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse. It is well known in the industry that preventative and primary care programs deter costly medical burdens. Yet, with funds primarily directed to cover fixed and inflationary costs, there is little left over to make significant, long-term progress toward improving the health of AI/ANs. This Administration can make a difference as well by targeting some of the funding increases to support infrastructure development and capacity building such as to support provider and staff housing, Health Information Technology, and long-term and elder care.

## HOUSING AND STAFFING

Recruitment of health professionals is greatly impeded by the lack of staff housing. The Indian Health service delivery areas are some of the most remote communities in the country. Many villages and Indian reservations lack basic services like sanitation and safe water with many being served from a central supply source. In addition, housing is crowded with many families living together in close quarters. The lack of availability of housing for incoming providers willing to work in these third world conditions makes a difficult recruitment situation even more challenging. Tribal efforts to train and hire local workforce are improving but housing will continue to be an issue.

IHS must work with the Administration and Congress on addressing the shortage of staff housing by identifying much

needed funds separate from the IHS Health Care Facilities Construction Priority System. The lack of adequate staff housing in rural areas is crippling efforts to recruit and retain trained and qualified personnel. Funding to maintain and replace the few existing houses has not been made available for the past 20 years.

## JOINT VENTURE CONSTRUCTION PROGRAM

Another proven effective means for improving infrastructure in tribal communities is the IHS Joint Venture Construction Program (JVCP). The JVCP is a partnered effort between Tribes and IHS, and has been a cost-effective mechanism to address the health care facilities shortage separate from the IHS Facilities Construction Priority System. Joint Venture projects leverage both tribal and IHS funding to ensure construction and staffing of safe and modernized facilities for American Indians and Alaska Natives. These partnerships allow IHS to provide funding for staffing, equipping, and operating the facility while the participating Tribe covers the costs of design and construction. When implemented, Joint Venture projects have been successful and vital to improving access to care and reducing health disparities throughout Indian Country. The Joint Venture projects coming to completion in FY 2017 are Muskogee (Creek) Nation Eufaula Indian Health Center, Oklahoma; Flandreau Health Center, South Dakota; and Choctaw Nation Regional Medical Center, Oklahoma. In addition to these Joint Venture projects, one other facility, the Northern California Youth Treatment Center, is scheduled to open in FY 2017. When these facilities are fully operational, they will serve an approximate user population of 13,000.

The JVCP program is a proven way to accelerate the construction of much needed facilities infrastructure and increase access to better quality care in communities with dire health care needs. Tribes advocate for IHS to announce a new cycle for JVCP applications. Not only is there a need for replacement and new clinics and hospitals, but Tribes also need resources to address urgently needed basic emergency medical services facilities and staffing in extreme remote locations as well. The Jicarilla Apache Nation provides an example of the opportunity sought to maximize the Federal/Tribal partnership JVCP:

The Jicarilla Apache Nation would like increases to the EMS program. The JAN is in developmental stages of establishing a new station to house EMS staff at the southern end of the reservation on NM Route 550, 70 miles from Dulce, NM. Funds are needed to increase staffing levels to provide more services in the remote area of the reservation, where a Tribal owned travel center and casino exist, Apache Nugget Travel Center. Additional staffing (7) would include qualified EMTs, Paramedics, and Administrative Assistants.

## HOSPITALS &amp; CLINICS +295.5 MILLION — CONTINUED

## HEALTH INFORMATION TECHNOLOGY

The wide scale adoption of appropriate health information technology will enable I/T/U providers to communicate with fewer errors to pharmacies, better coordinate care across settings, alert physicians and caregivers of preventive care options that would benefit the patient, and reduce duplicative testing results — among many other potential benefits. A basic EHR system would be expected to include: patient demographics, patient problem lists, medications, clinical notes, prescriptions, ability to view laboratory results, and the ability to view imaging results.

The biggest barrier to achieving this has been the lack of dedicated and sustainable funding for the IHS to adequately support health information technology infrastructure, including full deployment and support for EHRs. Resources, including workforce and training, have been inadequate to sustain clinical quality data and business applications necessary to provide safe quality health services to the 2.2 million American Indian and Alaska Native enrolled members of 567 federally recognized Tribes. The IHS/Tribal/Urban health delivery system represents some of the most remote locations in the United States and many reservations and villages are further isolated by lack of roads and public utilities. Over 60% of the IHS appropriated budget is administered by Tribes, primarily through self-determination contracts or self-governance compacts.

The information systems that support quality health care delivery are critical elements of the operational infrastructure of hospitals and clinics. The current IHS health information system is called the Resource and Patient Management System (RPMS), and is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most tribal facilities, from patient registration to billing. The IHS remains the only federal agency to have successfully certified its electronic health record (EHR) product according to criteria published by the Office of the National Coordinator for Health Information Technology (ONC).

The explosion of HIT capabilities in recent years, driven in large part by federal regulation, has caused the IHS health information system to outgrow the agency's capacity to maintain, support and enhance it. The IHS was fortunate to receive Recovery Act dollars and benefit from incentives available through the HITECH Act, and used these dollars to grow RPMS in response to the new regulatory requirements. However, those funds are no longer available, and no new funds have been appropriated to support operations and maintenance for the certified RPMS suite. This has resulted in a mass exodus of Self Governance Tribes who have opted to withdraw their IT shares to seek

other commercial HIT solutions which promise to more readily address their needs; and, in fact, this has caused a domino effect in that the IHS agency technology budget is decreasing more rapidly because of the withdrawal of these IT shares. For example, one large Tribe recently withdrew its shares, resulting in a -\$2.5 million impact (-3.7%) on the Headquarters IT budget. This is a harbinger of the vicious cycle that will result if the IHS cannot sustain the RPMS and related systems. Tribal programs, concluding that IHS solutions no longer support the best quality of care and patient safety, will be forced to adopt commercial solutions at considerable expense.

As a result of these grossly disparate levels of funding for all of IHS, and with competing priorities for limited resources to address mandates such as ICD-10 conversion and CMS Meaningful Use and more recent CMS requirements, the IHS has been forced to literally “kick the can down the road” on addressing its growing disparities in IT infrastructure, including software, to the point that we are literally at a crisis point. We must take action now in order to avert a major meltdown of our existing RPMS system which, if this occurs, will severely cripple our ability to deliver health care within the safety and quality standards enjoyed by the rest of America. If action is not taken immediately to address these issues, deferment will dramatically increase the cost of remediation by factors of ten-fold or more. IHS needs to make a strategic decision not on how it will address the antiquated RPMS system and implement a more modern operating platform. The current system is not consistently supported at local facilities and, when not deployed or used properly, it frustrates the delivery of quality patient care. IT improvements are needed to ensure patients and providers can look up IHS system information from any of the twelve areas where the patient might enter the health system. Specifically, funds are needed to enhance and expand the current IT system to allow for better care coordination. Additionally, secure industry experts are needed to assist IHS in vetting the current IT system in developing state of the art Patient, Provider secured portal sights for information exchange and access to normalize data for inclusion in the Information Data Collection System Data Mart and National Data Warehouse.

Tribes and Urban sites agreed with the Tribal Budget Workgroup that IT is very vital for quality healthcare. Adding a specific “budget line” item for IT, thus, breaking it away from the H&C line item, would greatly benefit the IT infrastructure.

## TELEHEALTH AND BROADBAND

Telehealth is a critical component of care in rural and frontier tribal communities and reservations. It reduces both the cost and stress of travel (for patients and their escorts) in medically

## HOSPITALS & CLINICS +295.5 MILLION — CONTINUED

underserved areas where many suffer low access to medical specialists.

- Several telehealth initiatives have been very successful in Indian country, but are hampered by both technical and organizational issues.
- Bandwidth at rural locations severely limits the ability to deliver telehealth services.
- The IHS has not been funded to support a national telehealth program that would offer both clinical and technical leadership, best practices and analytics.
- Additional funding of \$75 million per year is needed for a fully capable telehealth program.

The successful utilization of a variety of telehealth technologies and services in Indian country is well documented. However, these successes were achieved on a largely regional basis, driven by visionary leaders, with various and not reliably sustainable funding sources. The IHS has not yet been resourced to establish either a sustainable telehealth infrastructure or governance program that would prioritize resources in accordance with identified need, establish and promote best practices, and formally evaluate and report on successes and issues. The IHS recently awarded a large contract for tele-emergency and other specialty telehealth services in the Great Plains Area, but the costs for this have been imposed on already underfunded Service Units, and again without any program structure that will ensure success and apply lessons learned to future telehealth initiatives. While we applaud this necessary investment to address urgent quality of care issues brought through Congressional oversight, we must urge that equal investments be made in the rest of Indian country who suffer similar issues of poorly resourced facilities and lack of capacity to bring up standards of care to minimal level of safety, much less to meet national accreditation standards. It is the Tribes' understanding that the IHS estimates a fully operational enterprise telehealth program could be supported

at a cost of \$75 million annually. These would have to be new resources, as the agency has no capacity to transfer dollars from other programs to support telehealth. Operational costs would be augmented by third party revenues generated from telehealth encounters, but these revenues will not be sufficient to enable the telehealth program to exist without additional appropriations.

## LONG-TERM CARE AND ELDER CARE

Infrastructure development and capacity building investment are needed in order to address the growing need with regard to long-term care and elder care. A critical component to achieve the full potential of H&C is funding new authorities under the Indian Health Care Improvement Act (IHCIA). The provisions in this law represent a promise made by the federal government to significantly improve the health of our people, yet six years after the IHCIA was reauthorized, most of the new programs remain unfunded. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHCIA authorities. Tribes are especially interested in full funding of Section 124 — Other Authority for Provision of Services (25 U.S.C. § 1621d) as it would provide our elders hospice care, assisted living, long-term care, home-and community-based care and convenient care services. This funding is needed to keep elders in their communities close to their families and cultural practices and background. The funding will assist the tribal communities in time-honored responsibilities of taking care of their elders. Increases in Home Health Care will also extend the time a patient is able to remain in their home reducing the higher cost of institutionalized care.

## DENTAL SERVICES +67.2 MILLION

Oral health care access is one of the greatest health challenges Tribal communities face. Tribal communities are struggling under the weight of devastating oral health disparities. In the general U.S. population, there is one dentist for every 1,500

## SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI) REAUTHORIZATION AND EXPANSION

Few programs have proven to be as effective as the Special Diabetes Program for Indians (SDPI). Tribes are implementing evidence-based approaches that are attesting to the improvement of quality of

life, lowering treatment costs, and yielding better health outcomes for tribal members with type 2 diabetes. However, the disparities still exist. The progress made as a result of the SDPI is at risk due to shorter authorization periods, flat funding and more tribes needing access to SDPI funds, as reported in the Indian Health Service Special Diabetes Program for Indians 2011 Report to Congress. Current program authorization will expire on

September 30, 2017. Tribes support long-term or permanent authorization of the SDPI program and request for a minimum increase of \$50 million for a new total of \$200 million. Current programs should be held harmless from inflation erosion, and the additional funds will allow for tribes not currently funded to develop programs which has been highly effective in reducing the devastating impact that diabetes has in Tribal communities.

## DENTAL SERVICES +\$67.2 MILLION — CONTINUED

people, but in Indian Country, there is only one dentist for every 2,800 people. Nationally, American Indian children have the highest rate of tooth decay than any population group in the country. On the Pine Ridge Reservation, the W.K. Kellogg Foundation found 40% of children and 60% of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. Nationally, 59% of AI/AN adult dental patients have untreated decay, this is almost three times as much as U.S. Whites. It is not uncommon to hear stories of elderly patients waiting out in the cold for one of just a few dental appointments available in one day. Or, for patients to wait for months to get an appointment. Patients get frustrated with this system and often abandon the search for care altogether. This delayed or deferred care has long-term impacts over a patient's overall health and wellbeing. Research is finding that there are linkages between dental disease and other chronic conditions like diabetes, heart disease, dementia, and arthritis, all of which are significant diagnoses among the AI/AN population.

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

It is clear why the TBFWG has prioritized increased access to dental care year after year. Yet the state of oral health for American Indian and Alaska Natives has not been substantially improved. It is not an exaggeration to say that the current dental care delivery system is failing Tribal communities. Tribes as sovereign nations have been searching for innovative solutions to address the unique barriers that keep oral health care out of reach for many tribal members. Tribal communities have pioneered an important part of the solution. In Alaska, the use of Dental Therapists (DTs) over the last decade have filled a gap where dentists are not available. Dental therapists are primary oral health providers and work as part of the dental team with

a dentist to provide a limited scope of services to patients. DTs live and work in communities they serve providing routine care to patients so that the need for emergency services is minimized and patients are experiencing greater overall oral health outcomes. Alaska's DTs have expanded dental care to over 40,000 Alaska Natives and now, elementary schools in Alaska with relationships with DTs have started cavity free clubs.

Language in the 2010 IHCA amendments has been interpreted to limit expansion of DTs in the lower 48 without state legislation authorizing DTs as a provider. This limitation has not deterred Tribes from advocating for and pursuing opportunities to incorporate DTs into their programs. In 2015, several Tribes in Washington and Oregon announced that they will use DTs as part of their dental team. Two tribes and the Urban Indian Health Program in Oregon are working through a state pilot project program, their first student will return from training the summer of 2017 to offer services with more students in the pipeline for graduation in 2018 and 2019. The Swinomish Indian Tribal Community operates its own dental licensing board to license dental professionals at the Tribe, including a DT. Since introducing a DT to the dental team in January 2016, Swinomish dental clinic has increased their patient load by 20%, increased complex rehabilitative care by 50%, and the dental team is completing treatment plans more quickly and more often. In 2017, the state of Washington signed a bill into law authorizing DTs as a provider for the tribes in the state.

While these are remarkably positive steps for the Tribes in these states, all Tribes in Indian country should have access to DTs. The TBFWG continues to request that IHS use its dental services funds to expand DTs to tribes in the lower 48 within the existing law. In guidance issued by the agency in January 2014, IHS erroneously noted that any DT expansion in Tribal communities can only occur if a state legislature approves. However, as Swinomish has demonstrated, Tribes, as sovereign nations, do not need approval from the state to license and employ DTs. IHS should revise, update and re-issue guidance on the use of DTs in Tribal communities. The revised guidance should clarify that the limitation in IHCA applies only to the proposed national expansion of the Community Health Aide Program (CHAP), and does not otherwise prevent Tribal health care programs from providing DT and other dental midlevel services in their communities. With IHS's commitment to national expansion of the CHAP, revised guidance on DTs would be timely. In addition, IHS should issue a comprehensive report detailing the effects of DTs on clinics in Alaska, mature programs like SEARHC could serve as an important example of what dental programs with a whole suite of dental health aide providers could look like. Finally, IHS should commend tribes in Washington and Oregon



for being on the forefront of public health dentistry and being out in front of the State at the cutting edge of health policy.

## MENTAL HEALTH +\$122.6 MILLION

Tribal leaders report Mental Health as a significant priority for FY 2019 and recommend a \$122.6 million increase above the FY 2016 budget enacted. This increase would mean a 153% increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of Tribal communities to develop innovative and culturally appropriate prevention programs that are so greatly needed in tribal communities.

AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. However, tribal health continues to receive inadequate funding resources to address these issues. Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, suggesting that American Indians and Alaska Natives are not receiving the services they need to help reduce the disparate statistics.<sup>9</sup> Funds are needed to support infrastructure and capacity in tele-behavioral health, workforce development and training, recruitment and staffing, integrated and trauma-informed care, long-term and after-care programs, screening, and community education programs. Mental Health program funding supports community-based 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 currently focused on the integration of primary care and behavioral health services, suicide prevention, child and family protection programs, tele-behavioral health, and development and use of the RPMS Behavioral Health Management Information System.

Stabilization services are needed to address short and long term care that provides access to a multi-disciplinary team of nurses, psychiatrists, and other behavioral health providers 24/7

to ease pressures on emergency and urgent care services and to free equally and critically needed hospital space, which is often not necessarily the most appropriate environment for behavioral health patients. The goal is to stabilize patients before further treatment, assessment(s), evaluation(s), or referrals are completed. There is also another crucial need for protective transition center(s) for homeless women & children, and homeless men & children as they lose employment due to illness or otherwise. Adults and children fleeing their home due to domestic violence situations also need temporary shelter that offers safety, and counseling services that will assist and support them in stabilizing their crises. Once stabilized, they can be assessed for appropriate referrals that need to be completed to promote healing while empowering him or her to proactive life decisions.

Suicide continues to plague American Indians and Alaska Natives throughout Indian Country. Suicidality is often in combination with other behavioral and mental health issues including depression, feelings of hopelessness, history of trauma, substance abuse, domestic violence, sexual abuse and other negative social issues. Moreover, American Indian and Alaska Native people experience high rates of depression and psychological distress and higher suicide rates across the national average. Furthermore, one of the main risk factors known to contribute to such psychological distress and behavioral health concerns is historical trauma which continues to manifest through this population and specifically today's generations through intergenerational trauma.

Intergenerational effects of historical trauma on long-term health have been documented among American Indian and Alaska Native populations through adverse childhood events (ACEs) studies. These studies assess prevalence of personal experiences — physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect and family experiences — an alcoholic parent; a mother who has been a victim of domestic violence; a family member in jail; a family member with a mental illness; and the loss of a parent through divorce, death or abandonment. Higher scores are correlated with poorer long-term outcomes. As generations of families transmit the damage of trauma throughout the years it becomes a cumulative, collective exposure to traumatic events that not only affect the individual exposed, but continue to affect the following generations, thus compounding the trauma even further.

The Attorney General's Advisory Committee on AI/AN Children Exposed to Violence, comprised of experts in the area of AI/AN children exposed to violence recently released its report. It describes the foundation that must be put in place to treat

9 Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry*, 162, 1723-1732.

Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with first nations women in group counseling. *Canadian Journal of Counseling*, 34, 3-13.

## MENTAL HEALTH +\$122.6 MILLION — CONTINUED

and heal AI/AN children who have experienced trauma: “We must transform the broken systems that re-traumatize children into systems where Tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed.”

Another significant factor reinforcing these mental health concerns is economic. According to the American Community Survey the poverty rate among American Indian and Alaska Natives was 29.2% in 2013, compared with 15.9% for the nation as a whole. On many reservations, economic development is much lower than in surrounding cities. There are far fewer jobs, and unemployment is much higher in the reservation communities. On some reservations, unemployment is as high as 80 or 90%, leading to a sense of hopelessness and despair. The inability to provide for one’s family often leads to a sense of loss of identity, despair, depression, anxiety and ultimately substance abuse or other social ills such as domestic violence.

## TRANSITIONAL HOUSING

Transitional housing and protective transition centers displaced or homeless veterans returning home from active duty service, and/or individuals returning home after a long period of incarceration, will benefit from a transitional living environment, in assisting them readjust to their environment and surroundings. Such individuals may suffer from Traumatic Brain Injury and/or Post Traumatic Stress Disorder, and may need short or long term care with access to multi-disciplinary levels of care.

There is a need to enable the I/T/U programs to expand access to multiple programs for services and implement a comprehensive, coordinated network of care. Without a significant increase in funds for FY 2019, IHS and tribal programs will continue to experience difficulty with properly staffing outpatient community based mental health treatment facilities. Likewise, despite the need for mental health services throughout AI/AN communities, limited resources restrict the ability to hire qualified, culturally competent and licensed providers to relocate to rural areas. With behavioral health issues striking the crisis point in many Tribal communities, as evidenced by testimonials at local, regional and national meetings, the TBFWG has made behavioral health services a major budget priority for FY 2019.

This category summarizes the need for additional funds to support many programs that share the common goals of moving our People from crisis to healthy lifestyles and improving quality of life. This request identifies the need to improve programs’ ability to reduce health-related complications, prevent the onset

of unhealthy lifestyles, and educate our communities to deal with behavioral health issues.

ALCOHOL & SUBSTANCE ABUSE  
+\$114.8 MILLION

Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities and people continue to be afflicted with the epidemic of alcohol and other drug abuse. Tribal leaders agree that this topic remains a high priority for FY 2019. The Workgroup recommends a program increase of \$114.8 million above the FY 2016 budget enacted.

Alcohol and substance abuse has grave impacts that ripple across Tribal communities causing upheaval and adverse experiences that begin or perpetuate a cycle of abuse breaking the social fabric of our traditions and ties to one another. Stigmatization and lack of understanding of the disease of addiction make addressing the challenge even more difficult. The problems range from individual social and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide. Increasing resources to combat Alcohol and Substance Abuse is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities. The purpose of the Indian Health Service Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent.

Current alcohol and substance abuse treatment approaches (offered by both the IHS and Tribal facilities) employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, and inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming through the exploration and development of partnerships with stakeholder agencies and by establishing and supporting community alliances.

New approaches are also needed to reduce significant health disparities in motor vehicle death rates, suicide rates, rates of new

HIV diagnoses, binge drinking and tobacco use. There is also a need for funds to provide alternative treatment modes such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to the overused and abused medications along with development and support of regional treatment centers. At present, waiting lists are indicative of our treatment programs for alcohol, illegal and prescription drug use. When our programs are not able to receive patients when an addict is ready, this is where he or she falls through the cracks. We need these funds to increase the number of residential substance abuse treatment beds to increase access to care.

Adult and youth residential facilities and placement contracts with third party agencies are funded through the IHS budget for alcohol and substance abuse treatment. However, as a result of diminishing resources, placement and treatment options, decisions are often attributed more to funding availability than to clinical findings. Providing this treatment is costly to the community and program funding is not consistent or stable. While a number of Tribes have been successful in finding grants and other non-IHS resources to manage alcohol and substance abuse outpatient programs, the long-term sustainability of these programs are questionable. IHS is in a unique position to assist the Tribes plan, develop and implement a variety of culturally responsive treatment options to help individuals become sober and prevent from relapse. Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability several culturally responsive in-patient treatment centers have had to close their doors leaving a major gap in service availability and more specifically availability of detox beds with the rising number of heroin and opioid addictions. And, because grant funding is never guaranteed, vulnerable people and communities often slip through the cracks and fall back into drug habits when grant resources run out. The needed increase must be applied to IHS funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and care to our struggling tribal members and their families.

Breaking the cycle means that we must prevent and offer early intervention with our at-risk youth and expand the scope of treatment in Youth Regional Treatment Centers. Alcohol and Substance Abuse funds are needed to hire professionals and staff intermediate adolescent services such as group homes, sober housing, youth shelters and psychiatric units. Our communities need increased adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care.

The science is starting to catch up, but there is a need for a paradigm shift in thinking in order to break down the stigmas that are a barrier to addressing the disease of addiction. One tribal leader said it most plainly and simply, “Alcoholism, if left untreated, is a terminal disease.” In fact, if left untreated, addiction places considerable burden on the health system in unintentional injuries, chronic liver disease, cirrhosis, and facilitates the transmission of communicable diseases such as HIV and Hepatitis C, both having catastrophic effects on our health system.

Effects from historical trauma, poverty, lack of opportunity, and lack of patient resources compound this problem. AI/ANs have consistently higher rates relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues.

According to a study in 2009-2010 American Indian and Alaska Natives were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people. The study found that AI/ANs needed treatment at a rate of 17.5% compared to the national average of 9.3%. The Great Plains area has the highest alcohol-related death rate in the country. This death rate is 13.9 times the United States all-races rate and 1.3 times higher than the second highest rate, which is the Albuquerque area (Indian Health Service, 2001). According to SAMHSA (2007a), South Dakota, North Dakota, Nebraska, and Iowa had the highest rates of underage (aged 12 to 20) binge alcohol use (29.5%) and binge alcohol use among persons 18 to 25 years (58%). These states had the highest percentage of persons with dependence on or abuse of alcohol and needing treatment services. National data indicates that Alaska and New Mexico have the largest percentage of AI/AN treatment admissions for illicit drug use in the country.

Additionally, we now know that inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources, such as overloading the agency’s outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections). The increased number of patient visits to private sector emergency departments also puts an increased burden on Purchased/Referred Care Services.

## ALCOHOL &amp; SUBSTANCE ABUSE +\$114.5 MILLION — CONTINUED

Smoking and smokeless tobacco is often the first drug which individuals experiment; furthermore, research has demonstrated that it increases risk to using illegal drugs. Smoking rates are significantly higher among American Indian and Alaska Natives when compared to non-AI/AN populations. Moreover, cigarette smoking is linked to approximately 90% of all lung cancers in the U.S. and it is a leading cause of death among AI/AN people. Such chronic illnesses exacerbate individuals' mental well-being and overall health and wellness. Increased funding will support the need for prevention and education on this topic and particularly targeting youth while promoting non-tobacco using adults as role models for establishing social norms in Indian communities.

As noted in the FY 2017 report, domestic violence rates are alarming, with 39% of AI/AN women experiencing intimate partner violence - the highest rate in the U.S. The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle. This is apparent in the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relationship to children's cognitive development.

The National American Indian/Alaska Native Behavioral Health Strategic Plan provides a comprehensive approach to address

alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. IHS, Tribal, and Urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture based prevention and treatment.

PURCHASED/REFERRED CARE  
+\$278.6 MILLION

Purchased and Referred Care Services (PRC), is funded by the United States federal government to purchase care from private sector providers when services are not available through IHS. PRC funds are intended to supplement and complement other health care resources available to eligible AI/AN people. They are used in situations where: (1) no IHS direct care facility exists, (2) the direct care element is incapable of providing required emergency and/or specialty care, (3) the direct care element has an overflow of medical care workload, and (4) supplementation of alternate resources (i.e., Medicare, private insurance) is required to provide comprehensive care to eligible AI/AN people.

Challenges with the IHS PRC system have arisen because the IHS appropriation for PRC has not kept pace with the growing need among tribal populations for this service and the cost of care. The limited PRC funds are then generally reserved only for claims that are qualified as emergent in nature and may not be used for preventive, non-emergency specialty or chronic care services. The IHS in determining medical necessity uses the following priority schedule:

## MEDICAL PRIORITY DETERMINATION

Priority I – Emergent

Priority II – Preventative Care Services

Priority III – Primary and Secondary Care Services

Priority IV – Chronic Tertiary and Extended Care Services

Priority V – Excluded (Cosmetic and experimental)

With the continued and increasing shortage of providers and services directly available within IHS and tribal health facilities, the demand for Purchase/Referred Care continues to remain a critical priority for all Tribes. In addition to medical priority there are other restrictions on the use of PRC funds, including a specific authorization for each PRC provided, residence requirements for eligible Tribal members and verification that there are no other available resources, (private insurance, Medicare, Medicaid, etc.).

CATASTROPHIC HEALTH  
EMERGENCY FUND (CHEF)

**Request: Keep the CHEF threshold at \$19,000 and eliminate the requirement for annual inflationary increase.**

CHEF is a centrally managed fund at IHS that provides reimbursement to local IHS and Tribal Purchased and Referred Care (PRC) programs for catastrophic health care cases during the year. Such CHEF cases must exceed a designated cost threshold, which is currently required to be increased annually. The increasing CHEF threshold places an undue burden on small Purchased and Referred Care programs to provide the cash flow required to pay for these catastrophic medical cases up front, and wait for possible reimbursement later in the year. CHEF appropriations do not automatically increase for inflation each year, therefore, to annually inflate the threshold further decreases the purchasing power of local health programs. Very small programs have limited resources for PRC overall and would be required to deny critically needed medical care due to the requirement to fund catastrophic cases. Accordingly, it is recommended that the CHEF threshold be kept at \$19,000 and the requirement for annual inflationary increase be eliminated.



#### PURCHASED/REFERRED CARE +\$278.6 MILLION —CONTINUED

American Indian and Alaska Natives currently experience shorter length of life than their white counterparts experience, live in poverty, attain lower educational levels, and have historically relied upon the Indian Health Service for all health-care coverage. Poverty and extreme rural geography of most tribal nations play a large part in limited access to healthcare and health professionals for AI/ANs. These two factors are also combined with requirements by the IHS that medical claims are considered Priority I: Emergent before payment.

When claims are submitted and pass the “emergent” qualification, they must also receive specific authorization, the Tribal member must satisfy residency requirements, and it must be verified that no other payer resources are available to the patient. The IHS is meant to be the payer of last resort for AI/ANs and will reject claims if the individual has access for other types of coverage. The existing PRC process is extremely slow and prone to errors; often, a claim will be lost, delayed or denied, which often puts the burden for payment on the patient when other third-party payer sources are available but unidentified and not billed timely. The patient’s future access to private-sector healthcare services is decreased when paying for those visits becomes completely the patient’s responsibility, because the patient will likely not have the means to continually cover the cost of the visit. This then leads to a larger public health concern as fewer individuals in Tribal communities will be receiving the specialty and preventive care they need before a condition becomes emergent.

Tribal members face unique health disparities and challenges. The AI/AN population has specialized medical issues that are not standardized across all population groups, such as high rates of diabetes, cardiovascular disease, traumatic injury, and infant mortality/difficult pregnancies, making health screenings, preventative care and recommended follow-up appointments imperative. Furthermore, because of the high rates of poverty located in these regions, this population is at severe risk for health problems caused by poor nutrition, poor hygiene or lack of proper medical care, again illustrating the genuine need for preventative health care and referral care.

An increase to IHS PRC funds will allow more Tribal members to access private-sector care before the healthcare condition becomes an emergency, improving and increasing the overall health of the AI/AN population.

#### PUBLIC HEALTH NURSING +\$24.5 MILLION

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

#### HEALTH EDUCATION: +\$16.7 MILLION

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

#### COMMUNITY HEALTH REPRESENTATIVES (CHR): +\$29.5 MILLION

The CHR program helps to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained members of the Tribal community. CHRs integrate basic medical knowledge about health promotion and disease prevention with local community knowledge. They often play a key role in follow-up care and patient education in Native languages and assist health educators implement prevention initiatives. Their role is crucial in Indian country. They are considered an integral member of the health care team. With the opportunity provided under the IHCA, which expands the permissible uses of appropriated funds to include community-based care, additional resources are needed to increase CHR trainings and increase the CHR workforce.

## ALASKA IMMUNIZATION – LEVEL FUNDING

**Hepatitis B Program:** Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor hepatitis B infection, as well as hepatitis A and hepatitis C infections, throughout the state of Alaska. With respect to hepatitis C, after a dramatic increase (127%) in newly identified cases from FY14 to FY15, in FY16 we continue to maintain this high new case rate. In FY16, immunizations maintained high vaccine coverage rates; hepatitis A vaccination coverage was 89% and hepatitis B vaccination coverage was 94%.

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

## URBAN INDIAN HEALTH +\$20.2 MILLION

Thirty-four urban Indian health providers (UIHPs), which operate from 59 sites in 21 states, were established under law to fulfill the federal government’s trust responsibility for health care to AI/ANs who live off reservations and are therefore considered to be “urban Indians”. UIHPs, which are managed by executive directors who are answerable to boards of directors, provide state-of-the-art, culturally competent health care to more than 100,000 AI/ANs. Rather than use federal employees, UIHPs serve urban Indians with a combination of their own staffs and outside consultants.

Despite their broad mandate and critical responsibilities, UIHPs are underfunded on several important matters, including funding, reimbursements from Medicaid and the Department of

Veterans Affairs (DVA), and insurance. In bipartisan fashion, House Interior Appropriations Subcommittee Chairman Ken Calvert (R-CA) and Ranking Member Betty McCollum (D-MN) summed up the inequities faced by UIHPs in report language to their FY17 funding bill:

*“The Committee recognizes that seven out of ten American Indian/Alaska Natives live in urban centers, according to the latest census data. Many of these individuals are, or are descendants of, individuals encouraged by the Federal government to move to urban centers during the termination and relocation era of the 1950s and 1960s, and are thus entitled to receive vital culturally-appropriate health services from urban Indian organizations, just as they would have received health services from IHS-run and tribally-run facilities if they lived on or near a reservation. Unfortunately, urban Indian health organizations are struggling to recover their costs because they are not designated in relevant statutes as eligible providers on an equal par with IHS and Tribal Health Program facilities.”*

1. **Funding:** Although more than 70% of AI/ANs are considered to be urban Indians, according to the most recent census, only 1% of IHS’ budget is spent on urban Indian health care. In fact, the increase in funding for urban Indian health care from FY2012’s enacted amount of \$43,053,000 to FY16’s enacted amount of \$44,741,000 does not even keep up with health care inflation. Worse, UIHPs, unlike IHS and tribal providers, are unable to access Purchased/Referred Care funding or any other category of funding in IHS’ budget. Clearly, funding for urban Indian health must be significantly increased if the federal government is to finally more faithfully fulfill its trust responsibility. However, it is also imperative that such an increase not be paid for by diminishing funding for already hard-pressed IHS and Tribal providers.
2. **Reimbursement from Medicaid:** In recognition that the responsibility for AI/AN health care belongs to the federal government, not the states, the federal government pays 100% of the costs incurred by the states to reimburse IHS for the Medicaid services the agency provides to AI/ANs. This rate is known as the Federal Medical Assistance Percentage (FMAP). The FMAP rate is 100% for IHS and tribal providers, but not UIHPs.

A long-overdue extension of the 100% FMAP rate to UIHPs would result in a minimal cost and, as IHS reports, “*help both the State and the UIHP access more federal dollars to support health care. While these federal dollars would initially do nothing more than supplant existing state contributions for care, in the longer term, the increased FMAP could allow UIHP...to negotiate with the State for higher rates of payment. The higher rates of payment*

#### URBAN INDIAN HEALTH +\$20.2 MILLION — CONTINUED

*could support the expansion of UIHP service offerings and improve patient care.”*

3. Reimbursement from DVA: In 2010, IHS and DVA signed a memorandum of understanding (MoU) to promote inter-agency collaboration which “recognize(d) the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs.” This MoU was recently extended until 2019. Given that AI/AN serve in the military at higher rates than any other race, DVA and IHS should be commended for working together to better serve those AI/AN veterans who have sacrificed so much for us.

However, the MoU has been implemented for IHS and tribal providers, but not UIHPs. This omission must be addressed. AI/ANs, including veterans, often prefer to use Indian health care providers for reasons related to performance, cultural competency, or availability of non-health care-related services. Consequently, AI/AN veterans are more likely to receive adequate health care when they can determine how, when, and where they are served. DVA sometimes experiences surges in demand which understandably outstrip its ability to serve, and these surges can often be satisfactorily addressed through the use of UIHPs.

4. Insurance: The Federal Tort Claims Act (FTCA) allows federally-supported health care centers to secure medical malpractice liability protection with the federal government acting as their primary insurer at no cost. IHS and tribal providers are covered under the FTCA, but UIHPs are not. Consequently, UIHPs must divert precious dollars from health care to pay for expensive malpractice insurance. Given the financial constraints under which UIHPs must work, this inequity must be corrected.

#### INDIAN HEALTH PROFESSIONS +\$13.3 MILLION

The FY 2019 budget request for an additional \$13.3 million to fund Indian Health Professions would help the Indian Health Service with workforce development efforts — especially in the recruitment of newly trained qualified health professionals. Of this increase, \$778,000 is for inflation proofing. The additional

funding would provide a long-term solution to high vacancy rates in direct care positions all across the Indian Health Service. Safe, quality care cannot be provided if provider vacancies cannot be filled or if staff is not adequately trained. Tribes and the U.S. Department of Health & Human Services unanimously agree that much more needs to be done to address quality of care issues within the IHS.

The Indian Health Care Improvement Act (IHCIA) P.L. 94-437, as amended, authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) Program which manages the Scholarship Program, Loan Repayment Program (LRP), health professions training related grants, and recruitment and retention activities for IHS. The IHS made its first scholarship awards in 1978 when Congress appropriated funds for the program. The IHP programs work synergistically to recruit and retain health professionals to provide high quality primary care and clinical preventive services to AI/AN communities.

The IHP Scholarship program includes the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. It also includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for students enrolled in a federally recognized Tribes pursuing a health profession or allied health profession program. Students accepting funding for programs under the Scholarship and Loan Repayment Programs incur a service obligation and payback requirement.

#### THE INDIAN HEALTH PROFESSIONS PROGRAM HAS SEEN MUCH SUCCESS THROUGHOUT THE YEARS INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

- Enabling AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian Self Determination in the delivery of health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

## INDIAN HEALTH PROFESSIONS +\$13.3 MILLION — CONTINUED

The Loan Repayment Program (LRP) is an invaluable tool for recruiting and retaining healthcare professionals by offering health care professionals the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to \$20,000 per year in loan repayment funding and up to an additional \$5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid. Generally, individuals who come to IHS on the student loan repayment program stay with IHS for eight years, providing a much needed stable continuum of care for our people.

The IHP Extern Program is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. Students are employed up to 120 days annually, with most students working during the summer months. It is indisputable that adequate staffing levels and capabilities, as well as state of the art equipment, are essential for quality care. Emergency medicine physicians, nurses, and other highly trained staff are essential for crisis and disaster management and to improve patient outcomes.

Tribes continue to support efforts by the agency to engage in creative recruitment and retention practices for physicians and dentists, including allowing scholarships to be tax-exempt from income, shortening hiring times for medical professionals, and allowing fulfillment of service obligations through half-time clinical practice. Like most rural health providers, IHS has difficulty recruiting and retaining medical staff at many of its sites. As a result, patients experience very long wait times, and serious illness is often left untreated. Alternative solutions include: increasing funding to build staff housing on reservations and Alaskan Native villages, creating specialized residency programs within IHS to attract a service provider corps with more diversified professional expertise, allowing active military-service providers to fulfil their service obligations at an I/T/U health facility, and increasing professional development opportunities for existing staff. This, and more, needs to be done to effectively improve recruitment and retention of medical and health professionals at the Indian Health Service.

Overall, physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties. IHS is at a disadvantage to compete successfully with physician and dentist private sector salaries. Some IHS Areas experience vacancies for medical professionals up to five years. In the

long-term, this means that clinics close, thereby denying care to AI/ANs. With a nation-wide physician shortage, this problem is growing. The I/T/U system has seen a sharp rise in its reliance of itinerant providers to provide coverage. Use of itinerant providers can double, or even triple the cost outlay for providers as they usually demand a higher salary and rotate in and out on a monthly basis, costing more to cover temporary relocation expenses. While this is an adequate short-term solution for urgent coverage, the long-term impact on the quality of care and patient continuity of care affecting successful health outcomes is undeniable. Because IHS focuses on primary and community based care, the need to recruit *and retain* professional providers is key to successful disease prevention and treatment for AI/ANs. It is vital that the Administration work with Congress to be able to offer competitive pay rates and better working environments to ensure that providers are seeking out the IHS as a desirable place to work.

## TRIBAL MANAGEMENT GRANTS – LEVEL FUNDING

The purpose of the Tribal Management Grant (TMG) Program is to assist federally recognized Tribes and Tribal organizations in assuming all or part of existing IHS programs, services, functions, and activities (PSFAs) under self-determination and operate these programs at the Tribal level. There has been a resurgence of interest in Tribes and Tribal consortia in exploring their option to exercise self-determination rights to assume management of health PSFAs, in part due to the ability to now recover Contract Support Costs. TMG also assists established self-determination contractors and self-governance compactors to further develop and improve their management capability and conduct health program planning.

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



#### TRIBAL MANAGEMENT GRANTS - LEVEL FUNDING — CONTINUED

under the Self-Determination and Education Assistance Act. All federally-recognized Tribes and Tribal organizations are eligible to apply for Tribal Management Grants. Priority is given to newly recognized Tribes and Tribes and Tribal organizations addressing material audit weaknesses.

### DIRECT OPERATIONS +\$2.2 MILLION

The Direct Operations budget supports the IHS Headquarters and 12 Area Offices. The IHS's mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. The agency is responsible for a comprehensive health service delivery system for approximately 2.2 million AI/ANs from 567 federally recognized Tribes in 35 states. The IHS system consists of 12 Area offices, which are further divided into 170 Service Units that provide care at the local level. Health services are provided directly by the IHS, through Tribally contracted and operated health programs, through services purchased from private providers, and through urban Indian health programs. IHS Headquarters, in partnership and consultation with Tribes, provides overall direction and leadership for the entire I/T/U system.

In FY2017, IHS headquarters unveiled a new organizational chart which realigned Headquarters function and also rolled out the final 2016-17 Quality Framework and Implementation Plan. The new organization and plan supports the goal to provide high quality patient-centered, timely, effective, safe, and reliable health care. The Quality Framework describes the vision, goals, and priorities to develop, implement, and sustain an effective quality program that improves patient experience and outcomes, strengthens organizational capacity, and ensures the delivery of reliable, high quality health care for IHS Direct Service facilities. The IHS is also committed to sharing best practices, models, and policies with Tribes and Urban Indian programs and strengthening partnerships with Tribes, local communities, and regional health care systems. Tribes understand the need for management support for agency-wide goals which address quality of care issues.

### SELF-GOVERNANCE +\$4,000

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

new authorities in the IHCIA, Self-Governance Planning and Negotiation Cooperative Agreements, and funding to support the activities of the Tribal Self-Governance Advisory Committee, which advises the IHS Director on Self-Governance policy issues. With Tribes and Tribal consortia becoming more interested in understanding P. L. 93-638 and the detailed process involved if they are to exercise their option to assume management of health PSFAs, there has been a need to increase OTSG staffing to provide Self Governance 101 and advanced training nationwide.

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements to assist Tribes in planning and negotiation activities associated with Self-Governance. Cooperative Agreement awards involve much more substantive Federal program-specific involvement than a grant, which is key to a successful Self-Governance planning and negotiation process. For those Tribes wanting to advance their efforts to enter into Planning and Negotiation Cooperative Agreements, more staff are required to respond to technical assistance requests.

These Cooperative Agreements provide resources to Tribes first entering self-governance as well as existing Self-Governance Tribes interested in expanding their current PSFAs. Title V of the ISDEAA requires that a Tribe or Tribal Organization complete a planning phase to the satisfaction of the Tribe. The planning phase must include legal and budgetary research and internal Tribal government planning and organization preparation relating to the administration of health care programs. The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes will be necessary to support those PSFAs. These Cooperative Agreements also provide resources to Tribes to help defray the costs related to preparing for and conducting Self-Governance negotiations. This enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs and assist the Tribe during the negotiation of a self-governance compact and funding agreement. Self-Governance formalizes and recognizes the government-to-government relationship between the United States and each Tribe, and empowers Tribes to plan, design and carry out programs and activities that are most responsive to the health care needs of their communities. Also, additional staff time is required to participate in contract and compact negotiations for an increased number of Self Governance Tribes and Tribal consortia.

## FACILITIES

The Indian Health Service system is comprised of 45 hospitals (26 IHS operated, 19 Tribal) and 612 outpatient facilities (83 IHS operated, 529 Tribal). At these facilities in 2016, there were an estimated 39,300 inpatient admission as 13.7 million outpatient visits.

|               | HOSPITALS | HEALTH CENTERS | ALASKA VILLAGE CLINICS | HEALTH STATIONS |
|---------------|-----------|----------------|------------------------|-----------------|
| <b>IHS</b>    | 26        | 51             | N/A                    | 32              |
| <b>Tribal</b> | 19        | 287            | 163                    | 79              |

On average, IHS hospitals are 40 years of age, which is almost four times as old as other U.S. hospitals with an average age of 10.6 years.<sup>10</sup> A 40-year-old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized — about 52% — for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic and outdated design which makes it difficult for the agency to deliver modern services.<sup>11</sup>

Improving healthcare facilities is essential for:

- Eliminating health disparities
- Increasing Access
- Improving patient outcomes
- Reducing operating and maintenance costs
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates
- Improving staff and operational efficiency
- Increasing patient and staff safety

The absence of adequate facilities frequently results in either treatment not being sought; or sought later, prompted by worsening symptoms; and/or referral of patients to outside communities. This significantly increases the cost of patient care and causes travel hardships for many patients and their families. The amount of aging facilities escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. AI/AN populations have substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited outdated facilities as direct threats to patient care. For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance” with the Medicare Hospital Conditions of Participation (CoPs).<sup>12</sup> “Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in backlogs totaling approximately \$166 million.”<sup>13</sup> In fact, over one third of all IHS hospitals” deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.<sup>14</sup>

For many AI/AN communities, these failing facilities are the only option that patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere.

<sup>10</sup> Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals (2015 ed., pp. 176-179); <https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/>

<sup>11</sup> The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress. Indian Health Service. July 6, 2016. Accessed at [https://www.ihs.gov/newsroom/includes/themes/newihstheme/display\\_objects/documents/RepCong\\_2016/IHSRTC\\_on\\_FacilitiesNeedsAssessmentReport.pdf](https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf) on November 7, 2016. p. 12

<sup>12</sup> Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011.

<sup>13</sup> Ibid, p. 14.

<sup>14</sup> Ibid, 15.

## MAINTENANCE & IMPROVEMENT +\$30.7 MILLION

The recommended program increase for Maintenance and improvement (M&I) is \$30.7 million over the FY 2016 enacted budget. This amount builds upon the prior President's FY 2017 Request. M&I funding is the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through Tribal contracts and compacts. These funds directly support healthcare delivery and are required to achieve and maintain accreditation standards as well as ensure that the facilities meet building codes and standards. The FY2016 Maintenance and Improvement (M&I) enacted funding level is \$73.6 million which for the first time since 2010 provided sufficient funding for some of the major repair projects. Tribes were appreciative of this funding to help sustain existing facilities and urge that these levels be maintained as it is needed to address the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). This is an IHS required report on the current backlog which now totals approximately \$500 million.

## SANITATION FACILITIES CONSTRUCTION +\$44.8 MILLION

In FY 2019, the Workgroup recommends an increase of \$44.8 million for Sanitation Facilities Construction. Since 1959, IHS has used Sanitation Facilities Construction to as an “integral component of IHS disease prevention activities” which has decreased mortality rates from environmentally related diseases by 80% since 1973.<sup>15</sup> “However, as of the end of FY 2015 about 24,200, or 6 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 188,228 or approximately 47 percent of AI/AN homes were in need of some form of sanitation facilities improvements.”<sup>16</sup>

Currently, IHS estimates the backlog for sanitation facilities at \$2.5 billion. IHS maintains a priority system for construction projects known as the Sanitation Deficiency System (SDS). Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. This increase will enable more projects to be funded off of this list, thereby improving health for AI/ANs.

## HEALTHCARE FACILITIES CONSTRUCTION +\$59.3 MILLION

The National Budget Formulation Workgroup recommends a program increase of \$59.3 million over the FY 2016 enacted budget for *Other Authorities* within the HCFC line item. At current rates of funding, a new facility built today would not be replaced for another 400 years!<sup>17</sup>

Currently, IHS uses its Health Care Facility Construction (HCFC) appropriations to fund projects off the “grandfathered” HCFC priority list until it is fully funded. This priority system was developed in the late 1980s at the direction of Congress. The original priority list was developed in the early 1990s with 27 projects on the list. There are 13 remaining projects on this “grandfathered” list which is currently estimated to cost \$2.1 billion. Once those 13 projects are funded, the remaining \$8 billion can be funded with a revised priority system that will periodically generate updated lists.

The appropriations provided to Congress are the primary source for new or replacement healthcare facilities. Because of the shortage of appropriations, IHS funds multiple projects over several fiscal years which allows projects to move forward simultaneously and helps distribute the funds geographically benefiting more than one service area. Importantly, IHS development process ensures that the newly designed facilities are culturally appropriate, and are done in consultation with the Tribes they serve.

The lack of modern facilities is a major barrier to accessing quality health care in Indian Country. The Indian Health Care Improvement Act now provides other avenues to address the insufficient space for health care delivery that is plaguing numerous Indian Tribes across the nation. In certain cases, Joint Venture Construction projects in which a Tribe designs and builds the facility and IHS requests funds from Congress to staff, equip and operate it or in the case of the Small Ambulatory Program, Tribes with small populations would benefit or modular construction for interim needs could be provided.

## FACILITIES APPROPRIATIONS ADVISORY BOARD (FAAB) ADVISEMENT

Tribal leaders participate on the IHS Facilities Appropriations Advisory Board (FAAB) to study the policies, procedures, and funding recommendations related to facilities issues. This assures that the methodologies utilized to determine the requested

<sup>15</sup> IHS FY 2017 Congressional Budget Justification, CJ 168.

<sup>16</sup> Ibid, CJ 169.

<sup>17</sup> “Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare — The National Tribal Budget Formulation Workgroup’s Recommendations on the Indian Health Service Fiscal Year 2018 Budget.” June 2016. P. 64.

## HEALTHCARE FACILITIES CONSTRUCTION +\$59.3 MILLION — CONTINUED

funds are accurate for needed infrastructure improvement in Indian country. The FAAB transmitted advisement to the National Budget Formulation Workgroup on February 14, 2017 and included a Facilities Appropriations Information Package so that Tribal Leaders representing all 12 IHS Areas would have up to date information on all of the programs funded through IHS Facilities Appropriations — Maintenance and Improvement, Sanitation Facilities Construction, Health Care Facilities Construction, Facilities and Environmental Health Support and Equipment. (See Appendix A)

In summary the FAAB specified the following in terms of Health Care Facilities Construction (HCFC):

- There is a need of over \$15 billion for (18,000,000 ft<sup>2</sup>) IHS/Tribal Health Care Facilities Construction.<sup>18</sup>
- IHS/Tribal facilities only have about ½ of the facility space needed to provide the AI/AN service population healthcare.<sup>19</sup>
- The current rate of HCFC appropriations (~\$85 million/annually) is insufficient to cover the annual growth in HCFC need.<sup>20</sup>
- Just to replace existing IHS facilities every 60 years (twice a 30 year design life), would require ~\$500 million/annually.<sup>21</sup>
- HCFC appropriations of ~\$1 billion/annually would provide 95% of the needed facility space by 2040.<sup>22</sup>

## FACILITIES &amp; ENVIRONMENT SUPPORT +\$13 MILLION

The BFWG requests an additional \$13 million for the Facilities and Environmental Health Support (FEHS) budget line item. The FEHS provides resources to staff and support its headquarters, regional, area, district, and service unit activities. These activities include Facilities Support, Environmental Support and Office of Environmental Health & Engineering (OEHE) Support. Facilities support include operations and management staff for facilities and staff quarter and construction management support. Environmental Health Support provides staff and

operating costs for environmental health service, injury prevention, institutional environmental health and sanitation facilities construction staffing. OEHE support includes IHS headquarters staff, engineering services staff and direct support and management of overall facilities appropriation services and activities.

The IHS delivers a comprehensive, national and community-based and evidence-based Environmental Health program which has 5 focus areas: Children's environment, Safe drinking water, Vector-borne and communicable disease, Food safety, and Healthy home. They work hard to identify environmental health hazards and risk factor in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, tribal, and community members.

## EQUIPMENT +\$32.4 MILLION

The Tribal request for a program increase of \$32.4 million for Equipment represents the minimal amount necessary to address critical medical equipment needs at health facilities managed by the IHS and Tribes. This fund supports necessary equipment replacement for the 90,000 devices worth \$500 million at all health facilities. Renewal is necessary to replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment to enhance speed and accuracy of diagnosis and treatment. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on healthcare providers using modern and effective medical equipment/systems to assure the best possible health outcomes.

To replace the Equipment on a 6 year cycle would require approximately \$80 million annually for this budget line alone. This fund also support transfer of excess Department of Defense medical equipment (TRANSAM) TO IHS/Tribal programs, replaces ambulances, and provides equipment funding for Tribal facilities constructed with non-funding. IHS replaces four to six over-aged/over-mileage ambulances per year.

<sup>18</sup> HHS, IHS. The 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress. Accessed February 10, 2017 at <https://www.ihs.gov/newroom/reporttocongress>

<sup>19</sup> *ibid*

<sup>20</sup> *ibid*

<sup>21</sup> DHHS, IHS, OEHE, DES Architect/Engineer Guide. 2016 Page 36 #8

<sup>22</sup> HHS, IHS The 2016 IHS and Tribal Healthcare Facilities' Needs Assessment to Congress. Accessed February 10, 2017 at <https://www.ihs.gov/newsroom/reportstocongress/>



## 3RD RECOMMENDATION

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*Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficiency of federal dollars at the local level.*

Budget Authority for Indian Health Service to move dollars from one line item to another as needed to fulfill needs.

Current appropriations law often creates a barrier for the IHS to fully utilize authorized annual funding. The IHS is granted only one-year authority to obligate/re-obligate funding, and

if savings are achieved in one fund, IHS is limited in its ability to reprogram funding to meet other critical health needs, such as for Purchased and Referred Care that may be denied. It is requested that IHS be granted greater budget flexibility to reprogram funding to meet health service delivery priorities, in consultation with Tribes.





# 4TH RECOMMENDATION

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## *Support the Preservation of the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable care Act (P.L. 111-148)*

The Indian Health Care Improvement Act (IHCIA) was enacted in 2010 as part of the Patient Protection and Affordable Care Act (ACA), though it is unrelated to the underlying healthcare reform legislation. It was tacked onto to the end of the law at Section 10221. It serves as the backbone legislation for the Indian Health Service (IHS)/Tribal/ and Urban Indian health system which provides healthcare services for American Indians and Alaska Natives (AI/ANs) in fulfillment of the federal government's trust responsibility for health that is derived from statutes, treaties, and Executive Orders. Provisions included in the IHCIA were a result of years of negotiations, meetings and strategy sessions. Tribes worked collaboratively with Congress to develop a final product that included impactful and bipartisan reforms.

Tribes fought for over a decade to see this legislation move, and when ACA was moving through Congress in 2010, it was thought that this would be a good vehicle to get it enacted, not because it was related to healthcare reform. The specific IHCIA authorizations and provisions represented an entirely discrete legislative effort that just so happened to culminate in the same public law.

The IHCIA provides a wealth of new resources and opportunities for Tribal health care institutions, families, providers and

patients. With the permanent reauthorization of the IHCIA, the Indian health care system has begun a new chapter in the delivery of quality health care to AI/ANs. In addition, there are Indian-specific provisions in the ACA other than the IHCIA that provide important protections and funding opportunities for the I/T/U system.

- **Section 2901** which states that any I/T/U should remain the payer of last resort the payer of last resort for services provided by such notwithstanding any Federal, State, or local law to the contrary.
- **Section 2902** which grants I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.
- **Section 9021** ensures that any health benefits provided by a Tribe to its members are not included as taxable income.

We urge the Administration to insist that IHCIA and other related ACA provisions should be preserved in any health repeal legislation to avoid putting the Indian health system into immediate jeopardy and erasing important gains for the health of AI/ANs.

### MEDICAID REFORM AND INDIAN COUNTRY

Over 40 years ago, Congress permanently authorized the IHS and tribal facilities to bill Medicaid for services provided to Medicaid-eligible American Indians and Alaska Natives to supplement inadequate IHS funding. The House Report stated: "These Medicaid payments are viewed as a much needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."

At the same time, Congress ensured that States would not have to bear any associated costs by reimbursing them at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and tribal facilities. As Congress and the Administration consider Medicaid reform, it is critical that AI/ANs are protected by ensuring that the federal government continues to fully fund Medicaid for Tribes. This ensures that much needed 3rd Party Revenue can reach IHS and Tribally operated health facilities, and guarantees access to healthcare for many AI/ANs.

Similarly, AI/ANs are afforded several critical protections that must be preserved including the right to continue to see the IHS or Tribal healthcare provider of their choice; an exemption from income for eligibility determinations of treaty and trust-related income; the right of Indian healthcare providers to be promptly paid by managed care entities at the network rate or the rate set out in the State plan; and the right of Indian healthcare providers to be paid a wraparound payment by the State in the event the managed care entities do not pay them the full amount under the State plan.



## 5TH RECOMMENDATION

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### *Provide dedicated funding to begin implementing provisions of the Indian Health Care Improvement Act*

The Indian Health Care Improvement Act was permanently reauthorized as part of the ACA in 2010. This historic law has opened up many new opportunities for the Indian health system, but not all provisions have been equally implemented — representing yet another broken promise to Indian Country. With the passage of the Patient Protection and ACA, the American health care delivery system has been revolutionized while the Indian healthcare system still waits for the full implementation of the IHCIA. For example, mainstream American healthcare increased its focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and is now a standard of practice. Replicating these same improvements for Tribes in the IHCIA was a critical aspect of the reauthorization effort. Tribes fought for over a decade to renew IHCIA and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized.

To provide context for how much of the law has not been implemented, the follow represent several categories of programs that have not been implemented and funded:

1. **Health and Manpower** – 67% of provisions not yet fully implemented.  
*Includes:* establishment of national Community Health Aide Program; demonstration programs for chronic health professions shortages
2. **Health Services** – 47% of provisions not yet fully implemented  
*Includes:* authorization of dialysis programs; authorization hospice care, long term care, and home /community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment an office of men's health.
3. **Health Facilities** – 43% of provisions not yet fully implemented  
*Includes:* demonstration program with at least 3 mobile

health station projects; demonstration projects to test new models/ means of health care delivery

4. **Access to Health Services** – 11% of provisions not yet fully implemented  
*Includes:* Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs
5. **Urban Indians** – 67% of provisions not yet fully implemented  
*Includes:* funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health
6. **Behavioral Health** – 57% of provisions not yet fully implemented  
Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants to for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides
7. **Miscellaneous** – 9% of provisions not yet fully implemented  
*Includes:* Provision that North and South Dakota shall be designed as a contract health service delivery area

Clearly, a plan must be put in place to ensure that the intended benefits of this law are actually realized. It is critical that additional funds be allocated so the full implementation of these programs can continue without compromising other critically needed services. We urge the Administration to add funds to the FY 2019 Budget Request so that the dream of the IHCIA can finally become a reality.



## 6TH RECOMMENDATION

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### *Advocate that Tribes and Tribal Programs be Permanently Exempt from Sequestration*

In FY 2013, Indian health programs were subject to a 5.1 % automatic, across the board cut. This means a staggering \$220 million left the IHS, which already is under funded by an average of 41%. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS direct service programs were left with an impossible choice – either deny services or subsidize the federal trust responsibility. In fact, many did close their doors for several days per month and forced others to deliver only PRC for Priority I. The Indian Health Service is one of only four federally funded services providing direct patient care; however, it was the only one of the four not exempted from sequestration. This oversight, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected.

For fiscal years 2014-2016, Congress has found a way out of sequestration for discretionary programs. However, the Budget

Control Act (BCA) (P.L. 112-25), has mandated sequestration each year through FY 2021. Indian health simply cannot take any more sequestration cuts. Section 256 of the BCA explicitly holds IHS to 2% for any year other than FY 2013. However, with an already underfunded rate of 50% for the IHS, even a 2% cut is too much. Tribes should not be held responsible for the inability of the federal government to balance its books.

Should sequestration occur in future years, the Workgroup encourages the Administration to work with Congress to ensure that Tribes do not find themselves in this situation again, and the FY 2019 budget should reflect that commitment by permanently exempting the IHS from sequestration.





## 7TH RECOMMENDATION

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### *Support Advance Appropriations for the Indian Health Service*

With the ongoing polarization in Congress, passage of a timely budget has become increasingly difficult and Continuing Resolutions (CRs) have become the appropriators' solution of choice in an effort to avoid a government shutdown. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. The lateness in enacting a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011).

The negative consequences for the Indian Health Service and Tribes have been substantial. Under CRs, annual funding levels are uncertain and timing of payments are unknown. Health Services must be limited to the funding in hand, new grant awards are put on hold, and provider recruitment grinds to a halt. In short, funding delays for health services can be measured in lives lost. Tribal health programs cannot enter into contracts with outside vendors and suppliers. In some cases, Tribal health programs are forced to take out private loans to cover the costs of expenses between the start of the fiscal year and the time when Congress passes a full budget. All these inefficiencies take away funds an already starved health system. Advanced appropriations can help mitigate such catastrophic effects. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts.

Advanced appropriation identifies the level of funding available for the IHS in the appropriations process one or more years before it is applicable. Thus, advanced appropriation provides more certainty to operate the Indian health care delivery system. This change in the appropriations schedule will allow Indian Health programs to effectively and efficiently manage budgets, coordinate care, enter into contracts, and improve health quality outcomes for AI/ANs. Advanced appropriations for IHS would support the ongoing treatment of patients without the worry if — or when — the necessary funds would be available. Health care services require consistent funding to be effective. Advanced appropriations will help the federal government meet its trust obligations to Indian Country and bring parity to this federal health care system at no additional cost.

As in past years, the TBFWG continues to request that the Administration support Advance Appropriations for IHS in its FY 2019 Budget Request.



# CONCLUSION

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The Indian Health Service budget represents a sacred promise made to our ancestors to provide healthcare services to all American Indians and Alaska Natives. Although the federal government has repeatedly reinforced this trust responsibility through laws, executive orders, and national policy, progress on fulfilling this obligation has been negligible due primarily to a chronic lack of appropriations. It is a promise that has yet to be fully upheld by the United States. This is clearly evidenced by huge budget gap year after year, where appropriations of \$5 billion don't even come close to funding the total need for expanded services and investment in infrastructure tagged at \$32 billion. This undeniable negligence has resulted in the unnecessary deaths and early on-set of debilitating chronic diseases for our people. Health disparities for our people are among the worst in the country. Access to safe, quality health care is challenging at best, and non-existent in some of our most remote communities. Third world conditions exist in many villages and on reservations due to lack of basic infrastructure including facilities, equipment, IT networks, housing, and safe water and sanitation. Many of our communities are without a comprehensive and culturally competent health professions workforce capable of meeting existing and future health care challenges.

The last several decades have represented a historic new era between the Tribes and the United States. Bipartisan support in Congress and the Administration has allowed the IHS budget some growth from its severely under-resourced starting base. Engagement in meaningful Tribal consultation during this Administration has resulted in officials becoming more attuned to the needs of Tribal communities, and this has been reflected in budget requests to Congress. It is critical that we build on this to strengthen the government-to-government relationship during the years to come with our partners in this new Administration and Congress.

The quest for better healthcare is not over. Together as Tribes, and as our federal trustee, we must rally to ensure that the treaties our ancestors signed are honored. The rights we have as indigenous peoples cannot be forgotten amidst the complicated

budget environment of Washington. Though the IHS falls in the discretionary budget, our treaties are not discretionary, and we urge this administration to build upon the necessary gains we have built together, and go further.

IHS is not just another federal program, it is not welfare. It is our treaty right. The FY 2019 Budget is not just another policy proposal, but is a moral document, laying the foundation for the next Administration to take the bold step to outline a pattern for generations of American Indians and Alaska Natives to come.

The above budget proposal encourages the Administration to make a bold investment in IHS so that we can begin to move towards full funding of the IHS and the health of our people will finally be closer to that enjoyed by other Americans. We hope that our new leaders use this opportunity to make lasting reforms to improve quality at IHS so that those receiving their care at federally-operated facilities are no longer put at risk. The time to act has long past, and with new leadership vowing to change "business as usual" it is the hope of the Tribes that these lasting impacts will be made.

We also reiterate our support for maintaining IHCA and other Tribal specific provisions in the Affordable Care Act. As Congress and this new Administration reform entitlements such as Medicaid it is also critically important that AI/ANs are protected by requiring collaboration and consent of Tribes when states make changes to the Medicaid program. The federal trust responsibility for health is not limited to IHS but is with the whole federal government.

We call upon our new HHS Secretary and President to engage in a renewed partnership with Tribes such that our treaties are fully honored and that the First Americans are no longer the last Americans when it comes to healthcare access. The first step in fulfilling this promise is the development of a strong budget request for IHS.

# ACKNOWLEDGEMENTS

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# APPENDIX A

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## *Hot Issues by IHS Service Area*

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### ALASKA

#### 1. FULLY FUND VILLAGE BUILT CLINIC LEASES – BINDING OBLIGATION

The Village Built Clinics (VBCs) are essential for maintaining the Indian Health Service (IHS) Community Health Aide Program (CHAP) in Alaska, which provides the only local source of health care in rural, and in many cases frontier, areas. The CHAP program is mandated by Congress as the instrument for providing basic health services in remote Alaska Native villages. The CHAP program cannot operate without the use of safe, well-equipped clinic facilities. The IHS has for many years consistently severely under-funded the leases of VBCs by as much as 90%. In addition, lease rental amounts for the VBCs have failed to keep pace with costs. The IHS has instead shifted its statutory responsibilities onto economically-poor villages and already underfunded Tribal Health Organizations (THOs). Failure to fully fund leases has resulted in temporary and permanent closure of some of these critical clinics that provide first (and often the only local) response, wellness and prevention activities, and varied services dependent on the scope and capacity of the individual facility.

Village Built Clinic leases are a Binding Obligation, congressionally mandated, and should be fully funded as per the 2015 Village Clinics in Crisis Report. IHS should request the fully funded amount in the Hospitals & Health Clinics line item in addition to other IHS Binding Obligations.

#### 2. JOINT VENTURE CONSTRUCTION PROGRAM

The IHS Joint Venture Construction Program, a partnered effort between Tribes and IHS, has been a cost-effective mechanism to address the health care facilities shortage separate from the IHS

Facilities Construction Priority System. The JVCP program has increased access to care in communities with dire health care needs. Alaska Tribes advocate for IHS to announce a new cycle for JVCP applications. Alaska Tribes are ready to step up and partner with IHS in order to increase access to health care in our remote communities.

#### 3. SMALL AMBULATORY GRANTS PROGRAM (SAP)

In many of the rural communities in Alaska and indeed in many rural America communities, the only access to health care is the Tribal Health Program in those communities and therefore serving all members of the community. Congress recognized this fact when it authorized in Section 306 of the Indian Health Care Improvement Act (IHCIA) IHS to award grants to Tribes and/or Tribal Organizations to construct, expand, or modernize small ambulatory health care facilities. It has been more than a decade since IHS received appropriations to support the Small Ambulatory Grants Program. Alaska Tribes ask that IHS advocate for a new appropriation of funds to support this much-needed program.

#### 4. MAINTENANCE & IMPROVEMENT

Many facilities and clinics are in dire need of improvement. With the average age of many Tribal facilities well beyond initial recommendations or design, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health and potentially patient safety is compromised. In order to provide

the level of care necessary to ensure a minimum standard of patient care, more resources need to be provided at the facility and clinic level.

## 5. SANITATION FACILITIES

The Arctic Research Consortium of the United States reports that over 5,000 rural homes in Alaska are considered unserved (homes without running water and wastewater service within the home). Furthermore, for the existing water and wastewater systems all over the state of Alaska, many are failing or out of regulatory compliance. These developing world conditions are unacceptable in this day and age and this country of great wealth, especially as new technologies are making it more feasible to have water and waste systems put in which are more affordable and sustainable. Many tribal communities in the United State also do not have a taxable land base to provide for such needed infrastructure necessary to promote public health.

The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced, by about 80 percent since 1973. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

The provision of Indian sanitation facilities is a very important component of the overall effort required to achieve a reduction in waterborne disease outbreaks, a goal highlighted in Healthy People 2020 "Topics & Objectives" for Environmental Health. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

## 6. STAFF HOUSING

Recruitment of health professionals is greatly impeded by the lack of housing. IHS needs to work with the Administration and Congress on addressing the shortage of staff housing and appropriating much needed funds separate from the IHS Health Care Facilities Construction Priority System.

The lack of adequate staff housing in rural areas is crippling efforts to recruit and retain trained and qualified personnel. The current system is not addressing the need and funding for staff

housing must be identified separate from the facilities priority system. The ability to provide safe housing for providers willing to work in isolated rural communities has become a critical issue as funding to maintain and replace the few existing houses has not been made available for the past 20 years and very limited funding has been available to build new staff housing. Many communities lack any permanent housing options for providers or even temporary housing for visiting specialists or locum staff. Locum staff working in rural clinics often are required to sleep on cots, or on the floor, in sleeping bags or are placed in costly lodging options, if even available. This disrupts their ability to be well-rested and alert when providing routine and 24/7 on-call emergency patient care.

## 7. WORKFORCE DEVELOPMENT

### 7A. INDIAN HEALTH PROFESSIONS SCHOLARSHIP

Indian Health Professions are critical in order to meet the recruitment and retention needs faced by Tribal health programs. The shortage of providers is one of the greatest barriers to access to care. One solution that invests in Tribal individuals and health programs is to "Grow Your Own." This also has the added benefit of building capacity, reduces turnover and helps support culturally appropriate approaches.

Alaska Tribes advocate for the expansion of the Indian Health Professions scholarship program to extend opportunities for individuals interested in pursuing these highly successful community-based alternative careers paths such as Community Health Aide Practitioners, Behavioral Health Aides and other alternative provider-extender certified programs. As this country faces shortages in all health professions, these alternative provider-extender models provide an effective way to ensure access to care in remote communities with chronic provider shortages. Scholarships are a way to finance the training and certification so that rural communities can afford to recruit and retain these new providers. The alternative is that many communities will go without access to basic health care, resulting in costly care needs down the road or even unnecessary early death.

### 7B. CHAP TRAINING

The shortage of available Community Health Aides (CHA) and Practitioners (CHAP) available to Village and other rural areas presents a significant risk to the health of Alaska Native people and the strength of the ATHS. The Alaska CHAP program trains, certifies and supports our CHAP who are considered the "backbone" of the Tribal health system. CHAs and Practitioners are the only providers of primary and emergency care in most rural Alaskan communities. When this care is not available, beneficiaries needing even the most routine of care are forced to travel, at great personal and Tribal Health Program expense, to regional



hubs. Often times, the shortage of primary care results in symptoms going unaddressed and even minor maladies escalating into far costlier procedures.

For trauma and other medical emergencies, it quickly becomes a matter of life and death. Adequately funding the CHAP training program is an essential step in ensuring the rest of ATHS functions correctly. The CHAP training program is a successful model which can be replicated in other rural Tribal communities where providers are difficult to recruit and retain. In order to meet the needs, training funds for the Training Centers are necessary to provide additional training staff and to increase training center capacity in Alaska to allow current CHAs the timely training needed to achieve certification. Currently there is a backlog of training slots of 1-2 years within Alaska. This compromises care and puts a burden on supervising physicians when CHAs are not able to complete training within a reasonable timeframe.

We applaud that the CHAP program is a model being considered by the IHS as a way to provide physician extenders into remote clinics where it has been difficult to recruit and retain providers. If this were to occur, however, the additional amount needed to expand and/or establish new CHAP training centers will have to be considered.

## 8. BEHAVIORAL HEALTH

Alaska Tribes have consistently listed Behavioral Health as a main priority for several years. Alaska continues to suffer from the highest suicide and unintentional deaths rates in the country. Most of these tragic events are associated with substance use and/or abuse.

### INCREASE FUNDING FOR BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT

Alaska has been progressive in replicating its highly successful CHAP training model by creating an innovative Behavioral Health Aide Model which focuses on prevention, intervention, treatment, case management and aftercare services in our rural communities. The trained and certified BHAs are a critical component of our care teams providing a local outreach and remote services for those who are affected by trauma, substance use and mental illness. Traumatized individuals or those with substance use and/or mental health disorders often experience difficulty trusting others, including behavioral health providers, at the outset of their healing processes.

Staff turnover, partially caused by the highly stressful nature of the job and remote locations with high costs of living make recruitment and retention very challenging and therefore

establishing trust with the vulnerable individuals needing care. Alaska's behavioral health programs statewide struggle with hiring Masters level qualified and licensed providers necessary to improve the quality, quantity and consistency of the behavioral health workforce in Alaska. The BHA program helps address these challenges.

We strongly advocate for increased funding to assist with the recruiting, retaining and training of culturally-responsive Alaska Native behavioral health providers. This includes funding programs which support Alaska Native students studying within the field of psychology through initiatives such as Alaska Native Community Advancement in Psychology as well as those training to serve as certified BHAs.

## 9. ALCOHOL AND SUBSTANCE ABUSE

Alcohol and Substance Abuse has grave impacts that ripple across Tribal communities causing upheaval and adverse experiences that begin or perpetuate a cycle of abuse breaking the social fabric of our traditions and ties to one another. Stigmatization and lack of understanding the disease of addiction make addressing the challenge even more difficult. The problems range from individual social and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide. Increasing resources to combat Alcohol and Substance Abuse, including the opioid addiction is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.

## 10. DENTAL SERVICES

Oral health is a leading health indicator going beyond the mouth, gums and teeth. Poor oral health is correlated to several chronic diseases including diabetes, heart disease, stroke, and is even associated premature births and low birth weight. Frontier and rural communities in Alaska have had limited options and capacity to provide dental services. This challenge has forced innovation, including the dental health aide training program, and has provided an evidence based model in remote villages. Supporting Dental Services and oral health is essential in protecting health.

## 11. HEALTH IT

Across the ATHS, the use of Information Technology in the maintenance of patient and provider records, as well as the referral and tracking of healthcare services, is essential. Because of unique geographic challenges and the ATHS referral system, adequately functioning Health IT services are even more important than in many urban areas in the Lower 48 states as it impacts emergency and routine medical consultation and care

coordination with providers hundreds or even thousands of miles away. Providing adequate financial resources to carry out these functions is critical to the ATHS.

It is critical as Health IT rapidly evolves that IHS maintain a strong Office of Information Technology. Resources will continue to be needed to ensure that IHS include and work collaboratively with Tribes to further develop its Information Data Collection System Data Mart and ensure that Tribes can access their co-owned data. Doing so will improve overall clinical data reporting and provide the President the most accurate data for developing the President's Budget, while allowing Tribal leaders and administrators the most accurate data in determining resource allocation and program development.

IHS will also need the resources and time to collaborate with other federal agencies and departments, such as the Centers for Medicaid and Medicare Services (CMS), the Health Resources Services Administration (HRSA), and the Department of Veterans Affairs on guidelines and reporting requirements. This collaboration will reduce the need for largely redundant/duplicative systems and reducing the administrative burdens and cost, allowing for more resources to be dedicated to patient care. It is imperative that the IHS' development of systems keep pace with the evolving requirements for The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and Patient Centered Medical Home models. MACRA permanently replaced the sustainable growth rate (SGR) formula under former Meaningful Use of EHRs.

#### 11A. TELEHEALTH

Telehealth is a critical component of care and is intricately paired with the CHAP program. The ATHS is a true system of care that provides services to over 152,000 AN/AIs and is comprised of:

- 180 small community primary care centers
- 25 sub-regional mid-level care centers
- 4 multi-physician health centers
- 6 regional hospitals
- Alaska Native Medical Center tertiary care

Telehealth increases local capacity to provide care with medical oversight. It reduces both the cost and stress of travel in medically underserved areas in a state that has one of the lowest rates of medical specialists in the United States.

#### 11B. INCREASE FUNDING FOR TELE-BEHAVIORAL HEALTH

Tele-behavioral health capabilities (Video Tele-conferencing—VTC) are essential to Alaska to expand services to rural communities. Many of our Alaskan villages are in remote areas off the road system, which severely compromises access to care. VTC offers promise, but some areas still require infrastructure development. In many villages, digital connectivity is non-existent or rely on a satellite-based Internet system that is slow and unreliable. According to the Federal Communications Commission nearly 81% of rural Alaska residents lack access to modem broadband services with sufficient speed needed for high quality voice, data and video transmission.

In Alaska, recruiting and retaining clinicians, psychiatrists and other behavioral health providers statewide is challenging. Due to the remoteness of villages across the state and difficulty with transportation to these villages, maintaining licensed providers in every rural community is impossible. Therefore, Tele-behavioral health is a significant and crucial component to the spectrum of resources which must be provided remotely to support Alaska's Behavioral Health programs. Alaska Tribes support the need for the IHS to increase funding for tribal behavioral health programs to appropriately supply clinics throughout the state with Video Tele-Conferencing equipment and the necessary Internet connectivity in order to sustain and expand service delivery access to village based services.

### 12. RESOURCE AND PATIENT MANAGEMENT SYSTEM

The Resource and Patient Management System (RPMS) is an antiquated system that is eating resources and failing to protect patients. IHS should instead consider alternatives, informed by consulting with tribes and sister agencies, including possible redirecting resources in order to meet the demands. Emblematic of the issue is an update of input that Alaska raised in regards to the IHS FY 2018 Budget Formulation Consultation as the issues are not only still relevant, but the situation has worsened. Last year's submission on this topic:

#### 13. RPMS LABORATORY PACKAGE ISSUES

An urgent area of concern which has repeatedly been raised with the IHS without resolve, and which has direct effect on patient safety is the need to fix several RPMS Laboratory Package Issues. Specifically, there are five high-priority action items related to the RPMS laboratory package that greatly impact patient care, and which have been identified by the National Laboratory Professional Service Group ("Lab PSG") since at least 2012.

These action items remain unresolved despite repeated past assurances from the Indian Health Service.

1. Auto-verification of In House Testing;
2. Auto-verification of Reference Laboratory Testing;
3. Microbiology interface for Vitek and Microscan;
4. Critical Value flagging of Qualitative Test Results;
5. Ask-at-Order Questions not Passing from EHR to Lab Package.

Continued neglect of these 5 issues creates the highest risk of causing harm to our people who seek care in an RPMS facility. These 5 issues are creating the greatest burden to smaller tribal / IHS clinics (which, typically, do not have laboratory professionals on staff) that must somehow manage the many “work-arounds” that these 5 issues create in order to protect patients. IHS must be provided resources to address not only national-driven initiatives such as ICD-10 and Meaningful Use, but also to address the backlog of RPMS patches, especially those which affect patient care. Not doing so has forced several Tribes to purchase alternative commercial systems. As one leader commented, “It’s about patient safety. That has to be first when making our decision.” Funding for OIT should be increased to ensure adequate resources not just for IHS OIT but for Tribal systems as well.

The update on the above issues, as stated before, remains dire. At this time, IHS Headquarters maintains a backlog of around 70 unresolved action items that nationwide RPMS Lab Package end users consider crucial for operation. This backlog includes some, but not all, of the high-priority action items called to Alaska Native Health Board’s attention in April 2016 and subsequently raised in the FY 2018 IHS Budget Formulation Consultation. IHS informed RPMS Lab Package end users in October 2016 that none of these backlogged action items would be addressed until IHS had installed RPMS Lab Patch 1039, Lab Patch 1040, and VA Mega-Patch #66. End users were then informed that, due to “delays in replacement of contracted staff” and problems pertaining to “the transition in contracts”, IHS would not be able to complete the installation of these patches until late FY17 or early FY18.

With regard to Alaska’s high-priority action items, the impact of these delays is readily apparent:

1. Auto-verification of In House Testing:  
Still on the backlog; not scheduled for any upcoming patch.

2. Auto-verification of Reference Laboratory Testing:  
Not even included in the backlog; not scheduled for any upcoming patch.
3. Microbiology interface for Vitek and Microscan:  
Still on the backlog; not scheduled for any upcoming patch.
4. Critical Value flagging of Qualitative Test Results:  
Scheduled for Patch 1040 (earliest potential fix: August 28, 2017).
5. Ask-at-Order Questions not Passing from EHR to Lab Package:  
Sent to EHR team for consideration; not scheduled for any upcoming patch.

Alaska has long advocated for increased resources for IHS OIT to address these issues. Continued neglect and lack of planning for contracted services has left the Agency unable to meet its time commitments for patch implementation. This, in turn, has delayed important “fixes” to the RPMS Lab Package, which continually feeds the ever-growing backlog, if indeed, the issues are even given an initial consideration. This is causing harm to our people who seek care in RPMS facilities. It is particularly burdensome to smaller tribal/IHS clinics (which, typically, do not have laboratory professionals on staff) that must somehow manage the many “work-arounds” this neglect creates.

Compounding this problem is the fact there is no Alaska Area RPMS Laboratory Consultant. Therefore, Alaska Tribal Health Programs that RPMS must rely heavily on staff at the national level for support. However, within the past year, IHS support staff for the RPMS Lab Package at the national level has been reduced by 50%, with no known plans by Alaska Tribal Health System representatives to replace support staff. Incredibly, it seems IHS has cut its own internal support staff, at the very time when IHS contract support services are in turmoil. Nor has the Agency made any effort to inform end users of plans for staff replacement. Alaska Tribes remain unclear at this point what support for the RPMS Lab Package looks like going forward.

#### 14. LONG-TERM CARE/ELDERCARE

Alaska Native elders prefer to be in their own home and communities throughout their lives. In the past, elders stayed at home with their families in multi-generational homes, but that is not always possible as their care needs exceed what their family and other supports can provide and they require nursing or assisted living care. Thusly, more Alaska Native elders are finding themselves in nursing and assisted living homes in urban areas, far from the land, family and friends where and with whom they were raised.

People over the age of 65 are one of the most rapidly growing segments of the population in Alaska. From a population growth projection, this population is expected to grow from 7,135 in 2004 to 15,135 in 2020. Increases in life expectancy can also lead to a higher prevalence of chronic disease and with it increased incidence of disability and functional limitations. American Indians and Alaska Natives reportedly have more disabilities than other ethnic groups (Jackson 2000, John and Baldrige 1996). Higher rates of disability and functional limitations along with the increasing numbers of elders exacerbate the need for long term care planning within the Alaska Tribal Health System.

Due to lack of housing, access to locally-available specialized care in rural clinics, and poor reimbursement options to cover costs, Alaska tribal health organizations are opting for nursing rather than assisted living home care. This is made more fiscally feasible in part because the Nursing home rates are cost-based in Alaska. More tribal health organizations might be interested in assisted living if the IHS provided some operating funding for individuals needing a lower level of care than nursing-level care. These services include residential care, such as nursing homes and assisted living facilities, home and community-based services, caregiver services, case management and respite care.

The authority under the Indian Health Care Improvement Act (IHCIA) which allows IHS to offer and fund long-term care services presents great promise for meeting the needs of our Elders and those with disabilities. Alaska Native elders and the disabled must have access to the long-term care services and support necessary to remain healthy and safe while retaining as much independence as possible in their own communities. Alaska tribes urge the IHS to target funds to implement LTC services as authorized under the IHCIA. There is also a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services to address reimbursement and certification/regulatory issues.

## 15. PURCHASED AND REFERRED CARE

Purchased and Referred Care (P/RC) funding levels only meet approximately half of the identified need for P/RC services and that denial of care under of PR/C is the critical issue facing the Tribes concerning the P/RC program. However, many Tribal health programs P/RC claims are not 100% paid, even under the current policies which were written in a way to limit access to care due to limited funds available for this program. Many Alaska Tribal health programs still must rely on P/RC funds because their programs do not have the resources or capacity to directly offer the needed or specialized medical care.

The majority of new facilities are for outpatient care; this has resulted in an increased need for referral to in-patient facilities with emergency rooms and higher acuity care services. While Medicaid Expansion has moved many facilities from being able to provide Priority One level of care to now providing Priority Three or Four levels, again access is still highly restricted based on old P/RC policies and a limited capacity to provide certain specialized services. Tribes believe that the ability to address Priority Four level of care promises the greatest return with regards to health status and quality of life improvement.

Indeed, it is what our Leaders negotiated for when negotiating with the United States government. Tribes advocate for flexibility on the use of P/RC funds to be based on actual patient need. In order to ensure safe, quality continuum of care for all Alaska Natives and American Indians, the P/RC manual must be updated to remove some of the existing barriers to eligibility for P/RC funded services. Additionally, efforts must be made to ensure the new authorities under the Indian Health Care Improvement Act for long term care, preventative and other services are incorporated into the updated P/RC manual. We fought long and hard for the IHCIA reauthorization and these new authorities must be incorporated into all of the long-outdated IHS policy and program manuals and health delivery system reform.

## 16. IHS ADVANCE APPROPRIATIONS

Late funding under Continuing Resolutions has significantly hampered budgeting, compact negotiations, operations, recruitment, retention, provision of services, facility maintenance and construction efforts of tribal and IHS health care providers. Providing sufficient, timely and predictable funding is needed to ensure the federal government meets its obligation to provide uninterrupted, safe health care for American Indian and Alaska Native people.

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

In FY 2010, the Veterans Administration (VA) medical care programs achieved advance appropriations due to the impact on patient care when funds are not made available in a timely manner. The fact that Congress has implemented advance appropriations for the VA medical programs provides a compelling argument for tribes and tribal organizations to be given equivalent status with regard to IHS funding. Both systems provide



direct medical care and both are the result of federal policies. Just as the veterans' groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of the VA to properly plan and manage its resources, so do tribes and tribal organizations who share similar concerns about the IHS health system.

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

## 17. SPECIAL DIABETES PROGRAM FOR INDIANS

Few programs have proven to be as effective as the Special Diabetes Program for Indians (SDPI). Tribes are implementing

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

Alaska Tribes request for a minimum increase of \$50 million for a new total of \$200 million. Current programs should be held harmless from inflation erosion, and the additional funds will allow for tribes not currently funded to develop programs which has been highly effective in reducing the devastating impact that diabetes has in Tribal communities.

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# ALBUQUERQUE

## 1. IMPROVING QUALITY OF AND ACCESS TO HEALTH CARE

The quality of and access to health care has been decreasing over the last 5 years due to the decreasing level of funding for medical care services at the local levels, the difficulty of recruiting health care professionals to rural Indian Reservations, and the rising cost of health care, medical equipment and overall facility maintenance. During these years Canoncito recommended to the Area Office to secure more federal funding for the ACL Service Unit and for the Canoncito Health Clinic and to spend the third party revenue generated at the Canoncito Clinic for medical services in the To'Hajiilee community, however, the level of services and funding continued to decreased. To address these issues, Canoncito contracted through PL 93-638 the clinical PFSA's at the ACL Service Unit, the AAIHS and HQIHS. Through Tribal management Canoncito was able to hire additional health care providers and increase health care services at the local level.

Improvement to quality of and access to health care improved for the To'Hajiilee community because of the following: Health care professionals at the clinic increased from 8 staffs to 16 staffs within 3 months. The Canoncito clinic operating budget increased significantly as all Tribal shares funds were brought to the Canoncito Health clinic for operational and medical services. For FY 2017, the ACL Service Unit declined to process

third party reimbursements for the Canoncito clinic however Canoncito is developing the third party billing system and when developed it will be able to keep all the third party revenue at the Canoncito clinic. Canoncito will utilize some of the third party revenue for specialized health providers to provide services to community residents once or twice a week. With an increase in funding there will be less health care providers turnovers, increase continuity of services for clients by the same health provider, and consumer service training will be provided to all employees. Communications with the ACL Service Unit will be improved because there will be less, and less need to utilize the poor communication systems on the Reservation which includes the phone systems, internet systems and the mail system for scheduling appointments and referrals. When using the former ACLSU referral system, it's very hard to schedule timely medical, dental and PRC appointments and sometimes, it may take up to 1 year to schedule a PRC appointment.

## 2. IMPROVING CUSTOMER SERVICE

Before Canoncito contract all clinical PSFA's at the ACL Service Unit in FY 2017, there were a lot of customer service problems at the ACL Service Unit and Canoncito Health Clinic. ACL health providers are spread too thin between the ACL Service Unit and the Canoncito Clinic and there are not enough permanent health providers. Every month at the local Canoncito town hall

meetings there are constant complaints about being turned down for PRC services, long waiting list for dental appointments, the 40 mile commute to the ACL hospital to acquire major health care, etc. There is a high turnover rate for ACL health providers that are contracted and this results in a poor continuity of health care services for local patients. To resolve some of this issues, Canoncito decided on Tribal management of PSFA's at the ACL Service Unit. To address the consumer service issue, Canoncito hired private sector consultants in the setup of the operational and clinical activities of the Canoncito clinic including customer service. These consultants who serviced private hospitals fully understand the need for customer services and the business concepts of generating revenue for business survival. As a new 638 contractor for clinical operations, we need to increase training in consumer service for our I.H.S. employees under IPA's and our local tribal employees to better serve tribal members and to coordinate health care service activities with other Tribal health programs and local government officials. Customer services has to be made a top priority for the Indian Health Service and the Tribes. Trust responsibility and Treaty obligations are not Investments for the United State Government, and there is no rate of return for the United States Government for these treaty obligations to provide health care services to Native Americans.

### 3. FACILITIES CONSTRUCTION

Indian Health Service's Health Care Facilities Construction (HCFC) FY 2016 funding level was \$105M, 1.91% of actual need. The current HCFC need is \$10.3B and HCFC is so underfunded that, at the current rate of appropriations, a new facility in 2016 would not be replaced for over 400 years. As HCHC funding is within the IHS total annual appropriations, any funding increases targeting HCHC would displace funding increases for health care line items. Hence, the current HCFC funding model simply cannot even come close to meeting HCFC need. However, since its inception with demonstration projects in 1992, the Joint Venture (JV) project has successfully lead to the construction of 30 different health care facilities, without using any agency construction dollars. Joint Venture has proven to be an effective alternative to relying on HCFC appropriations to build needed IHS and Tribal health care facilities. Unfortunately, the agency only solicits applications every few years.

**Background:** Section 818 of the Indian Health Care Improvement Act, P.L. 94-437, authorizes the IHS to establish joint venture projects under which Tribes or Tribal organizations would acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years. Participants in this competitive program are selected from among eligible applicants who agree to provide an appropriate facility to IHS. The facility may be an inpatient or outpatient facility. The Tribe

must use Tribal, private or other available (non-IHS) funds to design and construct the facility. In return the IHS will submit requests to Congress for funding for the staff, operations, and maintenance of the facility per the Joint Venture Agreement.

**Recommendation:** The Santa Fe Service Unit Health Board recommends that the agency solicit applications for Joint Venture approval on an annual basis. The need for new health care facilities is well- documented, it is unrealistic to expect HCFC funds be appropriated to meet need. It is inexcusable to have the only alternative construction model available that has been proven to be effective to be restricted to periodic and infrequent release.

### 4. ENHANCING AGENCY HEALTH CARE PROFESSIONAL RECRUITMENT

**Background:** In the past five years, the Santa Fe Service Unit (SFSU) has had difficulty recruiting physicians and nurse practitioners. In this period: SFSU has never been fully staffed with providers. When family nurse practitioner positions are advertised, commonly there are no applicants or one applicant at the very most. The open continuous announcement for medical officers has not produced a single qualified candidate (who didn't apply as a result of networking efforts of SFSU staff members) who proved available for consideration.

Considering the key health profession vacancy rate (FY16 Q4 data) indicators (nurses, physicians and pharmacists), six Albuquerque Area Services Units had a vacancy rate of 40% or more in one of these key categories. The consistent underlying problem: the applicants just aren't there.

For decades, the Indian Health Service (IHS) has relied on various iterations of recruitment strategies, but has been dependent of consistently having qualified recruiters in place. Currently, the Albuquerque Area does not have a professional recruiter. While having a recruiter available to "recruit," and assist with the inherently cumbersome application process, it's critical that the agency do something to increase interest in the agency and its mission among health care professionals.

The agency has made strides in improving recruitment at the HQ level and currently has a very robust recruitment tab on the agency's website. But there has never been any nation-wide public relations effort to enhance awareness of its mission with the American public and more importantly, the subset of health care professionals. Unfortunately, what media about the Agency that the average American citizen is exposed to is negative media, secondary to the multiple service units in the Great Plains Area (GPA) who lost CMS deemed status. Unfortunately, the media has "painted the entire Agency with the same failed GPA brush,"

casting negative aspersions evenly to all the other IHS Areas (like the Albuquerque Area) who do a very good job providing patient care.

**Recommendation:** The Santa Fe Service Unit Health Board recommends that the Albuquerque Area fill its Professional Recruiter vacancy without further delay. It also recommends that it contracts with a professional public relations firm to generate positive media stories about the great work that the preponderance of IHS and tribal health care facilities accomplish every day.

## 5. ADVANCED APPROPRIATIONS

Taos Pueblo and Picuris Pueblo Tribal Leadership support Advanced Appropriations. This would allow for financial stability, health care without interruption, reduced administrative costs and lead time for budgeting and adjustments.

## 6. SPECIAL DIABETES PROGRAM FOR INDIANS

Taos Pueblo and Picuris Pueblo Tribal Leadership supports actions to continue to have Congress fund Tribal community directed programs that provide critical services directed at Diabetes prevention. They do not support a competitive process for this funding. Funding should be allocated on an as need basis.

## 7. INDIAN HEALTHCARE IMPROVEMENT ACT

Taos Pueblo and Picuris Pueblo Tribal Leadership supports increased appropriations to support the unfunded IHCIA provisions including provisions for health services, health facilities,

general behavioral health programs and Indian youth suicide prevention.

## 8. TRIBAL DIALYSIS CENTER

**Background:** The Mescalero Apache Tribe was forced to close the Mescalero Dialysis Center in late 2014 due to financial issues and lack of reimbursements. Since the closure, the Mescalero Apache Tribe has been transporting 7-8 tribal member patients with dialysis to Alamogordo, NM (40 minutes each way) several times a week to obtain dialysis. This has become a financial strain on the Tribe and the patients as well. The Mescalero Apache Tribe requests new funding or special allocations to re-open the local Dialysis Center. This funding will assist with the re-opening and will determine program requirements and fully evaluate the true cost of the program.

The Mescalero Tribe has been utilizing local nursing home staff to transport dialysis patients to Alamogordo, NM. This has caused a severe hardship on the facility as the staff must adjust their time and schedule to accommodate the patients. The hours are long and place a hardship on the patients as well. Schedules are as early as 5:00 am to 6:00 pm. The impact of transportation is negative on the patients and actually harmful in many instances as some patients choose to drive alone.

**Recommendation:** To assist with funding or special allocations to re-open services from the Dialysis Center. Funding will assist the facility to maintain the high quality water, equipment, and hiring of competent staff until the program is able to generate revenue and to become self-sustainable.

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# BEMIDJI

## 1. SUBSTANCE ABUSE

**Background:** The impact of alcohol and substance abuse within the Area is having a dramatic negative effect on lives, families and communities of the native people. Increased funding is needed to combat this adverse societal condition.

**Recommendation:** There is a huge demand for increased funding to combat this adverse societal condition. Several Tribes within the Bemidji Area have declared a “state of emergency” with the growing epidemic of increased abuse of alcohol and

drugs, particularly opioids. This is a multifaceted problem, which requires involvement of multiple agencies from Tribal Leaders, law enforcement, education and health care professionals, to States, Federal Agencies and the community to solve. There is also a need for alternative resources such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to abused medications along with a regional treatment center.

There is also insufficient funding for after-treatment care to break the rehab treatment — prior situation cycle. Additional funding is needed for after-care centers.

Proposed Increase Amount: \$190,000,000

## 2. LONG TERM CARE FACILITIES

**Background:** Long-term care facilities are often off reservations causing cultural and transportation issues.

**Recommendation:** Funding is needed to keep elders in their communities close to their related cultural background. Local long-term care facilities will provide the time honored responsibility of tribal communities in caring of their elders. Community long-term care services would also alleviate transportation issues of family members visiting patients, thereby, increasing end-of-life quality.

Proposed Increase Amount: \$107,000,000

## 3. REGIONAL TREATMENT CENTERS

**Background:** Substance abuse treatment centers are often vast distances from patients' home communities.

**Recommendation:** There is a compelling case in the Bemidji Area for increased funding of IHCA, Section 708, authorizing increased adolescent care and family involvement services through a regional treatment center, primarily targeting Psychiatry Adolescent Care. Currently, there is inadequate funding available which attributed to the increased disparities with opioids and drug addicted habits.

There is also insufficient funding for after-treatment care to break the rehab treatment — prior situation cycle.

Proposed Increase Amount: \$35,000,000

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# BILLINGS

## 1. TRANSPORTATION OF PATIENTS

**Background:** There is a high cost to transport patients from Billings Area Indian Health Service Facilities to larger health care centers in Montana and Wyoming. All of the reservations in Montana and Wyoming are in rural areas that are in some cases over a 6 hour drive to get to larger hospitals such as those in Billings, Great Falls and Missoula MT.

**Recommendation:** Seek assistance in finding additional resources for patient transport? From who? From where?

## 2. RECRUITMENT AND RETENTION OF PROVIDERS

**Background:** There is a great need to retain providers in the Billings Area for consistency. Many of the providers that come to the Indian Health Service facilities in Montana and Wyoming do not stay long. It is also difficult to recruit new providers with the amount of dollars that can be offered to them.

**Recommendation:** Increase the amount of money that can be offered to providers for recruitment, retention and relocation to better compete with the private sector.



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# CALIFORNIA

## 1. ADULT DRUG AND ALCOHOL TREATMENT CENTER

**Background:** There are currently no culturally-based treatment centers available for Native Americans over the age of 18 in southern California. The SCTCA proposes a 20 bed in-patient facility that serves 26 Tribes and Urban area located in southern California. The Southern California Adult Health Center will provide culturally relevant substance abuse and mental health wellness to American Indian patients and families in southern California. Treatment will utilize a Trauma Informed Care platform with the objective to substantially improve outcomes of lifetime recovery for patients.

**Recommendation:** Establishing an Adult Healing Center in southern California is critical to addressing the unique needs of tribal adults in a secure setting. Most important, the Adult Healing Center will incorporate not only chemical dependency treatment, but also mental health services including individual and group psychotherapy, mental health assessments, and individualized treatment plans. The objective is that once patients are released back into their communities, they receive ongoing support and guidance from their local communities, tribal health clinics, and families. Each year, so many of our tribal Adults are sent to detention centers and non-relative settings where they suffer from a lack of connection and support from their tribal communities. The Adult Healing Center will support that connection and work with the families to ensure seamless transition back into their communities. The statistics are staggering when it comes to tribal adults and substance abuse, suicide, mental health issues, etc. The Adult Healing Center is an opportunity to begin the process of healing for our Tribal families and communities.

## 2. AFTERCARE FUNDING

**Background:** In anticipation of the opening of the California Area's first Youth Regional Treatment Center, during 2015 and 2016, the CAO contracted with a specialist to survey the Tribal and urban Indian healthcare programs regarding their substance use services offered to youth in their communities. So far, the consultant has surveyed 21 of the 54 programs in the state and reported a total of 8,041 youth from ages 12-17 at these sites. The survey found a gap in direct outpatient programs for youth, certified drug and alcohol counselors, licensed practitioners, and intensive case management. The lack of these services severely

hampers the success of the rehabilitation efforts once these youth are returned to their communities, especially relapse prevention activities.

**Recommendation:** The findings of the survey demonstrate that Tribal and urban Indian healthcare programs and their associated communities are in need of funding in order to provide basic behavioral health staffing levels, especially for adolescents who will require intensive follow up and counseling services for relapse prevention. It is recommended that funds are provided for communities to hire and train behavioral health staff that focus on substance use disorders in adolescents as well as adults.

## 3. ALLEVIATE PER CAPITA FUNDING DISPARITIES

**Background:** Additional funding is needed to alleviate the significant disparities that exist in per capita health care expenditures between Indian Health Service (I) and other healthcare agencies and populations. In FY 2015, the IHS spent approximately \$3,688 per American Indian/Alaska Native (AI/AN) patient for health care expenditures. This is much lower than health care expenditures for other populations. For example:

- In FY 2015, the California Department of Corrections spent approximately \$14,495 per prisoner for health care
- In CY 2015, the total U.S. population health care expenditure was \$9,990 per person
- In FY 2011, the Medicaid spending per enrollee was \$5,790

**Recommendation:** Increase funding for IHS to remove disparities in per capita health care expenditures to ensure AI/AN patients receive equitable funding for quality health care.

## 4. IMPROVE GPRA RESULTS

**Background:** Additional funding is needed to assist California Tribal and urban Indian healthcare programs with completing the screenings/tests for which data is reported for the Governing Performance and Results Act (GPRA). The California Area has no IHS or Tribal hospitals or inpatient facilities. All California healthcare programs provide only ambulatory care. In addition, many of the California Indian healthcare programs are in rural areas with limited access to referral or specialty care. As a result, California Area healthcare programs have difficulty meeting many of the GPRA measure targets for the screenings or

tests that need to be referred to outside providers. These issues prevent many of the California Indian healthcare programs from being able to improve on the GPRA measures or meet the targets, which also means patients do not have access to many preventive screenings or tests that need to be administered at referral facilities.

**Recommendation:** It is recommended that Tribal healthcare programs receive additional funding to assist with improving GPRA results and meeting annual targets. Since GPRA data represents the basic preventive care that all patients should receive, providing clinics with additional funding to improve GPRA results would lead to higher quality care for American Indian/Alaska Native (AI/AN) patients. Additional funding would assist healthcare programs with providing their patients with access to outside care and bringing in providers to provide that care.

## 5. HOOPA VALLEY TRIBE AMBULANCE SERVICE

**Background:** The Hoopa Valley Tribe (Hoopa) and the K'ima:w Medical Center ambulance service and is seeking Indian Health Service (IHS) funding to offset their rising operating costs. K'ima:w ambulance service provides critical advanced life support emergency medical services to the Hoopa Valley Tribe and surrounding communities including portions of the Karuk Tribe and Yurok Tribe, responding to approximately 980 calls this past year. The ambulance service started without any funding from the following: IHS, State of California, Humboldt County or the communities near the Hoopa Valley Reservation. In 1983, Hoopa used funds from IHS (Community Health Representative and IHS Headquarters) funds to obtain an ambulance from General Services Administration (GSA).

The Tribe is seeking IHS funding in the amount of \$850,000 to compensate for increases in operating costs for the K'ima:w Medical Center ambulance service. Medicare and Medi-Cal reimbursements in addition to the Hoopa Valley Tribe subsidizing operational costs are not sufficient to sustain the K'ima:w ambulance program. The IHS Emergency Medical Services (EMS) program does not provide operational costs to the IHS affiliated EMS Programs. The IHS does facilitate pre-hospital and out-of-hospital emergency medical training at no cost to IHS-affiliated tribal EMS programs who have not taken their EMS training shares. Only funding for EMS training is appropriated each year. Hoopa leaves their HQ EMS shares and is eligible to receive EMS training through IHS at no cost.

Currently Hoopa leases three GSA ambulances (additionally one is owned by the tribe) through the IHS/GSA Ambulance Shared Cost Program. The IHS subsidizes the cost of the ambulance so tribal programs lease the ambulance at a reduced cost. The

IHS pays for approximately 70 percent of the total cost of the ambulance and GSA pays for 30 percent. The GSA leases the ambulances to IHS affiliated EMS programs at a cost of approximately \$383 per month, \$75 per month for accessories and \$.41 per mile per ambulance.

**Recommendation:** Hoopa requests a line item be created and funded by IHS to assist in the operating costs for ambulance service in rural areas. In addition, Hoopa is requesting Congressional action for funding by their U.S. Representative. The Tribe recommends that if HQ has any additional end-of-year funds, that they be used for the ambulance program.

The IHS concurs that Hoopa continue to request additional appropriations through their Congressman; unfortunately their past Congressional requests have not made it out of the House Committee.

An Emergency Medical Services Workgroup was formed during the Tribal Self-Governance Consultation Conference in Anaheim. The tribal workgroup believes that the IHS is responsible for funding operational costs for tribal EMS programs. Currently the IHS is not able to fund these programs in accordance with Line 115 from the IHS Headquarters PSFA Manual of 2002. With the PSFA Manual scheduled to be updated in the near future, the tribes believe that this could be an opportunity to include funding for EMS programs. It was suggested that the workgroup meet at least twice before the Tribal Self-Governance Advisory Committee meeting in July.

## 6. NORTH FORK RANCHERIA

**Background:** Funding is needed for North Fork Rancheria due to corrections to historical Tribal User Population. In 1961, the federal government terminated the Tribe's federally recognized status and transferred the Rancheria land to fee for the lone resident then living on the Rancheria. The Tribe's status as a federally recognized Indian Tribe was restored in 1983 under a court-ordered settlement. Four years later, the lands within the Rancheria boundaries were restored as "Indian Country." The Tribe has a Cooperative Agreement from the Office of Tribal Self-Governance for the planning phase for a Title V Compact/Funding Agreement. A no-cost extension for this agreement has been granted.

In the 1994 active user distribution for California Area Shares, of a total of 60,480 active users, the Tribe had an active user count of 4. According to 2015 National Data Warehouse data, the Tribe has 594 active users, CVIH has a total active user count 7998. The Tribe is seeking a more equitable distribution of Area Shares based on their membership.

**Recommendation:** Redistribute the active users count from 1994 to properly fund North Fork Rancheria.

## 7. RECRUITMENT AND RETENTION

**Background:** Funding is needed for additional resources to augment recruitment/retention activities due to increasing difficulties in recruiting and retaining critical staff. Over the past several years, the Indian Health Service (IHS)/California Area Office (CAO) has received approximately \$6,000/year to address recruitment/retention activities. This funding has been used primarily to augment retention. Personnel vacancy rates in critical healthcare professions at California Tribal and urban Indian healthcare programs are reaching high rates not seen in recent history. This worsening trend is having a significant negative impact on clinic operations, including the ability to address critical quality of care requirements that have recently been announced by the Centers for Medicare and Medicaid services. Given the increased number of individuals who are now accessing health care in California, the availability of providers does not meet the current demand. Private sector health care organizations have greatly expanded their operations and are paying increasing salaries and bonuses to primary care providers that California Tribal and urban Indian healthcare programs are unable to match.

**Recommendation:** The IHS/CAO, in cooperation with other IHS Area Offices, recommends funding for the following activities:

- Actively participate with other Area Offices at medical conferences that involve primary health care providers
- Visit Family Medicine residency programs in California and participate in various speaking engagements
- Work collaboratively with clinics to develop recruitment materials that inform potential providers of the positive attributes associated with California Tribal and urban Indian clinics, such as no on-call duties, more time with patients, and locations that offer unique amenities in urban or more rural/frontier settings
- Assist clinics in identifying and utilizing more robust advertisement venues for vacancy announcements
- Additional funds are needed for the Tribal health programs to compete with market salaries and bonuses for their physicians and medical staff.

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- Additional funds are needed for the Tribal health programs to compete with market salaries and bonuses for their physicians and medical staff

## 9. URBAN INDIAN HEALTH FACILITIES

**Background:** The IHS funding allocation for Urban Indian health reflects only 1% of the total annual budget despite the fact that approximately 78% of the American Indian population in the U.S. resides off reservations and in urban areas. In California, 88% live in urban areas. There are 42 urban Indian health facilities in the nation (increased from 33 last year because the former NIAAA residential drug and alcohol treatment facilities were added to Title V with no added budget increase). In California there are 10 programs.

Urban Indian health facilities serve only federally recognized tribal members (or California Indians) with their Indian Health dollars. Because their I.H.S funds are so limited, they actively secure a lot of additional funding from other sources in order to provide more services to Indian people living in the urban area.

In calendar year 2015, nationally urban Indian health programs served 78,211 tribal members (over 2,000 members from California tribes) (unduplicated) for a total of 645,862 encounters and members from over 497 tribes total. In California, urban

programs served a total of 11,655 tribal members with over 99,427 encounters.

**Recommendation:** Please prioritize urban Indian health funding in addition to tribal health priorities to advocate that congress increase the budget for both. Please increase the Title V Urban Indian Health line item to no less than last year (\$10,000,000).

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## GREAT PLAINS

### 1. PRESERVE THE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA) AND THE AMENDMENTS ADOPTED TO IT THROUGH THE ACA.

The incoming administration has set as its priority to “repeal and replace the ACA. A critical component of the ACA is the IHCIA. The Great Plains Tribal Leadership strongly urge the new administration to preserve the IHCIA and amendments adopted to it through the ACA.

In 1999 tribes formed a National Steering Committee, supported by IHS, to develop and oversee the process of bring the IHCIA up-to-date and to extend the appropriation authority indefinitely. In 2010 the IHCIA amended and appropriations were permanently authorized by cross-reference in Section 10221 of the Affordable Care Act (ACA). Although the ACA was the legislative vehicle through which the IHCIA was passed, the IHCIA predates and is independent of the ACA. It provides important authorization for the delivery of health care services to American Indians and Alaska Natives (AI/ANs). As Congress addresses the ACA, it is critical that it leaves intact the IHCIA, exempting it from any repeal.

The only exception to the general request that the Indian provisions of the ACA related to the IHCIA be left unchanged relates to expansion of dental health aide therapist services allowed under section 119 of the IHCIA. Studies have amply demonstrated the quality of services provided by certified DTs and the positive impact they have in reducing the unmet need for dental services among AI/ANs. Any limitations on expansion of authority to certify DTs and or for tribes and tribal organizations to deploy them should be repealed so they can be available

outside the IHS Alaska Area on at least the same basis as they are allowed in that Area.

### 2. SAFEGUARD INDIAN-SPECIFIC PROVISIONS OF THE AFFORDABLE CARE ACT

In addition to enacting the IHCIA, the ACA contained several crucial Indian-specific provisions unrelated to the rest of the ACA, and these provisions must be safeguarded as reform moves forward. These provisions include Section 2901, which makes Indian health programs the payer of last resort; Section 2902, which allows the Indian Health Service (IHS) to bill Medicare Part B; and Section 9021, which codifies exemptions from taxation for AI/ANs who receive health benefits from a Tribe or tribal organization.

### 3. ENSURE MEDICAID REFORM UPHOLDS THE FEDERAL RESPONSIBILITY FOR INDIAN HEALTH CARE

As Congress approaches Medicaid reform, it should ensure that any reform efforts maintain the federal responsibility for Indian health care, rather than passing this obligation on to the states. In 1976, Congress amended Section 1905(b) of the Social Security Act to provide for a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services received through the IHS and tribal health programs. This ensures that the federal government pays 100% of the costs incurred by States to reimburse IHS and tribal health programs for Medicaid services received through them to AI/ANs rather than draining state Medicaid matching funds.



Congress must ensure that 100% FMAP for services received through the IHS and tribal health programs is maintained. Additionally, Indian-specific Medicaid protections should be preserved, including Section 1916(j) of the Social Security Act, which provides that AI/ANs are exempted from Medicaid premiums, co-pays or cost sharing of any kind.

#### 4. VA

The IHCA authorizes IHS and Tribes to enter into arrangements with the Department of Veterans Affairs and Department of Defense to share medical facilities and services which increase government efficiency and ensure care for American Indian and Alaska Native Veterans. We ask your support to correct and amend the Indian Health Care Improvement Act to exempt all VA co-pay requirements for Indian or Alaska Native veterans receiving medical care or services from the Department of Veterans Affairs.

#### 5. 100% FMAP

Provisions of the Social Security Act related to authority for IHS and Tribal health programs to be reimbursed by Medicare, Medicaid and CHIP, and, as applicable, for States to recover 100% FMAP when such services are received by an AI/AN through an IHS or tribal program should be protected. These are critical sources of funding for IHS and tribal programs and have been instrumental in the improvements tribes have been able to make in Indian health programs as they have assumed those programs under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended.

These are especially important in the Great Plains where a number of tribes have or are planning to expand the services they offer directly, rather than relying on the IHS to be the service provider. They expect to achieve improvements like those found throughout other parts of the country where tribes have assumed programs, and by relieving some of the burden on IHS in our Area also contribute to IHS being able to improve its direct services in our Area. One of the primary reasons provided in South Dakota for the lack of support for the Medicare Like Rates legislation is attributed to unsettled PRC claims.

#### 6. EMPLOYER MANDATE

Requiring Tribes to purchase costly health insurance for their employees or pay a tax penalty if they do not is a gross violation of the United States' trust responsibility to provide healthcare to American Indians and Alaska Natives. Tribal governments employ significant numbers of Tribal members as employees that provide government services and carry out federal programs, but also to provide employment for their citizens. Due to the unique

history of Tribes in the United States, many Tribes were relocated to areas that now have little to no sources of employment other than the Tribe. The provision of employment to members is thus often essential to the well-being of the entire Tribal community, as it provides jobs and stability for their citizens and furthers the self-reliance and self-governance of the Tribe as a whole. To take away these job opportunities because of an undue tax is nothing short of irresponsible to the families that live and work in these communities and an attack on Tribal sovereignty itself.

#### 7. IHS AREA OFFICE RESTRUCTURING

The IHS requested comments and recommendations related to the geographic location of the IHS Great Plains Area Office; centralization or further decentralization of Area Office services; staffing; budget; local involvement; transparency and oversight; partnerships; accountability; monitoring; and how the Area Office can support the Service Units.

In response the tribes through the GPTCHB convened a Tribal Great Plains IHS Area Restructuring Workgroup with tribally appointed representatives from the 17 Tribes and one service area that were charged with seeking, evaluating and analyzing information requested by the GPTCHB in order to make informed recommendations. In addition, the workgroup developed five subcommittees to focus on key priorities. Attached as an addendum are the charges for each subcommittee, as well as a summary of initial comments from subcommittee members.

Additionally, we requested the involvement of key IHS personnel to provide guidance and input in an advisory capacity. Great Plains leaders requested that the area office provide resources to support an in-depth analysis and legal review for recommendations.

Unfortunately, GPTCHB did not receive all the information requested by tribal leaders, nor did GPTCHB receive resources to make detailed recommendations as to how the Great Plains Area Office should be restructured. For example, tribes still do not have a good understanding of what programs are included in your "Area Office" and "Special Programs" line items, the staff associated with those programs, and the people they serve. Moreover, as discussed below, while we have requested budgets and staff associated with each PSFA, the materials provided by Area Office staff are incomplete and do not provide all the requested information.

Furthermore, while we appreciate the offer to make the H&C and PRC Area Emergency Funds immediately available at the Service Unit level, we do not agree that that will address all of the Area Office Tribal Shares issues. Tribes are looking for a fundamental

restructuring of the Area Office and an understanding of how its budget of \$37,376,508 for Area Office programs is actually being spent, and how those funds could better be used at the Service Unit level or otherwise to provide services to our people.

As a result, we recommend the following:

1. Commit to and formalize the IHS-Tribal Area Workgroup and sub-committees

Tribes have proposed to work with the Area Office in Committees dedicated to making reform recommendations in the following areas: Budget/Tribal Shares, Recruitment and Retention, PRC, Third Party Billing, and Behavioral Health. We recommend that the IHS commit to working with the Tribes of the Great Plains through these workgroups on a regular basis going forward.

2. Provided Tribes Budget Information for Each Area Office PSFA

Since Tribes met with the IHS in March of this year, they have repeatedly asked the Area Office to provide a breakdown of the budget associated with each Area Office PSFA.

IHS appears to believe that it has provided that information, but it has not. Instead of providing Tribes with a list of Area Office PSFAs and the budget associated with each PSFA, it has simply referred Tribes to budget summary documents or excel spreadsheets with line items that do not match up to the PSFAs. The Area Office should have at its fingertips the amount it spends on each PSFA described in its Area Office PSFA Manual and should be able to easily generate that list for tribes. The fact that it does not yet appear to be able to is concerning.

Tribes most recently reiterated their request for the budget for each PSFA in their October 25, 2016 Letter to Captain Buchanan. Captain Frazier provided the following response:

***IHS Response:*** The budget for each PSFA is identified in the Area tribal shares funding tables, Table 61 and rows 48 through 75 of the “Recurring Non Recurring Report FY 2016.xlsx”<sup>23</sup>.

This response was not responsive. The line items in the

documents referred to do not match up to each of the PSFAs listed in the Area Office PSFA Manual. Table 6 just contains general budget categories and is not broken out by PSFA. Rows 48 through 75 of the “Recurring Non Recurring Report FY 2016.xlsx” contain only some, but not all of the PSFAs listed in the Area Office Manual. For example, neither Table 6 nor rows 48 through 75 provide any budget information for the following PSFAs:<sup>23</sup>

- Office of Planning and Legislation, Division of Planning, Evaluation, Resource Allocation and Administrative Support
- Office of Planning and Legislation, Division of Statistics Analysis and Evaluation
- Environmental Health Support, Division of Environmental Health Services
- Office of Health Programs – Health Professions Recruitment
- Office of Health Programs – Pharmacy
- Office of Health Programs – Dental
- Office of Health Programs – Community Health Representative
- Office of Health Programs – EMS Program
- Office of Health Programs – EMS Training Programs
- Office of Health Programs – Urban Indian Health Programs
- Office of Health Programs – Health Education Program
- Office of Health Programs – Division of Nursing
- Office of Health Programs – Public Health Nursing
- Office of Health Programs – Women’s Health/Mobile Women’s Health Unit
- Office of Resource Management – Health Information Management
- Office of Environmental Health and Engineering

In addition, simply referring tribes to an excel spreadsheet without explaining the spreadsheet is not the best way to respond to tribal inquiries. Rather than simply providing raw documents, the Area Office should actually spend the time to provide tribes with a narrative response that can be readily understood by Tribal leaders. Simply providing raw documents, while they may be technically (although

<sup>23</sup> We note that Row 65 lists “Health Programs” as having a total recurring non-recurring budget of \$11,075,804. But it is not clear if that is for all Office of Health Programs PSFAs. Some Office of Health Programs PSFAs, such as Office of Health Programs, Medical Care Evaluation (Row 68), but the others listed here are not separated out. We request a breakout for each PSFA

partially) responsive to Tribal requests, does not foster understanding or a spirit of transparency between Tribes and the Area Office.

### 3. Identify Staff Associated with Each PSFA

In addition to asking for budgets associated with each PSFA, tribes have also asked for the number and salaries of staff associated with each PSFA. In its most recent response, IHS stated that:

*Positions are not defined by PSFA or Inherent Federal functions (IFF). All positions function under one or more PSFAs and many perform some percentage of IFF.*

It is difficult to understand how the IHS can have a budget associated with each PSFA without knowing which Staff are associated with each PSFA, as we would expect that staffing makes up the majority of the budget for each PSFA. While we recognize that individual staff may work on more than one PSFA, the Area Office must define the number of FTEs and individual staff along with their associated salaries associated with each PSFA. We reiterate our request for this information, or the alternative, which is to discuss why this information is not obtainable.

### 4. Provide Service Unit Budget books to Tribal leaders

We thank the IHS for doing the work required to prepare budget books for each Service Unit and request that those budget books be made publically available and be updated on a monthly basis. Providing the budget books on a dedicated website would be helpful.

### 5. Complete work on Area Office Budget Book and provide to Tribal leaders when complete.

### 6. Identify all Area Office Programs listed in Table 6, including citation to legislative and/or appropriations authority, and identify the individuals they serve

### 7. Identify all Special Programs listed in Table 6 and the individuals they serve<sup>24</sup>

It is the intent of the Great Plains tribal leadership to continue its pursuit of detailed budget, programs, staffing and operational information for the GPAIHS, and to recommend concrete management recommendations based on ongoing evaluation of information provided and the input of workgroup and subcommittee members.

<sup>24</sup> Similarly, Row 64 has an entry for "Resource Management," but those totals are not broken out by PSFAs associated with "Resource Management" – Business Office, Health Information Management, and "Office of Resource Management." We request a breakout by PSFA.

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## NASHVILLE

### 1. DOMESTIC VIOLENCE ON THE RISE

**Background:** Domestic Violence incidents have increased in certain Tribal communities. Tribes have reported the need for additional funding to support domestic violence prevention activities including support groups, family shelters and tele-behavioral health opportunities.

**Recommendation:** Tribes have recommended a recurring funding opportunity to support domestic violence prevention initiatives.

### 2. SUBSTANCE ABUSE REHABILITATION AND AFTERCARE

**Background:** When surveyed, the Nashville Area Tribes reported the need for additional funding to combat substance abuse, particularly opioid abuse, through detox, rehabilitation and after-care services.

In addition to funding needed to support detox and rehabilitation efforts, Tribes have reported a critical need for aftercare services. Time and time again, Tribal members are re-entering the community and reservation without access to professional support services to prevent them from falling into the same crowds

and behaviors that led them to past abuse. Additional funding would be directed to support groups, sober-living opportunities, job placement and other resources to encourage a clean and drug-free lifestyle.

**Recommendation:** Tribes have recommended additional recurring funding opportunities to support detox, rehabilitation and aftercare services.

### 3. OFFSET INCREASES IN PHARMACEUTICAL COSTS

**Background:** Additional funding is needed to support the growing costs of pharmaceuticals, which are particularly taxing on the general and PRC budgets for a small or rural ambulatory clinic.

As the cost of pharmaceuticals continues to rise, Tribes have expressed the need for additional funding to assist in offsetting those costs. Many of the larger Tribes across the country have identified other resources, such as gaming and other business venture revenues, to supplement their healthcare operation, particularly the PRC program. However, many small and rural clinics suffer from these rising costs and also from the barriers to new forms of revenue generation. Tribal health program budgets

become strained and, as a result, Tribal members are negatively affected.

**Recommendation:** Tribes have recommended additional resources be appropriated to support inflation costs. Current increases are appreciated but simply not enough to cover unmet needs.

### 4. MAINTENANCE & IMPROVEMENT FUNDING NEEDED

**Background:** Tribes have expressed the need for additional Maintenance and Improvement funding, as well as construction funding for new and expanded facilities.

Tribes have asserted that funding for clinic maintenance and improvements is not enough to be sustainable. Tribes have also raised concerns about the lack of funding to support new construction and expansion needs.

**Recommendation:** Tribes have recommended increases in both M&I and construction funding to support critical maintenance and construction needs.

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## NAVAJO

### 1. HOUSING SHORTAGE AT CROWNPOINT SERVICE UNIT (CPSU)

**Background:** The CPSU is one of the Service Unit under Navajo Area Indian Health Service and it provides health care in eastern portion of the Navajo Nation. The existing CPSU healthcare facilities include: a) 20-bed Crownpoint Healthcare Facility (CHCF) that opened in 1987; b) Pueblo Pintado Clinic that opened in 2001; and c) Thoreau Clinic that was first established in 1994 and opened a new clinic in 2011. On a yearly basis CPSU serve around 21,300 patients at these facilities. The Service Unit serves 16 Navajo Chapters that are located in Eastern Navajo Agency.

The CPSU is currently experiencing a staff housing shortage and this situation is adversely impacting the retention and recruitment of healthcare professionals. The existing Crownpoint Hospital was built in 1987 and this was the last time a number of

housing quarters were constructed. In 1987, there were approximately 265 employees and this number has grown today to over 400 employees. In year 2016, 86 housing quarters are available including: a) 36 housing units which built in 1987 when the hospital was constructed; b) 33 modular housing units that were purchased in 1967 (Long Mark Units); c) 16 houses that were built in 1962; and d) one house that was built in 1934. Hence, there has been no increase in housing quarters since 1987 while the number of personnel has grown significantly during the same time period.

The available IHS housing quarters in Crownpoint are usually fully occupied by physicians, nurses, medical technicians, medical technologists, x-ray technicians and other essential personnel. No private housing or public rental is available for the current healthcare work force in Crownpoint or in surrounding communities. The Crownpoint Hospital is located 60 miles northeast



of Gallup, NM and approximately 55 miles northwest of Grants, NM, and these are the closest towns to Crownpoint where some houses are available for purchase and/or rental.

Further, land around Crownpoint are considered to be Navajo Nation Trust lands, Indian Allotments, fee lands or State lands and this situation inhibits any healthcare professional from owning a private home or renting a home. In and near Crownpoint, there is public housing available that is provided by the Navajo Housing Authority (NHA). NHA receives funding from the U.S. Housing & Urban Development (HUD) and it provides low income rentals or mutual help housing program to eligible tenants. The only other housing resource is one privately owned trailer court. The CPSU and Navajo Area IHS officials are fully aware of the housing shortage but lack of federal funding to build additional IHS housing quarters is a major challenge. Historically, funding for IHS staff quarters became available when a new hospital or health center is constructed- hence no new construction has occurred since 1987. The only other available resources to finance IHS housing quarters are Medicare, Medicaid or private insurance revenues collected by CPSU but these funds are used to pay for personnel salaries, equipment or other costs associated with patient care.

To help address the housing shortage, Navajo Area IHS entered into a contract with private firm from Albuquerque, NM in 2014 to perform a housing feasibility study and to develop conceptual plans-the feasibility study identified the need for 80 new housing units for CPSU. The 2014 housing feasibility study was helpful in purchasing and setting up six manufactured homes in Crownpoint in May 2016-this has lowered the need for 80 housing units to 74. Also in spring 2016, additional funding was acquired with the assistance of Navajo Area IHS, and these funds will help in replacing four modular quarters (repair-by-replacement) and to construct 19-apartment complex sometime in 2017. Upon completing the two new housing initiatives, the Service Unit will still be in need of around 55 housing quarters based on the 2014 feasibility study.

**Recommendation:**

- Request for available federal funding to assist CPSU construct additional 55 IHS housing quarters.
- Enable CPSU to seek other options such as partnership with NAHASDA, HUD and/or other Tribal or State resources.

## 2. IT INFRASTRUCTURE AND SECURITY

**Background:** Information Technology (IT) Infrastructure and Security. Information Technology plays a vital and critical role in

every aspect of Indian Health Services. Much of the current systems are outdated and in need of upgrading and consolidation.

**Recommendation:** Allocate sufficient funding and continuing support to the IT infrastructure development requirement. The system must be up-to-date and ultimately reduce costs and meet efficiency imperatives through integration of IT needs among all segments of the Indian Health Service organization. Such development of a consolidated inter-operable system to replace the existing fragmented hospital systems can increase efficiency, better patient care, and provide opportunities for additional health awareness among citizens within the service area.

## 3. OFFICE SPACE SHORTAGE AT CROWNPOINT SERVICE UNIT (CPSU)

**Background:** The CPSU is one of the Service Unit under Navajo Area Indian Health Service and it provides health care in the Eastern portion of the Navajo Nation. The existing CPSU Healthcare Facilities includes:

- a) 20-bed Crownpoint Healthcare Facility (CPSU) opened in 1987;
- b) Pueblo Pintado Clinic opened in 2001;
- c) Thoreau Clinic that was first established in 1994 and opened a new clinic in 2011.

On a yearly basis CPSU serve around 21,300 patients at these facilities. The Service Unit serves 16 Navajo Chapters that are located in Eastern Navajo Agency.

The CPSU is experiencing office space shortage and is adversely impacting the retention and recruitment of employees, internships, health professional contractors, Navajo Nation Workforce employees, and volunteers on a daily basis. The Crownpoint Service Unit was built in 1987 with no projections or planning with staff development for future growth. In 1987, there were approximately 265 employees and this number has increased to over 350 employees in FY 2017. Due to the remote and rural location of Crownpoint Service Unit there is very limited economic development and no office development available in Crownpoint, New Mexico.

Crownpoint Service Unit has committed \$1M to Modular Office Buildings utilizing Medicaid Revenues from FY 2016, however, with various land/soil/material assessments and fabrication of modular buildings it will require \$4M to \$6M to complete Modular Office Buildings at Crownpoint Service. The cost assessment requires:

- a. Soil Assessments - Soil testing, foundation, topology graphs, and blueprints.

- b. Utility Resources - Water Lines, Sewer, Electrical and Gas Lines.
- c. Property Access - Parking lot, curbs, drainage access, light poles, fire hydrants.
- d. Pre-Fabricated Modular Office Buildings - Weather resistance, stability, and warranty and location of vendor(s).
- e. Propose to purchase at least 6 to 10 Office Modular Buildings. Supporting Documents Attached.

Crownpoint Service Unit, Crownpoint Community Leaders, and Navajo Area IHS officials are fully aware of the Office Space shortage but lack federal funds to build additional Modular Office Buildings is a major challenge. The only other available resources to finance Modular Office Building is with Medicare, Medicaid and/or Private Insurance Revenues collected each fiscal year by CPSU but these funds are used to pay for personnel salaries, medical and nursing contractors, patient transports, medical and non medical equipment, facility maintenance, and other costs associated with patient care.

**Recommendation:**

- Proposal and request for federal funding of \$4M to \$6M to purchase and/or construct Office Modular Buildings for Crownpoint Service Unit
- Permission to allow Crownpoint Service Unit to seek Grants and/or other Tribal or State resources.

#### 4. ORAL HEALTH

**Background:** Early childhood caries (cavities) is the number 1 chronic disease affecting young children. The Navajo Area dental program is able to see less than 29% of its user population and unable to meet Early Childhood Caries objective for dental access for children under the age of 0-2; thus, increasing dental treatment for children 0-5. In an effort to counter the high numbers of caries and reduce extensive dental treatment in children, training will be provided to the Navajo Community Health Representatives (CHR) to go into communities to promote oral health education and increase awareness surrounding oral health and subsequently decreasing caries in children across the Navajo Nation.

**Recommendation:** Expand Oral Health Education and Training for the CHR/Outreach Program. According to the American Dental Association, the standard for dentist to population ratio is 1:1200. Since there is a shortage of dental providers on the Navajo Nation, we are experiencing a ratio of 1:4200. It is imperative for training CHRs in order to counter the problem by providing education on oral health to the community. The infectious nature of dental caries and the potential of early

interventions require a high emphasis on preventive oral health care in primary pediatric care to complement existing dental services. However, many pediatricians lack critical knowledge to promote oral health.

Treatment services will never successfully tackle the underlying cause of oral diseases without the help of community health workers. The Navajo Community Health Representative Program will construct an essential organizational and workforce capacity to magnify access to oral health education, prevention and treatment services to all new and expecting mothers, infants, and children throughout the Navajo Nation.

It will cost \$48,006 to send 12 CHRs to attend Central New Mexico Community College to receive training with Community Dental Health Coordinator, the cost includes tuition, books, institution fee, and travel expenses.

#### 5. POVERTY

**Background:** In the United States, concerns over things like smoking and lack of access to health care are agreed upon as areas that affect the health of community members. Less obvious are education and income levels and their effect on health although there is a strong correlation between income levels and health. Community members who are poor are less healthy than those with means. In Indian Country, much of the population is poor with the resulting acute or chronic diseases, mental health issues, and mortality among Native Americans. Health systems can play an important role in improving the lives and health of community members through outreach and education initiatives for which funding is needed within Indian Health Service.

**Recommendation:** Finding appropriate solutions is difficult thus funding is needed for research of best practices among Indian communities with the understanding that locally customized programs can yield best results. Programs to inform and educate community members add value to improving the lives and health need funding after research is completed. Further, funding is needed for pilot programs and follow-on widespread implementation.

#### 6. NAVAJO AREA LAND PURCHASE

**Background:** Existing land areas utilized by Indian Health Service are not sufficient to accommodate the needs of the health service providers and patients. Additional facilities and structures require the purchase of needed land both for structures and parking. For instance, the Crownpoint Health Care facility has insufficient land on which housing structures can be built. For these health facilities, housing is critical for employees. If

housing is not available, it is difficult, often impossible, to recruit the much needed health care professionals and staff. Further, Gallup Indian Medical Center is in dire need of additional parking for patients and staff.

**Recommendation:** Allocate sufficient funding to purchase the required land for additional facilities and structures needed for patients, staff and medical professionals.

## 7. FUNDING AGREEMENT FOR LONG TERM CARE SERVICES

**Background:** Long Term Care is needed for the elders, especially in Western Navajo area, where many elders are unable to live at home alone and have no other methods for them to remain in their home without supportive assisted care. The assisted care does not include the use of nursing care; only enough assistance to have routine medication administration, such as, individuals that are frail, disabled, or have other issues, which can include forgetfulness or the mental inability to recall a medication regimen on their own.

A master plan completed by Tuba City Regional Health Care Corporation (TCRHCC) demonstrates that there would more than approximately 15,000 adults above 65 years old. Of this approximate age, in 2012, from the Tuba City Area Service Unit, 784 individuals needed placement in post hospital facilities after discharge from an inpatient setting. From TCRHCC alone, in fiscal year 2014, about 4 to 5 elders a month were sent to facilities, such as the; The Peaks in Flagstaff, Haven of Flagstaff, and Winslow Campus of Care.

Historically, in 2010, the Navajo Area Agency Report on Aging, performed a study of seniors who lived independently on the Navajo Nation. Results showed that greater than one in ten seniors needed assistance getting in and out of bed, getting dressed, or using a toilet. Nearly one-quarter needed assistance in taking a bath and nearly one-third needed help with food preparation. The burden of sadness they feel when forced to leave their community is extreme and they have significant difficulty communicating with off-reservation medical and care providers who do not speak Navajo. The community as a whole also suffers from the displacement of elders; without elders, children and teenagers lose the knowledge of their history and culture.

**Recommendation:** Long Term Care, Elder Care, on the Western Navajo Reservation A 90 bed Long Term Care facility on the Western Navajo Nation that could offer a comprehensive range of services, which will preserve the dignity and quality of life of the Navajo elders as they age and prolong the amount of time they are able to live independently. TCRHCC recognizes the

need for a Long Term Care facility for the population it services and has included it in the continuum of care for the elders/disabled in our communities and which also includes the Kaibeto Independent Living.

The TCRHCC Service Area community members have voiced their need for elder services, and specifically, an Elder Group Home Facility. In the 2011 Tuba City Service Area Community Health Survey, 78.7 percent of respondents stated that Care of the Elderly was “absolutely needed.” Out of 44 identified needs, these needs were first and third, respectively. A modern Long Term Elder Care Facility is desperately needed on the Navajo Nation and will preserve the personal dignity and quality of life for our Navajo Elders. When the facility is built the elders of the region will be able to remain close to their families and communities while benefiting from healthier living conditions and high quality care from trained culturally competent staff.

## 8. SEX TRAFFICKING IN INDIAN COUNTRY CLINICS AND HOSPITALS/HEALTH EDUCATION/PREVENTION

**Background:** Human trafficking is the obtaining or maintaining of another person in a condition of compelled labor or service through means of force, fraud, or coercion (cannot consent to enslavement), hence referred as modern day slavery. Trafficked persons considered victims are men, women, transgender, youth, children, and adults. Unfortunately, victims blame themselves, are usually unaware of their rights, and may not identify themselves as victims.

Human Trafficking is occurring among Native families, as young children are sold for sex in exchange for financial profit to support their families. Trafficking can happen in venues such as casinos, tribal fairs, local social events, businesses and community access areas such as, truck stops/shopping centers, to name a few. Trafficking can be fueled by economically desperate victims and the demand for cheap labor and commercial sex (Office for Victims of Crime, December 2010). Perpetrators are opportunistic and prey upon the vulnerable; they come in the form of individuals, romantic partners, gang members, tribal members, families, and people with power and status (Office for Victims of Crime, December 2010). The enactment of local tribal government laws are critical in maintaining the family unit and tribal cultural values.

Tribal reservations/villages have culturally appropriate services, but lack knowledge about human trafficking. Reported outcomes have identified lack of specific housing for American Indian/Alaska Native (AI/AN) trafficking victims on or off reservation, and transitional shelters are unable to provide needed protection

from traffickers or others. Additionally, Tribal Law Enforcement agencies lack resources and capacity to respond to reports. Lack of trafficking laws may impact tribal law enforcement's level of awareness and authority to arrest human trafficking offenders. Consequently, the Bureau of Indian Affairs (BIA) lack personnel to conduct investigations.

**Recommendation:** Provide assistance to tribal communities to develop relevant laws, statutes, ordinances, or codes on human trafficking. Tribal governments must enact legislation to allow for the prosecution of perpetrators.

Authorize and appropriate \$500,000 in funding to AI/AN organizations, under the Preventive Health line item, to address Sex Trafficking in their communities. Legislation must allow funding for victim protection, prosecution and public education on prevention.

Culturally sensitive service are critical to victims impacted by sexual trauma as a result of sexual assault and/or sex trafficking. Coordination among local communities, and multi-disciplinary professionals, in partnership with traditional practitioners, is a necessity to restore harmony and balance to impacted victims and families.

## 9. ONCOLOGY SPECIALTY SERVICES FOR THE NAVAJO RESERVATION

**Background:** There is an urgent need for Oncology Specialty services on the Navajo Nation. There are no available services for Navajo Native Americans, who require diagnostic, interventional therapeutic treatments for cancer diagnoses, cancer surgical inventions, cancer chemotherapy and cancer radiation therapy. There are over 550+ Uranium Mines that leach into the ground in Northern Arizona. These mines contribute to the cancer rate on the Navajo Nation. The poverty rate is 43 percent; double that of Mississippi, which is the worst among the 50 states. Navajo unemployment hovers at 42 percent, which is six times that of Alaska, who has the highest unemployment rate among the states. The median household income of \$20,005 is so low, that nearly every Navajo family qualifies for food stamps.

Imagine, as a patient you are urgently hospitalized and you have never been in the hospital and you don't speak English.

Primary cancers on the Navajo Reservation: Colon, Stomach, Liver, Breast and Gynecological Cancers.

Significant issues:

- No available medical services; difficulty with access to support resources for transportation, temporary housing

and meals for families of hospitalized patients receiving cancer treatment therapies, who are sent to urban healthcare facilities (Phoenix, Tucson, Albuquerque).

- Lack of available Navajo translation resources at urban healthcare facilities (Phoenix, Tucson, Albuquerque).
- Failed attempts to provide culturally sensitive care with respect to unique Navajo traditions and traditional medicine healing practices.

### **Recommendations:**

- Comprehensive Oncology Services; funding allocations to support the development, construction and implementation of a regional oncology diagnostic and therapeutic treatment center, on the Navajo Reservation to serve all tribal residents locally.
- Funding to support family needs, while accompanying patients receiving oncology services (temporary housing, meals and transportation).
- Financial support for oncology pharmacology costs associated with oncology services
- Present case for Specialty Care Clinic Construction and fund through Facilities Advisory Board at I.H.S. Headquarters.

## 10. VA MOU: SERVICE DELIVERY/ REIMBURSEMENT COSTS.

**Background:** The VA-IHS Reimbursement Agreements Program provides a means for IHS and Tribes to receive reimbursement from the VA for direct care services provided to eligible American Indian/Alaska Native (AI/AN) Veterans. This program is part of a larger effort set forth in the VA and IHS Memorandum of Understanding signed in October 2010 to improve access to care and care coordination for our nation's Native Veterans.

**Recommendations:** That the MOU continued to be reaffirmed by HHS/IHS and Department of Veteran's Affairs with the following:

- Although healthcare insurance coverage is important, it is only one component of access to care, most especially for our Navajo Veterans. We find that that although barriers to care due to cost are nominal for AI/AN veterans, barriers to care due to navigating the health-care system (at both VA, IHS, and Tribal Clinics), and due to lack of transportation remain substantial. Both VA and IHS must find ways to navigate their internal systems to accommodate and assist the AIAN Veteran.



- That IHS, and Navajo Area, be provided monthly reports and metrics that capture the total amount of funds disbursed, total # of veterans, total billed charges, total VA amount paid (inpatient, outpatient, ancillary, and pharmacy file sources), and total number of claims using the Central Fee Files and Fee Basis Claims System (FBCS) specific to the MOU. The amount of reimbursement is significant to
- The One Program One Rate proposal (New Veterans Choice Program) proposed by the VA is not beneficial for our Native Veterans, to include Navajo; as the VA's effort to improve continuity of care and health care access for all Veterans can be achieved by consolidating multiple community care (non-VA care) programs into one standard program with standard rates.
- Furthermore, according to the department, "the plan is consistent with title IV of the surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (also known as the VA Budget and Choice Improvement Act)."; this impacts the VA Reimbursement Agreements between the Indian Health Service (IHS) and Tribal Health programs to provide thousands of Veterans access to community care; most especially in the rural area.
- The presence of VA staff at IHS and Tribal Clinics is important for continuity of care and collaboration; most especially in Navajo; which should include mobile VA Clinics for outreach and services.
- Establish a domiciliary care center for elderly Navajo Veterans; as charged under the Department of Veterans Affairs Health Care for Homeless Veterans Program and Homeless Domiciliary Programs to provide outreach,

case management, and residential treatment services for homeless Navajo veterans.

- VA and IHS and Tribal Clinics continue to hire and utilize Navajo Traditional practitioners as an alternative in providing health care services

#### JUSTIFICATIONS:

- The VA wants to institute a co-pay system which will be problematic, and will eventually slow the process for Native Veterans The implementation of a co-pay system is contradictory; paying a co-pay would violate the government's responsibility to provide health care to Tribal Nations and veterans."
- The INTENT of the MOU was to assist and accommodate Native Veterans getting services at IHS facilities, rather than having to travel to outside VA hospitals.
- The Navajo Nation is the size of West Virginia and encompasses three states (New Mexico/Arizona/Utah), if the MOU was to be amended or extinguished, it would hinder and complicate the current process and would eventually affect all Tribal Nation and thousands of Navajo Veterans.
- This consolidation would also implement at counter rate vs. an all-inclusive rate. A counter rate being solely inclusive of service from the doctor and an all-inclusive rate including a percentage of costs associate with overhead to support the facilities.

In addition, as you may know the NIHB supports the all-inclusive rate to put funds toward the IHS or other facilities the veterans utilize.

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## OKLAHOMA CITY

### 1. PRESERVATION OF THE INDIAN HEALTHCARE IMPROVEMENT ACT AND OTHER PATIENT PROTECTION AND AFFORDABLE CARE ACT PROVISIONS SERVING AMERICAN INDIANS AND ALASKA NATIVES

Support for the retention of the IHCIA in any efforts to repeal or replace the ACA (P.L. 111-148) is of vital importance. The IHCIA is unrelated to the overall ACA, and revoking this law would have

catastrophic consequences for the Indian health system and AI/ANs nationwide. Provisions included in the IHCIA were a result of years of negotiations, meetings and strategy sessions between Tribes and Congress resulting in legislation that was not only impactful, but bipartisan.

First enacted in 1976, the IHCIA is the legislative embodiment of the federal trust and treaty responsibilities to AI/AN people for healthcare. IHCIA was permanently enacted in 2010 as part of

the ACA (Section 10221) in an effort to pass this long-stalled legislation. It serves as the backbone legislation for the ITU health system which provides healthcare services for AI/ANs in fulfillment of the federal government's trust responsibility for health that is derived from statutes, treaties, and executive orders.

IHCIA states that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians — to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy" and reaffirms a system for the federal government to do so. The law provides the foundational authority for the Indian Health Service to be reimbursed by Medicare, Medicaid and third party insurers, to make grants to Indian Tribes and Tribal organizations, and to run programs designed to address specific, critical health concerns for Native Americans such as substance abuse, diabetes and suicide.

Six years later, IHCIA has provided significant progress in the I/T/U system. IHCIA updates and modernizes health delivery services, such as cancer screenings, home and community based services, hospice care, and long term care for the elderly and disabled. It 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. Additionally, it provides many essential cost-saving provisions for IHS and Tribes, such as the authority for I/T/U health providers to be licensed in any state and practice at an I/T/U facility. The law also authorizes IHS and Tribes to enter into arrangements with the Department of Veterans Affairs and Department of Defense to share medical facilities and services which increases government efficiency and ensures that AI/AN Veterans (who serve at a percentage than any other group) are taken care of. IHCIA allows I/T/U providers to be eligible for participation in any federal healthcare program and for reimbursement from 3rd party payers which is critical to bring in additional resources into the I/T/U system.

Other provisions also exist within the ACA, separate from IHCIA, we strongly believe must be preserved to ensure that the Indian health delivery system remains viable. These provisions are also unrelated to the overall healthcare reform legislation and are as follows:

- **Section 2901** which states that any I/T/U be the payer of last resort for services provided notwithstanding any Federal, State, or local law to the contrary.
- **Section 2902** which grants I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.

- **Section 9021** ensures that any health benefits provided by a Tribe to its members are not included as taxable income.

**Maintaining Medicaid Benefits for AI/ANs.** Under current law, the federal government reimburses States for 100 percent of the cost of providing Medicaid services to AI/ANs. Any plan to change the manner in which State Medicaid costs are reimbursed by the federal government must include a carve out for services provided to AI/ANs so that the federal government obligation is not shifted to the States. Even though this is not an ACA provision, it is a vital component to ensuring the stability of the Indian Health system.

Repealing these provisions and the IHCIA now would have disastrous consequences for the Indian health system. I/T/Us would lose critical 3rd party revenue, legal authorities, and life-saving programs. In any path forward on healthcare reform, we urge you to ensure that this law is preserved so the Indian health system can continue to operate under a framework appropriate for 21st century healthcare delivery and honors the United States' trust responsibility to provide healthcare to AI/AN's.

## 2. SEQUESTRATION

Already suffering at a severely deficient funding level, Congress did not exempt IHS from Sequestration in FY 2013 as they exempted all other major federal health programs. This oversight instantly set the IHS back nationwide (all I/T/U) by approximately \$166 million, creating a funding hole that has not been recovered. It is imperative that IHS not be forgotten when exemptions to sequestration are granted to Veterans Health Administration, Medicaid, and Medicare, should sequestration rise again as a federal budget issue.

Further, the OCA continues to advocate that previous reductions resulting from Sequestration be restored. While the IHS has received some incremental increases in certain lines since FY 2013, these increases could not be reallocated to the exact lines/programs and exact locations affected by Sequestration. In several cases, new funding came with the new requirements to create programs or address other mandates, rather than be used to restore the effects of the dramatic cut in FY 2013.

## 3. MEDICAID REFORM AND THE INDIAN HEALTH SYSTEM

The Medicaid program is a critical component in the United States' fulfillment of its trust responsibility to provide for the healthcare needs of AI/ANs. Without continued access to Medicaid resources, the Indian health system will suffer.

All of the current Medicaid Reform proposals would have significant negative impacts on the Indian health system if they do not account for Indian Country's reliance on the Medicaid program to narrow the gap between the unmet needs of AI/ANs and the chronically underfunded Indian health system.

For decades, the Indian health system has been chronically underfunded, leading to a large gap in the healthcare needs of Indian people. In 2014 for example, the per capita spending for IHS patient services was \$3,107 as compared to \$8,097 per person nationally. Medicaid funding is crucial in filling the disparity gap created by inadequate IHS funding. Without it, many IHS and tribal facilities would not be able to offer necessary programs and lay off critical staff.

In FY 2016, IHS and tribally operated facilities received \$808 million in Medicaid funding for services provided to the Medicaid eligible individuals they serve. This represents 13 percent of the total funds received by IHS facilities in 2016. Medicaid today covers 34 percent of non-elderly AI/ANs and more than half of AI/AN children.

In 1976, Congress enacted Title IV of the IHCA which amended the Social Security Act to require Medicare and Medicaid reimbursement for services provided in IHS and tribally operated health care facilities. This was intended to help fulfill the federal trust responsibility and bring additional revenue into the Indian health system.

In order to ensure that Medicaid funding was supplemental to IHS funding, Congress enacted a complementary provision that provides that Medicaid reimbursements are not to be considered when determining future appropriations for the IHS.

Congress took steps to ensure that IHS access to state Medicaid services not unduly burden the states with what is a federal responsibility. Congress amended Section 1905(b) of the Social Security Act to apply a 100 percent FMAP for services provided to AI/ANs that were received through an IHS or tribally-operated facility. On February 26, 2016, CMS revised and expanded its interpretation of the 100 percent FMAP provision to include services provided by outside providers referred by IHS or tribal facilities.

Current Medicaid funding is not capped, as the cost of Medicaid is split between the states and the Federal government with the Federal government paying anywhere from 50 to 83 percent of the costs depending on a state's FMAP. Also included, is a special 100 percent FMAP rule for services provided to AI/ANs that are

received through IHS and tribal health care facilities. There is no cap or ceiling on the amount of Federal funding that is available.

Restructuring Medicaid as a block grant or per-capita program would eliminate the FMAP reimbursement methodology, including the special 100 percent FMAP rule for services provided to AI/ANs that are received through IHS and tribal health care facilities. The current proposals do not contain any carve out that would maintain federal responsibility for the cost of providing Medicaid services to AI/ANs.

Also, the Medicaid reform proposals do not contain any of the benefits and protections Congress previously enacted for Indian health programs and AI/AN beneficiaries. As a result, these proposals give rise to two main concerns for IHS, tribal and urban Indian health programs.

- First, that the Medicaid statute will be amended to allow States the flexibility to impose across the board requirements that will reduce access to Medicaid services for AI/ANs.
- Second, that Medicaid funding will be changed in a way that no longer recognizes that Medicaid funding for AI/ANs is a federal responsibility.

The following Tribal Medicaid protections must be preserved in any federal Medicaid reform proposal:

- Right of Indian health programs to participate in Medicaid on the same basis as other providers;
- Protections for AI/ANs from premiums and cost-sharing requirements;
- Tribal presumptive eligibility determinations;
- Use of documents issued by tribes as proof of citizenship for Medicaid enrollment;
- Protection from mandatory enrollment in managed care plans;
- AI/AN right to see Indian healthcare provider of their choice, even if not a Managed Care provider;
- Right of Indian healthcare provider to be paid by a managed care plan whether or not they are enrolled as a participating provider;
- Right of Indian healthcare provider to be promptly paid at the IHS Reimbursement Rate ("OMB Rate") or a rate set out in State plan;
- Disregard of certain Indian property from resources for Medicaid and CHIP eligibility; and
- Medicaid estate recovery protections.

Due to the unique nature of the Indian health system, funding for services provided to AI/ANs should also be continued to be reimbursed under the current 100 percent FMAP rule.

To the extent that any Medicaid Reform proposal contains carve outs or exceptions from a general block grant or per capita allocation rule, Indians should be included.

Without an exception or carve out for block grant or per capita allocation funding, a tribal set aside should be included.

The funding amounts could be based on historic funding for IHS, tribal and urban facilities in each state and be allocated to a separate “federal Indian Medicaid allocation” account. IHS, tribal, and urban programs would bill against the account until funds were exhausted, at which point CMS would add supplemental funding.

This mechanism would separate a Federal Medicaid program for AI/ANs from a block grant or per-capita program for the states. Such a Federal Medicaid program for AI/ANs would be administered by CMS through fiscal intermediaries.

The Medicaid program plays a vital role in augmenting the chronically underfunded Indian health system. Any version of Medicaid reform is sure to have wide reaching impacts on the provision of health care in Indian Country. It is of vital importance that AI/AN input is considered as Congress and the new Administration develops their plans for reform.

#### 4. SANITATION DEFICIENCY SYSTEM (SDS)

In the Introduction of the SDS Review draft dated March 2016, it is stated in the opening sentence of the second paragraph, “This guideline is intended to ensure uniform standards and procedures are applied for identifying deficiencies and for developing projects to address them in all IHS Areas.”

There are terms being used and defined by IHS which limits funding based on make-up of population which negatively impact the Indian population of Oklahoma. The primary term used is mainly the term “non-Indian community”.

During the IHS Headquarters (HQ) SDS review for projects for FY 2017, HQ made journal entry comments on 84 projects stating:

“This is a non-Indian community. As stated in the SDS Guideline ‘Most projects for non-Indian communities should be DL2 projects, since they are to make capital improvements.’ Change to DL3.”

The lower the Deficiency Level (DL), the fewer points assigned to the project, and determines whether the project is funded or even if the project is reported to Congress as a ‘need.’

The DL of a project should only be associated with the deficiency of the sanitation facility itself. An arbitrary definition of “non-Indian community” should not have any bearing on the DL since the DL is to report the sanitation condition of a facility.

Due to the unique history of Indian lands in Oklahoma, the vast majority of AI/ANs to be served in Oklahoma live on scattered sites, which are interspersed with non-Indian homes. This arbitrary labeling as “non-Indian” communities is inappropriate as these families are equally eligible for the program. All IHS funds only go to eligible AI/AN homes and all projects are pro-rated appropriately, irrespective of which community the AI/AN eligible homes are located.

P.L. 94-437 and Appendix E of the 2003 SDS Guideline reference deficiency levels with sanitation systems/facilities and do not associate the DL with the type of community.

This change of practice at HQ to lower SDS projects based on ethnic profiles rather than sanitation facility deficiencies substantially disadvantages Oklahoma and the AI/AN we serve.

The “non-Indian community” term should be removed from the Guideline, because the purpose of the Guideline is to uniformly apply standards and procedures for identification of deficiencies in sanitation systems for Native Americans.

#### 5. HOUSING FUNDS

Funds for Housing Support Projects serve the “Scattered Sites” for “New” and “Like New” homes. This funding is provided by IHS for sanitation systems, both water and wastewater. Annually, some Tribes only receive a quarter to a third of the necessary Housing funding for current demand.

The current demand is not being met by the combined Housing dollars and regular project dollars. For hundreds of homes in Oklahoma each year, these Native American families do not have the means to provide sanitary water and wastewater for their homes. Surfacing sewage contaminates surface waters which may be used for public water supply and/or recreation. These families are reduced to hauling water to their homes for domestic purposes.

The OCA housing funds must be increased to meet the demand of the service population. IHS HQ has routinely placed a lower priority on scattered sites which unfairly underfunds Oklahoma



and these Native American families who are equally eligible and in need. The result is that the OCA receives less Housing dollars proportionate to the number of Indian homes and population than most other Areas.

## 6. ENGINEERING FEES

SDS project exclusions for engineering fees have been applied erroneously. Engineering fees are eligible for IHS Regular funds on a pro-rata basis when IHS is not the project manager.

During the review process for FY 2017, HQ arbitrarily excluded many projects for having engineering fees regardless if they were eligible expenses. The exclusion of projects from the SDS need has a negative effect on regular funding for the Tribes and Nations located within the OCA.

In summary, the application of these policies to the OCA is an unfair application and we therefore, request transparency and fairness for the application of policy for the SFC program, particularly at HQ.

## 7. SDPI PERMANENT PART OF BUDGET

The Special Diabetes Program for Indians (SDPI) is a proven, successful program with measurable improvement in health outcomes. SDPI has been authorized annually until FY 2015 when it was authorized for only two years. Further, the funding level has remained stagnant at \$150 million nationally, which has not kept pace with the growing costs of medical care. This represents an effective decrease. Calculating for inflation, \$150 million in 2002 would be about \$115 million in 2014 – or 23 percent less. Tribes nationally have consistently recommended that SDPI be authorized on a permanent basis, and that the funding level be increased from the existing \$150 million to \$200 million annually. The OCA Tribes support the national recommendations for permanent authority for SDPI with a \$200 million funding level for FY 2018 and forward. Finally, the OCA Tribes support the current national allocation of these funds.

## 8. REDUCE CHEF THRESHOLD TO \$19,000 AND ELIMINATE INFLATIONARY INCREASE

Section 122 of the IHCA requires that the initial CHEF threshold be set at \$19,000, and increased each succeeding year by medical inflation. The recent appropriations level for CHEF, as well as an overall decrease in CHEF requests have resulted in funding nearly all of the eligible requests nationwide. To increase the threshold annually without a cap would place an undue burden on small PRC programs to provide the cash flow required to pay for these catastrophic medical cases up front, and wait for possible reimbursement later in the year. CHEF

appropriations do not automatically increase for inflation each year, which makes inflating the threshold all the more unreasonable. Very small programs have limited resources for PRC overall and would be required to deny critically needed medical care due to inadequate funding to float the cash for CHEF cases. Accordingly, the OCA Tribes recommend that the budget request include a request to keep the CHEF threshold at \$19,000 and eliminate the requirement for annual inflationary increase.

## 9. CONSTRUCTION FUNDING BEYOND PRIORITY LIST

Health Care Facilities Construction (HCFC) Appropriations are the primary source for new or replacement healthcare facilities. The number, location, layout, design, capacity and other physical features of healthcare facilities are essential in eliminating health disparities, improving patient outcomes and increasing Access. The absence of an adequate facility frequently results in either treatment not being sought, sought later prompted by worsening symptoms and/or referral of patients to outside communities which significantly increases the cost of patient care and causes travel hardships for many patients and their families. The health-care physical environment has long been recognized as having a substantial bearing on patient care experiences and patient outcomes. There is overwhelming rigorous research, more than 600 credible studies, that links the physical environment of care to health outcomes.

The IHS uses the HCFC appropriations to fund projects off the “grandfathered” HCFC Priority list until it is fully funded. In the late 1980s Congress directed IHS to develop the HCFC priority system. The system was implemented in the early 1990s with 27 projects on the initial list. Most projects are major capital investments exceeding annual HCFC funding resulting in projects being funded over several fiscal years. Projects are funded in phases according to acquisition, engineering, and project management requirements. Portions or phases of several projects are funded during a given fiscal year. This allows several projects to move forward simultaneously and helps distribute the funds geographically benefiting more than one Area. There are 13 remaining facility projects on the “grandfathered Priority List” with a current estimated completion cost of \$2.1 billion. Once those 13 projects are funded, the remaining \$8 billion need can be funded with a revised priority system that will periodically generate updated lists.

Approximately 5% of the U.S. annual health expenditures are investments in health care facility construction. In 2013, that \$118 billion investment in health care facility construction equaled ~\$374 per capita compared with IHS health care facility construction appropriation of \$77 million or ~\$35 per AI/

AN. That means the nation invests annually in health care facility construction for the general population over 10 times the amount per capita that it appropriates for IHS healthcare facility construction. This disparity in facility construction is reflected in patient outcomes and the immense need for facilities in IHS. In general, IHS facilities are old, undersized, with traditional layouts, and expensive to operate and maintain. The 2011 Facilities Needs Assessment Report to Congress estimated the need at ~\$8 billion. The need for new and replacement facilities currently exceeds 18.3 million feet at an estimated cost of about \$10.2 billion.

At the current rate of HCFC appropriations (~\$85 million/annually), a facility completed in 2016 would not be replaced for over 400 years. To replace IHS facilities every 60 years (twice their 30-year design life), would need HCFC appropriations of ~\$500 million/annually. The IHS would need HCFC appropriations of ~\$1 Billion/annually to reduce the need by 95% by 2060. The IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in health care facility construction. Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system becomes unsustainable.

## 10. MANDATORY CSC

While the FY 2016 Omnibus Appropriation Bill includes an indefinite amount and payment of full CSC, which is a significant improvement from past practices of underfunding, the OCA strongly supports permanent Mandatory CSC appropriations as the long term solution for CSC funding challenges. A mandatory appropriation is the most effective answer to the dilemma posed by locating a legally binding obligation within an appropriation structured to address discretionary service requirements. Paying CSC out of the Agencies' discretionary appropriations leaves Tribes at risk for future funding reductions and possible competition between CSC and program funds. Avoiding the reprogramming of funds from health care services into administrative costs is of highest concern. A mandatory appropriation precludes such consequences for the future, while assuring that Tribal contractors and compactors will be paid in full for services duly rendered to the United States.

## 11. ALLOCATING NEW APPROPRIATIONS AS RECURRING FUNDING RATHER THAN ONE TIME PROJECT BASED GRANTS

We urge the Administration to end the practice of using grants and competitive processes to fund Indian Country needs

and establish a permanent recurring base funding system for Tribally-determined programs and services.

Grant funding does not uphold the trust and treaty obligations of the United States. Funding for AI/AN Programs should reflect this trust obligation. Grant funding is intended to be temporary, yet, many Federal agencies use grants as the primary funding mechanism for Indian programs; it is often competitive, non-recurring and burdensome due to varied application processes and reporting requirements. It creates uncertainty in planning, includes extensive regulation and overly burdensome reporting requirements, restricts the use of indirect costs, and forces Tribes to compete against each other under agency established priorities and guidelines. Within the Health and Human Services Department alone there are 577 different grant funded vehicles for which tribes are eligible to apply. It is an administrative and bureaucratic impossibility to access such funds to develop programs that will meaningfully address the needs in Indian country. The grant application process is highly competitive, tedious and complex and there are many restrictions imposed on how the funds may be utilized. Often, a single grant application requires the participation of numerous Tribal staff members for an extended period of time with no guarantee of funding. Tribal programs and services cannot be effectively and efficiently operated if they are forced to operate on grant funding. Additionally, grant funding undermines core Self-Governance tenets and hinders a Tribe's ability to redesign programs and services that better address the needs of its community. Tribes that have the technical experience and financial resources end up receiving funding, while many others without these capabilities are locked out of the process. Lastly, funding provided by grants for specific diseases categories leaves patients that present with an "unfunded" diagnosis at a significant disadvantage. Rather than project or disease specific grant funds, the Indian Health System should prioritize flexible, recurring base funds. Streamlining all funding for Tribal governments and Tribal organizations will have a greater impact on all programs intended to serve our first people.

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# PHOENIX

## 1. IHS ADVANCED APPROPRIATIONS

**Background:** Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget was enacted by the beginning of the fiscal year. It is simply too difficult for the Indian Health Service, Tribally operated and urban Indian health programs to plan, budget for, and sustain their health care services to Indian patients when the U.S. Congress is not able to complete the appropriations process at least in close proximity to the required timelines. It is difficult to recruit and retain qualified medical staff, plan programs and services and purchase equipment and supplies when budget levels are distributed piecemeal throughout the year. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts. Two-year advance appropriations should likewise be enacted for the Indian Health Service to provide stable and predictable funding for the Indian Health Care system.

**Recommendations:** Tribes and urban Indian health programs in the Phoenix Area support two year advance appropriations for the Indian Health Service.

## 2. SPECIAL DIABETES PROGRAM FOR INDIANS

**Background:** In response to the growing diabetes epidemic among American Indian and Alaska Native (AI/AN) people, Congress established the Special Diabetes Program for Indians (SDPI) through the Balanced Budget Act of 1997. The SDPI is a \$150 million per year program that provides grants for diabetes treatment and prevention services to 404 Indian Health Service (IHS), tribal, and urban (I/T/U) Indian health programs across the United States. Diabetes is a debilitating chronic disease that requires tremendous long-term efforts to prevent and treat and American Indian people have been disproportionality effected by it. SDPI has afforded Tribal communities the opportunity to slow the increase in the diabetes prevalence rate.

**Recommendations:** SDPI expires on September 30, 2017. Tribes and urban Indian health programs seek the permanent reauthorization of the program and a long overdue increase of funding at \$200 million per year in Fiscal Year 2017.

## 3. NATIONALIZATION OF THE COMMUNITY HEALTH AIDE PROGRAM (CHAP)

**Background:** The Community Health Aide Program now operating in Alaska includes Community Health Aides

(CHAs), Behavioral Health Aides (BHAs) and Dental Health Aide Therapists (DTs). Since the 1980's Community Health Representatives (CHR's) in the lower 48 states have worked to educate and assist Tribal members and it continues to be a very popular program supported by Tribal leaders. It is welcoming that IHS is proposing to expand CHAP to the lower 48 states that will enhance the prevention health care focus in our communities. The infusion of the mid-level provider workforce in the IHS health care system makes a lot of sense in rural and frontier Tribal communities. They can be well trained and medical and dental providers will provide supervision. Training requirements can be met either online or in local educational institutions, depending on the subject matter. Overall the CHAP program is seen as cost effective and provides an opportunity for Tribal members that live on the reservation to become well trained and have meaningful employment.

**Recommendations:** Tribes in the Phoenix Area seek an increase of \$7.5 million in the CHR line item in FY 2019 to implement CHAP as well as to provide resources for Tribes to raise the salaries of the currently employed CHR's.

## 4. CORRECTIONAL HEALTH CARE IN TRIBAL & BUREAU OF INDIAN AFFAIRS (BIA) OPERATED INSTITUTIONS

**Background:** In October 2015, the Tuba City Regional Health Care Corporation began to reach out to Tribes and Tribal organizations in Arizona where Tribes operate 5 of 7 correctional facilities formally operated by the BIA to address poor inmate health. As a result, the Arizona Tribal Correctional Health Care Coalition was born and began to visit these locations and address possible solutions. Their concern was that Tribes and IHS bear the costs of health care for their inmates for which there are no delegated resources. Inmates and their families suffer when they are discharged in poor health. At the present time there is no federal funding for Tribal or BIA correctional health care, which is provided to inmates at other federal institutions by the Federal Bureau of Prisons. Medical services are extremely limited, i.e., dispensing medications to inmates and at some locations behavioral health counseling may be provided on an intermittent basis. Inmates that seek outpatient health care at the IHS or Tribal clinic must be transported and accompanied by corrections officers to the appointment.

**Recommendation:** Tribes in the Phoenix Area request that the Indian Health Service provide technical support to Tribes and the BIA seeking a Memorandum of Agreement with the U.S. Public Health Service to get Commissioned Corps Officers assigned to Tribal and BIA operated jails. Another remedy Tribes seek is that the BIA budget includes a correctional health care line item so that inmate healthcare may be arranged under the auspices of the local Tribe or the Indian Health Service in order for services to be provided more regularly at the correctional facility to the extent that space and security can be arranged.

## 5. TREATMENT OF CO-OCCURRING SUBSTANCE ABUSE & MENTAL HEALTH DISORDERS

**Background:** Tribes have long identified the need to address co-occurring mental health and substance abuse disorders among the afflicted American Indian population. In term of Fiscal Year 2019, this issue is addressed among our top five priorities. Tribes see the connection between the two issues and therefore seek comprehensive efforts to strengthen the Tribes' ability to aide individuals with a mental illness, to prevent alcohol and substance abuse, including prescription drug opioid abuse and to respond to suicidal and violent behavior that effect some of our youth and young adults. At the present time, behavioral health funding is limited to the level of resources that Tribes contract for through the IHS. Few Tribes have additional tribal dollars to contribute to these services. If a client is Medicaid eligible or has private health insurance some of the costs of inpatient, intensive outpatient or residential treatment may be defrayed, but in most cases inpatient hospitalization and psychiatric care is very expensive and located outside of Tribal communities.

**Recommendations:** The IHS, SAMHSA and Tribes assisted the U.S. Department of Health and Human Services develop a national Tribal Behavioral Health Agenda that was released in its final form on December 6, 2016. (See <http://store.samhsa.gov/product/PEP16-NTBH-AGENDA>). Instituting the recommendations that will result in strengthening behavioral health systems, related services and supports should be the highest priority of all partners going forward.

## 6. REHABILITATION SERVICES FOR INJURIES AND ILLNESSES

**Background:** Services provided by physical therapists, including audiology, occupational, respiratory therapy and speech-language pathology services were enhanced beginning in the 1980's at IHS facilities. Their role continues to address the needed services to American Indians that experience physical, mental and emotional trauma as a result of injury and debilitating illness. At the present time the resources for physical rehabilitation services

are included in the Hospital & Clinics line item and are limited to what's available at an IHS or Tribal facility. If the patient in PRC eligible and the injury or illness is deemed as a medical priority, the patient may get referred to the private sector.

**Recommendation:** Physical rehabilitation services restore one's ability to recuperate satisfactorily from injury and illness and promote the restoration of optimal health. An assessment of the services needed by the population and funding that can be addressed in the H&C and the PRC line items is needed. Some of the Tribes in the Phoenix Area expressed that appointment setting can be delayed due to the overwhelming workload of the Physical Therapy departments. In some instances the services are limited and should be expanded.

## 7. CONTINUATION OF THE TRIBAL HEALTH STEERING COMMITTEE FOR THE PHOENIX AREA IHS

**Background:** Dr. Ty Reidhead, Director of the Phoenix Area IHS agreed to obtain views on whether or not the Steering Committee should exist or some other form of it and what level of staffing support is needed at a special meeting held on November 30, 2017. This came about as a result of information that the Area office does not have sufficient funds to continue supporting the Steering Committee. The Steering Committee was established by a joint resolution adopted by the Inter Tribal Council of Nevada, Inter Tribal Council of Arizona and Utah Tribal Leaders on March 20, 1981. The concept was further defined and ratified by Tribal Leaders at a Joint ITCA/ITCN/Utah Tribes Meeting on January 20, 1983 which led to a Memorandum of Understanding signed on November 28, 1984, by Tribal Leaders representing the three organizations and Dr. George Blue Spruce, D.D.S. Phoenix Area IHS Director and Dr. Everett Rhoades, M.D., IHS Director. The purpose of the Steering Committee is to provide an open and objective forum to address and analyze American Indian health care concerns, policy issues and IHS appropriations. Its role was enhanced by Presidential Executive Memorandums on Tribal Consultation and it serves as the Tribal Health Board for the Phoenix Area IHS and assists in the identification of issues and coordination of Area office consultation. A representative serves on the National Indian Health Board to represent the Phoenix Area. It is comprised of 12 Tribal Leaders and there is one urban Indian health representative.

**Recommendation:** Tribes in the Phoenix Area value the role of the Tribal Health Steering Committee and the staff support it's provided by the Inter Tribal Council of Arizona. Because funding is limited, the Committee is comprised of 5 Tribal Leaders from Nevada, 5 from Arizona and 2 from Utah. It is doubtful that new members to represent the three-state region will be added



any time in the near future, although a strategy to broaden its role and the efforts of the Phoenix Area IHS to engage Tribes in meaningful consultation and confer with Urban Indian organizations must be the principal policy of any IHS administration.

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## PORTLAND

### 1. PUBLIC HEALTH EMERGENCIES

**Background:** Public Health Emergencies are becoming increasingly difficult for tribes to adequately respond to. Within reservation communities general public health and medical care infrastructure is often inadequate to meet basic needs, which places undue burden on them during times of disasters or emergencies. For most emergency funding, density of population is a large factor used in distributions which can negatively impact Tribes in the NW that are smaller and geographically dispersed.

Public health agencies are responsible for support during major events such as severe weather, infectious disease outbreaks, wildfires, active shooter events as well as preparations for national security. NW Tribes propose that federal assistance for public health emergencies is provided directly to them in a timely fashion. Supplemental funding from Federal sources can take months which results in loss of precious time to mitigate these events. :

**Recommendation:** Authorize a Public Health Emergency Fund established through the Secretary of Health and Human Services. Through the Secretary, public health emergencies could be declared after consultation with federal, state and local health officials. Funding should not be limited for a particular response but be available for a wide-range of emergencies and their overall impact within a community. It should also allow tribes the flexibility to utilize the funding as needed to appropriately respond to their particular emergency. Resources, training and support need to be shared throughout the year so, if and when disasters occur, each Tribe understands when and how to access emergency assistance.

### 2. BEHAVIORAL HEALTH & SUBSTANCE ABUSE

**Background:** Throughout Indian Country there is a high occurrence of substance abuse, mental health disorders, suicide, violence and behavior-related chronic disease. Each of these serious issues has a profound impact on the health of individuals,

families, and communities both on and off reservations. Mental health is closely tied to and affected by our physical, social, and spiritual health. Historical trauma, community violence, family history, and drug or alcohol use can all contribute to poor mental and physical health outcomes. For example AI/AN people are 1.7 times more likely to die of suicide than all U.S. races<sup>1</sup> and suicide is the second leading cause of death for AI/AN teens and young adults. Within Indian Health Systems, the focus is currently on integrating behavioral health into primary care in an effort to improve health outcomes. However, due to high rates of provider vacancies and patient workload, this isn't always possible in all facilities. Clinicians have noted there is also a great need for more recovery services for alcohol and substance abuse. The impact of substance abuse on communities and families can be seen in high rates of homelessness, children in foster care or living with relatives other than parents, incarceration, unemployment, low educational achievement, domestic violence and premature death. According to national data on drug and alcohol use AI/ANs have the highest rates of substance dependence or abuse of all ethnic groups at 14.9% compared to 8.4% for whites.

**Recommendation:** Provide additional funds to support the National Tribal Behavioral Health Agenda developed by SAMHSA<sup>2</sup> through collaborations with Tribes and IHS. Increases would be focused on healing from historical and intergenerational trauma, while utilizing socio, cultural and ecological approaches to improve behavioral health. Provide support for prevention as well as recovery while also strengthening behavioral health systems and related services and support, and improve national awareness and visibility of behavioral health issues faced by tribal communities. Expansion of the current telebehavioral health platform would also be beneficial. Current offerings are limited and not necessarily specific to behavioral health.

### 3. ENVIRONMENT AND HEALTH EFFECTS

**Background:** Adverse environmental health effects are a health equity and social justice issue. In the Pacific Northwest, AI/ANs have rates of asthma nearly double that of the general population. In addition AI/ANs are more likely to report having asthma symptoms everyday as well as health status in the “fair” or “poor” category. AI/ANs are also exposed to many other contaminants within their communities such as uranium, lead, and an emerging issue with environmental hazards related to clandestine methamphetamine labs. For example, the Spokane Tribe of Indians, based in Eastern Washington State, has suffered negative environmental and health impacts from the operation of the Midnite Mine by the Dawn Mining Company, which has been identified as an EPA Superfund Site<sup>3</sup>. Harmful substances like radiation, as well as other heavy metals including arsenic, cadmium, and manganese have been found to contaminate surface and ground water in the area.

**Recommendation:** Increase asthma treatment programs within IHS to assist in education and remediation of the environmental triggers associated with poor asthma control. Support and implement asthma homevisits on a broader basis to ensure that the home environment is addressed and any factors that contribute to the health effects are removed. It has also been demonstrated that Written Asthma Action Plans can assist individuals in better management of their disease. Portland Area Tribes recommend that more IHS providers are trained in how to develop these plans and work with patients to implement them<sup>4</sup>.

In addition Tribes recommend that the IHS, along with the CDC, compile health data to evaluate the health effects and impact on the community; and partner with other agencies (EPA, BIA, etc.) to explore additional funding options to address the health needs for those exposed either through the occupational environment or secondary sources. Additionally, more funding needs to be devoted to training and remediation for those tribes that are dealing with housing contamination due to clandestine drug labs. IHS has partnered with agencies such as ATSDR to host courses to train tribal housing staff but more funding needs to be devoted to these programs to ensure they can be delivered consistently and offered to all tribes within the region. Increased funding in the Sanitation Facilities program will also address training as well as provide evaluation and maintenance of current water systems to help mitigate or treat contamination from heavy metals such as lead and other harmful substances.

### 4. FOCUS ON PREVENTION

**Background:** Much of the funding distributed by IHS is based on user population or health disparities. This creates a resource

distribution imbalance geared toward larger tribes with higher disease rates. Since Portland Area is comprised of smaller, geographically disbursed tribes, the funds received in prevention aren’t sufficient to conduct larger interventions within a community. This also doesn’t reward programs that have shown better outcomes or are innovative in their approaches.

**Recommendation:** Expand on funding for Community Health Aide Programs (CHAPs), providing more resources for behavioral health and dental aides. By leveraging those individuals that are already living in a community it can build trust between providers and patients while also ensuring that services are available and delivered as close to the patient as possible. Many prevention programs with small investments can make large impacts within the community and prevent future expenditures for more costly chronic diseases such as diabetes and heart disease.

### 5. REGIONAL REFERRAL CENTER

**Background:** Currently the Tribes in the Portland Area do not have access to secondary or specialty care within the IHS system due to the lack of a hospital or specialty center which forces them to rely on PRC to cover these services. In 2005, as a result of Master Planning activities, three facilities were proposed to fill this unmet need within the Portland Area. The Portland Area Office in consultation with the Portland Area Facilities Advisory committee (PAFAC), a local tribal advisory group, is actively planning the first of these facilities. To support the ongoing efforts a Program of Requirements (POR) and Program Justification Document (PJD) were finalized in April 2016. In addition, Portland Area Tribes are aware that due to an increase in state run Medicaid managed care programs, which are contracting with providers, a reduction in the amount of appointments available and increased wait times for those not part of managed care programs is further reducing the amount of commercially available specialty care within the Area.

**Recommendation:** The current IHS Health Care Facility Priority system does not provide a mechanism for funding specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project under the new authorities in the Indian Health Care Improvement Act utilizing the submitted POR and PJD. The facility is anticipated to provide services such as medical and surgical specialty care, specialty dental care, audiology, physical and occupational therapy as well as advanced imaging, and outpatient surgery. It’s anticipated that this facility could provide services for approximately 50,000 users within the regional service area as well as an additional 20,000 in telemedicine consults.

## 6. STAFFING-RECRUITMENT/RETENTION/ HOUSING

**Background:** Both federally operated and tribally operated facilities have difficulty with recruitment and retention of qualified medical providers. Due to lack of funding, many recruiter positions have been abolished and those responsibilities have transferred to full time staff, making it difficult to devote meaningful time to these activities. Tribes are concerned that the expansion of Medicaid and Medicare, as well as, new funding authorities for Veterans Administration, has created more competition for the same amount of providers.

**Recommendation:** More needs to be invested in the reasons for attrition to better mitigate the issue. Portland Area Tribes recommend that an exit interview process, as part of a larger comprehensive approach, needs to be implemented to get candid feedback about why people choose to leave IHS, as well as, better information on attrition rates and staffing overall. Tribes would like to see more being done to advocate for special hiring authorities, such as, market pay for all provider positions including nurse practitioners and physician assistants to ensure that IHS and tribal facilities can be competitive in this current job market. It would benefit I/T/U to have the same competitive advantage as the VA in granting higher levels of annual leave accrual to providers under Title 38 PDP.

## 7. BEHAVIORAL HEALTH BILLING

**Background:** Medicaid regulations prohibit funding from being expended at I/T/U health facilities classified as Institutions for Mental Diseases (IMD) for patients between 21-65 years old. Given the severe underfunding of I/T/U programs, Portland Area Tribes strongly suggest that this regulation is too restrictive and has prevented American Indian and Alaska Native (AI/AN) patients from accessing greatly needed behavioral health services. The current law that excludes facilities exceeding 16 beds is hampering tribes and causing some private facilities to go out of business. This limits the access to care for many. It also creates and perpetuates health disparities for Medicaid enrollees. In addition, it limits the ability for tribes to refer and bill for services at these facilities. Even with greater expansion of Medicaid and Medicare coverage under the Affordable Care Act, this exclusion prevents many from accessing care due to limits in other funding and lack of reimbursement. Moreover, NW Tribes are requesting that encounter rates for Behavioral Health Services are standardized to ensure that those services that are provided locally are able to be billed appropriately to bring critical third party resources to those severely underfunded programs.

**Recommendation:** Portland Area Tribes strongly believe that the issue of IMD's need to be revisited and administrative policy options explored. They suggest HHS give states authority to use section 1115 waivers for tribally operated facilities or facilities that service AI/ANs and meet minimum criteria. The original provision was primarily enacted to eliminate the Federal government from shouldering the burden for mental health issues and places them at the state level but for Tribes there is a lack of coverage through states and they are unable to leverage the resources from Medicaid to assist with health delivery. This restriction has been in place since 1965 and healthcare delivery as a system has changed drastically from that time with many of the original concerns from lawmakers (i.e. warehousing the mentally ill) no longer an issue.

## 8. 100% FMAP REIMBURSEMENT FOR URBAN PROGRAMS

**Background:** Currently IHS programs are able to claim reimbursements for services provided within IHS facilities at the 100% Federal Medical Assistance Percentage (FMAP). The current interpretation of granting 100% FMAP to only those services provided in IHS facilities has limited funding for needed services to AI/AN patients. This dramatically impacts services provided by Urban Indian Health Organizations (UIHO) who use a combination of private and federal funds to provide care to AI/ANs living in urban areas.

Over half of the AI/AN population in the US live in urban areas without direct access to an IHS facility. Without the opportunity to bill for these services, patient care and already scarce resources are negatively impacted. The lack of funding affects care in many ways, including maintenance of facilities, acquisitions of equipment, recruitment and retention of providers and availability of secondary and specialty services for chronic conditions. Portland Area Tribes are concerned that without the 100% FMAP reimbursement most services are either paid for out of the state Medicaid program or the states have specifically excluded UIHO from their provider networks to avoid assuming those liabilities, since they are viewed as federal trust responsibilities.

**Recommendation:** Portland Area Tribes and Urban programs believe that expansion of provisions to include UIHO for 100% FMAP to allow for more direct services to be provided to AI/ANs in Urban areas. The increased ability to bill would allow those facilities to seek more revenue and provide more services. This would also shift some of the burden from state programs back to Federal and free up those resources for other state Medicaid eligible recipients. Because Portland Area Tribes strongly believe that expansion is key in fully realizing the federal government's legal

and moral obligation to AI/ANs as part of their trust responsibilities, they recommend that CMS reexamine the issue of FMAP and create a more comprehensive approach that includes tribal consultation to fully develop the rulemaking around the definition of an IHS facility and how that impacts reimbursements.

## 9. ORAL HEALTH

**Background:** AI/ANs suffer disproportionately from untreated tooth decay, periodontal disease and tooth loss. The 2015 IHS Oral Health survey found that AI/ANs also have twice the prevalence of untreated caries than the general U.S. population and more than any other racial/ethnic group<sup>5</sup>. They are also more likely than the general population to report poor oral health, oral pain, and food avoidance. Many adults don't utilize the dental system due to lack of access at their primary care facility, as well as, limited providers and appointments.

**Recommendation:** Increase funding to allow sites to utilize more market pay authorities and recruit highly qualified providers. Also the expansion of the Dental Health Aide Therapists (DT) program would allow sites to provide more preventative and routine care by allowing those DT's to do exams and basic services to free up dental providers to do more complex care such as restorative root canals, crowns and periodontal therapy. A barrier to broader adoption of the DT program is that it is operated out of Alaska so it can be difficult to find recruits that are willing to relocate for two years in order to complete the certification program. One of the benefits of DT's is that local individuals can be trained to provide services within their own community, and the remote training program prohibits some sites from participation. Portland Area Tribes believe that

the program needs to be expanded with more training options throughout the lower 48 states to allow more people to obtain the certification and that authorities need to be solidified to allow the therapists to be placed in federal facilities to ensure that these services are authorized to be billed through Medicaid or Medicare reimbursements.

## 10. HEPATITIS C DRUGS

**Background:** Recent data show that AI/ANs people have the highest rate of acute hepatitis C virus (HCV) infection and a HCV-related mortality rate that is nearly double the national rate<sup>6</sup>. There have been recent advances in treatment options for HCV that may likely reduce HCV-related deaths. Unfortunately, these treatments can be costly, which has been a barrier to many receiving the needed treatment. Many Medicaid programs and insurance companies mandate significant liver damage as a requirement for eligibility such as cirrhosis. The lack of access to acceptable treatment has created huge health inequities for AI/ANs patients, as well as, the fact that early treatment can prevent more costly disease and liver failure.

**Recommendation:** Additional targeted funding needs to be provided so IHS can adopt a similar policy as the Veterans Administration (VA) to ensure all patients with HCV are treated regardless of stage of liver disease. Screening needs to be emphasized and HCV positive patients need to be enrolled in care. Currently IHS facilities are highly dependent on Patient Assistance Programs, and third party payers to access HCV drug therapies, which leave gaps in treatment for many.

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# TUCSON

## 1. LONG TERM CARE SERVICES – “AGING IN PLACE”

**Background:** The target population for needed Case Management services is the Tohono O'odham Elder tribal members and disabled adults and/or other tribes who live on or near the Reservation boundaries of Sells, San Lucy, San Xavier and Florence. Surveys show that the elder population of the Tohono O'odham Nation prefers to age at home. The Tohono O'odham Nation which spans over 2.8 million acres currently

based on enrollment statistics of 2016 – 3,527 Elders live on the reservation.

The need for Case Management Services is essential for elders 55 and over, vulnerable and disabled adults in maintaining their independence and aging in place. Case management services will enable elders to prevent and alleviate minor problems and challenges to turn into outstanding issues. Health, social, environmental challenges can be prevented through on-site case managers located where elders gather, such as Senior Service congregate



sites. Case management at these locations can provide short-term or the primary service sought to assist. Case management services can assist with the following: applying for resources (i.e. Social Security), applying for other health benefits (i.e. Arizona Long Term Care), identifying other resources, contacting and making referrals on behalf of the elder. Senior Service staff and other programs may or may not have time or be qualified to assist with case management duties. Congregate sites are better equipped if there is case management services directly provided.

**Recommendation:** Additional funding in the amount of \$500,000) to develop a case management system and program.

## 2. TYPE 2 DIABETES

**Background:** The Tohono O’odham Nation community and leadership identifies key diabetes-related health issues affecting all tribal members. The distance of the dialysis center causes members to be transported over long distance leaving them tired and weak. Diseases of the eye such as glaucoma, cataracts, non-drainage of fluids contributing to near blindness and complete blindness causes residents to live with these afflictions without proper intervention due to financial burdens; amputation of limbs such as feet, legs, fingers resulting from neuropathy, which effects a person’s quality of life and increases their risk for unintentional injuries, such as falls; autonomic neuropathy-which is particularly threatening to the younger population where sexual dysfunction among tribal members with this affliction can contribute to domestic violence and increase the incidence of depression; fatigue that limits energy needed to live a robust life and feed the body, mind, soul and spirit –essential components to good mental health, without which depression occurs; diabetes and youth is particularly alarming and leaves us with concerns about the future of our youth.

**Recommendation:** The Special Diabetes Program for Indians (SDPI) program aims to concentrate all their efforts to provide diabetes-related education and prevention with all tribal members in order to impact strong mental health and overcome the diabetes-related health issues identified. However, for SDPI programs there must be a collaborative effort among tribal leaders to advocate for permanent funding for the SDPI grant in order for programs to continue their efforts.

## 3. VECTOR AND ANIMAL CONTROL

**Background:** The Tohono O’odham Nation (TON) and other Tribal Communities in Arizona are dealing with cases of previously unseen diseases (Rocky Mountain spotted fever) and are at relatively high risk for encountering mosquito-borne diseases (Dengue, Chikungunya, Zika) because of the proximity to

Mexico and frequent cross-border travel. Control and prevention of these diseases require coordinated vector- and animal-control efforts. Tribes, including TON have met with AZDHS, counties, and CDC to plan and promote best practices for surveillance and control, but lack sufficient funding and personnel support to establish long-term programmatic controls. These challenges require better integration with services from Natural Resources, Emergency Management, the Police Department, and Health and Human Services to ensure successful implementation.

### **Recommendations:**

- Strengthen the Environmental Health program, specifically by:
  - Adding staff/officers
  - Establishing Integrated Pest Control to deal with mosquito surveillance and control, dog ticks, bed bugs, and bees
- Redesign the Animal Control Program
  - Expand sterilization programs, identification tags, vaccination and animal welfare including a dog holding facility and euthanasia, and veterinary care.
  - Expand staff to respond and track dog bites and rabies concerns.
- Improve coordination and enforcement of animal control with law enforcement.

## 4. CMS 1115 WAIVERS AFFECTING ITUS

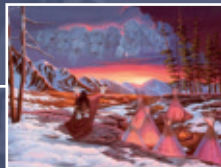
**Background:** A number of 1115 Waivers have been approved by CMS that have benefitted ITU’s. With the new Administration, how will these waivers be treated?

**Recommendation:** Recommended the TTAG continue to be supported financially through NIHB.



# SPECIAL THANKS

*To Lane Kendrick for providing the cover art, a depiction of the Lakota White Buffalo Calf Woman, for this publication.*



*“White Buffalo Calf Woman instructed the people that as long as they performed the seven ceremonies, they would always remain caretakers and guardians of sacred land. The people would never die if they took care of the land and respected all things of Mother Earth.*

*White Buffalo Calf Woman promised to return again one day in the form of a white buffalo calf that would change colors four times as it grew. That event would be a sign that it she would return again soon to purify the world and bring harmony, balance, and spirituality to all nations.”*

FROM JOHN FIRE LAME DEER, LAKOTA HOLY MAN

