



THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2020 BUDGET

April 2018

***“Partnering to Build a Strong and Sustainable Indian Health System:
Honoring Tribal Sovereignty to Fulfill the Federal Trust Responsibility”***

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EXECUTIVE SUMMARY

“Partnering to Build a Strong and Sustainable Indian Health System: Honoring Tribal Sovereignty to Fulfill the Federal Trust Responsibility”

Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 15-16, 2018, to exercise their right to provide meaningful input into the Indian Health Service budget request for the FY 2020 budget year. Following a thorough discussion of the Area Tribal health care needs, the national Tribal FY 2020 budget priorities and recommendations were established, as highlighted below.

- Urge the Administration to act swiftly to end growing health disparities and urgent life-safety issues at IHS and Tribal Health Facilities by implementing a strategy to fully fund IHS at \$36.8 billion phased in over 12 years

- Increase the President's Budget Request to a total of \$7 billion for the IHS in FY 2020 by adding at a minimum:

- +\$189.1 million for full funding of current services
- +\$275 million for binding fiscal obligations¹
- +\$1.5 billion for program increases for the most critical health issues (~36% above FY 2017 Enacted). Top priorities for program expansion include:
 1. Hospital & Clinics -----+\$409.0 Million
 2. Purchased/Referred Care -----+ 407.0 Million
 3. Mental Health -----+ 157.2 Million
 4. Alcohol and Substance Abuse -----+ 123.8 Million
 5. Dental Services -----+ 98.3 Million
 6. Health Care Facilities
Construction/Other Authorities----+ 81.4 Million
 7. Sanitation Facilities Construction--+ 72.5 Million
 8. Urban Indian Health-----+ 32.7 Million
 9. Maintenance & Improvement-----+ 32.5 Million
 10. Equipment -----+ 24.1 Million
 11. Public Health Nursing-----+ 21.9 Million
 12. Health Education -----+ 20.0 Million
 13. Community Health
Representatives (CHRs) -----+ 18.9 Million
 14. Indian Health Professions -----+ 16.2 Million
 15. Direct Operations -----+ 614,000



¹ Includes placeholder estimates for Contract Support Costs (CSC) and staffing for new facilities and new Tribes

- ▶ Support the Preservation of Medicaid, the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable Care Act (P.L. 111-148), or any subsequent replacement bill, and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act (IHClA), which have not yet been implemented and funded (~100 Million in FY 2020)
- ▶ Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
 - Health IT for full implementation of interoperable EHR systems & tele-health capacity (~\$3 Billion over 10 years)
 - Health Facilities Construction Funding & Equipment (~\$15 Billion over 10 years)
- ▶ Advocate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions
- ▶ Support Advance Appropriations for the Indian Health Service
- ▶ Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficient use of federal dollars at the local level.
- ▶ Support Funding of Tribes outside of a grant-based system

Native American Tribal governments are an integral part of the political fabric of the United States. As the Supreme Court of the United States determined in its 1831 decision in *Cherokee Nation v. Georgia*, 30 U.S., Tribal governments are “domestic dependent nations,” with many sovereign powers retained from the pre-contact period. The United States signed treaties and made sacred promises in order to engage in peaceful co-existence with American Indians and Alaska Native (AI/AN) Tribes. Prime Tribal lands were ceded in exchange for federal trust benefits, including health care for American Indians and Alaska Natives. This federal trustee relationship is unique to AI/ANs.

This is no less true today. House Interior, Environment and Related Agencies Appropriations Subcommittee Chairman, Ken Calvert (R-CA) stated in May 2017: “The United States has a legal and moral responsibility to provide the highest possible standard of health care to American Indians and Alaska Natives. This responsibility is grounded in the earliest treaties between the sovereign and equal nations and must not be compromised at the expense of lower priorities in the federal budget. Let me be clear. Congress must not balance the budget on the backs of American Indians and Alaska Natives.”

Despite these legally-upheld Trust responsibilities, Tribal communities continue to suffer the highest rates of health disparities of any other citizen group. In fact, the Centers for Disease Control and Prevention (CDC) website calls out AI/ANs as “People at High Risk for Developing Flu-Related Complications”, in the same category as children, elders and pregnant women. In the recent January 2017 Report to Congress “INDIAN HEALTH SERVICE Actions Needed to Improve Oversight of Quality of Care”, investigators cite substandard quality and access to safe care issues. CDC’s Morbidity and Mortality Weekly Report for October 20, 2017 reported that AI/AN had the highest drug overdose death rate by race in 2015, and the largest percentage increase in opioid-related deaths at 519%. This is no surprise given that IHS deferred or denied over \$371 million in purchased/referred care in FY 2016, meaning that patients must depend on highly addictive opioids to manage their conditions when permanent care solutions are not available.

Most of these unacceptable conditions are symptomatic of the chronic underfunding the IHS far below the level of need. This lack of funding predictably results in our people living sicker and dying younger than other Americans. With bipartisan collaboration between Congress and the Administration, the Indian Health Service budget has grown incrementally, with an overall increase of 50% since FY 2008. Although much needed, the reality is that the amount of funds appropriated has only resulted in maintenance-level services; most of the increases have been essential to cover expenses beyond our control which are related to population growth, inflation, and the rightful full funding of Contract Support Costs (CSC). Tribal Leaders are joining forces to insist that a true and meaningful investment be made to finally eradicate the atrocious health disparities which has overwhelmed Indian Country for years. It will take a true partnership between the Trustees of our Nation and Tribal Leadership to make this happen. And it will take decisive action by this Administration to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States. We must rise above just settling for the status quo.

“The United States has a legal and moral responsibility to provide the highest possible standard of health care to American Indians and Alaska Natives. This responsibility is grounded in the earliest treaties between the sovereign and equal nations and must not be compromised at the expense of lower priorities in the federal budget. Let me be clear. Congress must not balance the budget on the backs of American Indians and Alaska Natives.”

— HOUSE INTERIOR, ENVIRONMENT AND RELATED AGENCIES APPROPRIATIONS SUBCOMMITTEE CHAIRMAN, KEN CALVERT (R-CA), MAY 2017

The following document details the Tribal Budget Formulation Workgroup's request for FY 2020. As proposed, these necessary investments in the IHS delivery system are designed to advance efforts to achieve better health outcomes for our

people. Throughout the document you will see the Tribal priorities for program increases and details on the importance of each program area at the IHS.

FY 2020 NATIONAL TRIBAL RECOMMENDATION

Planning Base - FY 2017 Enacted (Services & Facilities)	\$4,239,886,000
Current Services & Binding Obligations	\$1,264,124,000
Current Services	\$189,124,000
Federal Pay Costs	10,133,000
Tribal Pay Costs	15,850,000
Inflation (non-medical)	14,430,000
Inflation (medical)	75,359,000
Population Growth	73,352,000
Binding Obligations	\$1,075,000,000
New Staffing for New & Replacement Facilities	75,000,000
Contract Support Costs - Estimated Need	900,000,000
Health Care Facilities Construction	100,000,000
Program Expansion — Services	\$1,306,411,583
Hospitals & Health Clinics	409,042,000
Dental Services	98,263,917
Mental Health	157,244,583
Alcohol and Substance Abuse	123,753,750
Purchased / Referred Care	406,993,000
Public Health Nursing	21,880,583
Health Education	19,951,083
Community Health Representatives	18,886,583
Alaska Immunization	0
Urban Indian Health	32,747,500
Indian Health Professions	16,196,833
Tribal Management Grants	416,667
Direct Operations	613,583
Self-Governance	421,500
Program Expansion — Facilities	\$219,947,500
Maintenance & Improvement	32,530,500
Sanitation Facilities Construction	72,543,917
Health Care Facilities Construction-Other Authorities	81,388,833
Facilities & Environmental Health Support	9,426,333
Equipment	24,057,917
PROGRAM EXPANSION SUB-TOTAL	1,526,359,083
% Change over Planning Base	36%
GRAND TOTAL	\$7,030,369,083

INDIAN HEALTH SERVICE FY 2020 NATIONAL TRIBAL RECOMMENDATION

(DOLLARS IN THOUSANDS)

FEBRUARY 20, 2018

LEBROARY 20, 2018

Sub Sub Activity		Current Service (Fixed Costs)							
		Estimates							
		Pay			Inflation			Population Growth	
		Federal Pay	Tribal Pay	Pay Subtotal	Non-Medical	Medical	Inflation Subtotal		
FY 2017 Enacted (Planning Base)									
SERVICES									
Hospitals and Health Clinics	1,935,178	6,642	10,156	16,798	2,423	23,213	25,636	34,854	
Dental Services	182,597	792	1,066	1,858	57	1,999	2,056	3,266	
Mental Health	94,080	286	530	816	20	1,048	1,068	1,521	
Alcohol & Substance Abuse	218,353	225	1,414	1,639	31	3,373	3,404	4,087	
Purchased/Referred Care	928,830	0	0	0	0	37,382	37,382	17,721	
Total, Clinical Services	3,359,038	7,945	13,166	21,111	2,531	67,015	69,546	61,449	
Public Health Nursing	78,701	302	494	796	27	2,031	2,058	1,432	
Health Education	18,663	41	134	175	2	596	598	344	
Comm. Health Reps	60,325	7	493	500	1	2,336	2,337	1,123	
Immunization AK	2,041	0	17	17	0	74	74	35	
Total, Preventive Health	159,730	350	1,138	1,488	30	5,037	5,067	2,934	
Urban Health	47,678	21	244	265	65	1,470	1,535	785	
Indian Health Professions	49,345	18	0	18	985	0	985	0	
Tribal Management	2,465	0	0	0	46	0	46	0	
Direct Operations	70,420	466	175	641	641	0	641	0	
Self-Governance	5,786	20	0	20	82	0	82	0	
Total, Other Services	175,694	525	419	944	1,819	1,470	3,289	785	
Total, Services	3,694,462	8,820	14,723	23,543	4,380	73,522	77,902	65,168	
FACILITIES									
Maintenance & Improvement	75,745	0	0	0	1,872	0	1,872	1,604	
Sanitation Facilities Constr.	101,772	0	0	0	2,349	0	2,349	2,072	
Health Care Fac. Constr.	117,991	0	0	0	3,886	0	3,886	0	
Facil. & Envir. Hlth Supp.	226,950	1,313	1,127	2,440	1,910	1,012	2,922	4,084	
Equipment	22,966	0	0	0	33	825	858	424	
Total, Facilities	545,424	1,313	1,127	2,440	10,050	1,837	11,887	8,184	
CONTRACT SUPPORT COSTS									
CSC Need	800,000	0	0	0	0	0	0	0	
Total, Contract Support Costs	800,000	0	0	0	0	0	0	0	
TOTAL, IHS	5,039,886	10,133	15,850	25,983	14,430	75,359	89,789	73,352	
\$ Change over prior year									
% Change over prior year									

		Binding Obligations					Program Increases	FY 2020 National Recomm	Comparison	
		Estimates			Binding Obligations Subtotal	Current Services & Binding Obligations Total			Change over Planning Base	
	Current Services Subtotal	Staffing for New Facilities	Contract Support Costs Need	Healthcare Facilities Priority List					\$	%
	77,288	75,000	0	0	75,000	152,288	409,042	2,496,508	561,330	29.0%
	7,180	0	0	0	0	7,180	98,264	288,041	105,444	57.7%
	3,405	0	0	0	0	3,405	157,245	254,730	160,650	170.8%
	9,130	0	0	0	0	9,130	123,754	351,237	132,884	60.9%
	55,103	0	0	0	0	55,103	406,993	1,390,926	462,096	49.8%
	152,106	75,000	0	0	75,000	227,106	1,195,297	4,781,441	1,422,403	42.3%
	4,286	0	0	0	0	4,286	21,881	104,868	26,167	33.2%
	1,117	0	0	0	0	1,117	19,951	39,731	21,068	112.9%
	3,960	0	0	0	0	3,960	18,887	83,172	22,847	37.9%
	126	0	0	0	0	126	0	2,167	126	6.2%
	9,489	0	0	0	0	9,489	60,718	229,937	70,207	44.0%
	2,585	0	0	0	0	2,585	32,748	83,011	35,333	74.1%
	1,003	0	0	0	0	1,003	16,197	66,545	17,200	34.9%
	46	0	0	0	0	46	417	2,928	463	18.8%
	1,282	0	0	0	0	1,282	614	72,316	1,896	2.7%
	102	0	0	0	0	102	422	6,310	524	9.0%
	5,018	0	0	0	0	5,018	50,396	231,108	55,414	31.5%
	166,613	75,000	0	0	75,000	241,613	1,306,412	5,242,487	1,548,025	32.4%
	3,476	0	0	0	0	3,476	32,531	111,752	36,007	47.5%
	4,421	0	0	0	0	4,421	72,544	178,737	76,965	75.6%
	3,886	0	0	100,000	100,000	103,886	81,389	303,266	185,275	157.0%
	9,446	0	0	0	0	9,446	9,426	245,822	18,872	8.3%
	1,282	0	0	0	0	1,282	24,058	48,306	25,340	110.3%
	22,511	0	0	100,000	100,000	122,511	219,948	887,883	342,459	62.8%
	0	0	100,000	0	100,000	100,000	0	900,000	100,000	12.5%
	0	0	100,000	0	100,000	100,000	0	900,000	100,000	12.5%
	189,124	75,000	100,000	100,000	275,000	464,124	1,526,359	7,030,369	1,990,483	39.5%
	\$189,124					\$464,124		\$1,990,483		
	3.75%					9.21%		39.5%		

INTRODUCTION

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 15-16 18, to develop the national Indian Health Service budget recommendations for the FY 2020 budget year. The budget priorities are highlighted below.

► Urge the Administration to act swiftly to end growing health disparities and urgent life-safety issues at IHS and Tribal Health Facilities by implementing a strategy to fully fund IHS at \$36.8 billion phased in over 12 years



- Increase the President’s Budget Request to a total of \$7 billion for the IHS in FY 2020 by adding at a minimum:
- +\$189.1 million for full funding of current services
 - +\$275 million for binding fiscal obligations²
 - +\$1.5 billion for program increases for the most critical health issues (~36% above FY 2017 Enacted). Top priorities for program expansion include:
- | | |
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| 1. Hospital & Clinics ----- | +\$409.0 Million |
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| 14. Indian Health Professions ----- | + 16.2 Million |
| 15. Direct Operations ----- | + 614,000 |

² Includes placeholder estimates for Contract Support Costs (CSC) and staffing for new facilities and new Tribes

- ▶ Support the Preservation of Medicaid, the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable Care Act (P.L. 111-148), or any subsequent replacement bill, and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act (IHCIA), which have not yet been implemented and funded (~100 Million in FY 2020)
- ▶ Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
 - Health IT for full implementation of interoperable EHR systems & tele-health capacity (~\$3 Billion over 10 years)
 - Health Facilities Construction Funding & Equipment (~\$15 Billion over 10 years)
- ▶ Advocate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions
- ▶ Support Advance Appropriations for the Indian Health Service
- ▶ Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficient use of federal dollars at the local level.
- ▶ Support Funding of Tribes outside of a grant-based system

As “domestic dependent nations,” Native American Tribal governments are an integral part of the political fabric of the United States. This complex history between Tribal nations and the United States government is documented by periods of autonomy and self-determination, assimilation, and termination. Signed treaties which promised federal trust benefits, including health care for American Indians and Alaska Natives (AI/ANs), were negotiated in good faith, in exchange for prime Tribal lands and peaceful co-existence. The result is a unique federal trust responsibility which sets Indian health care services in a different category than that of other federally-funded services and programs.

The IHS, for the past 6 decades, has been the agency primarily entrusted to carry out the federal health trust responsibility. IHS is the principal federal health care provider and health advocate for Indian people, and is one of only 3 federal direct patient care agencies in the nation. The IHS’ stated mission is “to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest possible level.” The IHS is charged with providing a comprehensive health service delivery system for American Indians and Alaska Natives. This noble mission has proven to be near impossible to achieve primarily due to historical chronic and severe underfunding of the agency.

By comparison, the FY 2018 Veteran’s Health Administration (VA) has a medical budget of approximately \$86 billion, more than 14 times that of IHS, while serving a population that is only four times greater than the IHS. This funding disparity has been pointed out by the National Tribal Budget Formulation Workgroup each year, and since 2010, the work group has requested that the Administration commit to fully fund the IHS over a 10-12 year phased-in period; a request which disturbingly continues to go unheeded. The fact that AI/AN patients still have only one-third the per capita health spending of the general U. S. population to address overwhelming health disparities is indefensible. The fact that our citizens are disproportionately at the bottom of almost all reportable health status indicators is shamefully predictable given the lack of investment in the IHS delivery system. This lack of funding has been consistently messaged as a fundamental reason why Indian reservations and Tribal villages continue to suffer from third world conditions resulting in documented disparate health outcomes. It is true that our life expectancy averages 4.5 years less than that of other Americans, and even as high as 20 years less in some remote Tribal reservations. Tribal leaders urge that this administration take action now to include long overdue investments into the failing IHS delivery system as an integral part of its plan to rebuild American infrastructure and reform health care. In short, we are asking for our trustees to partner with Tribal leaders to create a strategic roadmap to fully fund the Indian Health Service within a 12 year phase-in time period.

INCREMENTAL INCREASES TO A SEVERELY UNDERFUNDED BASE BUDGET DON’T WORK....

With bipartisan collaboration between Congress and the Administration, the Indian Health Service budget has grown incrementally, with an overall increase of 50% since FY 2008. Although much needed, the reality is that the amount of funds appropriated has only resulted in maintenance-level services; most of the increases have been essential to cover expenses beyond our control which are related to population growth, inflation, and the rightful full funding of Contract Support Costs (CSC).

A popular saying in the health improvement community is that “the system is perfectly designed to get the results it gets.” This certainly holds true for the Indian Health delivery system.

This underfunding of the IHS is clearly visible when examining the health disparities for AI/ANs. Among AI/ANs, the rate of drug overdose deaths is twice that of the general population, according to the IHS. Deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs. According to the Office of Minority Health, from 2009-2013, AI/AN men were almost twice as likely to have liver & inflammatory bowel disease (IBD) cancer as non-Hispanic White men and are 1.6 times as likely to have stomach cancer as non-Hispanic White men, and are over twice as likely to die from the same disease. AI/AN women are 2.5 times more likely

to have, and almost twice as likely to die from, liver & IBD cancer, as compared to non-Hispanic White women. In 2015, AI/ANs were three times more likely to die from hepatitis C than non-Hispanic whites, and twice as likely to die from hepatitis B. In 2014, suicide was the second leading cause of death for AI/ANs between the ages of 10 and 34 and adolescent AI/AN females have death rates at almost four times the rate for White females in the same age groups.³

These disparities clearly demonstrate the human consequences of underfunding IHS. Deferral of care due to funding and workforce shortages has pushed more and more Tribal members towards prescription opioids to treat health conditions that would otherwise successfully be treated with non-opioid therapies. This endless cycle of deferral and opioid dependency is a direct result of the underfunding of the IHS system. Limited funding resulted in nearly 80,000 Purchased/Referred Care (PRC) services (an estimated total of \$371 million) being denied in FY 2016 alone. Increasingly, Tribal members are being taken to private collections for PRC bills not being paid by the IHS, creating credit issues which impact other areas of their lives. When funding is limited, AI/ANs are less likely to get the right diagnostic testing for cancer and disease screening, leading to costlier care and higher death rates. Limited funding for

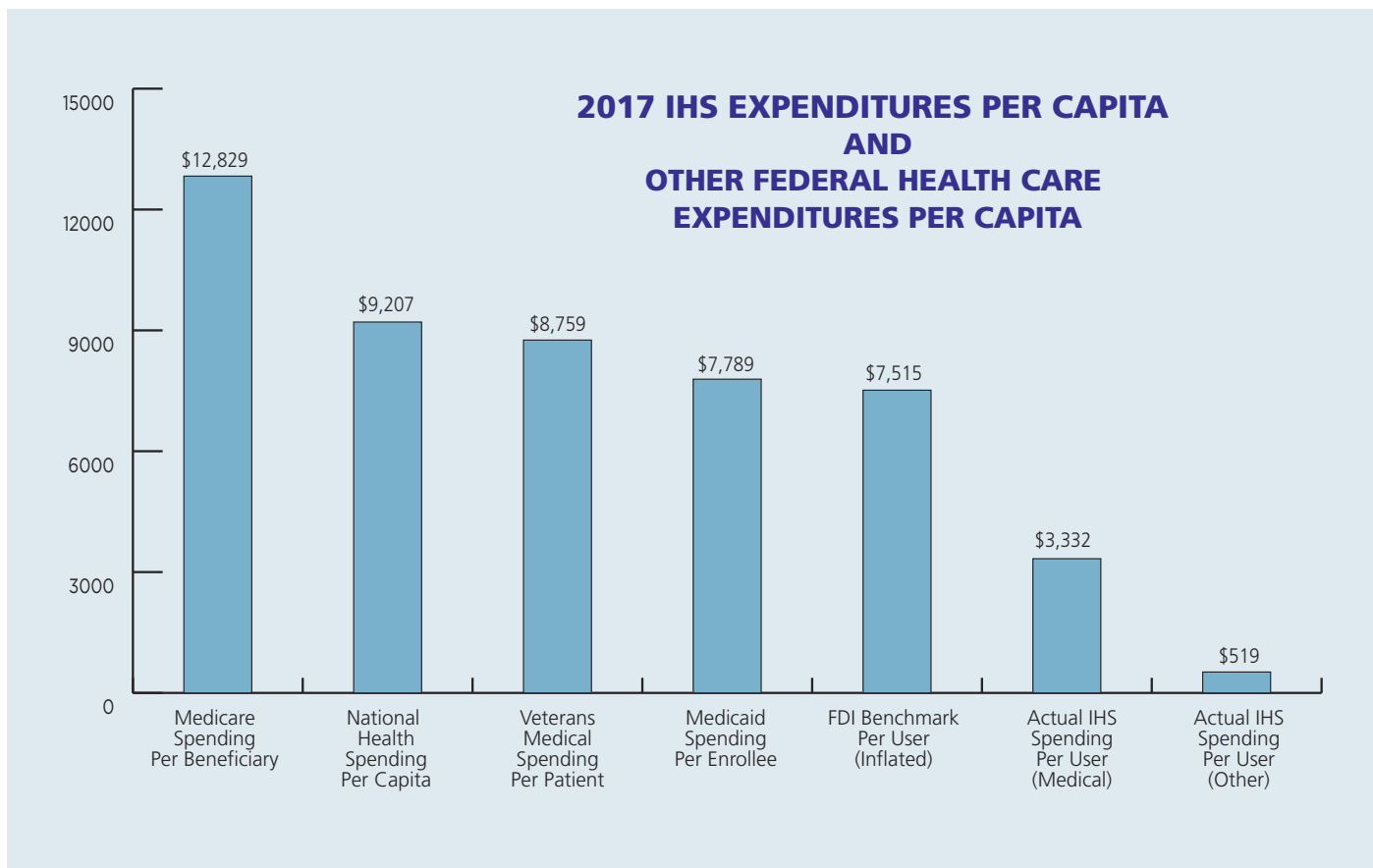
mental health and behavioral health means that AI/ANs have few treatment options and are therefore more at risk of suicide or serious complications from mental health challenges.

The time to act is *now*. We request that the Administration and Congress finally commit to making a reasonable investment in IHS so that our people can finally enjoy the same health status as other American citizens. We have prepaid for our health care, and continue to pay for it as evidenced by these startling statistics.

A sustainable Indian Health System means resources must reflect a TRUE COMMITMENT by the federal government.

Tribal Leaders are joining forces to insist that a true and meaningful investment be made to finally eradicate the atrocious health disparities which has overwhelmed Indian Country for years. It will take a true partnership between the Trustees of our Nation and Tribal Leadership to make this happen. And it will take decisive action by this Administration to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States. We must rise above just settling for the status quo wherein patient quality and safety are disregarded, resulting in lives being tragically lost. We must bring funding parity to Indian health and raise the per capita spending for medical care to at least that of other citizens. In 2017 AI/AN per capita spending was \$3,332 compared to national health per capita spending of \$9,207.

3 Office of Minority Health. Minority Population Profiles, American Indian and Alaska Natives. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39>. Accessed on March 21, 2018.



We must devise a plan to get closer to \$36 billion needed to eradicate the health crisis happening in plain sight every day within our Tribal reservations and villages.

HONORING TRIBAL SOVEREIGNTY TO FULFILL THE FEDERAL TRUST RESPONSIBILITY...

Recent progress in reinforcing Tribal Consultation on policies and decisions which impact Indian Country is commendable. What is glaringly lacking is the investments which must be made to bring about real change. The failure to fund needed, expanded health authorities after passage of the permanent reauthorization of the Indian Health Care Improvement Act is yet another example of the miscarriage of justice to fulfill the federal trust responsibility. This inaction compounds the fiscal challenges of delivering cradle to grave quality health care when preventative services, solutions to address workforce shortages, and eldercare needs are set aside due to lack of appropriations.

The TBFWG was also distressed to see the proposal to eliminate funding for the Community Health Representatives and Health Education programs in the FY 2019 President's Budget request. These programs are integral to the IHS/Tribal/Urban (I/T/U) system, and are essential components of delivery of care to some of the most vulnerable AI/ANs. Before major decisions like this are made in future years, we adamantly request that you consult with Tribes and refer back to the recommendations outlined in this document.

The following national Tribal BFWG 2020 recommendations set the necessary steps for this Administration to live up to its responsibility to American Indian and Alaska Native Tribal nations. To do any less is to set this country back, in an era when bringing back "honor and greatness" to these United States is the national priority.

Our Tribal leaders are ready to "step up" our partnership to reverse health disparities which are killing our people. We ask that you meet us half way by committing to put forth our FY 2020 budget recommendations. We also urge that the critical backlog in health care facilities, which have a waitlist going back decades, and need for immediate IT investment resulting from the VA's recent decision to move to CERNER, be factored into any major infrastructure plan as part of the President's promise to rebuild America. Not only will this address rapidly failing health infrastructure concerns, but it will also create jobs and spur economies within our poorest communities. For Tribes to be expected to wait up to 400 years for replacement of their health facility is unacceptable! Increasing appropriations

from the current average of \$100 million/year to \$750 million/year would match the U. S. expenditures in healthcare facility construction. Additionally, providing \$3 billion over 10 years is the most current estimate for IT investments needed which would allow the IHS and Tribal hospitals and clinics to migrate over to a new electronic health record system along with the VA. Both these infrastructure projects are too large to be absorbed within the existing funding stream and must be part of a larger capital development plan.

The trust responsibility to all American Indians and Alaska Natives must be honored. This is true whether services are provided directly through the IHS agency, under Tribal Self Determination compacts and contracts, or within Urban Indian programs. As Congressman Markwayne Mullin (R-OK) stated an Energy and Commerce Committee hearing on March 22, 2018, "Getting funding to Indian Country is vitally important because most health care for Native Americans is done through the IHS system. That was a federal government obligation through the treaties that were signed... The treaty was made with the federal government. It is not a handout. It is payment for land that was taken from the Tribes years and years ago. That obligation and that payment still stays in place."

The Tribal Budget Formulation Work Group is available to assist in any manner to advance fulfillment of this sacred trust responsibility.

"Getting funding to Indian Country is vitally important because most health care for Native Americans is done through the IHS system. That was a federal government obligation through the treaties that were signed... The treaty was made with the federal government. It is not a handout. It is payment for land that was taken from the Tribes years and years ago. That obligation and that payment still stays in place."

— CONGRESSMAN MARKWAYNE MULLIN (R-OK), MARCH 22

1ST RECOMMENDATION:

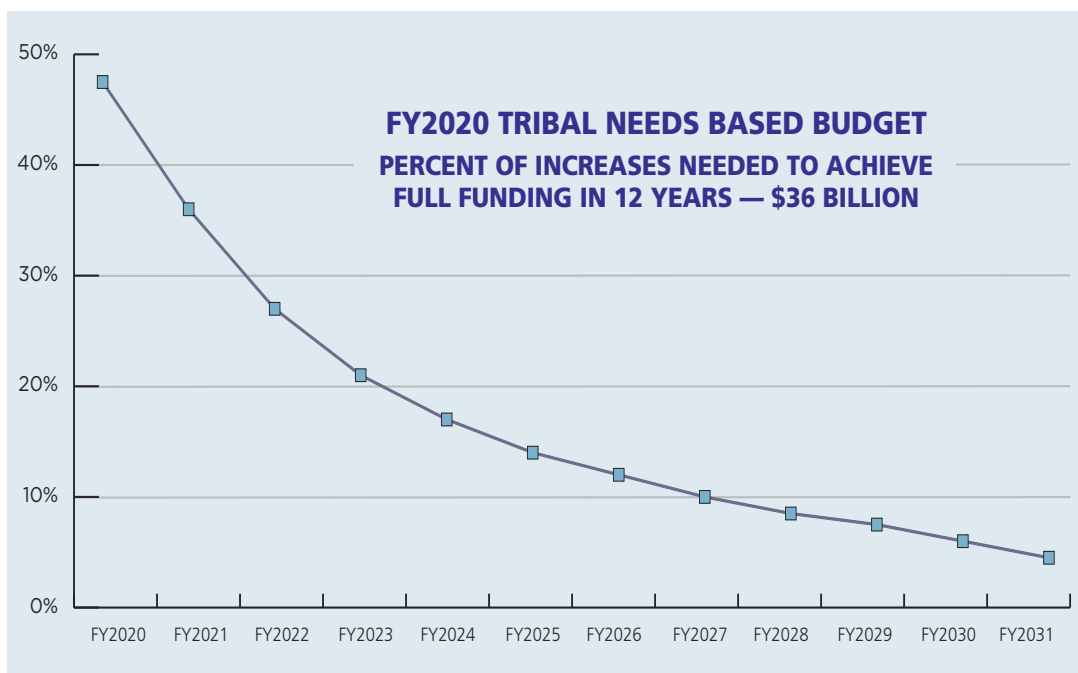
Fully Fund IHS at \$36 Billion Phased In Over 12 Years

Early in 2003, the Workgroup met to develop 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 level of funding was not even sufficient to maintain current services in the face of inflation and increases in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and

IHS's efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribal and Urban programs worked together to develop the first true Needs Based Budget (NBB) for FY 2005, and proposed an IHS NBB totaling \$19.5 billion. This includes amounts for personal health services, wrap-around community health services and facility investments.

The FY 2005 Budget Formulation Workgroup responsibly proposed a 10-year phase-in plan, proposing substantial increases in the first two years to build facilities and fund initial service start-ups, with more moderate increases to follow in the ensuing years. This approach was taken because the Workgroup understood that a proposal to fund 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 the 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 funding 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 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 2020 is now \$36 billion, based on the FY 2017 estimate of 2.9 million AI/ANs eligible to be 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 \$36 billion has been extended to twelve years.

FY 2020 AI/AN NEEDS BASED FUNDING AGGREGATE COST ESTIMATE

GROSS COST ESTIMATES

Source of Funding is not estimated

Need Based on FY 2017 Existing Users at I/T Sites	Need based on FY 2017 Expanded for Eligible AI/AN at I/T/U Sites*
1,638,637	2,895,571

SERVICES	\$ Per Capita	Billions	Billions
Medical Services	\$7,599	\$12.45	\$22.00
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 2017 FDI benchmark	\$ Per Capita FY 2017 * Existing Users	\$ Per Capita FY 2017 * All Eligible AI/AN Served at ITU sites
Dental & Vision Services	\$611	\$1.00	\$1.77
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 2017 @4% per year		
Community & Public Health	\$1,481	\$2.43	\$4.29
Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.	19% of IHS \$ is spent on Public Health. Applying this ratio, \$1,316 per capita = (.19/.81*\$5611).		
Total Annualized Services	\$9,691	\$15.88	\$28.06

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

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

TOTAL

Total Annualized Services + One-time Upfront Facilities Upgrades		\$22.39	\$36.83
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Gross costs for mainstream health care to AI/AN 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 AI/AN 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 — AI/ANs residing in service areas, including urban areas, discounted for AI/AN already partially served by I/T sites.

2ND RECOMMENDATION:

Increase the President's FY 2020 Budget Request for the Indian Health Service by a Minimum of 36% over FY 2017 Enacted Levels (\$7 billion in FY 2020)

CURRENT SERVICES AND BINDING AGREEMENTS

Tribal leaders are adamant that the FY 2019 budget request, as a starting point, provide an increase of \$464.1 million over the FY 2017 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 Current Services, to include funds required for binding agreements, creates a false expectation that more funds are available for expansion of needed programs and 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 \$464.1 million be requested as reflected in this section.

CURRENT SERVICES (FIXED COSTS) +\$189.1 MILLION

The Workgroup recommends an increase of \$189.1 million over the FY 2017 enacted IHS budget 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. Typically, the proposed funding by the Administration falls short of actual need. For example, the workgroup recommends an increase of \$74.4 million for population growth. Population growth estimates are determined by a 1.8% increase.

The FY 2020 Tribal Budget Request for Current Services also includes an increase of \$10.1 million for Federal Pay Costs and \$15.6 million for Tribal Pay Costs. Tribal and federal facilities cannot continue to offer salaries below the competitive market. Current IHS pay rates are so far below what other providers offer, (including other federal providers like the Veterans' Administration) that physician vacancy rates at IHS continue to linger at 34 percent; dentist vacancy rates are at 26 percent and physician assistant vacancy rates are at 32 percent.

No health system can run a quality program when lacking one-third of the necessary staff. 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 2020. We cannot allow pay scales for our health professionals to be so substandard that they are forced to look elsewhere to seek a fair wage.

The Current Services request also includes \$14.4 million for Non-Medical Inflation and \$75.3 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services within the different budgets of the IHS health care delivery system. According to the Consumer Price Index (CPI), the index for all items less food and energy increased 2.2 percent over the past 12 months. The medical inflation in 2018 is predicted to be 6.5 percent. The Workgroup asserts that the rates of inflation applied to Hospitals and Clinics, Dental Health, Mental Health, and purchased/referred care (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.

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 \$36 billion, the Indian Health system remains severely underfunded at \$5 billion. When compounded with rising medical inflation and population growth, and new unfunded mandates such as MACRA and compliance with Centers for Medicare and Medicaid Services (CMS) Meaningful Use and ICD-10 conversion requirements, Indian Health budgets are, in real dollars, trending backwards.

BINDING AGREEMENTS (FIXED COSTS) +\$275 MILLION

HEALTH CARE FACILITIES CONSTRUCTION (PLANNED) +\$100 MILLION

In FY 2020, \$100 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 around \$110 million per year, the reality is that it will be decades before the IHS catches up on its backlog of planned health facility construction projects. The IHS Facilities Appropriations Advisory Board's 2017 report on the funding gap for projects on the construction queue, supports the conclusion that the HCFC budget line has been historically underfunded. The current HCFC priority list has 13 remaining projects which total \$2.2 billion. A program increase of \$100 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 FY 2017 budget request that provided \$132.377 million in this budget line. As the FY 2019 appropriation makes its way through Congress, Tribes remain hopeful that these necessary investments in health facilities infrastructure will be supported by the Administration and Congress. This \$100 million for the FY 2020 budget supports the projects in the FY 2018-19 requests. Along with funds for staffing and quarters, an increase of \$100 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:

- ▶ Gallup Indian Medical Center, Gallup, NM
- ▶ Pueblo Pintado Health Center, Pueblo Pintado, NM
- ▶ Broadway Gap, Arizona
- ▶ Albuquerque Health Care System, Albuquerque, NM
- ▶ Sells Indian Hospital, Sells, 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.

NEW TRIBES FUNDING

In January 2018, six Virginia Tribal Nations (the Chickahominy, Eastern Chickahominy, Upper Mattaponi, Rappahannock, Nansemond and Monacan) were granted federal recognition. In absence of Congressional appropriation in FY 2018, IHS will continue to work with the six Tribal Nations to secure appropriate PRC bridge funding until full appropriations are provided. It is imperative that as Tribal Nations are federally recognized that Congress increase IHS appropriations accordingly. Delays in appropriations for newly recognized Tribes limits the IHS' ability to uphold the federal government's trust responsibility to provide health care.

TOTAL FY 2020 REQUEST FOR FIXED COSTS:

Current Services \$189,124,000

- Federal Pay Costs \$10,133,000
- Tribal Pay Costs \$15,850,000
- Inflation (non-medical) \$14,430,000
- Inflation (medical) \$75,359,000
- Population Growth \$73,352,000

Binding Agreements \$175,000,000

- New Staffing for New & Replacement Facilities \$75,000,000 *
- Health Care Facilities Construction (Planned) \$100,000,000
- Newly Recognized Tribe Funding \$ (TBD)*

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

CONTRACT SUPPORT COSTS (ESTIMATE) +\$100 MILLION

The Work group projects an estimated budget increase of \$100 million over the FY 2017 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 pending CSC policy. As written, this draft 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.

The estimated \$100 million increase over the FY 2017 enacted 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. The total FY 2019 CSC request is estimated to be \$800 million. The Indian Self-Determination and Education Assistance Act requires that 100% of these costs be paid, and is therefore this budget line is considered to be a legally mandated requirement. Over 60% of the IHS budget is 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.

In fiscal year 2020 and beyond, the Tribes universally support the Administration 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.

PROGRAM EXPANSION INCREASES — SERVICES BUDGET

The National Tribal Budget Formulation Workgroup recommends the FY 2020 Program Increases outlined in this section that represent a critically needed infusion of resources, totaling \$1.5 billion (+36%) above the FY 2017 Enacted Budget. These increases represent the minimal infusion of resources which are critically necessary to bring the IHS health delivery system up to a safer standard of care. These national priorities identified and agreed to by Tribal leaders are the result of a year-long Tribal consultation process which started with discussion by individual Tribes and urban Indian health programs who brought their priorities to inter-Tribal meetings held by each IHS Area Office, and then finally, a national work session during which Tribal Leaders representing each region of the country came together to develop the national priorities for the Indian health care system. These recommendations build upon prior progress that has been gained through efforts by IHS, Tribes and Urban Indian programs which supports the marginally funded system as we know it today. The following FY 2020 Program Increases are necessary to improve the delivery and quality of health care and reduce the high occurrence of health care disparities which are magnified throughout the American Indian/Alaska Native population.

HOSPITAL & CLINICS: +\$409.4 MILLION

Adequate funding for the Hospitals & Clinics (H&C) line item is the top priority for fiscal year 2020, as it provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the **core funding** that makes available direct medical care services to AI/ANs in the United States. Increasing H&C funding is necessary as it supports medical care services provided at IHS and Tribally-operated facilities, including emergency care, inpatient and outpatient care, medically necessary support services, such as laboratory, pharmacy, digital imaging, information technology, medical records and other ancillary services. In addition, H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs such heart disease and diabetes, treatment and rehabilitation due to injuries, maternal and child health care and communicable diseases including influenza, HIV/AIDS, and hepatitis.

It also supports the Domestic Violence Prevention Program, the IHS Quality Consortium for Federal Hospitals, the Improving Patient Care Initiative, Trauma Care at a limited number of facilities, Facility Staffing and Operations and Tribal Epidemiology Centers. Tribes support the continuation of investments in direct medical care; however, it should not be at the expense of reducing other line items that support the delivery of health care, such as public health infrastructure and preventative services. These issues are addressed elsewhere in this report. It should be noted that the FY 2018 President’s Budget Request for the Hospitals & Clinics line item, totaled a \$16.7 million dollar increase over the FY 2017 Annualized Continuing Resolution. \$14.7 million of the increase was targeted for staffing and operations at the two new health care facilities, one in Oklahoma and one in South Dakota. \$1 million was made available for a limited cooperative agreement with the National Congress of American Indians to extend the Healthy Lifestyles in Youth Grant beyond August 2017. The focus on direct medical care continues by the Administration which is

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 573 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. Each contracting and compacting Tribe has the right to access and utilize the current IHS electronic health record (EHR) – the Resource and Patient Management System (RPMS). However, Tribes are choosing to leave the system because IHS has not been able to properly maintain and update the system – which further exacerbates the challenges because this results in less funding for IHS to operate and maintain the system. In addition to the slow transition of Tribes, IHS faces a uniquely challenging situation because the Veterans Health Administration (VHA) is also in the midst of planning to transition to a Commercial Off-the-Shelf (COTS) system. As a result, the future viability of RPMS is at risk, because RPMS is linked to the VHA EHR and regularly receives technical updates and changes as a result of VHA's work.

Request:

Given the current challenges with RPMS and the changing health care environment, the Tribal Budget Workgroup strongly recommends that the IHS adds an Information Technology-specific budget line and that additional resources specifically for I/T/U IT requirements be committed to allow IHS to either update the current EHR or initiate a process similar to that of the VHA. This recommendation would also protect H&C funds to support direct care for patients. The recommendation is for an additional \$3 billion over 10 years to replace RPMS.

evident in the proposed FY 2019 Budget Request for H&C at \$268 million above the FY 2018 Continuing Resolution. Tribal leaders support the increase, but disagree with the decision to shift \$123 million from important preventative services and flat lining other line items to help provide this increase.

The demands on direct care services are a continuously challenge in our facilities. We experience constant and increased demand for services due to population growth and the increased rates of chronic diseases that result in growing patient workloads. Adding rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment, these resources are 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 medical criteria for referrals through PRC to the private sector that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the direct care provided at an IHS or Tribal facility. For these reasons and the numerous access to care issues that Tribal members experience, an increase of \$409 million is not exorbitant, but realistic in terms of fulfilling unmet needs across Indian country.

Tribes are committed and seek the commitment of the Department of Health and Human Services (HHS) to make meaningful impacts in terms of improved health outcomes. This will be difficult to achieve if we continue to receive limited resources to address basic primary, secondary and urgent care needs. The AI/AN population suffers from significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse than other groups. Preventative and primary care programs deter costly medical burdens. Minimal increases that we've seen to date from the Administration are primarily directed to cover pay costs and inflation and staffing and operations at specific facilities. These are very important, but there is little left over to make significant, long-term progress and real gains in improving the health of AI/ANs.

A critical component of realizing the full potential of the Indian health care system is by funding new authorities in the Indian Health Care Improvement Act (IHCA) under the H&C line item. The provisions in this law represent a national promise made by the federal government to significantly improve the health of AI/AN people, yet eight years after the IHCA was reauthorized, most of the new authorities remain unfunded and not implemented. For Tribes, this is a huge disappointment, more broken promises by the federal government. Tribes are especially concerned about Section 124 - Other Authority for Provision of Services (25 U.S.C. § 1621d) as it would provide our elders the hospice care, assisted living, long-term care and home-and community-based care and convenient care services that are long overdue. FY 2020 should be the year when the Administration commits to funding this new authority and other priority sections of the IHCA that are further identified in this report. We must begin to see the positive impacts of

Indian Health Care Improvement Fund

The Indian health system faces significant funding disparities when compared to other Federal health care programs. For example, the final enacted FY 2017 budget (\$5.039 billion) to serve a user population of 1.6 Million AI/AN totals just \$3,332 per user. The actual spending per IHS user in 2017 was just \$3,851 vs. \$12,829 for Medicare and \$8,759 for Veteran's Affairs users. Historic allocations of resources appropriated to the IHS have created such significant inequalities throughout the Indian Health System when reflected by line items in a per capita amount. Further disparity exists within the IHS as some operating units are funded at even less per user when compared to the national average. The IHCIA established the Indian Health Care Improvement Fund (IHCIF) to eliminate the deficiencies in health status and health resources of Indian tribes. The legislation requires a report to Congress documenting the level of funding needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal organization.

Despite an increase in AI/AN health disparities, a rising user population, and legislative authority to fund the IHCIF to address resource deficiencies, Congress has only provided \$186.6 million for the purpose reducing health disparities and raising the health status of AI/AN people. Prior to FY 2018, the IHCIF had not been funded since FY 2012, when \$11.9 Million was allocated to locations with the greatest level of need according to the Federal Disparity Index (FDI). The FDI is used to prioritize funding in the IHCIF formula to the lowest funded operating units. In 2018, a new IHCIF Workgroup is currently meeting to review and update the existing IHCIF data and recommend updates, if any, to the current formula. Under the existing formula, the IHS was only funded at 56.2% of its level of need (LNF) in FY 2012; and according to more recent data, growth in users, changes in health indices, and inflation is only funded at 46.6% LNF in 2017.

Unless funds are targeted to address funding disparities, serious health deficiencies will continue to increase. 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. Access to quality health services remain a priority for all AI/ANs. The IHCIF was established to help to address these types of issues.

Request:

- The IHS Tribal/Federal Workgroup should continue 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.

a law that was over 20 years in the making and permanently reauthorized in 2010.

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 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 that 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 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.

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 Health Aide Therapists (DHATs) 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. DHATs 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 DHATs have expanded dental care to over 45,000 Alaska Natives and elementary schools in Alaska with relationships with DHATs have started cavity free clubs.

Language in the 2010 IHCIA amendments has been interpreted to limit expansion of DHATs in the lower 48 without state legislation authorizing DHATs as a provider. This limitation has not deterred Tribes from advocating for and pursuing opportunities to incorporate DHATs into their programs. Several Tribes in Washington and Oregon announced in 2015 that they would use DHATs as part of their dental team. Two Oregon Tribes and the Urban Indian Health Program established DHAT programs under state pilot project legislation. The first Oregon student returned from training in the summer of 2017 and is providing services in her community. The Swinomish Indian Tribal Community in Washington operates its own dental licensing board to license dental professionals at the Tribe, including a DHAT. Since introducing a DHAT 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 DHATs as a provider for the Tribes in the state. This prompted the Port Gamble S'Klallam Tribe to hire a DHAT at the end of the year. Notably, ten more students from Washington, Idaho and Oregon are in the Alaska DHAT Training Program with anticipated graduations in 2018 and 2019. Tribes in several other states including Idaho and Arizona are working on bills in the state legislature to authorize dental therapy in these states.

While these are remarkably positive steps for these Tribes, all Tribes in Indian country should have access to DHATs. The TBFWG continues to request that IHS use its dental services funds to expand DHATs to Tribes in the lower 48 within the existing law. In guidance issued by the agency in January 2014, IHS erroneously noted that any DHAT 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 DHATs. IHS should revise, update and re-issue guidance on the use of DHATs in Tribal communities. The revised guidance should clarify that the limitation in IHCIA 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 DHAT and other dental midlevel services in their communities. With IHS's commitment to national expansion of the CHAP and the formation of the CHAP Technical Advisory Committee, IHS should issue a comprehensive report detailing the effects of DHATs on clinics in Alaska. Mature programs like Southeast Alaska Regional Health Consortium (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 the Tribes in Idaho, Washington and Oregon for being on the forefront of public health dentistry and taking the lead in their States at the cutting edge of health policy.

MENTAL HEALTH +\$157,245 MILLION

Tribal leaders report Mental Health as a significant priority for FY 2020 and recommend a \$157.245 million increase above the FY 2017 budget enacted. This increase would mean a 167% increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of Tribal communities to further develop innovative and culturally appropriate prevention and treatment 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, studies are suggesting that American Indians and Alaska Natives are not receiving the services they need to help reduce the disparate statistics.⁴

Funds are needed to support infrastructure development 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.

4 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*.

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 make 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.

According to the Office of Minority Health, suicide was the second leading cause of death for AI/ANs between the ages 10 and 34 in 2014. Suicide was the leading cause of death for AI/AN girls between ages of 10 and 14; in AI/AN females from ages 15 to 19, rates of completed suicides were almost 4 times higher than in white females. In 2014, approximately 9% of AI/ANs ages 18 and up had co-occurring mental illness and substance use disorder in the past year—almost 3 times that of the general population.

Lack of behavioral resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. In the California Area, for example, the lack of funding is reflected in the 2017 Government Performance and Results Act (GPRA) Data. Over 2,500 youth and almost 10,000 AI/AN patients were not screened for depression at tribal programs in the California Area. Of patients that were diagnosed with depression, only 30% received a prescription for antidepressants with enough medication (with refills) to last 12 weeks, and only 10% received enough medication (with refills) to last 6 months. Additionally, over 4,000 women were not screened for domestic violence and over 13,000 patients were not screened for alcohol use. An increase in funding and subsequent staffing would allow a greater percentage of the population to be screened, seen by behavioral health specialists and most importantly, treated.

Furthermore, one of the main risk factors known to contribute to psychological distress and behavioral health concerns among the AI/AN population 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 a report that describes the foundation that must be put in place to treat 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. The poverty rate among American Indian and Alaska Natives was 28.3% among single-race American Indians and Alaska Natives in 2014, the highest rate of any race group. For the nation as a whole, the poverty rate was 15.5%, according to the Census Bureau. 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

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 that assists them while they 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 2020, 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 TFWWG has made behavioral health services a major budget priority for FY 2020. 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 +\$123,754 MILLION

Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities 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 2020. The Workgroup recommends a program increase of \$123,754 million above the FY 2017 enacted budget. 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, 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. Currently, 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 is 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.

Methamphetamine, opioid and heroin use is high in many IHS regions, with limited treatment facilities available. Tribes and Tribal entities across the nation are developing initiatives to combat the epidemic that is causing harm and has a devastating impact on families and communities. Tribal leaders in the Bemidji Area have declared a “state of emergency” with the growing epidemic of increased abuse of alcohol and drugs, including meth and opioids; Tribes in Washington are taking a stand against opioid addictions and Tribal entities in Alaska have declared a ‘war on alcohol and drugs’; The combined effect of alcohol and drugs is devastating. The average age of death for those dying due to alcohol addictions at the Wind River reservation is 38; for those addicted to alcohol and drugs the average age of death is 33.

In FY 2008, Congress appropriated \$14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, that funding continues to be allocated through competitive grants, despite Tribal objections. For over a decade, Tribes have noted that IHS reliance on grant programs is counter to the federal trust responsibility, undermining self-determination tenets. Some Tribes receive some funding, others do not. Grants create a “disease du jour” approach, where funding is tied to only one identified hot topic issue. If an area for example is suffering more from alcohol addictions than from meth or opioids, that area cannot redesign the available programs to meet the needs of that area.

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 HHS and IHS must move away from the inefficient use of grants, in order to stabilize programs and ensure the sustainability of 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 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 (2007), 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.

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

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 +\$406,993 MILLION

Purchased and Referred Care Services (PRC) continues to remain a top funding priority for the IHS and Tribal Nations. PRC, historically called Contract Health Services or CHS, was established to allow for IHS and Tribal operated facilities to secure care from private sector providers when services, especially emergent and specialty care services, are not available through the Indian Healthcare Delivery System.

IHS and Tribal operated facilities serve primarily rural populations and provide limited primary care and community health services. PRC funds are critical to securing the care needed to treat emergent and specialized health issues like heart disease, cancer, and injuries, all of which are prevalent in Indian Country and are considered leading causes of death amongst American Indians and Alaska Natives. PRC funds are used in situations where: (1) no direct care facility exists, or (2) the direct care facility doesn't have local expertise to provide required emergent and/or specialty care.

Because of inadequate funding for the Indian Healthcare Delivery System and PRC, IHS and Tribal Nations are forced to ration health care based on a limiting medical priority system (see table below), to ensure that those limited dollars last for an entire budget year. Often PRC funding doesn't extend beyond Priority I status, which thereby creates significant challenges in the health status of individual AI/ANs and communities. Tribal members who cannot access PRC resources face enormous risk of personal financial responsibility for care received outside the direct I/T/U health delivery system and in an increasing number of cases, patients have been faced with collection

notices which ruin personal credit. The existing PRC backlog is not simply the result of delayed payment due to bureaucratic inefficiencies within the IHS. Many PRC providers are unfamiliar with the IHS system and the laws that govern the provision of health care to AI/AN. First, there are the payer of last resort provisions which require private insurance, and other coverage through Medicare and Medicaid, to pay claims prior to IHS PRC programs. In cases where a patient does not have an alternate resource, the determination process may take weeks. Similarly, in cases where a patient fails to attain prior authorization due to lack of understanding of the process, the PRC restrictive rules which are designed to restrict access to these funds and ration care, do not allow payment on the claim and financial liability lies with the patient. Lastly, some PRC services may meet medical priority but be denied due to lack of funding. In emergent cases, patients will need to receive this care regardless of ability to pay. These scenarios do happen frequently and result in delays or denials of payment of PRC providers, which further adds to the problem.

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)

Racial and socioeconomic inequity has material effect on mortality and access to services. AI/ANs suffer disproportionately from obesity, hypertension, heart disease, and diabetes. Because of poverty and extreme rural geography of most Tribal Nations, AI/ANs have historically relied upon the IHS direct and referral programs for all of their healthcare coverage.

IHS and Tribally operated facilities are treating some of the highest rates of diabetes in the U.S., which would be even higher were it not for the remarkably successful Special Diabetes Program for PRC restrictive rules which are designed to restrict access to these funds and ration care, do not allow payment on the claim and financial liability lies with the patient.⁵ Because of these disproportionate incidences of disease and medical conditions within the AI/AN population, medical treatment costs are much higher, and the need to identify culturally appropriate prevention interventions is even greater. A significant

⁵ Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Mar 28, 2017 3:10:58 PM.

increase to IHS PRC funding will allow more Tribal citizens to access private sector care before their healthcare condition becomes critical. Increases may also extend the medical priority system reality beyond Priority I emergent care, improving and increasing the overall health of the AI/AN population.

PUBLIC HEALTH NURSING +\$21.9 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, and education programs. The request includes inflation plus \$21.9 million in expanded services.

HEALTH EDUCATION: + \$20 MILLION

The Health Education program is vital to bridge primary care with community health outreach and education. The focus of this program is to provide communities with education and awareness relating to preventative health, emergency response, and public health, including communicable diseases. In addition, health educators serve as the system liaisons between individual, health care providers, and community organizations to coordinate resources and services which promote health education programs. It is known that most chronic diseases that impact Indian Country are preventable with guided behavior changes. If unhealthy behaviors go unattended, the consequences are high health costs for treating these preventable diseases. Health promotion, health education and prevention are good IHS investments which produce effective and efficient approaches in addressing primary, secondary, and tertiary prevention, as well, bridging community, school, work place, and clinical settings. The Indian Health Service Health Promotion Program incorporates a holistic model which starts with promoting individual behavioral changes and includes community-based support to impact health outcomes through promotion of nutrition, physical activity, car safety, and emotional well-being. Overall, health promotion and health education results justify the value of this IHS investment by comparing cost of programs against

measurable health benefits; for example, pounds reduced to address obesity, increased fruit and vegetable consumption to combat chronic internal diseases, lives saved when using infant/toddler car seats, screening for early intervention of cancers, traditional healing to promote well-being, improved activity to promote fitness, and expanding the number individuals trained in healthy lifestyles to spread community awareness. And lastly, health promotion and health education improves the overall quality of life and well-being of Indian Country. The request includes inflation over the FY 2017 base in program expansion.

COMMUNITY HEALTH REPRESENTATIVES (CHR): + \$18.9 MILLION

CHRs help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. The CHR is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the communities served. This trusting relationship enables the worker to serve as a liaison, link, and intermediary between health and social services and the community to facilitate access to and coordination of services which improve the quality and cultural competence of service delivery. These representatives provide services like in-home patient assessment of medical conditions, providing glucose testing or blood pressure tests to determine if the patient should seek further care, and providing transportation for medical care, in which at times CHRs often pay for patient expenses from their own pocket. They also help interpret prescriptions which is critical to patient safety. CHRs are part of the direct provision of health services and are authorized in federal law within the Indian Health Care Improvement Act. Without these services and the people who provide them thousands of patients will not receive the care or attention they need. The result will be reduced health outcomes and patient safety issues for the most vulnerable and remote members of federally recognized Tribes. The request includes inflation over the FY 2017 base in program expanded services.

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 programs (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, provide culturally competent health care to many urban AI/ANs. The TBFWG recommends a \$32,748,000 increase, which would change the urban line item to \$83,011,000. Under the current budget, the amount each UIHP patient is budgeted for equates to \$721.42. The increase would elevate the amount to only \$1,256.04, which is still a small fraction of what every day Americans receive, but would make a huge difference to UIHPs. They also only have access to the urban Indian line item, which means, if split evenly among programs, each facility would only receive \$2,441,500, an increase from \$1,402,294 per facility. It is also imperative to remember that there are seven potential National Institute of Alcoholism and Alcohol Abuse (NIAAAs) programs that are in the process of being transferred, meaning the line item will be split 7 more ways.

UIHPs have a broad mandate and critical responsibilities, but are underfunded on several important matters, including funding, reimbursements from Medicaid and the Department of Veterans Affairs, and insurance. In bipartisan fashion, House Interior Appropriations Subcommittee 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, less than 1% of IHS' budget is spent on urban Indian health care. In fact, the increase in funding for urban Indian health care from FY 2012'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. UIHPs are also unable to access Purchased/ Referred Care funding or any other category of funding in IHS' budget. 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 and 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 would rightfully place care for Urban Indians under the federal trust responsibility.

3. **Reimbursement from DVA:** In 2010, IHS and The Department of Veteran's Affairs (VA) 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/ANs 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 +\$16.2 MILLION

The IHS system competes with the private sector in recruiting and maintaining health providers. However, there are few tools available to the IHS and Tribes that provide unique advantages in recruitment, principal among them – the IHS Scholarship and Loan Repayment Programs. Despite these unique opportunities, IHS is limited in its use of the programs due to significant underfunding and administrative policy. For example, in FY 2016, 613 health profession positions who applied for the Loan Repayment Program (LRP) were not funded. Meanwhile, IHS is disallowing Tribes who contract and compact programs to receive LRP funds when their vacancy rates are less than IHS. This seems at odds with the program and could result in negative impacts for contracting and compacting Tribes long-term.

Additionally, the program requirements themselves are overly restrictive. Currently, LRP only allows traditional health care providers to apply, effectively leaving IHS without any mechanisms to recruit and retain other health professionals – in particular managers and administrators. Given the recent accreditation issues and lack of experienced and well-trained management to replace retirement aged managers, now is the time to broaden the scope of the program to allow health managers to apply for the program.

To address the short and long term issues of staffing shortages the agency needs to deploy a workforce development pipeline approach that can aggressively assist in meeting the staffing need for health care professionals and managers. The Association of American Indian Physicians (AAIP), National Indian Health Board (NIHB), American Dental Association, and Tribal health department and colleges endorse measures that will ensure the future health professional needs can be resolved with approaches as defined by recent collaborations among the above.

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.

Strategies for the Short Term:

- Fully fund Health Professions Scholarship Program – applicants preparing to enter professional education schools.
- Fully fund and increase award levels for the Loan Repayment program to levels commensurate with other federal loan repayment programs (e.g. Navy/VA).
- Increase funding for Native medical school programs such as INMED.
- Provide accelerated loan repayment for service in extremely underserved areas.

- Provide accelerated loan or scholarship repayment for those recipients who return to their home Tribal communities to serve.

Strategies for the Long Term:

- Develop regional combined STEM/clinical programs to stimulate those students at a young age to develop the motivation to enter professional school.
- Decentralize funding previously diverted to universities back to Native entities that have proven records in developing and implementing programming for Native students into the health professions.
- Ensure Federal Income Tax laws and policies do not negatively impact students receiving Scholarship or Loan Repayment funding. Presently the IHS Scholarship and LRP are subject to Federal Income Tax Withholding, while other federal program receipts are exempt e.g. as like National Service Corp Program, VA or Military.

TRIBAL MANAGEMENT GRANTS +\$417,000

The Tribal Management Grant Program is established under the authority of 25 U.S.C. 450h (b) and 25 U.S.C. 450h (e) of the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, as amended. The request for Tribal Management Grants includes adjustment for inflation of \$46,000 over the 2017 enacted level and a program increase of \$417,000. The purpose of the TMG Program is to assist federally-recognized Tribes and Tribally-sanctioned Tribal organizations in assuming all or part of existing IHS programs, services, functions, and activities (PSFAs) through a Title I contract and to assist established Title I contractors and Title V compactors to further develop and improve their management capability.

TMGs are available to Tribes and Tribal organizations under the authority of P. L. 93-638 section 103(e). These grants assist Tribes and Tribal organizations to:

- ▶ Secure technical assistance for the purpose of 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.
- ▶ Plan, design and evaluate Federal health programs serving the Tribe, including Federal administrative functions.

TMGs consist of four types of awards designed to enhance and develop health management infrastructure. The project types include feasibility studies, planning and evaluation studies, and health management structure framework development. TMGs are necessary to assist Tribes and Tribal organizations assuming all or part of existing IHS PFSA's through Indian Self-Determination and Education Assistance Act (ISDEAA)

agreements under Title I and Title V to develop, improve and implement management structures to improve their management capability.

DIRECT OPERATIONS +\$614,000

The Direct Operations budget supports the IHS Headquarters and 12 Area Offices. The IHS mission is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The IHS is the only HHS agency whose primary function is direct delivery of health care. IHS is responsible for a comprehensive health service delivery system for approximately 2.2 million AI/ANs from 573 federally recognized Tribes in 36 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.

IHS has made progress and will continue to pursue implementation of the Quality Framework at all levels of IHS and in partnership with Tribal/Urban Indian organization partners as a key priority. The IHS leadership team is focused on ensuring quality agency-wide, and as stated in testimony in an Oversight hearing on September 13, 2017, expects this perspective and commitment will continue to produce results. IHS is strengthening the agency's use of standards by developing new policies that define the standards and implementing system level reporting and oversight through Agency-wide improvements. IHS restated its commitment to doing all that is necessary to be removed from GAO's High Risk list. The GAO's High Risk Report cited 14 recommendations that focus on IHS, derived from seven reports issued over a period of six years (2011 to 2017). The focus of these efforts is on ensuring Quality of Care and making improvements in the Purchased/Referred Care program.

SELF-GOVERNANCE +\$422,000

Tribal Self-Governance, known as Title V of the Indian Self-Determination Education and Assistance Act (ISDEAA,) authorizes Tribes and Tribal Consortia to assume programs, functions, services, or activities (PFSA), placing the accountability of service provision at the local Tribal governance level. This is achieved through the negotiation of self-governance compacts and annual funding agreements between IHS and Tribal governments/Tribal consortia. PFSA's priorities are determined by the populations served by the Tribal government/Tribal consortia, with particular emphasis on responsive administration of those PFSA's to serve the needs of the community. The Self-Governance budget supports negotiations of Self-Governance compacts and funding agreements.

This budget also supports oversight and coordination of IHS Agency lead Negotiators (ALN), technical assistance on Tribal consultation activities, analysis of new authorities in the IHCA, Self-Governance Planning and Negotiation Cooperative Agreements, and funding to support the activities of the Tribal Self-Governance Advisory Committee (TSGAC) which advises the IHS Director on Self-Governance policy issues. The request includes \$82,000 for inflation, \$20,000 for pay costs and \$102,000 to maintain current services as a binding obligation. An additional program increase of \$422,000 is included, for an overall budget request of \$6,310,000 to support and expand Self-Governance training and technical support in FY 2020.

Self-Governance Planning and Negotiation Cooperative Agreements

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements. These agreements assist Tribes in planning and negotiation activities; technical assistance, analysis and systems review are all part of those negotiation activities. IHS ALN's, Tribal technical advisors and financial expertise are required to successfully advance

Tribes wanting to advance their administration of health systems. The budget supporting Planning and Negotiation Cooperative Agreements assist Tribes to secure expertise, and IHS to ensure staff are available to respond to technical assistance requests. There are two types of cooperative agreements to assist Tribes in attaining Self-Governance:

- **The Planning Cooperative Agreement** helps Tribes with the activities to assume PFSAs that were either directly provided or part of Title I annual funding agreements. Costs supported by the planning cooperative agreements includes legal and budgetary research, internal Tribal government planning, and organization preparation relating to the administration of health care programs.
- **The Negotiation Cooperative Agreement** assists Tribes to defray the costs related to preparing for and conducting self-governance program negotiations of Title V compact and annual funding agreements. These cooperative agreements provide funds to support Tribal and federal negotiation teams, who work together in good faith to enhance each self-governance agreements.

FACILITIES

The Indian Health Service system is comprised of 45 hospitals (26 IHS operated, 19 Tribal) and 529 outpatient facilities (125 IHS operated, 611 Tribal). At these facilities there were an estimated 39,300 inpatient admission and 13.7 million outpatient visits in 2016.

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
IHS	26	59	N/A	32
Tribal	19	284	163	79

On average, IHS hospitals are 40 years of age, which is almost four times more than other U.S. hospitals with an average age of 10.6 years.⁶ 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 create 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.⁷ 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

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

7 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 on November 7, 2016. p. 12

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 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).⁸ “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.”⁹ 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.¹⁰

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. As several Tribal leaders have testified, all our patients’ want is to feel comfortable and safe within the environment in which care is being provided; this is difficult to do when facilities are in disrepair, overcrowded, and medical equipment has outlived its useful life.

MAINTENANCE & IMPROVEMENT +\$32.5 MILLION

The recommended program increase for Maintenance and Improvement (M&I) is \$32.5 million. This request represents \$36.007 million over the FY 2017 enacted budget (47.5% increase). While M & I appropriations have increased over the last few years, it has yet to meet the outstanding financial need. Rising regulatory and/or executive order requirements, limited vendor pool in remote locations and increased costs due to remote locations of Native American health facilities have a significant impact on the increasing need for funding. The program increase would also assist in addressing the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR), which is about 500 million. BEMAR is reported to Congress annually and it is the basis of supporting the need for M&I funding.

Adequate funding to support maintenance and improvement objectives include routine maintenance and ensuring compliance with accreditation standards of the Joint Commission on Accreditation of health care Organizations (JCAHO) or other applicable accreditation bodies. Investments that improve the patient outcomes, increase access, and reduce operating costs are proven to be cost-effective.

SANITATION FACILITIES CONSTRUCTION +\$72.5 MILLION

In FY 2020, the Workgroup recommends an increase of \$72.5 million for Sanitation Facilities Construction. Since 1959, IHS has used Sanitation Facilities Construction as an “integral component of IHS disease prevention activities” which has decreased mortality rates from environmentally related diseases by 80% since 1973.¹¹ “However, as of the end of FY 2016 about 22,898, or 5.7 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 173,674 or approximately 43 percent of AI/AN homes were in need of some form of sanitation facilities improvements.”¹²

The total sanitation facility need in FY 2017 as reported in the Sanitation Deficiency System is estimated to be \$3 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.

8 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.

9 Ibid, p. 14.

10 Ibid, 15.

11 IHS FY 2018 Congressional Budget Justification, CJ 156.

12 Ibid, CJ 156.

HEALTHCARE FACILITIES CONSTRUCTION +\$81.4 MILLION

The National Budget Formulation Workgroup recommends a program increase of \$81.4 million over the FY 2017 enacted budget for Other Authorities within the Health Care Facilities Construction (HCFC) line item. Currently, IHS uses its 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 list. There are 13 remaining projects on the “grandfathered priority list” which is currently estimated to cost \$2.2 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.

Nationally, the Indian Health Service has 12 new inpatient/outpatient health facilities, Small Ambulatory Health, Staff Quarters Program, and the Joint Venture Construction Program planned for construction. The existing facilities are obsolete with an average age of 47 years and have long surpassed their useful lives.¹³ The facilities are grossly undersized for the identified user populations, which has created crowded conditions among staff, patients, and visitors. In many cases, existing services have been relocated 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 numerous inefficiencies within the health care system.

As the existing health care facilities age, associated building equipment and components are also deteriorating to a point of failure and the decreasing availability of replacement parts on this aged equipment ultimately disrupt the already limited health care services. For example, piping systems which provide potable water for health services frequently experience failures, requiring the systems to be shut down for extended periods of time. This often results in patient care to be discontinued until appropriate repairs can be made. The rural and often isolated conditions associated with many health facilities complicates the repair of failed systems and extends the time required to make needed repairs. The constant system failures deplete designated maintenance and improvement funds and require the use of third party collections or other funding sources that would otherwise be used for direct patient care. In terms of medical and laboratory equipment, the IHS makes every attempt to keep pace with changing and updated technologies; however, due to limited equipment funds, IHS health facilities will typically use equipment well beyond their expected useful life. The construction of new health care facilities alleviates many of the problems associated with failing building systems

and equipment while simultaneously modernizing medical and laboratory equipment technologies.

Overall, inconsistent funding levels for health care facilities hinders progress on the construction of much needed facilities. The delay in implementing projects in a timely way results in higher construction costs, often doubling the cost of a project over a 10-15 year period, which is generally the lifespan of a project from the time a project is placed on the Priority List until it is fully constructed. These unreasonable timelines add to the growing health disparities and gaps in access to care. Without modern infrastructure, IHS has not been able to keep pace with available new and emerging health care technologies, including the use of tele-medicine and tele-health as solutions to address access issues. Most of the IHS facilities serve remote and undeveloped areas. Increased funding for these healthcare facility projects will provide greatly improved access to quality health care in all underserved areas of Indian Country.

Facilities Appropriations Advisory Board (FAAB) Advisement

Tribal leaders participate on the IHS Facilities Appropriations Advisory Board (FAAB) to review and provide guidance on the policies, procedures, and funding recommendations related to facilities issues. This assures that the methodologies utilized to determine the requested funds are accurate for needed infrastructure improvement in Indian country. The FAAB presented a report to the National Budget Formulation Workgroup on February 15-16, 2018 and included a Facilities Appropriations Information Package so that Tribal Leaders representing all 12 IHS Areas would have the most current information on all of the programs funded through IHS Facilities appropriations. In summary the FAAB specified the following in terms of HCFC:

- The current rate of HCFC appropriations (~\$110 million/year), a new facility in 2017 would not be replaced for 300 to 400 years.¹⁴
- To replace IHS facilities every 60 years (twice a 30 year design life), would need HCFC appropriations of ~\$500 million/annually.¹⁵
- The IHS would need HCFC appropriations of ~\$1 Billion/annually to reduce the need by 95% by 2040.
- IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in healthcare facility construction.¹⁶

¹⁴ Estimate based on data from The 2016 IHS and Tribal Healthcare Facilities Needs Assessment Report to Congress and the HFDS data system. Assumes: HCFC Appropriations would be consistent, re-occurring and adjusted annually for inflation; and about 22% of the HCFC funds on average would be replacing existing facility space.

¹⁵ DHHS, IHS, OEHE, DES. Architect/Engineer Guide. 2013. Page 36 #8

¹⁶ Getzen, Thomas E. Health Economics and Financing. 4th Edition, John Wiley and Sons Inc. 2010

¹³ Letter from the Tribal Budget Formulation Workgroup on FY 2019 Budget dated February 16, 2018

- Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable. As noted in the 2016 Facility Needs Assessment Report¹⁷

FACILITIES & ENVIRONMENT SUPPORT +\$9.4 MILLION

The TBFWG requests an additional \$9.4 million for the Facilities and Environmental Health Support (FEHS) budget line item for a total of \$245.8 million. The FEHS provides resources to staff and supports 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-born and communicable disease, food safety, and healthy homes. They work hard to identify environmental health hazards and risk factors in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, Tribal, and community members.

¹⁷ DHHS, IHS. The 2016 Indian Health Service and Tribal health Care Facilities' Needs Assessment Report to Congress. June 2016. Accessed on October 6, 2016 at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

EQUIPMENT +\$24.058 MILLION

The Tribal request is for a program increase of \$24.058 million for a total of \$48.3 million for Equipment. This number represents the minimal amount necessary to address critical medical equipment needs at health facilities managed by the IHS and Tribes. IHS and Tribes manage approximately 90,000 biomedical devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately \$500 million. Increased support 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.

Average Equipment useful life is approximately 6 to 8 years. To replace the equipment on a 7 year cycle would require approximately \$70 million annually. In the United States, a facility's annual medical equipment maintenance costs should be between 5% and 10% of medical equipment inventory value, which would equate to \$25 to \$50 million annually for the IHS. This fund also supports 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.



3RD RECOMMENDATION:

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

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.”¹⁸

Medicaid is a critical lifeline in Tribal communities. Moving Medicaid to a block grant system, as proposed in the President’s FY 2019 Budget Request, will have major fiscal impacts on Tribal health reimbursements, and would devastate Tribal health. Decreasing Medicaid decreases scarce resources available to cover our cost of care, and further restrict the eligible patient population. This puts an unequal burden on the IHS budget which is so reliant on these resources to make up our funding shortfalls. We urge the administration to ensure that American Indians and Alaska Natives are exempt from any burdens put on Medicaid like work requirements, so that fiscal strain doesn’t unintentionally fall back to the IHS. American Indians and Alaska Natives already have access to health care through the IHS, so work requirements only serve to inhibit the use of Medicaid in Tribal communities.

Indian Healthcare Improvement Act Implementation and Preservation

The Indian Health Care Improvement Act 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 the end of the law at Section 10221. Provisions included in the IHCA 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.

The IHCA provides a wealth of new resources and opportunities for Tribal health care institutions, families, providers and patients. With the permanent reauthorization of the IHCA,

the Indian health care system has begun a new chapter in the delivery of quality health care to AI/ANs.

Yet, not all provisions have been equally implemented — representing yet another broken promise to Indian Country. 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 which IHS, once again, falls short of meeting. Replicating these same improvements for Tribes in the IHCA was a critical aspect of the reauthorization effort. Tribes fought for over a decade to renew IHCA 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 represents several categories of programs that have not been implemented and funded:

- ▶ 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
- ▶ 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 of an office of men’s health.
- ▶ 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

¹⁸ H.R. Rep. No. 94-1026-Part III at 21 (May 12, 1976), reprinted in U.S.C.A.A.N. 2796.



► 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

► 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

► 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

► 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. For FY 2020, the TBFWG has prioritized five provisions of the IHCA for additional funding on top of regularly-appropriated IHS base funding. 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 appropriations to the FY 2020 request so that the dream of the IHCA can finally become a reality.

4TH RECOMMENDATION:

Fund Critical Infrastructure Improvements which impact patient care including Health IT and Health Facilities and Construction Funding and Equipment

The workgroup believes that critical infrastructure improvements must happen if we are to improve patient safety and care. Investment in Health information technology is becoming urgent. The Veterans' Administration's announcement to move off of their Electronic health record system, has put our RPMS system in serious jeopardy. If we do not have the support of the VA to help sustain RPMS development and support, IHS MUST have the resources to also replace our aging technologies. Tribes not using RPMS must also have resources to adequately maintain their EHR system. To have inaction will put our patients at serious risk for clinical errors and substandard care coordination. We have seen this time and time again where RPMS lack of capabilities have resulted in clinical errors and delayed diagnoses of curable conditions.

With potential national infrastructure investments on the horizon, we also urge the administration to put forth a bold plan for modernizing IHS facilities which are some of the oldest health facilities in the country. At current rates of funding, if a new facility were built today, it would not be replaced for 400 years! These aging facilities are full of ancient medical equipment and put patients at risk. One Tribal Administrator who recently took over their clinic facility, stated that the IHS equipment turned over to the Tribe should be put in a museum, it was that outdated. We implore you consider the impact which facilities and equipment have on delivering safe care, and URGE you to propose a strong, supplemental infrastructure package for the agency. It is about time that IHS is afforded a place to treat patients that is in line with 21st Century standards.

5TH RECOMMENDATION:

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%. Other federally-funded direct patient care agencies were exempted from this same cut. 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. Others shifted resources from non-direct care programs to meet pressing demands on the clinical delivery system. 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 2014-2019, 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 any 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 2020 budget should reflect that commitment by permanently exempting the IHS from sequestration.



6TH RECOMMENDATION:

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 from 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 2020 Budget Request.

7TH RECOMMENDATION:

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.



Our seventh request supports flexibility for federally-operated health facilities and IHS headquarters to have the authority to adjust programmatic funds across accounts. This will maximize efficiency and effective use of federal dollars at the local level. Local control will mean that resources are driven by need, instead of priorities that might not be relevant to immediate health issues.

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.

8TH RECOMMENDATION:

Support funding of Tribes outside of a grant-based system

The health needs of Indian people are chronic and multi-faceted; such needs deserve to be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes receive assistance and benefit from somewhat consistent increases, while other Tribes do not. This creates two pools of Tribes – those that have technical experience and financial resources receive funding, while many others without this capacity see no benefit in appropriated increases. The strings attached to federal grants in terms of reporting, limitations on use of funds, and timelines distract from patient care. This creates additional administrative burden for receiving Tribes which cannot be offset through means that would be available if IHS distributed the funds via regular programmatic increases. Finally, when grant programs are established, Contract Support Costs, which are administrative costs normally provided in addition to base funding, are not allowed. Instead, indirect costs are taken from within a grant award, resulting in less funding to provide direct project services. For these reasons, grant programs are counter to the federal trust responsibility.

Since 2008, 50% (about \$40 Million) of the increases to the total Behavioral Health budget (Mental Health and Alcohol & Substance Abuse Programs) is due to a growth in special grant programs and initiatives rather than increases to existing Behavioral Health programs. Instead of project or disease specific grant funds, the IHS needs to prioritize flexible, recurring base funds. Grants create a “disease de jour” approach, where the funding is tied only to an identified hot topic issue. For instance, if a patient presents with an “unfunded” diagnosis that is not covered by grants for specific disease categories that patient is left without many alternatives. This does not bode well for the many chronic diseases from which AI/ANs disproportionately suffer. For example, a large focus on the methamphetamine epidemic 10 years ago may have distracted from the rise in patients addicted to prescription pain medicine, thus contributing to the opioid crisis in Indian Country today.

While the United States generally is now facing an opioid crisis, a particular service unit in one IHS area may struggle most with alcohol addiction and under the grant making process cannot redesign the available programs and services to meet Tribal community needs. As such, IHS should never use a grant program to fund ongoing critical Indian Health needs.

Tribal leaders report frustration when federal agencies make autocratic decisions on who will be awarded grants and for what scope. This practice, Tribes argue, goes against Self determination. For example, CMS provided 3-year grant funds to address quality of care issues within the Great Plains Area and awarded this to a non-tribal, albeit well-meaning company, without any direct input from the benefiting Tribal Councils. Tribal leaders recently expressed that they are offended by the federal government's efforts to once again trying to “fix” the Indians. Tribal leaders have long related that they would prefer have the funds put directly into IHS budgets. This, they argued, would have greater chance of sustainable success citing that other similar efforts in the past to “fix” the Indians reportedly have failed.

Other Tribes report being challenged by local technological capacity issues when attempting to submit grants. They report not being able to electronically get grants out the door due to web-based applications dropping off, complicated by the real lack of readily available tech support. While this was not as much of an issue until the IHS recently switched their grant application process 100% to [grants.gov](https://www.grants.gov) it still points out the problems associated with using grant mechanisms to distribute funds. Before this policy change, Tribes could work with IHS tech support and have some flexibility when technical issues arise. Between connectivity issues and lack of technical expertise, including unavailability of technical IT support at the time when grants were due, Tribes have actually lost funding on which they had previously relied. They found out the hard way that is no “grace period” or flexibility within the rules of [grants.gov](https://www.grants.gov).

At least one small then-Direct Service Tribe lost over \$350,000 annually for their SDPI program, a 5 year grant which represented about 20% of its overall health funding. Subsequent appeals to IHS headquarters by the Tribal Chairman, a process taken since the IHS staff themselves were the ones responsible for submitting the grant on time, fell on deaf ears due to authorizing SDPI grant officials inability to set exceptions to the strict federal grants rules. Now the Tribe's mostly Diabetic patient population must rely on limited PRC funds to get the care they need including dialysis and supportive services until SDPI funding opens up in the next 5 year grant cycle, if at all. This strict adherence to grant requirements has greatly devastated the Tribe's whole health care delivery program and is yet another example of how the broken IHS grant policies creates a widening gap between the "haves" and the "have-nots". Meanwhile, the reality is, there are patients who are suffering, and who now require costlier care which sadly the SDPI program they previously benefited from, was set up to prevent.

Funding for ongoing health services in FY 2020 should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. Across Indian Country, the high incidence of chronic health conditions like heart disease, suicide, substance abuse, diabetes, and cirrhosis is well documented. Grant funding used to address any Indian health issue creates limited and restrictive funding and access to culturally appropriate care.



CONCLUSION

The Indian Health Service budget represents a sacred promise made to our ancestors to provide healthcare services to all American Indians and Alaska Natives. Time and again, Congress and the courts have affirmed this federal trust responsibility, but the resources needed to fulfil this promise have not been forthcoming by the United States government. Our people continue to suffer from preventable or treatable diseases and die younger than other Americans. The lack of funding at the Indian Health Service, as well as lack of investment in Tribal Public Health systems and basic infrastructure, is the primary reason for these health disparities.

No medical system in this country can be sustained with annual budgets which provide only a fraction of resources to cover needed costs.

The recent crisis within the VA health system is evidence of this. The VA's Budget is 14 times that of the IHS yet served only 4 times the population with direct care services. Our Indian communities are combating on-going historical trauma not unlike that of untreated PTSD due to war experiences. We have patients who have lost limbs due to untreated diabetes or unintentional injuries associated with the third world environments in which we live. Health care is rationed and expectations for quality care in outdated facilities and equipment are so low that patients have nearly lost all hope. Tribal leaders can no longer acquiesce to lip service and excuses from our federal trustees. The message is clear: the Indian Health System has failed its mission and cannot go on as it is. Serious investment is needed to make it whole.

Increases in the IHS budget since FY 2009 have been welcome; however, these incremental amounts have barely allowed the IHS system to keep up with population growth and inflation. To bring the system up to the level that other Americans enjoy, it is necessary to have meaningful investment in health programs and infrastructure, including modernization of facilities and health technologies. For AI/AN Tribes, 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. With health professional vacancy rates consistently 30 percent across the system, it is just not possible for IHS or Tribes to provide the competent and safe care our patients need and deserve.

The IHS Budget is not just another policy proposal. It is a moral and legal obligation that has direct impacts on the lives of AI/ANs. The rights we have as indigenous peoples cannot be forgotten amidst the complicated budget environment of Washington. The treaty obligations that our ancestors fought for are not a welfare program. We call upon this Administration to be staunch in its FY 2020 Budget Request which will give the Tribal Health system the resources to dig itself out of disparities which continue to suppress our people. Investments in the right areas can help us exercise self-determination and strengthen our nations' ability to make sustained progress in improving the health of this nation's First Peoples. This means we have to change "business as usual" and take a long-term strategic approach which will lead to reversing preventable and costly disparate health outcomes.

The TBFWG recognizes the efforts of our Tribal Leaders who have fought so hard to make progress in improving the health care of our people over the past 40 years. We implore to your sense of honor to work with us on a 12- year plan to fully fund the IHS and end decades of shameful disparities plaguing our Tribal communities. We reiterate our support for maintaining federal protections for AI/ANs under Medicaid and the IHCA; these protections are needed to ensure that we do not further lose services which benefit our people. We also urge the Administration to look for opportunities to bring forth needed investments in Indian Country throughout all of its agencies outside of the IHS including the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institutes of Health, the Centers for Medicare and Medicaid Services, and the VA. Likewise, we support new solutions to facilitate effective use of limited Indian health funds, including advance appropriations for IHS, flexibility in funding for direct service sites, and steering



the HHS and IHS away from funding our programs through grant-mechanisms which are contrary to our self-governance principles.

We hope that this document provides a strong guideline for you as you consider the FY 2020 budget request and the opportunity it provides to make meaningful progress toward satisfying the United States' trustee obligation to provide quality health care to Indian Tribes. As the Tribal-leader led budget formulation workgroup, we believe that working through our government-to-government relationship, we can effectively partner

to achieve real progress for the IHS. These budget recommendations must be acted on now if we are to build a strong and sustainable Indian health system and honor Tribal sovereignty to fulfill the federal trust responsibility. We look forward to working with you directly as you engage in conversations on the FY 2020 budget.

ACKNOWLEDGEMENTS

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APPENDIX

Hot Issues by IHS Service Area

ALASKA

1. Investing in Infrastructure

Sanitation Facilities

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.

Alaska has clinics (where temperatures can drop to -30 degrees or colder) that have instructions posted in outhouses on how to capture a urine sample. It is unfathomable in this day and age and with the vast wealth of this nation that we have communities suffering these developing world conditions. 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. New methods and technology are being developed to address this problem, however, many tribal communities in the United States do not have a taxable land base to provide for such needed infrastructure necessary to promote public health leading to increased risk of infection and costly community outbreaks of communicable disease.

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. 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.

Joint Venture Construction Program

Alaska Tribes request that IHS to announce a new cycle for the IHS Joint Venture Construction Program (JVCP) applications. JVCP, 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 are ready to step up and partner with IHS in order to increase access to health care in our remote communities.

Small Ambulatory Grants Program (SAP)

Alaska Tribes ask that IHS advocate for a new appropriation of funds to support this much-needed program. 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. 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. These facilities support lower cost care in home locations that allow for early interventions and preventative care. The time for this investment is past due.

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 life, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities. When patients and providers lack access to a well-functioning infrastructure, the

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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.

Staff 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 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.

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 health-care 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 (OIT). Resources will continue to be needed to ensure that IHS 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 Medicare & Medicaid 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 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.

Data Reporting & Measures

Alaska Tribes have long requested that IHS collaborate with sister agencies on reporting requirements. IHS needs to budget for such collaboration in both planning and implementation. For example, HRSA and IHS began collaboration in 2009 based on decades-long Tribal requests for greater compatibility among data systems and reporting requirements exploring potential opportunities to "streamline processes and requirements for dually-funded programs" tribes continue to divert program funding to comply with the reporting requirements of both agencies, creating an unnecessary administrative burden and incurring unnecessary costs.

One member shared that they participated in the UDS beta-testing. They found that problems persisted and they continued to have issues with the validity of the numbers. One problem, for example, was alignment across "pages." One page, was sorted by zip codes would not reconcile with the page on financial resources. That was within the system itself.

Problems comparing numbers from RPMS persisted as well, some numbers showing significant differences between the two systems.

In some cases, some problems could be resolved if there were unified standards in quality measures between agencies. This includes RPMS, UDS, GPRA, and Meaningful Use. The example provided was immunizations. The different agencies have different parameters that ascribe a different set of data. In some cases, it is the schedule of immunizations that differ, in others the problem stems from different definitions for age groups. These differences result in having to maintain multiple sets of measures for each of the systems increasing the costs of providing care and raising administrative costs taking from patient care services.

IDCS DM

ANHB submitted comments on October 30, 2015 regarding IHS' Information Data Collection System Data Mart (IDCS DM). Alaska Tribes proffer that IHS needs to consider the input from that letter in budgeting and continued development of the IDCS DM. First and foremost, IHS needs

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to support tribal sovereignty, and recognize that tribes do not relinquish ownership of the data when they participate in data reporting. The design and budgeting needs to include for mechanisms that allow Tribes and Tribal Health Organizations to have direct access to the raw data (not simply reports and not through an IHS employee). Secondly, IHS needs to budget that as part of the design, IHS include and work in partnership with Tribes and THOs in the design and recognize the need for an IHS OIT standard allowing for self-validated information to be accepted and incorporated. Thirdly, IHS should budget for and include in its planning process collaboration with sister agencies, and other Departments, in designing a system that accepts or is compatible with varying vendors such as NextGen, Cerner, Allscripts, Dentrax, etc. Finally, IHS would make available resources to support the standardizing nomenclatures needed to map multiple Electronic Health Records specific codes.

These issues are of particular interest as sister agencies, such as the Health Resources Services Administration (HRSA), are looking at designing and implementing IDCS Data Mart. As such, they may be looking to IHS as a potential model for their own. Alaska Tribes have long encouraged IHS to work collaboratively with sister agencies to create efficiencies and reduce non-congruent, but largely duplicative requirements in order to help ensure that the greatest amount of resources are dedicated to providing health care services to Alaska Natives and American Indians (AN/AlIs).

Resource and Patient Management System

The Resource and Patient Management System (RPMS) is an antiquated system that is consuming 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. IHS has no plans to have RPMS meet the 2015 Certified EHR specifications, limiting the ability of THOs to apply for Meaningful Use incentive funds and eroding the ability of RPMS to provide the highest possible health care.

RPMS & Commercial Off the Shelf Solutions

IHS and Tribes need to immediately begin to assess alternatives to RPMS – such as Cerner or NextGen solutions. We may need multiple solutions, and need to investigate interfaces and cross-EHR compatibility. The IHS has unique requirements – such as Purchase and Referred Care and the NDW, all of which will require some level of customization regardless of the final solution. Many sites lack the appropriate infrastructure to support a modern EHR – such as compatible printers, scanners, computers, laptops, tablets, and mobile devices. Network bandwidth

needs to be assessed as we move towards centralized or hosted solutions. Workflows need to be documented and/or changed. Data and analytics solutions – such as population health – need to be evaluated and/or developed. All this points to a complex, national approach to evaluate EHR solutions but also technology, infrastructure, processes and standards. Immediate funding is needed to begin assessing EHR COTS solutions, taking a deep hard look at current infrastructure, and beginning the process of upgrading infrastructure where it is lacking.

According to IHS data distributed to the IHS Modernizations Workgroup:

- Between 2015 and 2017, the number of RPMS sites dropped from 472 to 404. RPMS sites dropped from 75% of all sites to only 61% of sites.
- COTS EHR sites rose from 124 in 2015 to 221 in 2017 – a 97% growth.
- Almost all of the shift from RPMS to COTS EHRs is occurring at tribal sites, not at federal or urban sites. Tribes are making the decision to move from the RPMS and investing their own funds to move to COTS. In fact, the number of tribal sites with RPMS dropped from 318 to 253 between 2015 and 2017. Whereas the number of tribal sites on COTS EHRs grew from 123 to 211 in the same 2-year span.”

RPMS Laboratory Package Issues

Emblematic of the issue is an update of input that Alaska raised specifically in the IHS FY 2018 Budget Formulation Consultation and again in the FY 2019 as the issues are not only still relevant, but the situation has worsened. IHS Headquarters continues to maintain a backlog of over 70 unresolved action items that nationwide RPMS Lab Package end users consider *crucial* for operation. This backlog includes a number of high-priority action items previously called to the attention of the Alaska Native Health Board. Among these items is the lack of a functioning RPMS interface for microbiology equipment. This issue alone is expected to create significant health risks for patients who seek care in RPMS facilities in Alaska and across the country. Arguably, IHS's neglect of this one issue has the potential for creating more patient harm among Alaska Native People than all other unresolved action items combined.

The emergence of antibiotic resistant organisms is now recognized as a major public health crisis affecting patients across the United States, leading to more than two million infections and over 20,000 deaths each year according to the Centers for Disease Control and Prevention. Nowhere is this threat more apparent than within Alaska Native and American Indian communities, where the emergence of antibiotic resistant organisms, *Clostridium difficile* colitis, and other related complications has significantly

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altered the lives and well-being of our patients. In an attempt to address this crisis, The Joint Commission now requires healthcare organizations to develop and implement a program for antibiotic stewardship. In fact, IHS recently created a committee to assist federal and tribal sites in implementing this program. Laboratory testing, including rapid diagnostics and molecular instrumentation, is considered a vital component of any antibiotic stewardship program. Unfortunately, because the RPMS Lab Package lacks interface capabilities for microbiology equipment, federal and tribal sites utilizing RPMS – from small outpatient clinics to critical access hospitals - cannot meet the standard of care for effective, accurate, and timely infectious disease management. This places our providers and patients at a terrible disadvantage, and far below the standard of practice outside Indian Country. We consider the development and support of interface capabilities for microbiology equipment to be of paramount importance in improving patient safety and quality of care within Alaska Tribal Facilities utilizing RPMS.

Other important and long-standing issues pertaining to the RPMS Lab Package that remain unaddressed by IHS include:

- Auto-verification of In House Testing;
- Auto-verification of Reference Laboratory Testing;
- Lack of a certified blood bank package
- Ask-at-Order Questions not passing from EHR to Lab Package.

Despite the importance of these issues, IHS has made very little to no progress toward resolution. Nor has the Agency made any effort to inform end users of plans for resolution or allocation of resources. Alaska Tribes remain unclear at this point what support for the RPMS Lab Package looks like going forward.

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 166,000 AN/Als 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.

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.

2. Investing in People

Workforce Development

INDIAN HEALTH PROFESSIONS SCHOLARSHIP

Indian Health Professions scholarships 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

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costly care needs down the road or even unnecessary early death.

CHAP TRAINING

The shortage of available Community Health Aides (CHA) and Practitioners (CHAP) available to villages and other rural areas presents a significant risk to the health of Alaska Native people and the strength of the ATHS. The Alaska CHA 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 CHA training program is an essential step in ensuring the rest of ATHS functions correctly. The CHA 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 CHA 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 of funding needed to expand and/or establish new CHAP training centers will have to be considered.

3. Investing in Programs and Building parity

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 after-care 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.

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 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, including opioid addiction is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities.

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

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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 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 have shown to be highly effective in reducing the devastating impact that diabetes has in Tribal communities.

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.

Hepatitis C Treatment Funding Parity

Hepatitis C virus (HCV) is a chronic infection and a deadly disease that left untreated destroys the liver. The most recent national data show AN/AI suffer both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any U.S. racial/ethnic group. However, there are new medications that can reliably cure HCV with few adverse effects. These new drug regimens have made early detection and treatment of HCV critical as curing a patient of HCV greatly reduces the risk of liver cancer and liver failure. Unfortunately, HCV drugs aren't on the IHS formulary, so clinicians must spend considerable time mounting often unsuccessful attempts to get third-party payers such as private insurers, Medicaid, and patient-assistance programs for reimbursement.

The Veterans Affairs received additional resources for Hepatitis C and consequently implemented a program supported by funding and resources, resulting in VA clinicians being able to provide treatment for all their patients with HCV, whereas IHS clinicians cannot. AN/AI people deserve the same quality of care and the same level of resources as the VA, particularly since the IHS serves the population with the highest HCV-related mortality and highest incidence of acute HCV in the country.

IHS needs to work with the Administration and Congress to advocate for funds to build parity with the VA in addressing Hepatitis C Virus (HCV) and to ensure new

HCV medications are available in the IHS' National Core Formulary. IHS needs to advocate for the elimination of HCV in the AN/AI population and support efforts to enhance prevention, screening, and treatment of HCV in all AN/AI communities.

4. Supporting the Continuum of Care

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 reimbursement 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 provided in the reauthorization of the Indian Health Care Improvement Act (IHICIA), 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 IHICIA. There is also

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a need to support and coordinate the efforts of IHS and the Centers for Medicare & Medicaid Services to address reimbursement and certification/regulatory issues.

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 the denial of care under of P/RC, due to a lack of funding, is the most critical issue facing the Tribes concerning the P/RC 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 IHCA reauthorization and these new authorities must be incorporated into all of the long-outdated IHS policy and program manuals and health delivery system reform.

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, was 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, so that tribal programs can know what their next year's funding will be in advance and thereby better plan their budgets and administer their programs.

5. Supporting Sovereignty and Striving for the Best Care & Program Stability

The trend of IHS funding programs via grant mechanisms is inconsistent with the principles of self-governance and the ISDEAA. It is detrimental to programs, workforce development, and program stability. Furthermore, the Secretary of the Department of Health and Human Services is required to facilitate the inclusion of programs under the ISDEAA. 25 U.S.C. § 458aaa-11. In an era of full funding of contract support costs (CSC), the IHS should not be going out of the way to create grant programs to be implemented separate from ISDEAA agreements in order to avoid having to pay CSC. Full funding for CSC is critically needed to help defray the administrative costs, so that program funding does not have to be diverted to help administer the program.

Grant programs are also an inefficient use of funds in that the grant program cannot adequately reach all tribes, is limiting on community based approaches, does not create stability in programming, and is not flexible. Alaska Leaders support the inclusion of all tribal communities that need the funds. The grant methodology guarantees that a vast number of tribal communities will be left out, and often those are the communities with the least capacity and the most need. Alaska tribes have argued for non-competitive, non-grant funding via the Tribal Shares methodology because it offers flexibility for Tribes to pool resources together and/or leverage the funds (e.g. as tribal match

ALASKA CONTINUED

funds), and to seek additional resources in ways that grant funds are not able to be utilized.

The Federal government has a legal and moral obligation to provide these resources to the tribes, and Alaska Tribes will not relieve the Federal government of its Trust Responsibility by condoning the continued exclusion of those tribes that have not received funds, nor the taking away of programs and resources from current recipients via a grant funding mechanism. Furthermore, the grant funding mechanism has a built-in uncertainty, which destabilizes efforts to combat the problems for which they are intended to address. Alaska Tribal leadership want our program staff five years into a program to be looking for who to mentor next, not wonder whether they will have jobs or not. We want to grow our own and recruit professionals that are looking to build a career and who are vested in the long-term strategy to address the health concerns in our communities.

Distribution of via grants funding is paternalistic in nature, reflecting the priorities of those removed and far away—not driven by the communities' needs. Alaska Tribes are fighting for full funding of the IHS. Until such time that this Federal Trust Responsibility is met, IHS should facilitate the Tribes' ability to maximize their flexibility to leverage funds and garner more resources, and to self-determine how to run their programs to best meet the needs of American Indians and Alaskan Natives in their communities. Alaska Tribes need programs and staff to have the ability to implement long term strategy which includes mentorship and recruitment of Alaska Native professionals vested in an enduring vision.

ALBUQUERQUE

1. Concern over the impact of the current Presidential administrations actions on the Affordable Care Act (ACA) and the impacts on the Indian Health Services, Native American and Tribal Health care systems

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. Opportunity for IHS to identify a new patient centered Electronic Patient User Health record system (EHR) that is patient friendly.

Many of the Nation's leading health care providers have developed patient web-based electronic health record systems that allow patients to review and retrieve results of care and tests and to also communicate with Providers. Such systems allow patients to be more informed about their care and that of their families and also to perform some of the functions below:

- Send and receive messages with your care team
- View test results
- Request prescription renewals and view current medications
- Schedule primary care appointments, request an appointment with a specialist, view past appointments, and cancel or confirm upcoming appointments
- Verify registration information and/or pay your co-payment
- View and accept newly available appointments
- Access your health summary including allergies, immunizations and current health issues

Background: The I.H.S. has been linked to the RPMS system via the Veterans Administration for many years. With the recent information provided by the Veterans Administration on the transition and vetting that is occurring with the VA system to identify a new system, this may be an opportunity for I.H.S. to identify a new system to support a patient centered system; vetting of a more patient friendly health management system should be considered.

Recommendation: Link to budget recommendations or provide action that needs to be taken to address issue.

- Develop a pilot program with an I.H.S. outpatient health center, a Tribal health system to allow patients to access their information via a web-based system.
- Establish a workgroup with IT and patient records systems industry experts, I.H.S. and tribes to review current industry products, identify successful models that could integrate to tribal systems, identify costs and finally make recommendations.

3. Reauthorization of the Special Diabetes Program for Indians (SDPI) Funding as a permanent annual appropriation

As noted on the NIHB website, the National Indian Health Board (NIHB) and Tribes continue to request long-term renewal of SDPI, and continues to advocate for funding longer than 2 years as current legislation moves through Congress.

On September 29, 2017, President Trump signed a 3 month extension for the Special Diabetes Program for Indians (SDPI) into law as part of the Disaster Tax Relief and Airport and Airway Extension Act (H.R. 3823). The program would have expired on September 30, 2017, but now is set to expire on December 31, 2017. It is funded level funding from previous years (\$150 million).

Background: 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. The SDPI has two major components: the Diabetes Prevention and Healthy Heart Initiatives and the Community-Directed Diabetes Programs.

The SDPI provided funding to build programs that fueled hope for changing the course of the epidemic. During the 17 years of the SDPI, the grant programs have successfully implemented evidence-based and community-driven strategies to prevent and treat diabetes.

Although it is not possible to determine the extent to which these remarkable outcomes are due solely to the SDPI, nothing else has impacted diabetes resources across the Indian health system as much as the SDPI over the past 17 years. The SDPI has provided funding for services, training, support, and clinical data to help the Indian health system make tremendous improvements in the health of AI/AN people. Guided by Congress's vision, scientific research, and community-driven priorities, SDPI funding supports one of the most comprehensive and effective systems to prevent and treat diabetes in the U.S. Partnerships with Tribes have been essential to the success of the SDPI in diverse communities and settings nationwide.

Recommendation: At the Jicarilla Apache Nation, the funding that the SDPI program provides is critical to meeting the health prevention needs in the community not only related to diabetes, kidney disease but also other complications related to this disease process. In the community, there is a positive impact to patient care with the funding provided by this program. If the funding ceases to exist, staffing and critical programs will have to be absorbed by another funding source. If this funding was reauthorized as a permanent annual appropriation, the local programs could plan accordingly to meet the needs of the patients served. Having a three month funding source for FY 2018 offers a high risk to such a positive ongoing program

4. Annual Joint Venture Opportunities

The average age of IHS health care facilities is greater than 37 years. Because of increasing user population and insufficient space, many facilities are severely overcrowded. This impedes American Indians/Alaska Natives access to health care and precludes increasing the number of health care providers. When a facility is replaced, the new one is

ALBUQUERQUE CONTINUED

typically three to four times larger than the old one. This expansion provides access to health care for the 10-year projected user population and space for additional staff and some new services.

When the IHS lacks sufficient resources to address ongoing facility operation and maintenance needs, these deficiencies, which could compromise health care, must be added to the maintenance backlog each year. This backlog (IHS and tribal) is approximately \$515 million. As such, the IHS Health Care Facilities Construction program is almost totally ineffective in replacing the clinics needed for caring for Native Americans.

However, there is an effective alternative model: Joint Venture. 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.

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

BILLINGS

1. Substance Abuse

Wind River Service Unit has noted an increase in Methamphetamine, heroin, and opioid abuse.

Background: Epidemiologic data reveals that substance abuse on the Wind River Reservation causes early deaths. The average age of death for alcohol abuse is 38 years of age, and if combined with drug abuse the age of death drops to 33 years. If the person is able to quit both substances, the age of death raises to 73 years. A recent poll sent out to Tribal members had over 300 responses, and showed a major concern by the community in regards to the impact of substance abuse on and around the reservation.

Recommendation: Any cuts in budget areas that support Substance Abuse programs would have a detrimental effect on the health and life expectancy of the Tribal members on the Wind River Reservation.

2. Access to Care

The Wind River Reservation is the seventh-largest Indian Reservation by area in the United States, encompassing a land area of 3,473.272 square miles, or land and water area of 3,532.010 square miles, and the fifth-largest American Indian Reservation population.

Background: A recent poll sent out to Tribal members had over 300 responses, and showed a major concern by the community in regards to access to care. Access to care includes: new buildings for clinics strategically located to limit travel of the community members; Home Health services that take the care to the patients; as well as Educational Services and resources such as Diabetes, Nutrition, and Suicide prevention.

Recommendation: Any cuts in budget areas that support access to care would have a detrimental effect on the health of the Tribal members on the Wind River Reservation.

3. Housing

The Wind River Reservation is the seventh-largest Indian Reservation by area in the United States, encompassing a land area of 3,473.272 square miles, or land and water area of 3,532.010 square miles, and the fifth-largest American Indian Reservation population. There is a shortage of adequate housing on the Reservation.

Background: A recent poll sent out to Tribal members had over 300 responses, and showed a major concern by the community in regards to housing. A recent issue regarding housing is if a house has been exposed to Methamphetamine use or manufacturing, then the

process and cost of making the unit habitable again runs around \$10,000 per housing unit.

Recommendation: Any cuts in budget areas that support housing would have a detrimental effect on the health of the Tribal members on the Wind River Reservation.

4. Shortage of Qualified Medical Providers

The shortage of providers is a challenge and will only continue to increase.

Background: Both the Northern Cheyenne Service Unit (NCSU) and the Northern Cheyenne Board of Health (NCBH) have routinely had challenges recruiting and retaining qualified medical providers. Due to shortages, not only does this affect patient access to care, but it also affects other providers and medical support staff. Providers become overworked and this leads to burnout, stressed employees, and decreased continuity of care. Providers are known to leave our facilities for a less stressful job only 29 miles away in a health facility located off the reservation. This is a great issue, as we (Tribal) have lost more than one provider due to this. It affects our patient's relationship with their provider, as that patient will now have to develop a new relationship with their new provider or any provider for that matter, whom ever can see them for their next appointment.

Recommendation: It would be beneficial for the NCSU and the NCBH to be able to be equally competitive in the job markets. An increase in funding to offer competitive salaries and up-to-date medical equipment to attract providers is essential to providing quality of patient care.

5. Resource and Patient Management System

The Resource and Patient Management System (RPMS) is an antiquated system that can be laborious and unappealing to potential medical providers.

Background: the Northern Cheyenne Board of Health (NCBH) uses RPMS for Behavioral Health, Public Health Nursing, and Community Health Representatives Programs. Our providers are able to coordinate patient care with the Northern Cheyenne Service Unit (NCSU). It can be laborious to connect directly to the NCSU's RPMS system if users are not on-site (located within the NCSU), as we connect remotely. The systems can be slow and communication is vital with the Area Office to "investigate" our issues and correct them. This slows down productivity and does have financial effects. As a Tribal entity, pursuing expanded in-house third-party billing, this is important to us.

Medical providers are sometimes discouraged by the outdated RPMS and wish to continue the old-way of

BILLINGS CONTINUED

completing clinical documentation and that way is on paper. Another choice to not using RPMS is the medical providers documenting their encounters at their own office and faxing the visit back to the facility. This then becomes burdensome to other providers for coordinated care efforts and medical coders who read and code clinical documentation for third-party billing.

Recommendation: Dramatic increase in funding for Office of Information Technology is critical to modernize our systems. The safety and quality of care of our patients is our priority. With modernized systems our providers can focus on our patients and enable our providers to delivery better care. The health care system is ever-changing and we must keep up-to-date on technology.

CALIFORNIA

1. Recruitment and Retention

Funding for additional resources to augment recruitment/retention activities due to increasing difficulties in recruiting and retaining critical staff.

Background: 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. In addition, several Tribal programs are having difficulty in hiring and retaining Commissioned Officers due to budgetary constraints and the costs associated with detailing the Commissioned Officers to the program.

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
- Provide supplemental pay for Commissioned Officers assigned to Tribal health programs.

2. Joint Venture Construction Program

Tribes and their respective tribal health programs have repeatedly expressed concerns of a lack funding support of new or expanded space construction projects for tribally managed healthcare facilities.

Background: The IHS supports new or expanded space construction projects through several programs including the Health Care Facilities Construction (HCFC) program, the Joint Venture Construction Program (JVCP), and the Small Ambulatory Grants Program (SAP).

Section 818 of the Indian Health Care Improvement Act, P.L. 94-437, authorizes the IHS to establish the JVCP in which Tribes or Tribal organizations acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for 20 years. Participants are selected from eligible applicants who agree to provide an appropriate inpatient/outpatient facility to IHS. The Tribe must use Tribal, private or other non-IHS funds to design/construct the facility. Then the IHS will submit requests to Congress to fund staff, operations, and maintenance of the facility per the Joint Venture Agreement.

Each year that the JVCP application process is announced, the CAO ensures distribution applications to every tribal health program, serves as a technical advisor to all California applicants throughout the application process, and upon final review, submits the application to IHS Headquarters. Eligibility and final selection is carried out by IHS HQ. The CA Area received 19 pre-applications for JVCP including:

2002 (2): Shingle Springs and Lake County

2007 (11): Bishop Paiute Tribe, California Valley Miwok Tribe, Chapa-de, Santa Clara Valley, Karuk, Northern Valley, Pit River, Redding Rancheria, Round Valley, Santa Ynez, and Tuolumne Me-Wuk

2010 (2): Shingle Springs and Redding

2015 (4): Consolidated (Redwood Valley), Northern Valley, Susanville, and Toiyabe.

In 2005, the IHS/CAO was successful in receiving a JVCP award in which Lake County Tribal Health Consortium in Clear Lake, California entered into a joint venture project with the IHS.

Recommendation: The CA Area will continue to support and advocate for CA Area Tribes and their respective tribal health programs via technical assistance and available IHS resources such as Maintenance, Improvement, and Equipment (MI&E), Tribal General Equipment, and Sustainability funds.

The JVCP scoring criteria changes are needed to make California Tribal applicants more competitive and due

consideration is given to their unique service populations, geographic locations, health care facilities, and delivery of appropriate health care services.

3. Hoopa Ambulance Service

The Hoopa Valley Tribe (Hoopa) is located in Hoopa Valley, California and is a Title V compactor. Hoopa and the K'ima:w Medical Center (K'ima:w) ambulance service is seeking Indian Health Service (IHS) funding to offset their rising operating costs.

Background: 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.

Current Status: During the FY 2019 Budget Formulation, Hoopa requested 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

CALIFORNIA CONTINUED

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.

GREAT PLAINS

1. Ensure Medicaid reform upholds the Federal Trust 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.

2. Budget Formulation Process

Tribal leaders in the Great Plains region is requesting a review of the budget formulation process. Tribal leaders requested a needs-based budget is presented to the appropriations committee responsible for funding the Indian health service. A needs based budget would include budget projections that take into consideration drastic increase of HIS eligible users. The budget would also factor the needs for updated equipment and updated facilities into the formulation process.

An October 2016 Office Inspector General report indicated that the IHS experienced a 70% increase in user population in the last 15 years at IHS facilities while the capacity to provide inpatient care has decreased significantly. Current budget forecasts are based on salaries which are outdated and inadequate to recruit and retain the level of provider care needed. Budget justifications and allocations should include projections that provide incentives for providers to serve in remote and rural reservation areas.

The same 2016 OIG report indicated that outdated equipment and facilities contribute to the inability for some IHS service unit facilities to maintain standards required for CMS participation terms of participation. Great Plains Tribal leaders request that budget forecasting include the project needs to bring facilities and equipment to modern standards.

3. Special Appropriations for Facilities.

Subtitle G Section 709. Inpatient and Community-Based Mental Health Facilities Design, Construction and Staffing: Authorizes the establishment, in each IHS area, of not less than one inpatient mental health care facility, or equivalent, to serve Indians with behavioral health problems.

Tribes have long identified the need for a facility and programming for behavioral health (including people with co-occurring addiction, mental health, and criminal justice disorders) that will include detoxification, treatment, recovery support including sober living / transitional housing, and services for pregnant women and children. There should be separate facilities and programming for both genders and also for youth (separate from adults). Behavioral Health has been a high priority in the GP Area, yet the Indian alcoholism programs have never fully been integrated into IHS planning processes, such as Health Systems Planning and resource requirement methodologies.

4. South Dakota/North Dakota CHSDA

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

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

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

The viability and sustainability of implementing the ND/SD as one Purchased and Referred Care Delivery area is even greater with the adoption of Medicaid Expansion in North Dakota and with the pursuit of expansion in South Dakota.

5. 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 to an IHS request for comments and recommendations related to the geographic location of the IHS Great Plains Area Office the tribes, through the GPTCHB, convened a Tribal Great Plains IHS Area Restructuring Workgroup. The Workgroup included tribally appointed representatives from the 17 Tribes and one service area and were charged with seeking, evaluating and analyzing information requested by the GPTCHB in order to make informed recommendations. The workgroup developed five subcommittees to focus on key priorities; Budget/ Tribal Shares, Recruitment and Retention, PRC, Third Party Billing, and Behavioral Health. Additionally, the workgroup 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.

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.

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.

NASHVILLE

1. Opioid Crisis

The Opioid Epidemic is ravishing Tribal Nation communities, families and children yet funding for Treatment and Aftercare Programs are limited

Background: Tribes have reported the need for additional funding to support culturally appropriate treatment and aftercare programs and prevention initiative, yet are not considered for funding and excluded from the table when discussions occur on the opioid crisis. For example,

- SAMHSA Grants to States. Tribes not eligible by law.
- SAMHSA-Accountable for educating States on involving Tribal Nations if law prohibits direct funding to Tribal Nations.

Recommendation: Tribal Nations request that the IHS Director advocate for direct funding for Treatment and Prevention activities to combat the Opioid Crisis within Indian Country.

2. Substance Abuse Rehabilitation and Aftercare

When surveyed, the Nashville Area Tribal Nations reported the need for additional funding to combat substance abuse, particularly opioid abuse, through detox, rehabilitation and aftercare services.

Background: 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: Tribal Nations have recommended additional recurring funding opportunities to support detox, rehabilitation and aftercare services.

3. Funding to reduce the Hepatitis C Influx

Additional funding is needed to ensure that Tribal Nations and their citizens are educated on the prevention of Hepatitis C (HCV) and that all those affected have access to treatment.

Background: The prevalence of Hepatitis C (HCV) in the Native American population in the United States is believed to be higher than in the general population.

Unfortunately, Tribal Nations lack adequate information regarding Hepatitis C transmission. Community members may engage in behaviors that are assumed to be of low or no risk, but pose significant threat of infection. Promotion of testing for Hepatitis C is critical for early detection and linkage to care for optimal health outcomes. The availability of new prescription medicine makes it possible to cure Hepatitis C in most patients. Additional funding would be directed towards prevention and treatment education, Hepatitis C testing, infectious disease management, medication support teams to promote adherence, and other appropriate ancillary services.

Recommendation: Tribal Nations are recommending that IHS advocate for additional funding to support Hepatitis C prevention programs, promote and provide access to testing, to facilitate access to care and comprehensive care management, and to support those Tribal citizens living with Hepatitis C.

4. Reduce Obesity and Support of Integrated Care Models

According to the World Health Organization (WHO), obesity is a global epidemic. As obesity has risen so has the correlating health problems.

Background: Tribal Nations have taken a proactive approach to obesity and are encouraging its Tribal citizens to participate in wellness programs. These programs are designed to increase better health outcomes; however, there is still more that needs to be done. Obesity is linked to diabetes and our medical records have indicated that Nashville Area diabetes prevalence rate is 21% which is more than 1.4 times higher than the IHS-wide age-adjusted rate; and 2.6 times higher than the U.S. age-adjusted rate for all races of 6%.

Obesity rates amongst some of the Tribal Nations within the Nashville Area are well over 50%, with the percentage of overweight citizens rising. Obesity is most classified as a medical condition. The practical effect of such a classification is that the psychological aspects predisposing toward obesity often go unrecognized. There is a critical feedback loop between the psychological and medical aspects which negatively contribute toward the development of obesity and the self-esteem of those who are obese.

Recommendation: Additional funding is needed to effectively provide education and develop programs to prevent as well as treat psychological symptoms which tend to maintain obesity. An effective point of intervention would be to integrate staff from Behavioral Health into Primary Care utilizing a holistic treatment model.

5. Access to Health Care Facility Construction Funding

Health Care Facilities Construction funding is needed in the Nashville Area.

Background: \$100 million has been requested under Binding Obligations for previously approved health facility construction projects in accordance with the IHS Planned Construction Budget, referred to as the 5-Year Plan. While the Nashville Area has supported increased funding for Health Care Facilities Construction in the past the Area has not historically benefited from this program. With the development of a revised Health Care Facilities Construction Priority System and language in the permanently reauthorized Indian Health Care Improvement Act regarding new funding mechanisms for health care facilities construction provided some hope that future funding might be available to replace outdated Nashville Area health care facilities. IHS has yet to approve the revised priority system for implementation or to create an Area Distribution Fund to address Nashville Area facility construction needs. In a recent report distributed by the IHS FAAB, there's a need of over \$15 billion for IHS/Tribal Health Care Facilities Construction. Annual Appropriation on average of \$85 million is insufficient to cover the annual growth in Facilities Construction need.

Recommendation: The Nashville Area Tribal Nations request that IHS adequately demonstrate and advocate for increased facilities appropriations. Additionally, IHS Director should develop and implement an Area Distribution Fund for the Facilities line item, so that other Area facilities get smaller projects completed while IHS continues to work on the "grandfathered" priority list.

NAVAJO

1. HIV/AIDS

Background: The Navajo Nation HIV prevention Program has operated with four HIV health educators charged with providing prevention education, condom distribution, and HIV screening to an estimated population of 300,000 Navajo individual residing with a land base of nearly 26,649 square miles. Estimates from the Centers for Disease Control and Prevention (CDC) indicate approximately 50,000 Americans become infected with the Human Immunodeficiency Virus (HIV) annually. As a result, the number of people living with HIV in the United States continues to grow by tens of thousands each year, creating more opportunities for HIV transmission. Since 1987, the Navajo Nation has seen a steady increase in new cases of HIV infection with the Navajo Area Indian Health Services (NAIHS) reporting treatment of 503 cases. In 2014, forty-one (41) new cases were diagnosed, yielding a new case rate of 12.6 per 100,000 per year. According to an October 2017 report by the National I.H.S. HIV/AIDS & HepC Program Coordinator, there were 3,700 American Indian and Alaska Native adults and adolescents living with HIV infection at the end of 2013. Forty five percent of all AI/AN HIV diagnoses reside in the Southwest in the Navajo, Albuquerque, Phoenix, and Tucson I.H.S. Areas; and the cited leading routes of HIV transmission are men who have sex with men (MSM), injecting drug use, and heterosexual transmission. In Indian Country, Syphilis is on the rise and is associated with the facilitation of HIV transmission. Given that most patients diagnosed with HIV are referred to non-I.H.S. facilities, the I.H.S. National Core Formulary stocks TRUVADA only for the treatment of HIV post exposure prophylaxis (PEP). HIV medications are expensive and due to the low volume of patients with HIV, it is not cost effective for I.H.S. to stock TRUVADA as Pre-Exposure Prophylaxis (PrEP) on the I.H.S. National Core Formulary.

In October 2011 during the Fall Session of the 22nd Navajo Nation Council enacted, CO-41-11 Resolution, by ratifying the 2011 NN HIV/AIDS Act. The Health Education & HIV Prevention Program Rapid HIV Screening outreach in the field and in Navajo Correctional facilities yield the follow risk factors: 1 in 3 people have unprotected sex where more than half of Navajo Nation females reported unprotected sex with Males; and 1 in 6 persons had unprotected sex with multiple partners, while 1 in 12 had intercourse with someone whose HIV status was unknown. Additionally, a large percent had been incarcerated before.

Clinical services must be coupled with comprehensive sexual education. The effects of the social determinates of health may be harsher with respect to HIV because of its communicable nature. Social determinates of health- the conditions in which people are born, grow, live, work and

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age, including the health system- weigh more heavily in the cause and course of every leading category of illness than do any attitudinal, behavioral, or genetic determinate, including early sexual initiation and high alcohol use serves as a co-morbidity to HIV. This is the case for heart disease, diabetes, and cancer and it is equally true for the HIV/AIDs epidemic on the Navajo Nation. The intergenerational trauma, childhood abuse, suicide and self-harming behaviors, substance abuse and high risk sex behaviors are quite apparent among anyone who cares for or works with youth on the Navajo Nation. Because we address high rates of HIV, we must address all of these issues as well. Utilizing culturally-appropriate and well-tested curricula such as digital media, Native Stand, or Respecting the Circle of Life serve to mitigate these intersecting issues and must be integrated into the school system. Shrinking budgets and health service cutbacks have direct health implications for most people living with HIV. Indian Health Service is mainly a primary care, community health system and does not fund for tertiary or specialty care. Continued growth in the population living with HIV on the Navajo Nation ultimately lead to more new infections if prevention, care, and treatment efforts are not coordinated and intensified; Federal budget and Sequester & Rescission, cuts deterred HIV prevention services and harm reduction activities.

Recommendation:

- The Navajo Nation requests the Centers for Disease Control (CDC) to directly fund the Navajo Nation HIV prevention Program to further the goals of the National HIV/AIDS Strategy and the Navajo Nation HIV/AIDS Act by implementing High-Impact Prevention approaches to service design and implementation.
- The Navajo Nation requests the Secretary of Health and the office of HIV/AIDS Policy (OHAIDP) convene a discussion session annually on issues of HIV prevention in AI/AN communities with concerned and engaged community partners on the Navajo Reservation.
- The Navajo Nation requests that OHAIDP work with CDC to fund a HIV capacity building assistance provider to assist Tribes and Native community-based organizations with the implementation of public health strategies and evidence-based prevention interventions.
- Increased funding for youth-based prevention activities with a youth-specific Health Educator is needed to oversee school health programs in the school district(s), including develop needed summer education programs, e.g. Health Basketball Camps, coordinate with school officials to delivery needed health and sex education to young Navajo youth.
- Conventional methods of outreach at youth seemingly became archaic, thus the focus on digital media to

reach young MSM and young Heterosexual youth appropriately reach the Internet generation.

- Other prevention activities include advertisement on smart phones and dating Apps, in addition to the use of social media, i.e. Facebook, Craig's List, and text messaging with culturally appropriate sexual health promotion messages to young Navajo youth to begin as a Pilot Project to expand to other outreach programs on the Navajo Nation.

2. Integrated Quality Public Health & Clinic

Navajo Nation Department of Health (NNDOH) obtains grievances concerning quality of care from 638 and IHS facilities. Quality of care is concerning medical malpractice and competency of effective providers. This has triggered severe emotional suffering for the Navajo people and mistrust in 638 and IHS facilities. There is a need for public health services at the various levels of Navajo Nation (NN) government. The issue is stability due to numerous changes of downsizing of leadership, implementation of local government, Chapter Planning Committee and trend of Navajo election every four years. Also political appointment system of Division Directors does not provide continuity of leadership and affects continuity of services to the Navajo people.

Background: Include historical information or data that explains the hot issues in more detail. NNDOH conducted Public Health (PH) Forums at Tuba City, Shiprock, Chinle, Rock Springs, and Gando concerning grievances received. The Navajo people have attested to medical malpractice. The Navajo people are demanding resolution of these grievances and oversight of 638 and IHS to decrease or prevent medical malpractice. Reports of health disparities and inadequate health care services for Native Americans have been of concern to the Federal Government for almost a century. In 2016, the Office of Inspector General conducted several studies looking at the quality of care and longstanding issues at IHS facilities. One conclusion of these studies indicated that IHS may be missing opportunities to identify and remediate quality problems because of its limited interaction with these facilities. Also, coordination between local agencies has also constrained quality improvement initiatives. The recent political campaign during the Navajo Nation presidential election assured its constituents that the NNDOH, intend to elevate itself equal to State Department of Health to improve the health and well-being of the Navajo People. To date, there are no plans or budgetary assistance from NNDOH to support initiatives including improved staffing or enhancement of programs. Core Group (former NNDOH staff) is governing the Public Health program without soliciting input from all stakeholders involved in the healthcare of Navajo Nation.

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Recommendation: Link to budget recommendations or provide action that needs to be taken to address the issue. NNDOH, IHS, and 638 staffs need to meet on a consistent basis to address patient grievances and other concerns that may arise regarding the quality of care on the Navajo Nation. All stakeholders must work together to investigate patient concerns and, if validated, use this information to develop ways care can be improved. Amplification of oversight to 638 need to be made by HEHSC. Conditions of 638 facility oversight need to be evaluated to determine if conditions remain relevant with current practices. Key concepts in which all agencies must come to agreement: 1) Clear concept of what Public Health is in terms of health delivery system; 2) Clear distinction between PH and Clinical Health Services so leaders and people understand the two health systems; 3) Orientation and training on how PH system works to provide major support to the community, planning & development.

- Health care systems are highly regulated by national accredited agencies so caution need to be taken seriously by outside entities that want to regulate, monitor or evaluate these health systems.
- Integrate health system need Mission, Vision Statements and establish goals and objectives for quality health care for the Navajo people.
- Accreditation of Navajo Nation Public Health Program by and accreditation entity will clarify questions by stakeholders. IHS and 638 will be easier for integration of public health and clinical services.
- Sucession of leadership is very important. Leadership of IHS and 638 have been stable but retirement of workforce will happen. IHS and Navajo Nation need to stay on the progression of Growing Our Own especially with doctors and nurses, Federal support is a must for this initiative.
 - » PH issues are related to housing, waste management, water, electricity, roads, homelessness, fire protection, stores, public safety, elderly, prevention, counseling/treatment of abuses, land issues, faith based systems.
 - » Guidance by Department of Health (DOH) to chapters on Public Helath programs to promote health community including reinforce land use and community planning.
 - » NNDOH to help Chapter Land Use Planngng Committee and Chapter Officials to identify Public Health priorities. There are examples of excellent public health programs with policies & procedures and an opportunity for DOH to solicit input to establish a good public health program on Navajo Nation.

Additional Comments: Integrated Quality Public Health & Clinic.

Residence of the Navajo Nation have many inequalities compared to non-Navajos in surrounding states. Disparities include social, health and healthcare challenges.

Background: Navajo experience greater unemployment, higher rates of poverty, and lower levels of education. Navajos have higher than average risk factors for mental health, suicide, obesity, substance abuse, other chronic illnesses and death by accidents. Some of the disparities are due to geographic isolation and impoverishment. Some of the physical and mental health disparities faced by Navajo populations can in part be accounted for by the lack of funding for public health initiatives.

Recommendation: Indian Health Service should fully fund initiatives that combat the unique challenges faced on the Navajo Nation. Specifically, funding should be targeted at areas that help promote healthier lifestyles, reduces chronic illnesses and treat the entire health of Navajo patients- physically, mentally and spiritually.

Funding should address the multi-faceted need of Navajos including, but not limited to; substance abuse, dietary challenges, heart disease, diabetes, stroke, motor vehicle safety, nutrition, opioid abuse, teen pregnancy, physical activity and obesity, community water issues, the social determinates of health, mental health, provider shortages, etc.

There are many excellent healthcare facilities on the Navajo Nation, who are able to address the above needs if sufficient funding is provided.

3. ACA, Level of Funding Per Capita

There is no integrated Navajo area, Quality Public Health and Clinic services. Research is needed to study the needs of Navajo area health care system. The health services provided are operating in separate silos with confusion and delay of referrals of clients. There is no plan or system in place and this makes it difficult to work collaborate with health care organizations on the Navajo Nation to address the issues related to funding including ACA, Level of Funding and per capita.

Background: Include historical information or data that explains the hot issues in more detail.

Historically, the level of government funding for delivery of healthcare remains unchanged despite rising health care costs and patient's needs. This especially holds true for Indian Health Services (IHS) and Native Americans. Between 1986 and 2013, the collective population of registered users across the 28 IHS hospitals increase by 70 percent (from 695,941 users to 1,181,613 users). By comparison, the overall U.S. population increased by

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32 percent during that same period. This has led to an increase in patient burden on many facilities preventing access to care. Expenditures per capita for health care in Native Americans also remain low. Per the IHS profile in 2015, the per capita spending on Native Americans was \$3,688 when compared to \$9,990. Despite the increase demand in care, IHS budget for 2018 was \$6.1 billion dollars, a \$56 million reduction from the previous year.

Due to lack of federal funding, many facilities support their operations through third party billing, including public programs such as Medicare and Medicaid. In addition to the permanent reauthorization of the Indian Health Care Improvement Act, the Patient Protection and Affordable Care Act (PPACA) expanded Medicaid eligibility. Since 2012, over 30 state have adopted Medicaid expansions, including Arizona and New Mexico. Experiencing greater unemployment and higher rates of poverty, Navajo patients were able to greatly benefit from Medicaid expansions. Patients now have greater choice on where they can assess care. Facilities have also benefitted from the increased reimbursement for direct services. Medicaid coverage also serves as an alternative resource for indirect services/referrals, providing much needed relief to the often overextended Purchased Referred Care funding.

This is now being compromised with the new government administration efforts to repeal the expansions in the PPACA. Support for services is also in jeopardy due to the reduction in the Level of Funding for the FY 2018 Budget. The funding includes several areas of critical needs such as Purchased/Referred Care, Behavioral Health, Preventative Health Services, Health Care Facilities Construction, Sanitation Facilities Construction, Contract Support Cost and these some areas identified without some very critical, devastating areas of health conditions experiencing by the Native Americans.

Recommendation: Link to budget recommendations or provide action that needs to be taken to address issue.

- Prioritize health care needs for Native American patients and provide more funding; increase LOF and Per Capita.
- Funding for Native Americans needs to be increased as most the allocations to provide services only half (50%) with additional coverage comes from other types of insurance such as Medicare, Medicaid, and private health insurance.
- The health disparity is widening with less funding from the federal government as the population increases each year.

4. Oral Health

Expand oral health education and training for the CHR/ Outreach Program in order to further integrate oral health into overall health, thus improving overall community health status.

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. Dental caries results in lose sleep, inability to concentrate, inattentiveness, and subsequent poor performance in school. In 2014 approximately 76% of Navajo Children entered kindergarten with severe untreated dental decay.

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 (CHRs), who will go into communities to promote oral health education and increase awareness surrounding oral health and subsequently decreasing caries in children across the Navajo Nation.

The objective of the training is to increase individual and community-based oral health prevention activities, thus reducing the overall dental disease burden among the Navajo people. By increasing their oral health knowledge, CHRs will educate pregnant women that by improving their own oral health during their pregnancy, less of the bacteria causing dental decay will be passed to their children, thus reducing the disease burden. Young mothers and grandmothers will be taught the importance of keeping “baby teeth” healthy. The entire family will be able to practice better oral health habits, thus reducing dental decay, improving birth outcomes, improving diabetes outcomes in adults, and enabling future elders to maintain their natural teeth throughout their lifetime.

Recommendation: 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 and family practice physicians lack critical knowledge to promote oral health as part of improving overall health.

Treatment services will never successfully tackle the underlying cause of oral diseases without the help of community health workers. The Navajo Community Health

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Representative Program has begun to 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. Four CHRs are now certified as Community Dental Health Coordinators (CDHCs), who serve as oral health resources and role models for their peers. Our immediate goal is to have a CDHC-certified CHR in each of the eight Navajo service areas and eventually to have one serving within each chapter house.

It will cost \$50,000 to send 12 CHRs to attend Central New Mexico Community College to receive training with Community Dental Health Coordinator, the cost includes educational supplies, travel and lodging expenses. The American Dental Association has agreed to cover the tuition, books and institutional fees associated with the CDHC training. This will allow all remaining CHRs to participate in a two day Smiles for Life oral health training, which is specifically designed for frontline community health workers.

** Many Navajo facilities do not have this cost built into their budget.

Expected outcomes: by increasing the overall oral health knowledge of all CHRs and certifying more CHRs as community Dental Health Coordinators to serve as resources and role models, we expect the following early outcomes:

- Increase numbers of pregnant women will see the dentist and have their dental needs addressed, thus decreasing adverse birth outcome, such as low birth-weight babies and premature births
- Reduce the incidence of early childhood caries by educating new mothers about the importance of oral health during well-baby visits and utilizing fluoride varnish at each visit
- Increasing the number of children who are seen by an oral health professional by their first birthday.
- Increasing the number of children in Early Head Start and Head Start who have healthy mouths
- Decreasing the number of children who enter kindergarten with severe dental decay

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

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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.

The following language has remained in the Indian Health Service Appropriations language for almost two decades regarding the Indian Health Care Improvement Fund (IHCIF): "...the Indian Health Care Improvement Fund **may** be used, as needed, to carry out activities typically funded under the Indian Health Facilities account" (emphasis added). From FY 2013-FY 2015, approximately \$34 Million was appropriated to the IHCIF, but not distributed via the Level of Need Funded (LNF) formula to Service units, tribes, or tribal organizations. In order to ensure the

IHCIF appropriation is prioritized as intended by the Indian Health Care Improvement Act, the OCA proposes that the following language be inserted instead: "...provided further, that the Indian Health Care Improvement Fund may be used to carry out activities in accordance with 25 USC § 1621(a)(c)." OCA also recommends that any future appropriation to the IHCIF be distributed to in accordance with the section or with the funding methodology developed by the newly-formed joint Tribal/Federal Workgroup.

2. Exemption from future sequestrations (Similar to VA, Medicare, and Medicaid)

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 2016 for example, the per capita spending for IHS patient services was \$3,337 as compared to \$9,990 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.

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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 IHCIA 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.

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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

Another negative impact to Tribes and their members in the State of Oklahoma is the allocation or appropriation of funds for Housing Support Projects. These funds 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.

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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. Overall decreases in requests, combined with limited appropriation increases to CHEF have resulted in nearly full funding for all of the eligible CHEF requests. However, allowing the threshold to increase 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 cash flow 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. Additionally, OCA Tribes join other tribes in requesting that IHS update the PRC and CHEF policies to reflect the recent court decision in Redding Rancheria v. Hargan.

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 healthcare 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

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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

Beginning in FY 2016 the IHS received an indefinite amount and payment of full Contract Support Costs (CSC) separated from the Services Account, a significant improvement from past practices of underfunding. With an aggressive agenda and Tribal consultation during FY 2016, an updated CSC Policy was adopted by the IHS to reflect the policy to fully fund these obligations and achieve consistency in calculations. The OCA continues to strongly support permanent Mandatory CSC appropriations as the long term solution for CSC funding challenges. A mandatory appropriation is the most effective solution to permanently address this legally binding obligation of the IHS.

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.

12. Helping direct Service Tribes to Move Funding Between Lines

Fundamental changes in the organization of health services for American Indians and Alaska Natives during the past thirty years have resulted in three distinct and separate entities: The Compact Tribes (CT), the Direct Services Tribes (DST) and the Urban Programs (U). Unfortunately, these changes have not benefitted each division equitably. Significant disparities have emerged between the DST and CT in which the DST are falling further and further behind operating levels enjoyed by the CT. This is demonstrated in several instances. One area in which disparities are significant is in certain administrative authorities enjoyed by the CT but not available to the DST. DST disparities from CT include:

- DST do not receive annual allocation in lump sum at the beginning of the year thereby not able to invest their funds in a manner permitting a significant return
- DST cannot reprogram funds
- DST are subject personnel limits
- DST are subject to restrictive salaries for medical professionals
- DST are subject to the effect of inadequate administrative personnel in offices such as procurement, personnel, finance, etc.

In addition to these administrative benefits enjoyed by the CT but not the DST, DST have been severely penalized by the withdrawal of so-called tribal shares from the Area and Headquarters of IHS. Removal of tribal shares from the Oklahoma City Area Office in 1994 resulted in approximately a 50 percent loss of personnel. At the same time, Area Office responsibilities increased tremendously. The Area Office now has considerable difficulty in timely providing services such as processing of personnel applications and hiring, procurement of goods and services, and financial management services. There is reason to conclude

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that withdrawal of tribal shares from the Area Office was done at the expense of the DST — in contravention of the original Congressional intent that self-governance should not operate at the expense of those choosing not to enter into a compact.

These disparities are compounded yet further by a third element: awarding of contract support costs to the CT. The many demands made upon the DST and their representative Health Boards require that they receive operational funds similar to those that have so benefitted the CT. DST require operational funds such as office space, administrative/clerical personnel, policy analysts, at least as urgently as does the CT. LIHB and other DST, have no funds for central planning, policy analysis, or attendance at critical meetings.

The above disparities are all experienced by the Lawton Service Unit, the Lawton Intertribal Indian Health Board (LIHB) and the Oklahoma City Area Office. This situation provides an excellent case study for examining causes and solutions of these serious and growing disparities.

13. Recommendations for Correcting Disparities Experienced by the DST

In order for the LIHB and similar DST organizations to reduce these disparities, they must be granted some of the authorities that have benefitted the CT. These include:

- Delegations of authority for personnel recruitment and employment to Service Units.
- Receipt of funds in a single allocation at the beginning of the fiscal year, patterned after that for the CT. The Congress acknowledged the benefit of this measure by extending it to the Urban Programs in proposed language in the reauthorization of the Indian Health Care Improvement Act (S. 1200).
- Basic administrative staff support must be made available to the Health Boards, such as an executive assistant, clerk, appropriate office space and operating expenses. Funds analogous to the Contract Support Cost funds provided to CT are necessary if the DST are to be able to carry out their various functions.
- A comprehensive study should be immediately commissioned to examine the causes of the increasing disparities experienced by the DST and to seek solutions that would place the DST in a much more favorable position. This might take the form of conversion of Advisory Boards to something like Boards of Directors. Such a study should include an assessment of the impact on the DST of removal of tribal shares from the Area and Headquarters Offices. The parameters of such a study must be worked out with the DST.

A reasonable approach to addressing these difficult disparities would be the establishment of a Demonstration Project for the LIHB and the Lawton Service Unit. The purpose would be to demonstrate the value and feasibility of delegation of certain authorities to the Lawton Service Unit, perhaps through the LIHB and to demonstrate the value of providing funding for the LIHB in a manner similar to that enjoyed by the CT. The creation of such a Demonstration Project might very well lead to a new paradigm placing the DST in an entirely more favorable circumstance.

This should be a five year project, with an appropriation of \$200,000 per year.

14. Developing a Regional Treatment Center

The Lawton Service Unit (LSU) of the Indian Health Service (IHS) encompasses ten counties in the southwestern quadrant of Oklahoma, home to the Caddo, Comanche, Delaware, Fort Sill Apache, Kiowa, Apache, and Wichita Tribes. The LSU serves 23,485 tribal members of which 4,625 are ages 10 to 19 years. In addition, Riverside Indian School (RIS), located in Anadarko, is for most of the year home to students in grades 4-12 (approximately ages 10-18).

Youth in the LSU catchment area face a myriad of risk factors including fragmented families with little structure/stable living conditions or income, history of substance abuse and mental health issues among family members, incarceration of family members, physical, psychological, and sexual trauma, peer pressure, bullying, substance abuse, neglect, abuse, emotional difficulties/depression, and suicide to name a few. An environment in which a high prevalence of mental health and substance abuse disorders is the result.

The 2014 Oklahoma Prevention Needs Assessment Survey produced by the Oklahoma Department of Mental Health and Substance Abuse Services cited the following issues among American Indians compared to non-Indians:

- 67.1 % of Indian children in grades 12 drank in their lifetime compared to 65.7 % of non-Indians
- 41.3 % of Indian children in grade 12 used marijuana in their lifetime compared to 36.5 % of non-American Indians
- 10.2 % of Indian children in grade 12 used prescription drugs in their lifetime compared to 7.4 % of non-American Indians
- 4.6 % of Indian children in grade 6 had been drunk or high at school and this further increased to 15.1 % of Indian children in grade 12

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- 10.5 % of Indian children in grade 12 had attacked someone with the idea of seriously hurting them compared to 7.1 % of non-Indians

Two years ago, Anadarko, the county seat of Caddo County, was the site of a suicide cluster involving four youths, three of whom were Indian. At the RIS in Anadarko, during 2016, 18 hospitalizations were required for suicidal ideation and less than one-half way through the 2017-2018 academic year, 11 admissions have been required.

A recent survey of students at the RIS showed that during the past three years, 476 students were in need of a mental health/substance abuse referral. Of students surveyed over the course of three years, 9.5% had a history of substance abuse in their family (13-14=13.8 %, 14-15=5.3 %, 15-16=9.7 %). Further, 30% of students had used some drug during their lifetime, 13% had used cannabis in the past 30 days, 6.5% had used alcohol in the past 30 days, and 0.8% had used any other drug including inhalants in the past 30 days. Further, 3.7% of the students had been in treatment/recovery and 0.8% desired treatment. Thus, there is a significant need for residential (inpatient) treatment for substance abuse/dual diagnosis youth among just the Anadarko municipal area.

The LSU catchment area, including RIS, has few mental health and substance abuse resources for young people, particularly those experiencing a high prevalence of risk factors and barriers to care. Present outpatient services are insufficient to deal with the serious problems of alcohol and substance abuse and accompanying co-morbidities.

The only American Indian youth treatment facility is located Tahlequah, which is in the extreme northeastern portion of the state, more than 200 miles from most of the LSU catchment area. Many families lack dependable transportation or funds to utilize such a distant facility. In 2016, the Tahlequah facility treated only three youth residing outside the local catchment area.

Thus, Indian youth in western Oklahoma experience serious barriers to treatment because family therapeutic intervention, which is paramount, would be exceedingly difficult as well. Most addictions take more than one course of treatment over time, therefore having a more local treatment center would improve the overall outlook for youth who are in need of said treatment.

A local Residential Treatment Center (RTC) is necessary to serve several complex functions. These include a scaled down treatment option before students are returned to the boarding school or to their home communities, an interim placement alternative for youth who need more

structure and a higher level of behavioral health services than that provided by a school. It is imperative to address more severe cases of emotional and behavioral problems before they reach crisis proportions.

Attention to emotional, behavioral, personality, environmental, and certain co-morbidities requires a center in which these can be comprehensively addressed.

15. Joint Venture Facilities Program

The OCAIHS would like to continue to voice our support for the use of the Joint Venture Program. No funds are needed by the Agency to begin this process, simply an awareness by the Congress and the Administration that the program is to be used at certain times or perhaps even ongoing. The IHS partners with Tribes or Tribal organizations (TTO) in Joint Venture Construction Projects where a TTO 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. 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 the staff, operations, and maintenance funding of the facility per the Joint Venture Agreement.

We consider the continued use of this program as **urgent and necessary** due to the following facts:

- 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.⁵² 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 need for new and replacement facilities in 2015 exceeds 18 million square feet at an estimated cost of about \$10 billion.
- At the current rate of HCFC appropriations (~\$85 million/annually), a new facility in 2016 would not be replaced for over 400 years.
- To replace IHS facilities every 60 years (twice a 30-year design life), would need HCFC appropriations of ~\$500 million/annually.

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- The IHS would need HCFC appropriations of ~\$1 Billion/annually to reduce the need by 95% by 2040.
- IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in healthcare facility construction.
- Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable. HIS has been given approximately 100 million dollars per year and as can be seen from the data above, that is nowhere near what is necessary to sustain and improve our system. That is why we feel it is urgent that the Joint Venture program be used regularly and as long as tribes have an interest and ability to pay for facilities and equipment with their own funding.

PHOENIX

1. Full Funding for the Indian Health Service

Tribal Leaders in the Phoenix Area support a concrete commitment by the Administration to secure full funding for the Indian Health Service (\$32 billion) to be phased in over 12 years. The following actions described in this briefing paper, include requested policy changes and budgetary increases. These steps will notably increase access to health care, shore up the IHS system's operational efficiency and safety, and improve the overall quality of health care for the American Indian population.

Background: The 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 have been 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.

Recommendations:

- Secure advanced appropriations (2-year funding cycles) for the IHS.
- Enact mandatory appropriations for the IHS.
- Provide additional funding in FY 2020 for three Phoenix Area priorities in the Indian Health Care Improvement Act (IHCIA) that was permanently reauthorized in 2010:
 - » A \$210 million program increase is recommended for the HCFC line item for Health Care Facility Construction projects on the current priority list of which \$25 million is requested to be designated for new grants for Joint Venture Small Ambulatory Projects.
 - » Without delaying progress on current priority projects, provide additional funding to institute the new HCFC priority system. A \$30 million program increase is recommended for the Office of Facilities and Environmental Health (OEHE) Support.
 - » Begin execution of the Arizona statewide Contract Health Services Delivery Area (CHSDA)/Purchased Referred Care (PRC) statutes. A \$135 million program increase is recommended for the Purchased/ Referred Care line item from which a designated portion for planning, research and Tribal consultation on this statute should occur.

PHOENIX CONTINUED

- Provide additional funding in FY 2020 to the Dental line item to reduce oral health disparities. (+\$40 million). Oral health care as a major need in the American Indian population. IHS has documented that the prevalence of tooth decay among American Indian children is at 76% by age 5, and American Indian adults suffer twice the prevalence of untreated tooth decay and/or periodontal diseases compared to the general U.S. population which is due to factors such as geographic isolation and lack of providers.
- Provide additional funding in FY 2020 to the Maintenance & Improvement line item (+\$85 million) to reduce the backlog of deferred maintenance that's reported by IHS at \$500 million.
- Provide additional funding in FY 2020 to the medical Equipment line item to address needs at new facilities and the replacement and repair of older equipment. (+\$18 million). Equipment funding has remained relatively flat and at the current rate of appropriations equipment would be replaced every 30 years rather than the recommended average lifespan of equipment at 7 years. To replace equipment on a 7 year cycle, it would require \$70 million annually.
- Increase the IHS annual requested estimate for New Staffing from \$75 million to \$125 million.
- Tribal Leaders support an infusion of resources to the IHS Urban Health line item (+\$35 million) and endorse Medicaid reimbursement at 100% FMAP for the American Indians and Alaska Natives that are served at these facilities. This may require amending the Social Security Act, which Tribes in the Phoenix Area fully support.
- The Indian health care system will be impacted by the Department of Veterans Affairs (VA) announcement on June 5, 2017, that it is ending use of the Veterans Health Information Systems and Technology Architecture (VistA) and purchasing a commercial off the shelf Electronic Health Record (EHR) product that is used by the Department of Defense. The IHS Resource Patient Management System (RPMS) is based on VistA, but has been upgraded over the years in coordination with the VA to meet IHS requirements. It's recommended that IHS seek new funding to cover the transition to an optimal EHR technology platform that can replace RPMS.

2. Special Diabetes Program for Indians

Tribes urgently request the U.S. Congress pass permanent reauthorization of the Special Diabetes Program for Indians (SDPI). The program was enacted into law in 1997 and without action by the U.S. Congress and the President, it is now set to expire on January 26, 2018.

Background: The rates of ESRD have begun to decline among the American Indian population and can be attributed to the frontline prevention and educational activities that SDPI programs conduct in Tribal communities. Diabetes Mellitus (DM) is the 5th leading cause of death across all ages in the American Indian population in the west. In the Phoenix Area IHS, it's the number one reason for an ambulatory visit among the Tribes in Arizona, Nevada and Utah and the second leading cause for an inpatient visit in the region.

Recommendations: Increase SDPI funding to \$200 million per year with an inflation adjustment for the over 400 SDPI programs conducted in Tribal and urban Indian communities in 35 states.

3. Support for Community Health Representative (CHR) and Health Education Funding Increase and Implementation of the National Community Health Aide Program (CHAP)

CHAP implementation is one of the high priority policy and program issues under discussion by the Tribal Leaders. Implementation will involve coordination among the Mental Health, Dental Health, CHR and Health Education programs to prepare for the comprehensive roles of the new paraprofessionals in the lower 48 states. Community Health Representatives and Health Educators are currently the principle paraprofessionals that conduct health promotion and disease prevention activities in Tribal communities in the lower 48 states. These two line items are long overdue for a program increase.

Background: IHS Headquarters has consulted with the Tribes and begun to methodically plan the national expansion of the program. Tribes in the Phoenix Area discussed the potential for incorporating Community Health Aides (CHA's), Behavioral Health Aides (BHA's) and Dental Health Aides (DHA's) in health care teams and tribally led health promotion disease prevention efforts. CHAP affords Tribes in the lower 48 states wide ranging opportunities, including career advancement for CHR's, Health Educators, Behavioral Health Technicians, Hygienists, Dental Assistants and others and the overall expansion of the public health workforce that is extremely needed in Tribal communities. Several states, including Arizona, are considering legislation to amplify the roles of Community Health Workers that are employed by community health clinics and other entities. The Arizona Community Health Outreach Workers Association (AzCHOW) is championing a voluntary certification process. CHR's have stayed apprised of this effort and provided input regarding how this process could be inclusive of the Tribes that employ the largest CHW workforce in the state, which are CHR's.

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Recommendations: Tribes in the lower 48 states recommend that the FY 2020 budget include the necessary resources to extend CHAP, including Dental Health Aide Therapy to the lower 48 states. The Phoenix Area recommends program increases in FY 2020 at \$17.5 million and \$7.5 million, respectively.

4. Seek Tribal Correctional Health Care Resources

The U.S. Supreme Court has determined that correctional facilities are required to provide health care services to inmates in accordance with the Eighth Amendment of the Constitution, *Estelle, et. v. Gamble*, 429 U.S. 97 (1976), *Brown, et al. v. Plata*, 131 S.Ct. 1910 (2011). Since 2009, the U.S. Department of Justice and Bureau of Indian Affairs have invested in modernizing jails throughout Indian Country, constructing new facilities that are designed to accommodate large inmate populations. These new Tribal facilities operate without licensed medical personnel to provide correctional health care services. The Inter Tribal Association of Arizona has joined a coalition of Tribes and Tribal Organizations that has been led by the Tuba City Regional Health Care Corporation to address this concern.

Background: Neither IHS nor the Bureau of Indian Affairs receives appropriations for this purpose and incarcerated individuals have to be transferred by law enforcement officers to IHS and Tribal clinics for outpatient services. Tribes are generally unable to provide funds needed to support medical and behavioral health staff in correctional facilities because unlike off-reservation jurisdictions that utilize property tax revenue for this purpose, federal law prohibits tribal governments from imposing property taxes. Tribal jails built since 2009 have already experienced outbreaks of tuberculosis and other communicable diseases and many inmates have chronic disease conditions, experience traumatic injury and behavioral health issues that require attention.

In 2016, IHS and Health Services Resources Administration (HRSA) announced that 27 additional IHS and tribal hospitals are now eligible for selection by health care providers in both their outpatient and inpatient settings under the National Health Service Corps (NHSC). Prior to that, only 12 facilities were eligible for the NHSC loan repayment program. This announcement is applauded as it opens up recruitment opportunities at the approved outpatient care sites including some Tribal facilities. Going forward access to primary health services and should be expanded to inmates across Indian country, including individuals incarcerated at BIA facilities.

Recommendation: Tribes recommend that the U.S. Public Health Service establish agreements with Tribes and/ or the Bureau of Indian Affairs to allow medical staff under the

U.S. Public Health Service Corp to be assigned to provide services at these correctional facilities. The NHSC designation needs to be expanded to include Tribal and BIA correctional facility sites in addition to state and federal correctional facilities.

The Social Security Act prohibits Medicaid participation for any individual who's an inmate of a correctional institution. It's assumed that states and local jurisdictions pay for the cost of correctional healthcare. At the present time there is no "inmate exception" for IHS and Tribal health care facilities for outpatient services provided to tribal member inmates and the costs for these services are increasing. Tribes in the Phoenix Area recommend that Congress amend Medicaid's "Inmate exception" so that an "Indian exemption" authorizes Medicaid reimbursement for the outpatient services provided to any individual who is an inmate of a tribal detention center.

5. Behavioral Health (Alcohol & Substance Abuse, Mental Health)

Tribal Leaders continue to advocate for the resources needed to address alcohol, substance abuse and mental health issues. Tribes experience crises that require professional behavioral response capacity as well as the need for psychological evaluation services in order for appropriate treatment to be accessed within Tribal communities or at state facilities that provide additional services not available in tribal communities. ITU's have not received direct resources to address prescription drug and opioid addiction treatment from the state or federal government. The states' comprehensive responses to the opioid epidemic have not widely involved measures to assist the Tribes. With this issue as well as the ongoing alcohol, cannabis dependence and methamphetamine use that effect tribal members, families and communities, efforts to heal our people must be continued in earnest.

Background: While reported visits to Indian health treatment facilities remain high for alcohol, cannabis dependence and methamphetamine, now prescription drug abuse, including addiction to opioid pain killers and heroin is affecting Tribes. According to a U.S. HIDTA report in 2007-2009, the AI/AN drug-related death rate was 1.8 times greater than the U.S. all races rate of 12.6 for 2008. In Arizona, for example, the 2014 Arizona Youth Survey included a question on past 30 day prescription drug misuse among 3,871 American Indian youth. The statewide average rate among 48,244 8th, 10th and 12th grade students was 6.3 percent, however among American Indian youth the average rate was about 7.9 percent.

Tribes have begun to be informed of state initiatives to address prescription drug abuse and the opioid epidemic. SAMHSA Opioid Abuse Grants were provided to the states

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in April 2017, but did not include resources for the IHS or a Tribal set-aside. The awards included language that encouraged the states to work with Tribes and urban Indian populations. Prior to that CDC awarded grants to the states' to help them respond to the opioid crisis, but these resources were not made available to the Tribes.

In 2016, IHS required that providers attend mandatory training and check State Prescription Drug Monitoring databases before prescribing opioids. In May 2017, IHS apprised the Tribes of the establishment of the IHS National Committee on Heroin, Opioid and Pain Efforts (HOPE) through an official charter that is tasked to: 1. Establish IHS policies, 2. Develop training for providers, 3. Establish effective pain management, 4. Increase access to Naloxone, 5. Expand access to Medication Assisted Treatment and 6. Reduce inappropriate use of Methadone.

In 2017, to address prescription drug and opioid addiction treatment, IHS included plans to conduct Naloxone training to 500 BIA law enforcement officials and institute Medication Assisted Treatment (MAT) training through its Tele-Behavioral Health Center of Excellence (TBHCE) under the Behavioral Health Integration with Primary Care initiative. In the FY 2018 IHS Budget Request, a slight increase in the national appropriation at \$678,000, allows IHS and tribal programs to maintain their current levels of activity, but is not sufficient to target prescription drug abuse and the opioid epidemic.

Recommendations: Tribes advise that integrated physical health and behavioral health treatment teams work to affectively address these issues and concerns. High consideration should be given to incorporate Traditional Healers as members of these teams. Tribes also recommend in FY 2020 that an increase of \$5 million be added to the Hospitals & Clinics line item to address opioid high risk infant care and an increase of \$5 million to the Substance Abuse line item to continue ramping up and sustain program efforts to address prescription drug and opioid misuse prevention, education and treatment.

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. Enhance Emergency Medical Services (EMS) Operated by Tribes

Emergency Medical Services (EMS) provided by Tribes through P.L. 93-638 contracts with the Indian Health Service in Arizona are reimbursed at capped fee-for-service rates established by the Arizona Health Care Cost Containment System (AHCCCS), the Medicaid state agency. These capped rates are currently up to three times less than the same services provided by ambulance companies certified by the Arizona Department of Health Services (ADHS).

Background: A prior Arizona Health Care Cost Containment System (AHCCCS)/Tribal Workgroup met two years ago to evaluate the reimbursement methodology for Tribal EMS providers. As a result, there was a rural rate increase of 15% in October 2016, but it has not remedied the inequivalent rates that apply to Tribal and Federal agencies under Arizona law. A new Tribal workgroup has been established by the Arizona Department of Health Services (ADHS) to address concerns with regard to the state's certification process that employs a rate negotiation process for private ambulance companies.

Tribal governments report that 638 operated EMS agencies meet all the CMS required standards of care such as; 1) Emergency Medical Technicians and Paramedics maintain certification, 2) certified staff participates in continuing education, 3) medical oversight is provided by a medical director, and 4) following State of Arizona Red Book/Protocols. AHCCCS further requires Tribal EMS agencies to maintain a provider registration number and a National Provider Identification (NPI) which includes licenses, disclosures, and agreements in order to obtain third party reimbursement.

Recommendation: Tribes in Arizona seek direct agreements with ADHS and AHCCCS for rates that are comparable to non-Indian ambulance companies operating in these same regions of the state that have met state certification criteria to address the rate issue. Tribes in the Phoenix Area further recommend a program increase in FY 2020 for EMS in the Hospitals & Clinics line item totaling \$20

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million as these programs have not received a substantial increase to their base funding for years.

8. Increase Recruitment & Retention of Indian Health Professionals

IHS and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: Physicians 34%; pharmacist 16%; nurse 24%; dentist 26%; physician's assistant 32% and advanced practice nurse 35%.

Background: IHS reported that a total of \$48.3 million was needed to fund all of the unfunded health professional loan applicants in FY 2016, but it was only able to fund 437 out of 939 applicants. The agency reported that only 456 of the new scholarship applicants were awarded this financial support out of 1,250 new online scholarship applications. An additional \$3.3 million in funding was needed to fund all of the qualified applicants.

Recommendation: Tribes in the Phoenix Area recommend a program increase of \$15 million to the Indian Health Professions line item in FY 2020 to increase funding for scholarships and to expand loan forgiveness options to individuals that are seeking to work in Tribal communities. Tribes seek measures to increase the recruitment and retention of professionals that are seeking to work in Tribal communities and engage Tribes in comprehensive efforts to promote American Indian and Alaska Natives into health careers. For example, Tribes support amending Internal Revenue Service (IRS) statutes to fully exclude IHS scholarships and loans from an individual's taxable income. They also recommend updating clinical and administrative Grade Salary (GS) levels to enhance IHS salaries to make them competitive with the Veterans Administration. It is further recommended that IHS continue its efforts to assist Indian Health Care Providers obtain continuing education credits.

9. Increase Resources for Tribes impacted by Rocky Mountain Spotted Fever (RMSF)

Significant concerns were noted about the ongoing RMSF health impacts that continue to cause illness and death in Tribal communities. RMSF is a bacterial disease known as rickettsiosis spread through the bite of an infected brown tick. Symptoms include fever and headache, rash, nausea, vomiting, muscle pain and loss of appetite. It can rapidly progress to a serious illness that can lead to amputation due to damaged blood vessels, paralysis and mental disability; untreated cases can result in death.

Background: Some coordinated efforts occurred a few years ago and the Tribes, the state of Arizona and federal agencies at the time made available resources and instituted a priority coordination of effort to address this issue. However, those resources have diminished and the health issue has not subsided. The White Mountain Apache Tribe, the San Carlos Apache Tribe and other Tribes have continued to make efforts to address RMSF and indicated that they are seeking additional resources to assist in their prevention efforts.

The San Carlos Apache Tribal Council declared a RMSF Public Health Emergency on December 5, 2017 and is seeking assistance from the U.S. Department of Health and Human Services, notably CDC, IHS, as well as the Arizona Department of Health Services to find new options for supporting RMSF prevention. The Tribe reports that from the spring of 2017 to the present, there have been 12 RMSF cases with 2 fatalities. The Tribe is stepping up all efforts to quell the RMSF outbreak, including instituting quarantines of residences and mandatory treatment of dogs.

Recommendation: Tribes recommend that the concerns of the San Carlos Apache Tribe and other Tribes affected by RMSF be heeded. The specific requests of the Tribe include that the U.S.HHS, including the Centers for Disease Control (CDC) and the Indian Health Service assist the Tribe with funding and technical assistance to quell the outbreak of RMSF on the reservation.

PORTLAND

1. Advanced Appropriations & Exemption from Sequestration

Background: Indian Health Service is currently funded through annual appropriations. Fiscal Year 2017 final appropriations were received in June 2017, leaving only three months in the fiscal year to expend funding. Incremental funding received through Continuing Resolutions makes it difficult for Indian Health Service, Tribal and Urban (I/T/U) health programs to plan, budget for and sustain services to American Indian and Alaska Native (AI/AN) people. Advanced appropriations would reduce administrative costs and allow federal and Tribal health programs to formally plan and address emergent health issues. In addition sequestration in 2013 resulted in an approximate 5% reduction in recurring funds. This loss of funding has only recently been restored through annual funding increases, further eroding purchasing power of an already underfunded system over the last 4 years.

Recommendation: Provide advanced appropriations to the Indian Health Service. This has greatly benefited the Veterans Administration, and could similarly benefit Indian Health Service and the Tribes that operate programs under P.L. 638. Also recommend exempting the Agency from any discretionary spending caps that may result due to further provisions of sequestration.

2. Medicaid Transformation – Waivers & Value Based Payments (VBP)

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. Current law also excludes Medicaid payments to facilities exceeding 16 beds. The IMD limitations are too restrictive and have prevented AI/AN patients from accessing needed behavioral health services. Additionally, Value Based Payment (VBP) models are being adopted by states to reform how health care is delivered and paid for. These models are based more on the quality of care they provide versus the quantity of care and move away from fee-for service.

Recommendation: Facilitate the expansion of Medicaid services and reimbursement to I/T/U health facilities through 1115 behavioral health waivers. Encourage the use of 1915(c) waivers for home and community based services to provide long-term care services in home and community settings rather than institutional settings. Assist in educating tribes on VBP models, including metrics, expected outcomes, incentives and penalties to ensure tribes can maximize collection revenue.

3. Information Technology & Electronic Health Record Replacement

Background: The Veterans Administration's (VA) will move to a new health record system, which will leave the Indian Health Service's current Registration and Patient Management System (RPMS) without system support. Portland Area Tribes recognize there will be a need for substantial investment in IT infrastructure and software in order to transition to an alternate system.

Recommendation: It is recommended that the software replacement have features to integrate behavioral health, as well as work with standardized Health Information Exchange (HIE) platforms to ensure data can be shared across health systems as seamlessly as possible. It's also crucial to have features for enhanced billing capabilities as third party resources from Federal and private sources have been key to healthcare delivery within the Indian Health Service system and will only increase in the future.

4. Permanent Authorization of Special Diabetes Program for Indians (SDPI)

Background: The Special Diabetes Program for Indians has become a critical program in addressing the diabetes epidemic among AI/AN people since it was enacted in 1997. Through the grant program, tribes and tribal organizations have benefited from the increased funding, support and focus to develop key measures and indicators to monitor diabetic patients and help those in the pre-diabetic range to delay or avoid the onset of the disease.

Recommendation: Permanently authorize the Special Diabetes Program for Indians to make it part of recurring base funding and subject to annual congressional increases.

5. Behavioral Health & Substance Abuse

Background: AI/AN people have many socioeconomic factors that contribute to poor behavioral health outcomes such as high rates of poverty, unemployment and lower rates of education. They are 1.7 times more likely to die of suicide than all U.S. races. Suicide is also the second leading cause of death for AI/AN teens and young adults. According to national data on drug and alcohol use, AI/AN have the highest rates of substance dependence or abuse of all ethnic groups at 14.9% compared to 8.4% for whites.

Recommendation: The Indian Health Service collaborated with Substance Abuse and Mental Health Services Administration (SAMHSA) and Tribes to develop a National Tribal Behavioral Health Agenda in December 2016 (see <http://store.samhsa.gov/product/PEP16-NTBH-AGENDA>). Recommend increased funding to implement

this collaborative tribal-federal blueprint for improving the behavioral health of American Indians and Alaska Natives. In addition fully fund IHCA sections 702, 704, 705, 709, 710, 711, 712, 714, 715, 723 and 724 to increase behavioral health funding to provide inpatient treatment, training for mental health technicians and expansion of tele-mental health as well as provide demonstration grants to tribes and tribal organizations.

6. Focus on Prevention

Background: Much of the funding distributed by Indian Health Service 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.

Recommendation: Increase funding for Community Health Aide Programs (CHAPs) in order to expand and implement the program nationally under IHCA section 111. Provide more resources for behavioral health and dental aides, in order to leverage individuals who already live in a community that can build trust between providers and patients, while also ensuring that services are available and delivered as close to the patient as possible. Low cost investments in prevention programs can have a tremendous impact within the community and prevent future expenditures for more costly chronic diseases such as diabetes and heart disease.

7. Dental Health Aide Therapists (DHATs)

Background: AI/AN people suffer disproportionately from untreated tooth decay, periodontal disease and tooth loss. The 2015 Indian Health Service Oral Health survey found that AI/AN people also have twice the prevalence of untreated caries than the general U.S. population and more than any other racial/ethnic group. 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 appointment wait times.

Recommendation: Expand the Dental Health Aide Therapists (DHAT) program to allow sites to provide more preventative and routine care by allowing DHATs to perform exams and basic services. This will allow dental providers to focus on complex care such as restorative root canals, crowns and periodontal therapy. One of the benefits of DHAT program is that local individuals can be trained to provide services within their own community. The training program is currently provided in Alaska. To allow more

people the opportunity to obtain certification, Portland Area Tribes would like the training program expanded to sites located within the lower 48 states. Authorities need to be established to ensure that the services provided by the DHATs are authorized to be billed through Medicaid or Medicare reimbursements.

8. Access to Treatment for Hepatitis C

Background: Recent data show that AI/AN 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. There have been recent advances in treatment options for HCV that has reduced HCV-related deaths. Unfortunately, these treatments can be costly, which has been a barrier to many receiving treatment. Many Medicaid programs and insurance companies mandate significant liver damage, such as cirrhosis, as a requirement for eligibility. The lack of access to acceptable treatment has created health inequities for AI/AN patients, as well as, the fact that early treatment can prevent more costly treatment for liver disease and failure.

Recommendation: Additional targeted funding needs to be provided so Indian Health Service 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, Indian Health Service facilities are highly dependent on Patient Assistance Programs, and third party payers to access HCV drug therapies, which leave gaps in treatment for many.

9. Public Health Emergencies

Background: Most Portland Area Tribes are not equipped to respond to public health emergencies related to severe weather, infectious disease outbreaks, wildfires and active shooter events. Emergency funding distribution is generally contingent on density of population. This can negatively impact smaller and geographically dispersed tribes that already have limited resources at their disposal.

Recommendation: Portland Area Tribes request the authorization of 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. In addition 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.

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10. Regional Referral Center

Background: Portland Area Indian Health Service doesn't have hospitals or specialty centers, which forces tribes to rely on Purchased Referred Care. Additionally, Portland Tribes are concerned with the limited amount of appointments available and increased wait times for Tribal members who are not part of the State's managed care Medicaid program.

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. Program of Requirements (POR) and Program Justification Document (PJD) were finalized in April 2016.

Recommendation: The current Indian Health Service 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 IHCA section 143. The facility would utilize the submitted Program of Requirements (POR) and Program Justification Document (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.

11. Staffing, Recruitment & Retention

Background: Both federally operated and tribally operated facilities have difficulty with recruitment and retention of qualified medical providers. Tribes are concerned that the expansion of Medicaid and Medicare, as well as, new funding authorities for Veterans Administration (VA), has created more competition for the same amount of providers. This has increased the need for multiple approaches like market pay and retention bonuses, to ensure qualified and competent staff commit to working for the Indian Health Service.

Recommendations: Expansion of Title 38 authorities for market pay for all provider positions, including physician assistants, to ensure that Indian Health Service and tribal facilities can be competitive in the current job market. It would also 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. Funding of IHCA section 112, 132 as well as 134 would also provide additional resources to address recruitment as well as training programs to increase AI/AN representation in provider positions.

12. Urban Program Funding

Background: Indian Health Service programs are able to claim reimbursements for services provided at Indian Health Service facilities at 100% Federal Medical Assistance Percentage (FMAP). Urban Indian Health Organizations (UIHO) who use a combination of private and federal funds to provide care to AI/AN people living in urban areas are not authorized to bill at 100% FMAP. Over half of the AI/AN population in the US live in urban areas without direct access to an Indian Health Service facility. Portland Area Tribes are concerned that without the 100% FMAP reimbursement to UIHOs, most services are either paid for out of the state Medicaid program or the states have specifically excluded UIHOs from their provider networks.

Recommendations: Portland Area Tribes and Urban programs recommend the expansion of 100% FMAP reimbursement to include UIHOs. This will allow for more direct services to be provided to AI/AN people in urban areas as well as increase the ability for UIHO's to collect revenue to improve service delivery.

13. Environment and Health Effects

Background: In the Pacific Northwest, AI/AN people have rates of asthma nearly double that of the general population. They are more likely to report having asthma symptoms everyday as well as health status in the "fair" or "poor" category. AI/AN people are also exposed to many other contaminants within their communities such as uranium, lead, and environmental hazards related to methamphetamine labs, and prolonged substance abuse. Many tribes are located within areas that have been designated as Super Fund sites by EPA or experienced contamination from pesticides or other commercial activities. 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 many Tribal communities.

Recommendation: Targeted funding to increase asthma treatment programs including education and remediation of the environmental triggers associated with poor asthma control. Funding to support and implement asthma home visits 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

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recommend that more Indian Health Service providers are trained in how to develop these plans and work with patients to implement them.

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 and substance abuse within homes. Indian Health Service 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.

TUCSON**1. Dental Health Aid Therapists (DHAT's)**

American Indian and Alaska Natives (AI/AN) experience higher health disparities in comparison to the general U.S. population (Batliner, 2016). Oral health diseases, in particular, affects the majority of AI/AN's, and oral health is one major health issue that has not been brought to the forefront among all the other health disparities affecting AI/AN's. According to the Pew Charitable Trusts (2017), 2.4 million Native Americans suffer from the poorest oral health care in United States due to the lack of dentists and among the top oral health issues that affect both Native American adults and children are tooth decay and untreated gum disease. Native American preschool children have four times more cases of untreated tooth decay, adults between the ages of 35 to 44 years have untreated decay and periodontal disease (Pew Charitable Trusts, 2017). Oral health can also be linked to other chronic diseases like diabetes, heart disease and poor nutrition (CDC, 2017). In the State of Arizona approximately 2.3 million people including Native Americans do not have dental health insurance and do not have access to oral health care (AZ State Legislative Senate Health & Human Services Committee, 2016). There is a need for funding for Dental Health Aid Therapists (DHAT's) to provide oral health services in rural Native American communities.

Currently in the State of Arizona a group call Dental Care for Arizona have submitted a sunrise application in which the proposal is moving forward to the full legislature. Multiple states have authorized dental therapists including Minnesota, Maine and Vermont. States including Alaska, Washington State and Oregon are also piloting dental therapy programs with Native American Tribes. A national survey sponsored by The W.K. Kellogg Foundation found that more than 80% of voters said they favored allowing dental therapists to practice in their states. The same survey, which polled 1,200 voters across the U.S., also found that 15% of respondents said they either could not find a provider in their area or could not find one that would accept their insurance (<http://www.dentaltherapyofarizona.org/>). 15 counties in AZ has a federally designated dental health professional shortage area. One third of our counties in AZ, are entirely dental health professional shortage areas (<http://www.dentaltherapyofarizona.org/>).

TUCSON CONTINUED

2. CMS 1115 Waivers

The Tucson Area, the Pascua Yaqui Tribe and the Tohono O’Odham Nation are concerned about the recent submissions by a number of States to CMS requiring limiting the length an Individual is eligible for Medicaid to a lifetime of five years and for individuals to be employed or actively seeking employment. We do not agree with these requirements and Tribal members should be exempted from requirements due to our unique status as Native people.

3. RPMS

The Pascua Yaqui Tribe and the Tohono O’Odham Nation are concerned about the lack of transparency in the development of an alternative EHR to RPMS. We recommend regular (quarterly) planning meeting be held open to all interested Tribes.



SPECIAL THANKS

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**THE NATIONAL TRIBAL BUDGET FORMULATION
WORKGROUP'S RECOMMENDATIONS ON THE INDIAN
HEALTH SERVICE FISCAL YEAR 2020 BUDGET**