

The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2021 Budget

*Ending the Health Crisis in Indian Country;
A Path to Fulfill the Trust and Treaty Obligations*



TRIBAL CO-CHAIRS

Andy Joseph, Jr.
Confederated Tribes of the Colville
Reservation

Bruce Pratt
Pawnee Nation

Victor Joseph
Tanana Chiefs Conference



Executive Summary

Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on March 14-15, 2019 to exercise their right to provide meaningful input into the Indian Health Service budget request for the FY 2021 budget year. Following a thorough discussion of each Area's Tribal health care needs, the national Tribal FY 2021 budget priorities and recommendations were established, as highlighted below:

- Urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life-safety issues at IHS and Tribal Health facilities by implementing a budget which fully funds IHS at \$37.61 billion phased in over 12 years
- Increase the President's Budget Request to a total of \$9.1 billion for the IHS in FY 2021 by adding *at a minimum*:
 - » +\$257 million for full funding of current services
 - » +\$424.5 million for binding fiscal obligations¹
 - » +\$2.7 billion for program increases for the most critical health issues (~46% above FY 2019 Enacted). Top priorities for program expansion include:
 1. Hospital & Clinics+\$729.5 Million
 2. Purchased/Referred Care+\$485.7 Million
 3. Mental Health.....+\$286.7 Million
 4. Alcohol and Substance Abuse.....+\$242.7 Million
 5. Dental Services+\$ 210.4 Million
 6. Maintenance & Improvement+\$139.0 Million
 7. Health Care Facilities Construction/
Other Authorities+\$114.4 Million
 8. Indian Health Care Improvement
Fund.....+\$96.2 Million
 9. Sanitation Facilities Construction.+\$89.6 Million

10. Community Health	
Representatives (CHRs)	+\$69.0 Million
11. Health Education	+\$56.6 Million
12. Urban Indian Health	+\$50.9 Million
13. Public Health Nursing.....	+\$45.9 Million
14. Equipment.....	+\$28.3 Million
15. Indian Health Professions.....	+\$18.1 Million
16. Facilities and Environmental Health Support.....	+\$5.7 Million

- 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 were passed almost a decade ago (~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 a comprehensive, inter-operable, and intuitive electronic health record (EHR) system, as well as telehealth capacity, and bolt-on applications which are designed to match the unique business model and needs of the IHS, Tribal, and Urban (I/T/U) health delivery system (~\$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

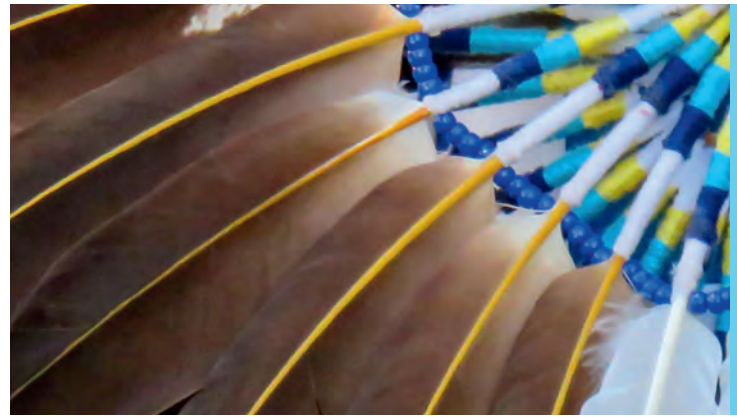
¹ Includes placeholder estimates for Contract Support Costs (CSC), the Section 105(l) lease obligations and staffing for new facilities and new Tribes

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- Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
 - Ensure that the Indian Health Service is taking adequate steps to fully anticipate and estimate its 105(l) leasing obligations while protecting other IHS programs for FY 2021 and work proactively with Congress to ensure its full payment as an indefinite appropriation
 - Recommend that the Special Diabetes Program for Indians be permanently authorized and increase funding to \$200 million per year, plus annual inflationary increases

Tribal Nations are separate and distinct domestic sovereign governments, but they exist as an integral part of the fabric and overall well-being of the United States. This status and distinction is recognized in the United States Constitution, several Supreme Court decisions, and numerous laws and treaties. In order to engage in co-existence with Tribal Nations and to support its own growth and expansion aspirations, which was to the detriment of Tribal Nations, the United States signed treaties and made sacred promises. As part of these agreements, millions of acres of Tribal lands and natural resources were ceded, often involuntarily, in exchange for the resulting federal trust obligations and responsibilities that exist in perpetuity, including, but not limited to, the health care for American Indians and Alaska Natives. These obligations and responsibilities do not exist as welfare, but as repayment on a nation-to-nation agreement. This special and unique relationship exists domestically only with American Indians and Alaskan Natives due to our sovereign government-to-sovereign government relationship with the United States.

This duty to fulfill this Trust obligation is no less true today. House Interior, Environment and Related Agencies Appropriations Subcommittee Chairwoman, Betty McCollum stated on March 6, 2019, “The federal government entered into treaties guaranteeing health care to our Native American brothers and sisters. My visits to Tribal communities across the nation, has shown me how we are failing, and failing greatly, at meeting our treaty responsibilities. Congress must not take our treaty and trust responsibilities lightly.” Unfortunately, as stated in the *Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans* which was released in December 2018 by the U.S. Commission on Civil Rights, “Due at least in part to the failure of the federal government to adequately address the wellbeing of Native Americans over the last two centuries, Native Americans continue to rank near the bottom of all Americans in health, education, and employment outcomes.”

Specific to health, Tribal Nation 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. Overall life expectancy for AI/ANs is 5.5 years less than the national average. According to CDC, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people. In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). In 2017,



American Indians and Alaska Natives experienced the second highest overall opioid overdose death rate at 15.7 deaths per 100,000.²

Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. Delays in receiving funding for basic health services further deters the ability to adequately address these disparities, thus perpetuating third-world conditions within Tribal communities.

These unacceptable health conditions can be directly linked to the persistent chronic underfunding of the IHS, and the other social and economic circumstances which exist in many Tribal reservations and villages. *The discretionary nature of the federal budget that systemically fails to fulfill trust and treaty obligation is a legal, ethical, and moral violation of the greatest order.* Unfulfilled Trust and Treaty obligations results in American Indian/Alaskan Native people *living sicker and dying younger* than other Americans. Bipartisan collaboration between Congress and the Administration, has allowed the Indian Health Service budget to minimally meet inflation and binding obligations with some small targeted funding for certain programs such as the Tribal Opioid Response Grants. However, even with an overall increase of 50% since FY 2008, this falls far short of addressing the years of disparate health disorders to bring AI/AN citizens to parity with all U.S. citizens. The Administration, with the support of Congress, must devise a plan to appropriate funds which go beyond just sustaining maintenance-level services which have been essential to cover expenses related to population growth, inflation, and legal obligations for

full funding of Contract Support Costs (CSC). Leaders of our Tribal Nations strongly urge that this Administration address the historic agreements which were essential to the power and growth of these United States by putting forth a real budget which will finally eradicate the atrocious health disparities which has overwhelmed Indian Country during these occupation decades. It will take a committed partnership between the United States and Tribal Nation leadership to honor these agreements. 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. To do otherwise is dishonorable to the Tribal Nations whom were the first conservationists for the vast resources which make up our great country.

The following recommendations are put forward by the Tribal Budget Formulation Workgroup as the national Tribal request for FY 2021. As proposed, these necessary investments in the IHS delivery system will provide the resources needed to achieve improved 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.

² Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. DOI: <http://dx.doi.org/10.15585/mmwr.mm675152e1>

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INDIAN HEALTH SERVICE

FY 2021 Summary of the National Tribal Budget Recommendation

+46% LEVEL

Planning Base (FY 2019 Enacted)		\$5,804,223
Current Services - All 12 Areas recommended full funding		\$257,004
Staffing Costs for Newly-Constructed Facilities Health Care Facilities Construction Projects (estimate)		75,000
Contract Support Costs Need (estimate)		100,000
Health Care Facilities Construction Projects Priority List (estimate)		100,000
105(l) Lease Cost Agreements (estimate)		138,000
Total Binding Obligations		413,000
Current Services & Binding Obligations Total:		\$670,004
RANK	PROGRAM EXPANSION	INCREASE AMOUNT
1	Hospitals and Health Clinics	729,503
2	Purchased/Referred Care (formerly CHS)	485,743
3	Mental Health	286,689
4	Alcohol and Substance Abuse	242,662
5	Dental Services	210,426
6	Maintenance & Improvement	138,979
7	Health Care Facilities Constr./Other Authorities	114,427
8	Indian Health Care Improvement Fund	96,227
9	Sanitation Facilities Construction	89,634
10	Community Health Representatives	69,004
11	Health Education	56,597
12	Urban Indian Health	50,888
13	Public Health Nursing	45,923
14	Equipment	28,339
15	Indian Health Professions	18,166
16	Facilities & Environmental Health Support	5,728
17	Direct Operations	700
18	Self-Governance	138
19	Tribal Management Grants	127
20	Alaska Immunization	44
Total (Program Expansion)		\$2,669,943
Total (Planning base + Program Expansion)		\$8,474,166
Percent over Planning base		46%
Total (Base + Current Services + Program Expansion)		\$9,144,170
Percent Over Planning Base		58%

FY 2021 National Tribal Budget Recommendation

March 15, 2019

(Dollars in Thousands)

(Dollars in Thousands)	FY 2019 Enacted	Current Services - Estimates*						
		Federal Pay CO, CS	Tribal Pay	Inflation		Population Growth	Current Services Subtotal	
				Non- Medical	Medical			
SERVICES								
Hospitals and Health Clinics	2,147,343	12,825	19,082	4,842	24,901	42,348	103,998	
Dental Services	204,672	1,410	1,892	213	4,948	3,906	12,369	
Mental Health	105,281	512	967	46	2,953	1,998	6,476	
Alcohol & Substance Abuse	245,566	467	2,607	131	7,939	4,556	15,700	
Purchased/Referred Care	964,819	0	0	0	37,546	19,254	56,800	
Indian Health Care Improvement Fund	72,280	0	0	0	0	0	0	
Total, Clinical Services	3,739,961	15,214	24,548	5,232	78,287	72,062	195,343	
Public Health Nursing	89,159	514	918	45	2,360	1,701	5,538	
Health Education	20,568	64	253	4	656	397	1,374	
Community Health Reps	62,888	13	988	6	2,422	1,258	4,687	
Immunization AK	2,127	0	34	0	83	43	160	
Total, Preventive Health	174,742	591	2,193	55	5,521	3,399	11,759	
Urban Health	51,315	59	836	167	1,654	986	3,702	
Indian Health Professions	57,363	56	0	1,874	0	0	1,930	
Tribal Management	2,465	0	0	99	0	0	99	
Direct Operations	71,538	963	154	1,159	0	0	2,276	
Self-Governance	5,806	73	0	101	0	0	174	
Total, Other Services	188,487	1,151	990	3,400	1,654	986	8,181	
Total, Services	4,103,190	16,956	27,731	8,687	85,462	76,447	215,283	
FACILITIES								
Maintenance & Improvement	167,527	0	0	6,702	0	3,351	10,053	
Sanitation Facilities Constr.	192,033	0	0	2,596	0	3,841	6,437	
Health Care Fac. Constr.	243,480	0	0	9,739	0	0	9,739	
Facil. & Envir. Hlth Supp.	252,060	2,442	1,366	4,423	1,054	4,815	14,100	
Equipment	23,706	0	0	60	858	474	1,392	
Total, Facilities	878,806	2,442	1,366	23,520	1,912	12,481	41,721	
TOTAL, SERVICES & FACILITIES	4,981,996	19,398	29,097	32,207	87,374	88,928	257,004	
CONTRACT SUPPORT COSTS								
CSC	822,227	0	0	0	0	0	0	
Total , Contract Support Costs	822,227	0	0	0	0	0	0	
TOTAL, IHS	5,804,223	19,398	29,097	32,207	87,374	88,928	257,004	

\$ Change over FY 2019 Enacted

\$257,004

% Change over FY 2019 Enacted

4%

* Current Services and Binding Obligations are estimates based on FY 2018 Enacted levels and/or reasonable projections of potential costs.

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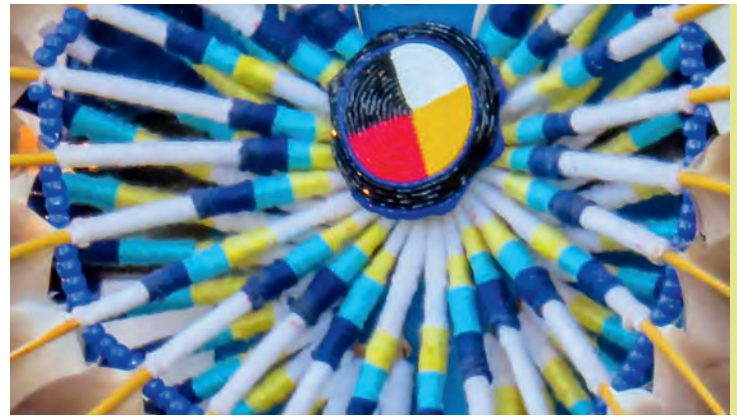
	Binding Obligations - Estimates*					Current Services & Binding Oblig. Total		Program Increases	FY 2021 National Recomm TOTAL	Comparison	
	Staffing for New Facilities	Contract Support Costs	Healthcare Facilities Priority List	105(l) Lease Cost Agreements	Binding Obligations Subtotal					change over FY 2019	
										\$	%
	75,000	0	0	138,000	213,000	316,998		729,503	3,193,844	1,046,501	49%
	0	0	0	0	0	12,369		210,426	427,467	222,795	109%
	0	0	0	0	0	6,476		286,689	398,446	293,165	278%
	0	0	0	0	0	15,700		242,662	503,928	258,362	105%
	0	0	0	0	0	56,800		485,743	1,507,362	542,543	56%
	0	0	0	0	0	0		96,227	168,507	96,227	133%
	75,000	0	0	138,000	213,000	408,343		2,051,248	6,199,552	2,459,591	66%
	0	0	0	0	0	5,538		45,923	140,620	51,461	58%
	0	0	0	0	0	1,374		56,597	78,539	57,971	282%
	0	0	0	0	0	4,687		69,004	136,579	73,691	117%
	0	0	0	0	0	160		44	2,331	204	10%
	0	0	0	0	0	11,759		171,568	358,069	183,327	105%
	0	0	0	0	0	3,702		50,888	105,905	54,590	106%
	0	0	0	0	0	1,930		18,166	77,459	20,096	35%
	0	0	0	0	0	99		127	2,691	226	9%
	0	0	0	0	0	2,276		700	74,514	2,976	4%
	0	0	0	0	0	174		138	6,118	312	5%
	0	0	0	0	0	8,181		70,019	266,687	78,200	41%
	75,000	0	0	138,000	213,000	428,283		2,292,836	6,824,309	2,721,119	66%
				0							
	0	0	0	0	0	10,053		138,979	316,559	149,032	89%
	0	0	0	0	0	6,437		89,634	288,104	96,071	50%
	0	0	100,000	0	100,000	109,739		114,427	467,646	224,166	92%
	0	0	0	0	0	14,100		5,728	271,888	19,828	8%
	0	0	0	0	0	1,392		28,339	53,437	29,731	125%
	0	0	100,000	0	100,000	141,721		377,107	1,397,634	518,828	59%
	75,000	0	100,000	138,000	313,000	570,004		2,669,943	8,221,943	3,239,947	65%
	0	100,000	0	0	100,000	100,000		0	922,227	100,000	12%
	0	100,000	0	0	100,000	100,000		0	922,227	100,000	12%
	75,000	100,000	100,000	138,000	413,000	670,004		2,669,943	9,144,170	3,339,947	58%
							\$670,004	\$2,669,943	\$3,339,947		
							12%	46%	58%		

Introduction

Tribal Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on March 14-15, 2019, to develop the national Indian Health Service budget recommendations for the FY 2021 budget year. The budget priorities are highlighted below:

- Urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life-safety issues at IHS and Tribal Health facilities by implementing a budget which fully funds IHS at \$37.61 billion phased in over 12 years
- Increase the President's Budget Request to a total of \$9.1 billion for the IHS in FY 2021 by adding *at a minimum*:
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- 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 2021)
- 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 a comprehensive, inter-operable, and intuitive electronic health record (EHR) system, as well as telehealth capacity, and bolt-on applications which are designed to match the unique business model and needs of the IHS/ Tribal and Urban (I/T/U) health delivery system (~\$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 to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
- Ensure that the Indian Health Service is taking adequate steps to fully anticipate and estimate its 105(l) leasing

³ includes placeholder estimate for CSC, staffing for new facilities, newly recognized Tribes, and 105(l) leases



obligations while protecting other IHS programs for FY2021 and work proactively with Congress to ensure its full payment as an indefinite appropriation.

- Recommend that the Special Diabetes Program for Indians be permanently authorized and increase funding to \$200 million per year, plus annual inflationary increases.

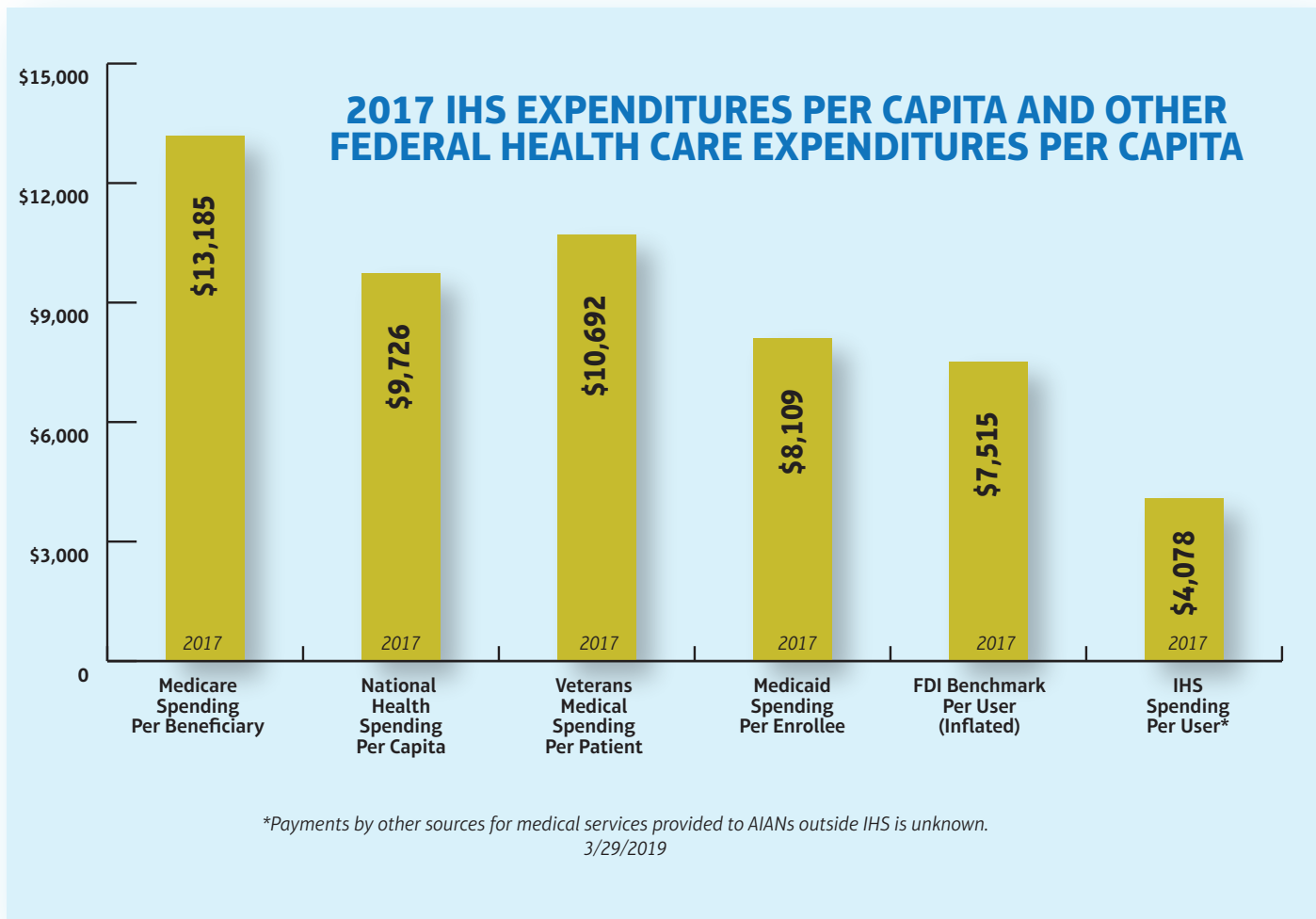
Tribal Nations are separate and distinct sovereign governments whose existence is woven into the fabric and overall well-being of the United States. This status and distinction is recognized in the United States Constitution, several Supreme Court decisions, and numerous laws and treaties. In order to engage in co-existence with Tribal Nations and to support its own growth and expansion aspirations, which was to the detriment of Tribal Nations, the United States signed treaties and made sacred promises. As part of this process, millions of acres of Tribal lands and natural resources were ceded, often involuntarily, in exchange for the resulting federal trust obligations and responsibilities that exist in perpetuity, including, but not limited to, the health care for American Indians and Alaska Natives. These obligations and responsibilities do not exist as welfare, but as repayment on a nation-to-nation agreement. This special and unique relationship exists domestically only with American Indians and Alaskan Natives due to our sovereign government-to-sovereign government relationship with the United States.

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U.S. Commission on Civil Rights, “Due at least in part to the failure of the federal government to adequately address the wellbeing of Native Americans over the last two centuries, Native Americans continue to rank near the bottom of all Americans in health, education, and employment outcomes.”

The vast majority of these unacceptable health conditions, among other health issues more broadly, are symptomatic of the persistent chronic underfunding of the IHS. Overall life expectancy for AI/ANs is 5.5 years less than the national average. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people. In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. In 2017, American Indians and Alaska Natives experienced the second highest overall opioid overdose death rate at 15.7 deaths per 100,000. A contributing factor in not adequately addressing these disparities is that IHS funding for the provision of health care services is not received in a timely manner.

The discretionary nature of the federal budget for IHS has failed to fully fund the Trust and Treaty obligation of an Indian Health System that provides adequate, quality healthcare. Many AI/ANs are experiencing the consequences of unfulfilled trust and treaty obligations and the Tribes are seeing their people living sicker and dying younger than other Americans. This is no surprise when considering the amount of funding in the IHS system. As you can see in the chart below, IHS spending per capita is just \$4,078 compared with \$9,726 per capita health spending nationally.



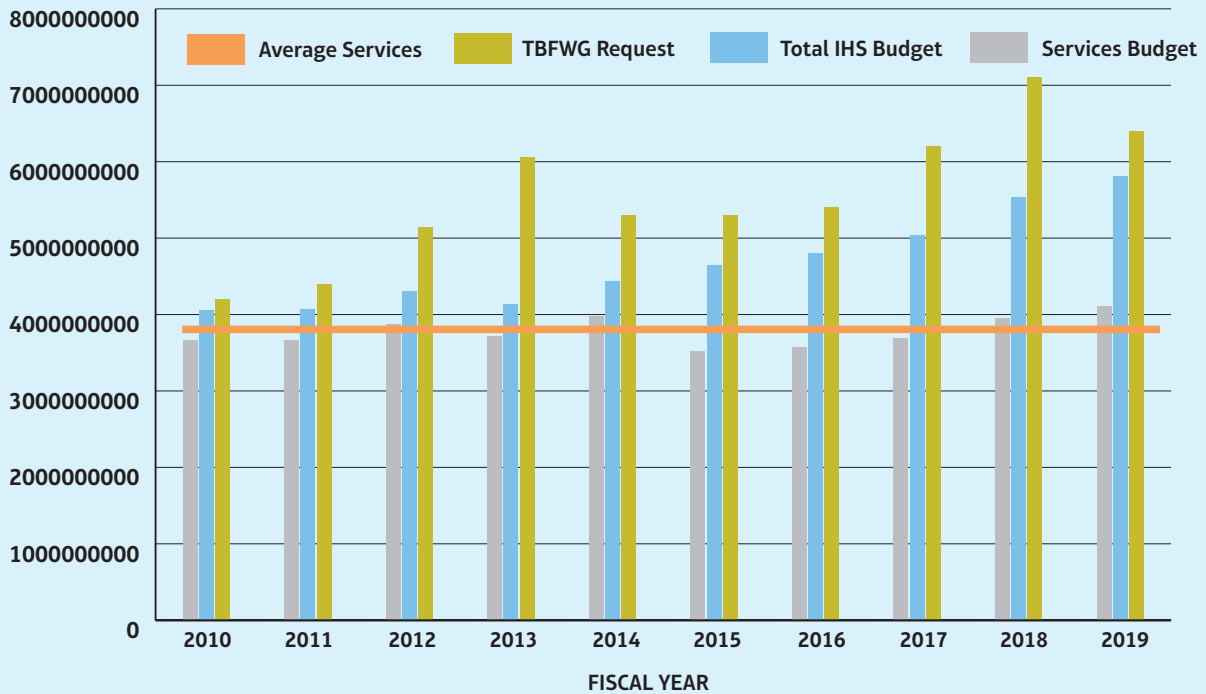
Ending the Health Crisis: Why haven't prior year incremental increases worked?

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Incremental increases are essential to cover expenses related to population growth, inflation, and the rightful full funding of Contract Support Costs (CSC). Leaders of our Tribal Nations 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 commitment between the United States and Tribal Nation Leadership to put a strategy and budget in place. AI/AN Tribes have put our best strategy and budget together in this FY 2021 Budget Request; it is time for these United States to put forward their best strategy and budget to fulfil Trust responsibilities. Decisive action by this Administration must occur to prioritize department resources to bring the health of AI/AN citizens closer to parity with the rest of the citizens

of the United States. We must rise above just settling for maintenance funding which only serves to sustain the unacceptable level of health care in Tribal reservations and villages.

The chart on page 11 depicts how funding for services has remained flat over time even as the overall IHS budget has seen increases in actual dollars to address other obligations.

IHS SERVICES BUDGET



Ending the Health Crisis Will Take a Major Investment

This year, the workgroup recommends a 46% increase for IHS which will raise the bar to address crisis level quality and safety issues inherent in I/T/U health facilities. We cannot begin to address substandard health outcomes in Tribal communities by only providing maintenance-level funding for current services. The major administrative challenges which plague the IHS, will not be resolved until we face the fact that we cannot continue to financially starve the core system. To only fund services at maintenance levels while demanding different results is disingenuous.

Significant consideration must also be placed on the known social determinants of health which impact the ability to show results. Economic conditions play a huge factor when looking to address health concerns, especially in under-developed, high cost rural communities. The poverty rate among American Indian and Alaska Natives was 28.3% in 2014, the highest rate of any race group. For the nation as a whole, the poverty rate was 15.5 percent, according to the Census Bureau. On many reservations, economic development is much lower than in surrounding cities. In some Tribal communities

unemployment is as high as 80 or 90%. 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. When the IHS is underfunded, it affects the ability to recruit, retain and train staff, and facilities deteriorate resulting in safety being compromised. This leads to a vicious cycle of forced closure by CMS of services or facilities, further exacerbating the economic opportunities for Tribal Nations.

These facts, combined with down-spiraling health disparities experienced by AI/ANs, demonstrate the human consequences of underfunding IHS. Deferral of care due to funding and workforce shortages has pushed more and more Tribal members into health conditions wherein prescription opioids are used to treat chronic pain that would otherwise successfully be treated earlier with non-opioid therapies, if they were available. Failure to address basic health needs through routine visits and preventative care also has led to preventable diseases becoming fatal when the diagnoses are too late to seek treatment. The underfunding of IHS is not just a fiscal challenge – time and time again, it means the difference between life or disability and even death for many AI/ANs – real lives and real dollars.



*“YOU WERE HERE LONG BEFORE
ANY OF US WERE HERE.”*

President Donald Trump

A New Path Forward to Fulfill Treat and Trust Responsibilities

The 35-day government shutdown at the end of 2018 and start of 2019, destabilized Native health delivery and health care provider access; as well as Tribal Governments, families, children and individuals. Some programs were forced to ration care, providers had to go without pay and some facilities closed their doors altogether. With the further likelihood of shutdowns and delayed federal appropriations, we firmly believe that advance appropriations for IHS will allow for greater planning, more efficient spending, and higher quality care and government services for AI/ANs. Advance appropriations would help honor the federal trust responsibility and help ensure that the federal government meets its obligations to the Tribes in the event that Congress cannot enact the federal appropriations by the start of the fiscal year.

Advance appropriations would also help promote government efficiency. In a report released in September 2018, the Government Accountability Office (GAO) (GAO-18-652) found that IHS and Tribes are given significant administrative burdens due to the fact that the IHS has to modify hundreds of contracts each time there is a continuing resolution (CR). In addition, the GAO found that “uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on Tribes and their health care programs.” Advance appropriations would create parity between IHS and other federal health providers and create better program stability. We urge the Administration to fully support IHS advance appropriations in the FY 2021 budget request as that will significantly aid advocacy efforts in Congress.

It is also important to ensure that the government meets its trust obligations through the Medicaid program as authorized through the Indian Health Care Improvement

Act. The ability to access Medicaid reimbursements helps our severely underfunded health systems receive third party revenue meant to backfill a portion of the federal government’s trust responsibility. In times of federal shutdown, the Indian health system relies more heavily on this alternate source of funding to operate. It is critical that AI/ANs continue to have access to Medicaid which it is now relied on as an important source of revenue to sustain operations of the Indian health system.

In short, the trust responsibility to all American Indians and Alaska Natives must be honored and legal obligations to provide safe and quality healthcare must be fulfilled. This is true whether services are provided directly through the IHS agency, under Tribal Self Determination compacts and contracts, or within Urban Indian programs. It is important to restate former House Interior, Environment and Related Agencies Appropriations Subcommittee Chairman, Ken Calvert (R-CA) words 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.”

The Tribal Budget Formulation Workgroup remains committed to work with this Administration to take actionable steps to fulfil this great country’s sacred trust responsibility to the 573 American Indian and Alaska Native nations in these United States.

1st Recommendation

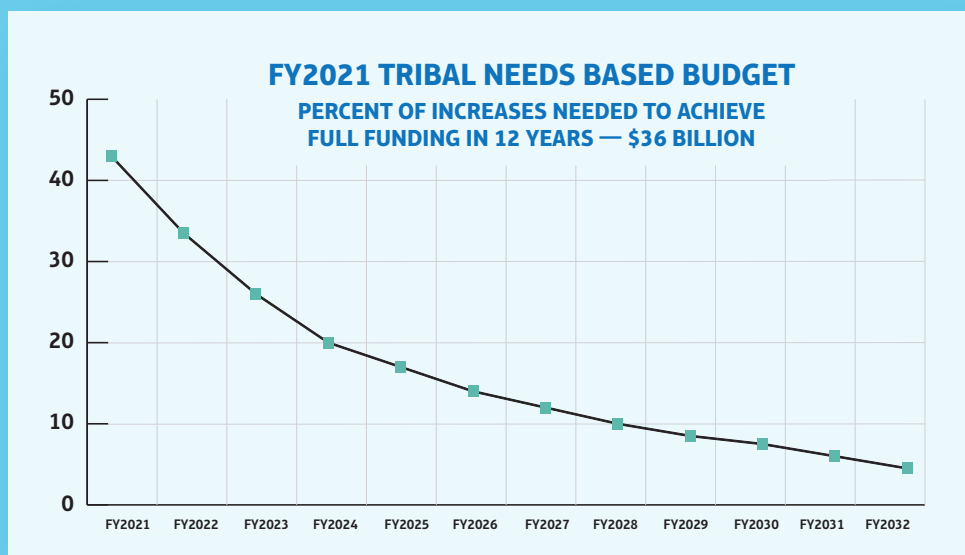
Fully Fund IHS at \$37.6 Billion Phased In Over 12 Years

Early in 2003, the Workgroup met to develop the national Tribal budget recommendations for FY 2005. Tribal leaders were disheartened that the planning base for the IHS budget was \$2.85 billion, which at the time was less than 15% of the total funding required to meet the health care needs for AI/ANs. This level of funding was not sufficient to maintain current services in the face of inflation and increases in the Indian population. Tribal leaders warned that chronic 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. It did not, however, consider new costly mandates brought about by CMS and other Administrative policies, including EHR deployment and new quality-driven compliance standards. Nor did the budget anticipate the new health authorities approved under the permanent Indian Health Care Improvement Act.

The FY 2005 Budget Formulation Workgroup in good faith proposed a 10-year phase-in plan, with substantial increases in the first two years to build facilities and start-up services with more moderate increases in the following years. As the Workgroup understood, meeting the NBB of \$19.5 billion in one fiscal year was unlikely, due to the importance of balancing the Federal budget and respecting other national priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at

one time. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and the Administration to fully fund the Indian health system and improve the health status of American Indians and Alaska Natives.

That work was done fifteen years ago. The failure to produce necessary funding to fulfill the initial 10-year plan, have caused per capita health funding gaps to grow, and the health disparities between AI/ANs and other populations to widen. The cost and amount of time required to close these funding and health disparity gaps has predictably also 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 2021* is now **\$37.6 billion**, based on the FY 2018 estimate of [2.9 million eligible] 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 \$37.6 billion has been extended to twelve years.



FY 2021 AI/AN NEEDS BASED FUNDING AGGREGATE COST ESTIMATE

GROSS COST ESTIMATES

Source of Funding is not estimated

Need Based on FY 2018 Existing Users at I/T Sites	Need based on FY 2017 Expanded for Eligible AI/AN at I/T/U Sites*
1,650,805	2,965,364

SERVICES	\$ Per Capita	Billions	Billions
Medical Services	\$9,726	\$16.06	\$28.84
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 2018 FDI benchmark; which is based on the National Health Expenditure (NHE) model.	\$ Per Capita FY 2018* Existing Users	\$ Per Capita FY 2018* All Eligible AI/AN Served at ITU sites
Dental & Vision Services	\$0.00	\$0.00	\$0.00
Dental and Vision services and supplies supplemental coverage in the Federal Employees Dental and Vision Insurance Program. The NHE model now includes dental & vision. This line item is retained for comparison purposes to last year's (FY 2020) Tribal budget request.	Retained for illustration purpose since this was included in past years. The new NHE benchmark includes dental and vision unlike the previous BC/BS benchmark.		
Community & Public Health	\$0.00	\$0.00	\$0.00
Community and public health services are not included in the FEHB BC/BS federal disparity index model. These activities are now included in the new FDI benchmark uses the NHE model. This line item is retained for comparison purposes to last year's (FY 2020) Tribal budget request.	Retained for illustration purpose since this was included in past years. The new NHE benchmark includes community and public health services.		
Total Annualized Services	\$9,726	\$16.06	\$28.84

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 \$10.3 billion to upgrade and modernize. A 30 year useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades. 25 U.S.C. 1631 et seq., requires the HHS Secretary to submit to Congress a report every five years that describes the IHS health care facilities needs (including inpatient health care facilities; outpatient health care facilities; specialized health care facilities such as for long-term care, alcohol and drug abuse treatment, wellness centers, and staff quarters; and the renovation and expansion needs). The report submitted to Congress in FY 2017 estimates a total facilities need of \$10.3 billion.

TOTAL

Total Annualized Services + One-time Upfront Facilities Upgrades		\$22.57	\$37.61
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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/ANs already partially served by I/T sites.

2nd Recommendation

Increase the President's FY 2021 Budget Request for the Indian Health Service by a Minimum of 46% over FY 2019 Enacted Levels (\$9 billion in FY 2021)

Current Services & Binding Agreements

Tribal leaders are adamant that the FY 2021 budget request, as a starting point, provide an increase of \$670 million over the FY 2019 enacted amount to cover Current Services and all other binding obligated requirements. Tribes have long insisted that the annual request must transparently disclose all known expected cost obligations in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. Deliberately understating the amount necessary to meet the entire fiscal obligation for binding agreements beyond Current Services creates a false expectation that a slight funding increase is available to expand needed program services. In fact, in past years, a 2-3% funding increase has not even been sufficient to maintain the status quo, effectively resulting in an actual decrease from the prior year. These real cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population growth, planned increases in staffing for new and replacement facilities, Contract Support Costs healthcare facilities construction priorities, Section 105(l) lease costs, 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 \$6.57 billion be requested as reflected in this section.

CURRENT SERVICES (FIXED COSTS) +\$257 MILLION

The Workgroup recommends an increase of \$257 million over the FY 2019 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. The Workgroup recommends an increase of \$88.9 million for population growth. Population growth estimates are determined by a 1.8% increase.

The FY 2021 Tribal Budget Request for Current Services also includes an increase of \$19.4 million for Federal Pay Costs and \$29.1 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 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 30 percent. No health system can run a quality program 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 2021. We cannot allow pay scales for our health professional to be so substandard that they are forced to look elsewhere to seek a fair wage.

The Current Services request also includes \$32.2 million for Non-Medical Inflation and \$87.4 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services as the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), the index for all items (less food and energy) increased 2.1 percent over the past 12 months. The medical inflation in 2019 is predicted to be 6 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.

2nd Recommendation

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 \$37 billion, the Indian Health system remains severely underfunded at \$5.8 billion. When compounded with rising medical inflation and population growth, Indian Health budgets are, in real dollars, trending backwards.

BINDING AGREEMENTS (FIXED COSTS)

+\$424.5 MILLION

Health Care Facilities Construction (Planned)

+\$100 million

In FY 2021, \$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 eight remaining projects which total \$2.4 billion. A program increase of \$100 million affords the advancement or possible completion of only two projects on the list that are already started. As the FY 2020 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 2021 budget supports the projects in the FY 2019-20 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:

- Albuquerque Health Care System, Albuquerque, NM
 - » Albuquerque West, NM
 - » Albuquerque Central, NM

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

Section 105(l) Leases (New +\$138 million)

The Indian Health Service has by historical accident, not provided fair and reasonable payment for health facilities built by Tribes for the provision of health services authorized within negotiated contracts and compacts. This was recently rightfully and successfully challenged. The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324(l), also referred to as "105(l)," authorizes the IHS to enter into a lease with a Tribe or Tribal organization for a facility used for administration and delivery of ISDEAA services. As held in *Maniilaq Association v. Burwell*, 170 F. Supp. 3d 243 (D.D.C. 2016), the IHS is required under ISDEAA § 105(l) to enter into a "lease" upon the request of any Tribe or Tribal organization furnishing a Tribally leased or owned facility in support of the programs, services, functions, and activities carried out under its ISDEAA contract or compact.

As of March 13, 2019, the IHS has received proposals from Tribes and Tribal organizations for FY 2019, totaling approximately \$42 million. In addition to the initial \$5 million IHS identified that may be used for these leases, IHS received \$25 million in FY 2019 appropriations for a total of \$30 million, with a remaining need of \$12 million for these lease costs. With an additional six months left in this fiscal year for IHS to receive lease proposals for FY 2019, the Tribal leaders agreed unanimously to the following:

Request \$138 million additional funds for FY 2021 for Section 105(l) leases and add a separate line item under the binding obligations for Congressional indefinite appropriation.

Newly Federally Recognized Tribes Funding

+\$11.5 million

In January 2018, six Virginia Tribal Nations (the Chickahominy, Eastern Chickahominy, Upper Mattaponi, Rappahannock, Nansemond and Monacan) were granted federal recognition. In absence of a definite Congressional appropriation in FY 2019, IHS has continued to work with the six Tribal Nations to identify need 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. We recommend an estimated \$11,500,000 for this item.

Contract Support Costs (Estimate) +\$100 million

The Workgroup has identified an estimated budget increase of \$100 million over the FY 2019 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 2019 enacted budget of \$822 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 2021 CSC request is estimated to be \$922.2 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 percent 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 2021 and beyond, the Tribes universally support the proposal to reclassify Contract Support Costs as a mandatory, three-year appropriation with sufficient increases year after year to fully fund the estimated need for such costs. This would reduce pressure on the overall IHS budget, which has been constrained due to the funding allocation of the Interior, Environment, and related Agencies Appropriations Subcommittee.

Total FY 2021 Request for Fixed Costs: Current Services (Fixed Costs):

Current Services.....	\$257,004,000
Federal Pay Costs	\$ 19,398,000
Tribal Pay Costs.....	\$ 29,097,000
Inflation (non-medical)	\$ 32,207,000
Inflation (medical)	\$ 87,374,000
Population Growth.....	\$ 88,928,000
 Binding Agreements.....	 \$424,500,000*
New Staffing for New & Replacement	
Facilities	\$ 75,000,000
Health Care Facilities Construction	
(Planned)	\$100,000,000
105(l) leases (New)	\$138,000,000
Newly Recognized Tribe Funding	\$ 11,500,000
Contract Support Costs	\$100,000,000

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

Program Expansion Increases – Services Budget

The National Tribal Budget Formulation Workgroup recommends the FY 2021 Program Increases outlined in this section that represent a critically needed infusion of resources, totaling \$2.7 billion (+46%) above the FY 2019 Enacted Budget. These national priorities identified and agreed to by Tribal leaders is the result of a year-long Tribal consultation process that includes discussion by individual Tribes and urban Indian health programs, meetings held by each IHS Area Office and a final national session in 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 to improve the delivery and quality of health care and reduce the high level of health care disparities that are magnified among the AI/AN population.

HOSPITAL & CLINICS: +\$729.5 MILLION

For FY 2021, the Workgroup recommends an increase of \$729.5 million over the FY 2019 enacted level for a total of \$3.2 billion for the core budget item of Hospitals and Clinics (H&C). The Indian Health Service provides comprehensive primary health care services to 2.6 million American Indians and Alaska Natives through a network of over 605 hospitals, clinics and health stations that provide direct care services or are carried out by contracting or compacting Tribes. This system of care gives each Tribe the ability to provide services for its members in the best way possible. This responsibility of health care services is based on a special relationship between Indian Tribes and the United States. Tribes have continually advocated for increases and full funding levels in the Hospital and Clinics line item, as it provides for base funding for medical services. Most of the services provided are primary and emergency care services. The Hospital and Clinics line item offers the most flexibility in supporting the delivery of health care across Indian country and are crucial to ensuring the provisions of high-quality care. In addition to basic primary health care services, it also provides funding for specialized programs such as, diabetes prevention, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, women's and men's health; geriatric health; disease surveillance; and healthcare quality improvements.

Hospital and Clinics line item increases are needed to fund adequate staffing levels as well as state of the art equipment, which are necessary for quality care. Emergency medicine physicians, registered nurses and advance practice nurses, and other highly trained staff are essential for crisis and disaster management to improve patient outcomes. Without full funding Tribal and federal facilities cannot continue to offer salaries within the competitive market. The ability to provide safe, quality care at Indian Health facilities is severely compromised when the IHS and Tribes are unable to fill vacancies or retain qualified staff. It is a matter of life or death in these situations.

Added medical inflation costs are rising higher with each fiscal year and the inability to keep up with medical costs creates a huge disparity in funding for health care costs compared to the rest of the U.S. population.

The demands on direct care services are a continuous 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.

A critical component to achieve the full potential of Hospital and Clinics is fully funding the Indian Health Care Improvement Act. The provisions in this law represent a promise made by the federal government to significantly improve the health of our people, yet this law remains unfunded. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHCA authorities. Tribes also request that funding these new authorities should be in addition to the base level Hospital and Clinics funding.

HEALTH INFORMATION TECHNOLOGY SERVICES (ESTIMATE \$3 BILLION OVER 10 YEARS)

A reasonable adequately-resourced IHS Health Information Technology (HIT) program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of

testing and procedures. The gains of deploying electronic health records (EHRs) in the clinical setting are numerous and important including: easier access to clinical data; the ability to establish and maintain effective clinical workflows; fewer medical and prescribing errors; improved patient care coordination; and stronger real-time support for clinical decision-making.

IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record and more than 100 applications. IHS' EHR met 2014 certification for meeting requirements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), which established standards and other criteria for structured data that EHRs must use. A properly resourced IHS HIT program directly supports better ways to: 1) care for patients, 2) pay providers, 3) coordinate referral services, 4) recover costs, and 5) support clinical decision-making and reporting, resulting in better care, wiser spending of our health dollars, and healthier communities. However, in 2015, the IHS was fiscally challenged in its ability to meet all the 2015 certification criteria and opted to elect modular certifications for RPMS, which had a fiscal note of approximately \$3 million, and was less than the cost of complete its 2015 certification.

In its FY 2020 Tribal Budget Recommendations, the TBFWG requested that the Administration support a new budget line for Health Information Technology and recommended a meaningful investment into the IHS HIT system to address the impact of the Veterans Health Administration (VHA) recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. This decision by the VHA put the future viability of RPMS at risk as IHS has relied on leveraging the VHA's development and technical updates of VISTA to support IHS's own legacy system. The TBFWG is pleased that the FY 2020 President's budget requests includes a separate budget line request for HIT Modernization of \$25 million. While we support this as a good first step, Tribes are very concerned that a more accelerated funding strategy is critical to appropriately and realistically advance the \$3 billion 10-year investment which will be needed to allow IHS to either update the current EHR & RPMS suite or initiate an alternatives analysis similar to the VHA. This recommendation for a separate HIT



budget line item investment will protect H&C funds from being siphoned off to pay for necessary HIT improvements at the expense of direct care for patients.

DENTAL SERVICES +\$210.4 MILLION

The Workgroup recommends an increase of \$210.4 million for oral health for total funding of \$427.5 million in FY 2021. Oral health care access is one of the greatest health challenges Tribal communities face. 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 U.S. Whites. It is not uncommon to hear stories of elderly patients waiting out in the cold for one of just a few dental appointments available in one; 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 well-being.

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

Community Health Aide Program (CHAP) Expansion

The lack of health care providers in Indian Country perpetuates health disparities of AI/ANs. When care is limited or not accessible symptoms go unrecognized, undiagnosed and untreated resulting in unnecessary increased costs for worsened minor conditions. One solution to address the health care provider shortage is to expand the Alaska Community Health Aide Program (CHAP) in the lower 48. Permanent authorization of the Indian Health Care Improvement Act (IHCIA) in 2010 allows for expansion of CHAP outside of Alaska.

Established in 1968, the CHAP is the frontline response to address the health care needs of Alaska Natives. The Alaska CHAP includes 550 certified and practicing providers responsible for over 300,000 encounters per year. The Alaska CHAP is community driven and recognized for its role in providing care in remote villages and for increasing access to care at Tribally managed hospitals and clinics.

Highlights of the CHAP include that the program:

- Respects that Tribes are sovereign nations with the authority to address the health needs of their community;
- Provides routine, preventive, and emergent care within Tribal communities;
- Respects the knowledge and resources in Tribal communities and grows providers from that source through accessible and achievable training programs;
- Involves community participation in the selection of the individual who will become a CHAP provider;
- Delivers patient-centered quality care that comes from providers that understand the history, culture, and language of their patients;
- Fosters a team approach to delivering health care services;
- Increases the efficiency of the entire healthcare team, allowing each member to practice at the top of their scope;
- Provides continuity of care in communities that face recruitment and retention challenges; and
- Results in cost savings to Tribes and individuals that no longer have to travel long distances or receive care outside of the IHS system.

CHAP includes three provider types — Community Health Aides/Practitioners (CHA/Ps), Dental Health Aides Therapists (DHATs), and Behavioral Health Aides/Practitioners (BHA/P). CHA/Ps play a principal role in improving access to care, health, wellness, and the overall quality of life experienced by AI/ANs. DHATs are part of a dentist-led team. DHATs educate patients about oral health and prevention, perform dental evaluations, give fluoride treatments, place sealants, clean teeth, place fillings and perform simple extractions. BHA/Ps work in concert with CHA/Ps and DHATs to wrap around the existing system of care to create a more successful and supportive environment for AI/AN individuals.

The expansion of this unique workforce in the lower 48 will address the shortage of AI/AN health care providers, increase access to culturally relevant care, address economic issues by providing a living wage to providers and health staff in Tribal communities and strengthen protective factors within communities.

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 IHCA amendments has been interpreted to limit expansion of DHATs in the lower 48 unless state legislation authorizes 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; a second student joined the dental team in 2018. 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 and Lower Elwha Klallam to hire a DHAT in 2018. Notably, eight more students from Washington, Idaho and Oregon are in the Alaska DHAT Training Program with anticipated graduations in 2019 and 2020. Tribes in 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 IHCA applies only to the proposed national expansion of the CHAP,

and does not otherwise prevent Tribal health care programs from providing DHAT and other dental midlevel services in their communities. With IHS' 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 +\$286.7 MILLION

Mental Health is a significant priority for FY 2021. Tribal Leaders recommend a \$286.7 million increase above the FY 2019 enacted budget for total funding of \$398.4 million. This increase would mean a 278% increase in funding for behavioral health services in Indian Country. This significant increase is needed to allow Tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that build upon the resiliency factors and inherent strengths already existing in Tribal communities. AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. However, inadequate funding resources limit Tribes implementing asset-based approaches 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, asset-based approaches, and community education programs. Mental Health program funding supports community-based clinical and preventive mental

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*.

health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities, as well as address adverse childhood events and historical traumas to break the cycles and conditions that contribute to perpetuating or exasperating poor mental health outcomes.

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. The goal in the emergency setting is to stabilize patients, assess and refer to the appropriate level of care. Many communities and areas lack a sufficient number of hospital beds for patients with mental health emergencies requiring further hospitalization, which puts pressure on emergency rooms and urgent care services to provide this care beyond initial stabilization, which leads to patients not receiving the appropriate level of care and emergency rooms routinely being on divert for regular medical emergencies due to beds being occupied with mental health patients who are waiting for appropriate beds to open up.

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. Proper funding levels would allow for earlier interventions reducing the need and therefore costs associated with these services allowing for more efficient use of resources that are also associated with better outcomes and improved quality of life.

There is also another crucial need for protective transition center(s) for homeless women and children, and homeless men and children as they lose employment due to illness or other compounding factors. Adults and children fleeing their home due to domestic violence situations also need temporary shelter that offers safety, and counseling services that will assist and support them in stabilizing their crises. Once stabilized, they can be assessed for appropriate referrals that need to be completed to promote healing while empowering him or her to proactive life decisions.

Suicide continues to plague American Indians and Alaska Natives throughout Indian Country. Suicidality is often in combination with other behavioral and mental health issues including depression, feelings of hopelessness, history of trauma, substance abuse, domestic violence, sexual

abuse and other negative social issues. AI/ANs, more than any other racial or ethnic group, suffer the highest burden of suicide rates, which has been increasing since 2003. In the 18 states participating in the National Violent Death Reporting System (NVDRS), the suicide rate among AI/ANs in 2015 was 21.5 per 100,000, more than 3.5 times higher than those among ethnic groups with the lowest rates.⁵

Lack of behavioral resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. The Centers for Disease Control and Prevention (CDC), reported in 2018 that reviewing data from 2003-2014 approximately 70% of AI/AN decedents resided in non-metropolitan areas, including rural areas. The residential status can affect the circumstances surrounding suicide. For example, AI/AN decedents were less likely than white decedents of having received a mental health diagnosis or having a mental health treatment plan. The high rate of suicides among AI/AN youths highlights the need for early prevention. In addition, programs that focus on individual life skills development and interpersonal social emotional learning programs to promote healthy relationships and conflict resolution might address the higher occurrence of intimate partner problems and arguments preceding AI/AN suicides. Also, the need for postvention, such as establishing survivor support groups, are key to interrupting or reducing the potential of suicide contagion.⁶

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)

5 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*.

6 Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides Among American Indian/Alaska Natives - National Violent Death Reporting System, 18 States, 2003-2014. *MMWR. Morbidity and mortality weekly report*, 67(8), 237-242. doi:10.15585/mmwr.mm6708a1

studies. These studies assess prevalence of personal experiences i.e. — Abuse, neglect, domestic violence, having a family member with mental illness, or the loss of a parent. Higher scores are correlated with poorer long-term health and social 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 affects the individual exposed, but continues to affect the following generations, thus compounding the trauma even further.

Transitional Housing & Aftercare needs

Displaced or homeless veterans returning home from active duty service, individuals returning home after a long period of incarceration, and/or returning home after substance use treatment will benefit from a transitional living environment that assists them while they readjust to their environment and surroundings. 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 2021, 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/certified providers in rural areas. The TBFWG has made behavioral health services a major budget priority for many years and continues this emphasis in FY 2021 as investment in behavioral health services has shown positive return. For example, treating depression and anxiety has shown between 3.3 to 5.7:1 return on investment in reduced/avoided medical costs, improved productivity, and improved health status.⁷ 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 +\$242.7 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 including, but not limited to, opioid addiction. Tribal leaders agree that this topic remains a high priority for FY 2021. The Workgroup recommends a program increase of \$242.7 million above the FY 2019 enacted budget for a total funding level of \$503.9 million. 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.

In 2015, AI/ANs had the highest drug overdose death rates (metropolitan: 22.1 and non-metropolitan: 19.8 per 100,000) and the largest percentage change increase in the number of deaths over time than any other group.⁸ Also concerning, youth and the critical need for prevention and early intervention, reservation-based American Indian students are at high risk for substance use compared with U.S. youths in general. AI/AN students reported substantially higher lifetime and last-30-day substance use rates compared with the monitoring the future students, with greatest disparity at eighth grade: last-30-day substance use relative risks for grade 8 were 2.1 (95% CI, 1.4-3.0) for alcohol, 4.2 (95% CI, 3.1-5.8) for marijuana, and 2.4 (95% CI, 1.7-3.3) for other illicit drugs.⁹ And while accurate national data is challenging a linkage study by the Northwest Tribal Epidemiology Center found that during 1999–2001, AI/AN and whites in Washington had similar age-adjusted total drug, opioid-involved, and heroin-involved overdose mortality rates. Overdose death rates increased significantly for both groups in subsequent years, but the increase was much sharper among AI/ANs than among whites. During 2013–2015, 184 drug overdose deaths occurred among AI/ANs in Washington,

7 Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry* (2016) 3:415–24. doi: 10.1016/S2215-0366(16)30024-4

8 Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12. DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1>

9 Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open*. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

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including 126 (68.5%) that involved opioids. The rates were higher for total drug (2.7 times), opioid-involved (2.7), and heroin-involved overdose mortality (4.1) among AI/AN than among whites.¹⁰

Current I/T/U alcohol and substance abuse treatment approaches 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. New approaches are also needed to reduce alcohol and substance abuse related 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.

When our programs are not able to receive patients when an addict is ready, their health continues to deteriorate and the costs to our health programs grow in both the behavioral health and medical sides. Costs to our Tribal communities also rise in the judicial, corrections and social welfare arenas. Improved funding would increase the number of residential substance abuse treatment beds to increase access to care so that it is available at the right place at the right time. 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 rationing of care can be seen in placement and treatment options. Decisions are often attributed more with funding availability than to clinical findings.

Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability and the challenges with the grant-funded model, several culturally responsive in-patient treatment centers have had to close their doors leaving major gaps

in service availability and more specifically availability of detox beds with the rising number of opioid and/or other addictions. Methamphetamine, opioid and heroin use is high in many IHS regions, with limited treatment facilities available.

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, those funds continue 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 and undermines self-determination tenets. For example, if an area is suffering more from alcohol addictions than from meth or opioids, that area cannot redesign their available programs to meet the needs of that area, due to grant restrictions. Furthermore, because grant funding is never guaranteed, vulnerable communities, with the greatest needs but least capacity, often slip through the cracks. The necessary increase must be applied to IHS funding base and away from the inefficient use of grants, in order to stabilize programs and ensure the continuity of the program and care to our struggling Tribal members and their families.

Breaking the cycle means that we must prevent and offer early intervention with our at-risk youth and expand the scope of treatment in Youth Regional Treatment Centers. Alcohol and Substance Abuse funds are needed to hire professionals, staff and 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, “Left untreated, alcoholism is a terminal disease.” In fact, if left untreated, as indicated earlier, 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, adverse childhood events, poverty and other social determinants of health, 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,

¹⁰ Joshi S, Weiser T, Warren-Mears V. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives — Washington, 1999–2015. *MMWR Morb Mortal Wkly Rep* 2018;67:1384–1387. DOI: <http://dx.doi.org/10.15585/mmwr.mm6750a2>

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.

In addition to funding needed to support detox and rehabilitation services, Tribes have also reported a critical need for aftercare services and transitional housing. 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 with which individuals first 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. Increased funding will support the need for prevention and education on this topic and particularly target the youth while promoting non-tobacco using adults as role models for establishing social norms in Indian communities. The need for prevention and education regarding all drugs is evident in recent verbal reports from Tribal leaders in Alaska that drug dealers had thrown little bags with crystal-meth in with the regular candy that gets distributed among children and youth at the end of potlatch gatherings.

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 and asset-based prevention and treatment.

PURCHASED/REFERRED CARE +\$485.7 MILLION

For FY 2021, the Workgroup recommends an increase of \$485.7 million for a total funding level of \$1.5 billion for the Purchased and Referred Care Services (PRC) line item. PRC is vital to ensuring adequate care is provided to American Indian and Alaska Natives and continues to remain a top funding priority. IHS and Tribal operated facilities serve primarily rural populations and provide limited primary care and community health services. PRC was established to allow for IHS and Tribal operated facilities to secure essential health care services from private sector providers when such services, especially emergent and specialty care services, are not available within the Indian Healthcare Delivery System.

IHS and Tribally operated facilities are treating some of the highest rates of diabetes in the U.S., however, AI/ANs continue to die at higher rates than other Americans from diabetes (210% higher), are 2.8 times more likely to die from alcoholism and 2.4 times more likely to suffer accidental death compared with other groups.¹¹ Because of the disproportionate incidence 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. Meeting the need for 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 (see table below), improving and increasing the overall health of the AI/AN population.

Historically, inadequate funding for the Indian Healthcare Delivery System and PRC forces IHS and Tribal Nations to ration health care based on an antiquated ranked medical priority system because the federal government has not met its trust and treaty obligations. 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 citizens who cannot access PRC resources face enormous risk of personal financial responsibility for care received outside the direct Indian health care delivery system and in an increasing number of cases, patients have been faced with collection notices which ruin personal credit.

11 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

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)

Funding deficiencies is one area that exacerbates the PRC backlog and at times, delays payments. Additionally, many PRC providers, due to frequent turnover, are unfamiliar with the IHS health care delivery 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 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 limit access to these funds, 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 and/or the Administration and Congress' inability to enact a timely fiscal appropriation. During the FY 2019 partial government shutdown, Tribal Nations across the country reported having to further ration health care, reduce services, and some facilities were near closing altogether. The shutdown from December 2018 through January 2019 further destabilized the health care provided to AI/ANs and Tribal Governments. Late funding continues to pose significant challenges to IHS and Tribally operated facilities as it limits their ability to execute contracts with outside providers and/or vendors to meet the health needs of AI/ANs.

INDIAN HEALTH CARE IMPROVEMENT FUND +\$96.2 MILLION

In FY 2021, the Workgroup recommends an increase of \$96.2 million for the Indian Health Care Improvement Fund, for total funding of \$168.5 million. Due to the significant underfunding of IHS, 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 and 2019, a new IHCIF Workgroup met to review and update the existing IHCIF data and recommended updates to the current formula. The final report from that group is forthcoming.

Recommendation:

- The IHS Tribal/Federal Workgroup should continue to work on the final IHCIF report.
- 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.

PUBLIC HEALTH NURSING +\$45.9 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 \$45.9 million in expanded services for total funding recommendation of \$140.6 million.

HEALTH EDUCATION: + \$56.6 MILLION

For FY 2021, the Workgroup recommends an increase of \$56.6 million for total funding of \$78.5 million. Investments in health promotion, health education and prevention produce effective and efficient approaches to improve the quality of life and well-being of an individual. Most chronic diseases that impact Indian Country are preventable and result in high health costs for the Indian Health system to treat diseases. By focusing on prevention, health education reduces the costs that the IHS and Tribes would otherwise spend on medical treatment (e.g. lives saved when using infant/toddler car seats and screening for early intervention) and greatly improve the health of American Indians and Alaska Natives. The work of health education is integral to the health care delivery system in Indian Country.

The Health Education program provides preventive health education, emergency response and public health, chronic and communicable disease education. Health educators also serve as a liaison between individual, health care providers, and community organizations to coordinate resources and services to promote health education programs. Their role in the Indian health care system is crucial in addressing primary, secondary, and tertiary prevention as well, bridging community, school, work place, and clinical settings—they demonstrate the Federal government's commitment to upholding its Trust responsibility to the Tribes by providing a comprehensive Indian health system that delivers high quality across a continuum of care.

The President's FYs 2019 and 2020 budgets proposed to discontinue funding the program and instead direct funds to health care services and staffing newly constructed facilities. Eliminating the health education program would create gaping holes in care for many Tribal communities. Too often, the Indian Health system does not have enough staff to meet the demand for its services and many AI/ANs rely on health education resources as their primary source of information about the Indian health system. The loss of health education funding would dissolve many opportunities for an AI/AN patient to receive communications regarding their own healthcare, while also limiting their access to available resources and information designed to assist them in making informed choices. Additionally, minimizing resources that effectively coordinate care for

patients also greatly reduces the ability for IHS and Tribes to effectively maximize their resources and treat patients.

COMMUNITY HEALTH REPRESENTATIVES: + \$69 MILLION

The Workgroup recommends an increase of \$69 million – and total funding of \$136.5 million for Community Health Representatives (CHRs) in FY 2021. The CHR is a frontline public health worker who is a trusted member of the community and they utilize their strong cultural understanding to serve the unique health of the patient and community. CHRs are part of the direct provision of health services and are authorized in federal law within the Indian Health Care Improvement Act. Without the services provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients will not receive their necessary services and many will become unable able to access their health care system. In FY 2018, IHS reported that over half of the visits performed by CHRs were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members.

CHRs integrate basic medical knowledge about health promotion and disease prevention with local, community knowledge to provide high-quality follow-up, which improves the quality of service delivery through culturally competent care. CHRs also assist in implementing initiatives which support patient safety and community-based care as they enable many patients to access their health-care system. Representatives provide services like in-home patient assessments of medical conditions, glucose testing and blood pressure tests to determine if the patient should seek further care, and may also provide transportation for medical care.

The President's budget request for FY 2020 proposes to phase out the CHR program and replace it with the National Community Health Aide Program (CHAP) with funds from CHRs budget to transition services to the National CHAP. While the Workgroup supports the expansion of CHAP, it should not come at the expense of this critical, and already highly successful program. If this request were to be accepted, services provided would fall flat and neither program would likely be able to effectively operate. Furthermore, for generations, CHRs have been integral to the fabric of health delivery in Indian Country and Tribes do not wish to see this historic program discontinued. Ninety-six percent of CHR programs are operated by the Tribes in partnership with the IHS

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and provides one of the best examples of the Nation to Nation relationship between the Tribes and the Federal government.

The Workgroup recommendation for this line item would be to increase funding for the sole purpose of service delivery of CHR program services and functions. The CHAP program is also supported as a separate recommendation. Tribes also look forward to meaningful consultation with the federal government in the event that significant alterations to life-changing Indian health programs are being considered.

ALASKA IMMUNIZATION +\$44,000

In FY 2021 the Workgroup recommends an increase of \$44,000 for the Alaska Immunization program over the FY 2019 enacted level for a total of \$2.3 million. The 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 FY 2014 to FY 2015 in FY16 we continued to maintain this high new case rate. In FY 2016, 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 +\$50.888 MILLION

Forty-one urban Indian health programs (UIHPs), which operate from 59 sites in 22 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 a wide range of culturally competent health care and social services to urban AI/AN communities including primary and oral care, HIV treatment, substance use disorder treatment, behavioral health, and other preventive services. The TBFWG recommends a \$50,888,000 increase, which would change the urban line item to \$105,905,000. Under the current enacted budget, the amount each UIHP is budgeted for equates to \$401.00 per patient. The increase would elevate the amount to only \$862, which is still a small fraction of what every day Americans receive, but would make a huge difference to UIHPs in providing care to urban AI/ANs.

The federal government should ensure that UIHPs are held harmless from unrelated budget shortfalls or funding diversions. When the federal government fails to fund or operate at full capacity, such as periods of a government shutdown, IHS is unable to provide the majority of funds to UIHPs resulting in a loss of critical funding and operational shortfalls. UIHPs do not benefit from or have access to § 105(l) *lease cost agreement* funding, and therefore should be held harmless from any § 105(l) *lease cost agreement* funding diversions. The chronic underfunding of UIHPs as they work to provide for a growing population of urban AI/ANs makes it essential to ensure their continued eligibility for grant or funding initiative opportunities.

It is also imperative to remember five National Institute of Alcoholism and Alcohol Abuse (NIAAAs) programs were added to Title V last year, meaning the line item has been split five more ways without an equivalent increase to the amount of the Urban Indian Health line item. The five priorities for UIHPs are listed as follows:

1. Increased funding for urban Indian line item:

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 FY17's enacted amount of \$47,678,000 to FY18's enacted \$48,533,000 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 and have been overlooked for available grant

funding. Funding for urban Indian health must be significantly increased if the federal government is to finally, and 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: There is a substantial risk for Medicaid reimbursements to be lost in light of the Centers for Medicare & Medicaid Services' recent decision to only exempt members of federally recognized Tribes from State imposed work and community engagement requirements in its recent approval of Arizona's Medicaid waiver. The result will hinder access to care in urban Indian communities and further burden an already overwhelmed and underfunded Indian health system.

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 the Department of Veterans' Affairs (DVA) In 2010, IHS and DVA signed a memorandum of understanding (MoU) to promote inter-agency collaboration which "recognize(d) the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual Tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs." This MoU was recently extended. 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.
5. Grants Availability: Because UIHPs suffer from significant underfunding, they often must seek additional funding opportunities including grants. If grant making is eliminated for IHS and Tribal facilities, UIHPs should retain eligibility for grants, including behavioral health funding. This should not impact the ability of grants distribution to transfer to direct funding for IHS and Tribal facilities.

INDIAN HEALTH PROFESSIONS +\$18.1 MILLION

In FY 2021, the Workgroup recommends increasing Indian Health Professions line by \$18.1 million for total funding of \$77.4 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 2017, 788 health professionals – nurses, behavioral health providers, dentists, mid-level providers

and pharmacists - who applied for the Loan Repayment Program (LRP) were not funded. It is estimated that an additional \$39.4 million would be needed to fund the 788 unfunded health professional applicants.

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. Consideration must also be given to the expansion of Alaska's Community Health Aide Program in the lower 48 and the inclusion of CHAP providers in the LRP or Health Professions Scholarship 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. For FY 2017, IHS estimated that an additional \$3.3 million was needed for the Health Professions Scholarship Program to fund all qualified scholarship applicants.
- 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.
- Provide direct funding for Tribal medical residency programs.
- Continue to authorize and fund the Teaching Health Centers program.
- Recognize Pharmacists, Licensed Professional Counselors, and Licensed Marriage & Family Therapists as non-physician providers under Medicare Part B, to ensure eligibility for reimbursement of services provided in our Indian health systems.

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 +\$127,000

The Tribal Management Grant (TMG) 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 \$127,000 over the 2019 enacted level for total funding of \$2.6 million. 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. TMG's are necessary to assist Tribes and Tribal organizations assuming all or part of existing IHS PSFAs through Indian Self-Determination and Education Assistance Act agreements under Title I and Title V to develop, improve and implement management structures to improve their management capability.

DIRECT OPERATIONS +\$700,000

The Direct Operations budget supports the IHS Headquarters and 12 Area Offices. The IHS's mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS is the only HHS agency whose primary function is direct delivery of health care. They agency is responsible for a comprehensive health service delivery system for approximately 2.6 million AI/ANs from 573 federally recognized Tribes in 37 states. 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. 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).

SELF-GOVERNANCE +\$138,000

Tribal Self-Governance, known as Title V of the Indian Self-Determination Education and Assistance Act, authorizes Tribes and Tribal Consortia to assume programs, functions, services, or activities 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. PSFA priorities are determined by the populations served by the Tribal government/Tribal consortia, with particular emphasis on responsive administration of those PSFA 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 IHCIA, 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. An additional program increase of \$138,000 is included, for an overall budget request of \$6.1 million to support and expand Self-Governance training and technical support in FY 2021.

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 ALNs, 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

2nd Recommendation

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 PSFAs 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 531 outpatient facilities (76 IHS operated, 476 Tribal). At these facilities there were an estimated 39,367 inpatient admission and 13.8 million outpatient visits in 2018.¹²

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
IHS	26	55	N/A	21
Tribal	19	280	134	62

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.¹³ A 40 year old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized – about 52% – for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and creates 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.¹⁴ 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.

At current rates of funding, if a new facility was built today, it would not be replaced for 200 to 250 years! 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 non-compliance, lowers productivity, and compromises service delivery. AI/AN populations have substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited that outdated facilities directly threaten a patient's care. For

¹² Source: Indian Health Service. IHS Profile Fact Sheet. Located at: <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>

¹³ *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179); <https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/>

¹⁴ *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

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).¹⁵ “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.”¹⁶ 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.¹⁷

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 +\$139 MILLION

The recommended program increase for Maintenance and Improvement (M&I) is \$139 million above the FY 2019 enacted for total funding of \$316.6 million. While M & I appropriations have increased over the last few years, it has yet to meet the outstanding financial need. With aging facilities, much older than the average in the United States, there remain significant maintenance needs at many IHS and Tribally operated facilities. Rising regulatory and/or executive order requirements, a 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

¹⁵ 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

¹⁶ Ibid, p. 14

¹⁷ Ibid, 15



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 +\$89.6 MILLION

In FY 2021, the Workgroup recommends an increase of \$89.6 million (total funding of \$288.1 million) for Sanitation Facilities Construction to be used for water supply, sewage disposal, and solid waste disposal facilities. The FY 2020 IHS Budget Request only included a \$1.2 million increase above FY 2019 Annualized Continuing Resolution. Tribal Leaders are concerned with this issue from a perspective of disease prevention, that without a substantial influx of resources, many Tribal communities could see a resurgence of environmentally related diseases. 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. The Facilities Appropriations Information Report of March 7, 2019, noted that the overall sanitation project need for existing American Indian/Alaska Native homes or communities by the end of 2018 was \$2.7 billion. The recommended increase will greatly alleviate the disparity in the level of access to safe drinking water and waste water treatment services that AI/ANs experience.

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. The recommended increase will enable more projects to be funded. These projects are cooperatively developed with and transferred to Tribes, which in turn assume responsibility for the operation of the facilities. Tribes have to seek funding through other sources, such as the U.S. Department of Agriculture's Water and Environmental Programs (WEP) to fund technical, managerial and financial capacity for water, waste water and solid waste management. Plus funding for Tribally led water/waste water operator certification and training is principally funded by the Rural Community Development program through the U.S. Department of Health and Human Services. Without the combined resources of IHS and these agencies, access to safe drinking water and vital public health services, in many Tribal communities would not be met.

HEALTHCARE FACILITIES CONSTRUCTION +\$114.4 MILLION

The National Budget Formulation Workgroup recommends a program increase of \$114.4 million over the FY 2019 enacted level for Other Authorities within the Health Care Facilities Construction (HCFC) line item for a total funding level of \$467.6 million. Currently, IHS uses its HCFC appropriations to fund projects off the "grandfathered" HCFC priority list until it is fully funded. As noted in the section of this report titled, "Binding Obligations," in 1989, Congress directed IHS to develop the current HCFC priority system. Originally there were 27 projects on the priority list. There are 12 remaining projects on the list which are currently estimated to cost \$2 billion. Once those projects are funded, IHS is required to implement a new priority system which is outlined in the Indian Health Care Improvement Act of 2010. It requires each IHS Area to generate an updated priority list every three years for a combined submission of top Area priorities to the U.S. Congress. Priority lists may now include, in addition to inpatient and outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and other health related renovation and expansion projects. Not later than one year after the establishment of the new priority system, criteria for ranking or prioritizing facilities other than hospitals or clinics will be submitted to Congress for consideration. The law also allows the development of innovative approaches to address the unmet need for health facility construction and authorizes that a

portion of construction funding may be used as an *Area Distribution Fund* to each IHS Area.

It is envisioned by the National Budget Formulation Workgroup that the recommended program increase may support other projects, such as Small Ambulatory Health Clinics and Health Stations, the Joint Venture Construction Program and innovative approaches that are developed in consultation with Tribes and in accordance with the policy to confer with urban Indian organizations. Many of the existing facilities are obsolete with an average age of 47 years and have long surpassed their useful lives. These facilities are grossly undersized for the identified user populations, which has created crowded conditions for staff, patients, and visitors. In many cases, existing services have been relocated outside the main health facility; often times to modular units, in order to provide additional space for primary health care services. These conditions create difficulties for staff and patients, increases wait times, and inefficiencies within the health care system become problematic.

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 aged equipment disrupt health care service delivery. For example, water supply systems which provide potable water to older health facilities 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 complicate and extend the time required to make needed repairs. Constant system failures deplete maintenance and improvement funds and sometimes 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 the failing infrastructure.

Facilities Appropriations Advisory Board (FAAB) Advisement

Tribal leaders participate on the IHS Facilities Appropriations Advisory Board (FAAB) to study the policies, procedures, and funding recommendations related to facilities issues. This assures that the methodologies utilized to determine the requested funds are accurate for needed infrastructure improvement in Indian country.

The FAAB transmitted advisement to the National Budget Formulation Workgroup on March 14-15, 2019 and included a Facilities Appropriations Information Package so that Tribal Leaders representing all 12 IHS Areas would have up to date information on all of the programs funded through IHS Facilities Appropriations – Maintenance and Improvement, Sanitation Facilities Construction, Health Care Facilities Construction, Facilities and Environmental Health Support and Equipment.

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

- The current rate of HCFC appropriations (~\$240 million/year), a new facility in 2019 would not be replaced for 250 years.¹⁸
- To replace IHS facilities every 60 years (twice a 30 year design life), would need HCFC appropriations of ~\$700 million/annually.¹⁹
- IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in health-care facility construction.²⁰
- Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable. As noted in the 2016 Facility Needs Assessment Report.²¹

FACILITIES & ENVIRONMENTAL HEALTH SUPPORT +\$5.7 MILLION

The TBFWG requests an additional \$5.7 million for the Facilities and Environmental Health Support (FEHS) budget line item for a total of \$271.9 million. The FEHS provides resources to staff and support its headquarters, regional, area, district, and service unit activities. These activities include Facilities Support, Environmental Support and Office of Environmental Health & Engineering (OEHE) Support. Facilities support include operations and management staff for facilities and staff quarter and construction management support. Environmental Health Support provides staff and operating costs for environmental health service, injury prevention, institutional environmental health and sanitation facilities construction staffing. OEHE support includes IHS headquarters staff, engineering services staff and

direct support and management of overall facilities appropriation services and activities.

The IHS delivers a comprehensive, national and community-based and evidence-based Environmental Health program which has 5 focus areas: Children's environment, Safe drinking water, Vector-borne and communicable disease, Food safety, and Healthy 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.

EQUIPMENT +\$28.3 MILLION

The Tribal request is for a program increase of \$28.3 million for a total of \$53.437 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. Renewal is necessary to replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment to enhance speed and accuracy of diagnosis and treatment. To replace the equipment on a 7 year cycle would require approximately \$80 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.

18 IHS Facilities Appropriations Information Report (Package). March 7, 2019. p. 3

19 Ibid

20 Ibid

21 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/newihssthem/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

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 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.”

The Indian Health Care Improvement Act’s enactment and permanent authorization in 2010 protects the future of Indian health and also secures a solid foundation for Tribes, Tribal organizations and Urban Indian Organizations (UIOs) to see that authorized programs and services become realized. Indian Country continues to advocate Congress for accompanying appropriations while engaging with IHS to ensure that the agency’s budget reflects Tribal priorities. In renewing the IHCA, Congress reaffirmed the duty of the federal government to AI/ANs declaring “it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians.”²²

The Medicaid system is a critical lifeline in Tribal communities. Efforts that decrease scarce Medicaid resources also jeopardize the ability to cover our cost of care, and further restrict the eligible patient population. This puts an unequal burden on the IHS budget which is dependent upon these resources to make up for funding shortfalls. The unique relationship between Medicaid and the Indian health system means that the Administration has the tools it needs to allow states to design Medicaid programs that best fit non-Indian populations while simultaneously respecting Tribal sovereignty and maintaining Medicaid as a critical source of funds for the Indian health system. Like States, Tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them.

Proposals in the President’s FY 2020 Budget Request will have major fiscal impacts on IHS and Tribal health reimbursements that would devastate Tribal health. We urge the administration to work with Tribes and strengthen its Tribal Consultation practices on issues like Medicaid work requirements and block grants, so that fiscal strain doesn’t unintentionally fall back to the IHS and Tribal Health programs.

Also, important existing Tribal protections in the Medicaid program must be preserved. These include:

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Purchase and Referred (PRC) is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under PRC.
- If an AI/AN elects to enroll in a Managed Care Organization (MCO), they are allowed to designate an Indian health care provider as their primary care provider if in-network.
- A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as “resources” for purposes of determining Medicaid eligibility for AI/ANs.
- Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery.
- An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider.

INDIAN HEALTHCARE IMPROVEMENT ACT IMPLEMENTATION AND PRESERVATION

The IHCA provides a wealth of resources and opportunities for Tribal health care institutions, families, providers and patients. Tribes worked collaboratively with Congress

²² 25 U.S.C. 1602



to develop legislation that included impactful and bipartisan reforms. Provisions included in the IHCIA are the result of years of negotiations, meetings and strategy sessions. The permanent reauthorization of the IHCIA safeguards the resources of the Indian health care system and has reignited hope for quality health care delivery.

Despite efforts to augment funding through third party revenue, the IHS remains a vastly underfunded foundation of the I/T/U health system — representing yet another broken promise to Indian Country. Mainstream America increases its healthcare focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and more recently, modernizing its Health Information Technology infrastructure. Supporting these improvements for Tribes in the IHCIA and other Indian-specific provisions is critical.

Tribes have worked tirelessly for over a decade to renew IHCIA and it remains 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 following represents several categories of programs that have not been implemented and funded, though authorized by IHCIA:

1. **Health and Manpower –**
Includes: Continue to support Community Health Representatives despite the President’s recommendation to transition to Community Health Aide Program (support both programs); demonstration programs for chronic health professions shortages
2. **Health Services –**
Includes: authorization of dialysis programs; authorization hospice care, long term care, and home /community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment an office of men’s health
3. **Health Facilities –**
Includes: demonstration program with at least 3

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

4. **Access to Health Services –**
Includes: Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs
5. **Urban Indians –**
Includes: funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health
6. **Behavioral Health –**
Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides
7. **Miscellaneous –**
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 outcomes of this law are actually realized. It is critical that additional funds are 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 2021 request so that the dream of the IHCIA can finally become a reality.

Furthermore, any rulings by the courts on the unconstitutionality of the ACA must sever the Indian Health Care Improvement Act and certain Indian-Specific provisions in the ACA that are of critical importance to the delivery of health services to Indian country, from the larger ACA. These Indian health provisions have a separate purpose and genesis from the larger ACA and should remain in effect.

4th Recommendation

Fund Critical Infrastructure Improvements which Impact Patient Care

The Workgroup believes that critical infrastructure improvements *must happen* if we are to improve patient safety and care.

HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE

IHS has enjoyed a 50-year history of successful, innovative and open source development of health information technology (IT). Each Tribe has the right to access and utilize the current IHS electronic health record (EHR) and the suite of applications offered through the Resource and Patient Management System (RPMS). RPMS has its origins on the Tohono O'odham Reservation in southern Arizona to its evolution as a comprehensive suite of over 100 applications supporting the full range of clinical and business processes at direct and Tribally-operated facilities serving AI/AN people across the country. Health IT modernization at the IHS has been driven by the increasing complexity and costs of maintaining legacy systems, an ever-changing regulatory environment, and the impact of plans by the VA to transition away from support for certain components on which IHS health IT is dependent. The Office of the Chief Technology Officer (OCTO) at the Department of Health and Human Services collaborated with IHS and the Office of the National Coordinator (ONC) in FY2019 to design and conduct a multi-faceted, expert-driven and research-based approach to evaluate alternatives for health IT modernization. The recommendations for next steps which will be necessary to modernize the IHS HIT system, including estimate of cost, will be determined by the Secretary of HHS in late FY 2019. These recommendations will provide the basis for a final Tribal request for the FY 2021 budget.

Introduction and Background

The IHS is the principal healthcare provider for 2.6 million American Indian and Alaska Native people in 37 states. The agency is unique among federal government healthcare systems, providing cradle-to-grave care to a defined population – members of 573 federally recognized Tribes – not as a statutory mandate but as a treaty obligation. AI/AN people inhabit some of the most isolated, rural, and spectacularly beautiful parts of the United States. The AI/AN population has some of the highest disease burdens and the lowest life expectancy of any ethnic group in America. The IHS has a mission encompassing personal, population and public health, and is required to report on the status of this mission to the Administration and to Congress.

As health care and health care delivery has evolved, healthcare organizations have faced the dilemma of when and how they will modernize the systems supporting their operations. The breadth of Indian Health Service mission, combined with the geopolitical diversity of Indian Country creates unique challenges for health IT design and delivery. These unique challenges are faced by other resource-constrained health care systems who are focused on helping their members achieve health equity by leveraging HIT solutions.

Modernization Investment: The Time is Now

Over 60% of the IHS appropriated budget is administered by Tribes, primarily through self-determination contracts or self-governance compacts. Many Tribes, however, are choosing to leave the RPMS system, and are taking their Tribal Shares of funding in order to leverage these funds for other Commercial Off the Shelf (COTS) solutions



which better meet their health delivery system needs. Decisions to look at alternative HIT solutions are influenced by the need to meet CMS and other quality performance and accreditation standards, internal and external financial and reporting requirements, the desire to optimize revenue capture to address budget shortfall, and issues with training & support availability, user-friendly interfaces, interoperability with both internal and external applications and EHRs, and patient portals, among other things. The non-existence of a dedicated HIT budget to adequately sustain the current RPMS and EHR is compounded by the fact that past IHS EHR development requirements have been imposed as unfunded mandates. Without new funding, these requirements are achieved at the expense of using H&C or third party resources usually reserved for direct patient care services. The ultimate impact has been inability to properly maintain, update and support the RPMS suite – which further exacerbates the challenges because this results in less funding for IHS to operate and maintain the legacy system as Tribes take their Tribal Shares to find alternative solutions.

The Tribal budget recommendation for an estimated \$3 billion, 10-year modernization investment proposes a comprehensive approach to modernization decision making. The TBFWG supports the HHS to work in partnership with Tribes on the development of a comprehensive qualitative, quantitative and research-based platform to identify and evaluate approaches to modernization of the IHS HIT. The strategy to implement HIT modernization for the Indian Health Service is an urgent need which cannot be deferred any longer. Patient care and safety lie in the balance of an already fragile health delivery system and deserve the best efforts of cutting-edge technology innovators, Tribal and federal veterans of healthcare in

Indian Country and icons of health IT leadership in the U.S. – brought together to help answer how to approach health IT modernization in the IHS. Frameworks developed, lessons learned, and alternative analyses determined will be applicable to multiple organizations who operate within rural and underserved areas of the country.

Why is this Important?

The IHS and Tribal health delivery systems have always focused on community and public health with a unique focus on holistic wellness and patient-directed clinical decision-making. IHS health IT evolved to support the same. Health IT modernization at the IHS has been driven by the increasing complexity and costs of maintaining legacy systems, an ever-changing regulatory environment, and the impact of plans by the VA to transition away from support for certain components on which IHS health IT is dependent. Current technical and enterprise architecture of health IT deployment create many factors that are driving the need for timeliness and criticality of a thoughtful evaluation of IHS options for health IT modernization.

The HIT Modernization project benefits include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, performance and other reporting requirements. By identifying and properly selecting the best match for proposed system capabilities, the system will support the mission of the IHS and the Tribes.

Additionally, the IHS and Tribes must have interoperability with the Department of Veteran's Affairs, Department



of Defense, referral health providers, academic affiliates, and community partners, many of whom are on different IT platforms. The IHS must consider an integrated EHR system that will allow for a meaningful integration to create a system that serves I/T/U beneficiaries in the best possible way.

In summary, the effort to modernize the IHS health IT system seeks to harness emerging technologies to design robust, adaptable solutions that support evolving models of care. These care platforms must be designed to support patient and community engagement in a continuing effort to reverse decades of health and health care disparity faced by AI/AN people. These circumstances have provided an opportunity to evaluate IT system design and modernization options for the largest rural health network in the US. The modernization effort will take into account the approach and the rubrics developed to support the current HIT modernization evaluation in underserved and under-resourced populations, with a focus on the future-proofing of health IT to support growth, and technological innovations to address value-based, patient centric medical home models.

INVESTMENT IN HEALTH FACILITIES CONSTRUCTION FUNDING & EQUIPMENT (\$15 BILLION OVER 10 YEARS)

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 200-250 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 is already severely underfunded. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS direct service programs were left with an impossible choice – either deny services or subsidize the federal trust responsibility. In fact, many did close their doors for several days per month and forced others to deliver only PRC for Priority I. The Indian Health Service is one of only four federally funded services providing direct patient care; however, it was the only one of the four, not exempted from sequestration. This oversight, which created an unsafe hardship

for Indian patients seeking care, must be permanently corrected.

For fiscal years 2014-2019, 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.

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 2021 budget should reflect that commitment by permanently exempting the IHS from sequestration.



6th Recommendation

Support Advance Appropriations for the Indian Health Service

Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies Appropriations bill, which contains the funding for the Indian Health Service, has been enacted by the beginning of the fiscal year. The belated enactment of a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011). These delays make it very difficult for Tribal health providers and IHS to adequately address the health needs of American Indians and Alaska Natives. According to the Government Accountability office (GAO): “uncertainty resulting from recurring [continuing resolutions] and from government shutdowns has led to adverse financial effects on tribes and their health care programs” (GAO-18-652). The GAO shows that because of that uncertainty in funding, IHS and Tribal providers have significant challenges recruiting and retaining health providers and Tribes are given significant administrative burdens due to the fact that the IHS has to modify hundreds of contracts each time there is a continuing resolution.

The 35 day partial government shutdown at the start of 2019 had a devastating impact on the Indian health system. Tribes throughout the country reported rationed care, reduced services, and some facilities closed altogether. This reckless shutdown destabilized Native health delivery and health care provider access; as well as Tribal Governments, families, children and individuals. With the further likelihood of shutdowns and delayed federal appropriations, Tribes firmly believe that advance appropriations for IHS will allow for greater planning, more efficient spending, and higher quality care for AI/AN patients.

An advance appropriation is funding that becomes available one year or more *after* the year of the appropriations act in which it is contained. 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. Advance appropriations for IHS would support the ongoing treatment of patients without the worry of 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.

Advance appropriations would allow Indian health providers to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passes a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when Congressional decisions funnel down to the local level.

As in past years, the TBFWG continues to request that the Administration support Advance Appropriations for IHS in its FY 2021 Budget Request.

7th Recommendation

Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts 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 means that resources will be addressed 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 / Referred Care that may be denied due to lack of funding. 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 to receive funding, and others without the capacity who 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.

Currently, about \$60 million of the Behavioral Health budget (Mental Health and Alcohol & Substance Abuse Programs) is dedicated to growing 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 is 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.*

Funding for ongoing health services in FY 2021 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.

9th Recommendation

Permanently Reauthorize the Special Diabetes Program for Indians and increase funding to \$200 million per year, plus annual inflationary increases

The Workgroup recommends that the Administration propose permanent authorization of the Special Diabetes Program for Indians (SDPI). In recent years, the highly successful program has only been renewed in short 1-2 year increments (and in 2017-18 just a few months!). This creates instability in the program, to the detriment of staff recruitment and retention, long-term planning, and overall effectiveness. The current authorization expires on September 30, 2019. In addition, SDPI has not received an increase in funding since FY 2004 which means the program has effectively lost about 25% in programmatic value over the last 15 years due to inflation and the significantly increased costs of diabetes care. Any renewal or permanent enactment should ensure that inflation is built into final funding levels.

Few programs are as successful as SDPI at addressing chronic illness and risk factors related to diabetes, obesity, and physical activity. SDPI has proven itself effective, especially in declining incidence of diabetes-related kidney disease. The incidence of end-stage renal disease (ESRD) due to diabetes among American Indians and Alaska Natives has fallen by 54% — a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost \$90,000 per patient, per year, so this reduction in new cases of ESRD translates into significant cost savings for Medicare, the Indian Health Service, and third party payers. We believe that permanent enactment of SDPI is a common-sense approach.

SDPI has had positive clinical and community outcomes including: the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2010 and has held steady at this improved average for 7 years; the average LDL (“bad” cholesterol) declined from 118 mg/dL in 1998 to 95 mg/dL in 2010; and more than 80% of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities and serves for AI/AN children and youth.

Permanent reauthorization of SDPI is a common-sense approach that will support a highly successful program.



Conclusion

The social determinants of health which help perpetuate the poor health status for AI/ANs could be dramatically improved with adequate investment into the health, public health and health delivery systems in Indian Country.

These investments create many socio-economic opportunities, improving communities ability to recruit and retain quality providers and professional staff. Tribes appreciate the efforts to at least maintain current level services through appropriation of incremental increases to the IHS budget. We have increasing concerns, however, that the full trust and treaty obligations have not been met with significant investment in infrastructure including equipment, buildings and technology. Additionally, funding for program costs are needed, including staffing capacity, in order have a real impact on improving health outcomes. Increases in the IHS annual appropriated budget since FY 2008 have only been enough to simply cover costs associated with inflation-proofing current level services, and to fund population growth, inflation, and the rightful full funding of Contract Support Costs. Funding must be identified to actually realize marked improvements in health outcomes and to build public health infrastructure for all AI/ANs.

This budget proposes a 46% increase in the total IHS budget for FY 2021. Fiscal trends confirm that this level of investment is critical if we are to restore the health of our people and wellness of our reservations and villages. Our history includes countless federal policies which have sought to destroy Native communities. The devastating health effects of these policies are seen today in both large and small ways. The 35-day government shutdown is only

the most recent example. This reckless political decision – over completely unrelated political partisan squabbles – destabilized Native communities and health systems. Yet again, the First Peoples of this great nation became casualties of a destructive federal decision.

The TBFWG implores the Administration to work with Congress in FY 2021 to enact a serious investment in Indian health that will honor and fulfill the promises made to our ancestors. One important first action is to support the enactment of Advance Appropriations for IHS. This will reaffirm that the government is committed to eliminating disruption to the IHS health delivery system, no matter what delays in the discretionary appropriations budget might occur. Advance appropriations is a common sense solution that will not place undue burden on the federal budget, but create greater sustainability for Tribal communities.

As important, and as noted multiple times in this document, the Administration must put in place a strategy to support stable and full funding for the IHS through any and all available means. Medicaid and other payer resources, for example, were used by many IHS and Tribally operated health systems to cover essential costs during the recent government shutdown. It is critical that the Administration honor the trust responsibility through permitting IHS and Tribal facilities to access to the Medicaid program; allowing states to tailor their benefit plans and requirements to fit unique Indian needs will ensure that Medicaid works in Indian Country. Work requirements, block grants and other barriers to AI/AN



enrollment do not reduce federal costs; they only revert the burden of these incurred expenses on the already under-funded IHS budget. Similarly, competitive grant programs are inefficient and lead to less available funding for programming by imposing administrative burdens over and above program costs. In many cases, grants do not reach the communities that need them the most and only advantage areas where administrative resources are available to research and apply for them.

The Indian Health Service budget represents a sacred promise made between these United States and our ancestors to fulfill the trust and treaty obligation to provide healthcare services to all American Indians and Alaska Natives. Time and again, Congress and the courts have affirmed this federal trust responsibility. This Administration must take actionable steps to fulfill this promise by putting forward a true and impactful budget proposal. Our proud Nations continue to suffer from preventable or treatable diseases and our citizens die younger than other Americans. This hidden truth must be addressed quickly and in a meaningful way. Failure to apportion an adequate level of funding for health services and programs within the Indian Health Service, as well as continued failure to invest in Tribal Public Health systems and basic health system infrastructure, are the primary reason for these unconscionable and avoidable health disparities. This document reflects the AI/AN Tribal budget priorities for this Administration to consider as it formulates the FY 2021 budget request. We believe that it provides a clear roadmap to make meaningful progress toward satisfying fulfillment of the agreement made

by the United States, as our federal trustee, to provide quality health care to the 573 federally recognized Tribes in America.

We, as Tribal leaders appointed to serve on the National Tribal Budget Formulation Workgroup firmly believe that by working collaboratively through our government-to-government relationship, together we can achieve real progress to eliminate health disparities and create wellness in AI/AN Nations. It is imperative that the budget recommendations be acted on immediately if we are to build a strong and sustainable Indian health system. Doing so will honor Tribal sovereignty and the federal fulfillment of the historic trust responsibility to our Nations. We look forward to working with you directly as you engage in conversations on the FY 2021 budget.

Acknowledgements

NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP AREA REPRESENTATIVES

- Alaska** ----- Victor Joseph, President/ Chairman, Tanana Chiefs Conference
Verne Boerner, President/CEO, Alaska Native Health Board,
Native Village of Kiana, Alaska Tribal Health Caucus
- Albuquerque** ---- Beverly Coho, AAIHB Vice Chair Member, Rama Navajo School Board Member
Clyde Yatsattie, Councilman Pueblo of Zuni
- Bemidji** ----- Phyllis Davis, Councilmember, Match-e-be-nash-she-wish Band of Pottawatomi
Indians of Michigan
Cathy Chavers, Chairwoman, Bois Forte Band of Chippewa Indians,
- Billings** ----- Terry Tayseu, Blackfeet Tribal Councilman
Dana Buckles, Tribal Executive Board Member
- California** ----- Michael Garcia, Vice Chairman, Ewiiapaayp Band of Kumeyaay Indians
Chris Devers, Vice Chairman, Pauma Band of Mission Indians
- Great Plains** ---- Richard Greenwald, Tribal Council Member, Oglala Sioux Tribe
Nathan Davis, Council Representative, Turtle Mountain Band of Chippewa Indians
- Nashville** ----- Edie Tullis Baker, Director, Health and Elder Services, Poarch Band of Creek Indians
Tihtiyas (Dee) Sabattus, Health Director, Passamaquoddy Indian Township
- Navajo** ----- Otto Tso, Navajo Nation Council Delegate
Theresa Galvan, Health Service Administrator, Division of
Behavioral & Mental Health. Navajo Nation
- Oklahoma** ----- Terri Patton, President, Wichita and Affiliated Tribes
Bruce Pratt, President, Pawnee Nation
- Phoenix** ----- Amber Torres, Chairman, Walker River Paiute Tribe
Laurie Thom, Chairman, Yerington Paiute Tribe of the Yerington Colony & Campbell Ranch
- Portland** ----- Andy Joseph Jr., Vice Chairman, The Confederated Tribes of the Colville Reservation
Steven Kutz, Council member, Cowlitz Indian Tribe
- Tucson** ----- Robert Valencia, Chairman, Pascua Yaqui Tribal Council
Edward Manuel, Chairman, Tohono O'odham Nation



TRIBAL TECHNICAL WORKGROUP

Alaska ----- Jacoline Bergstrom and Jerry Moses

Albuquerque ---- Sandra Winfrey

Bemidji ----- Jeff Bingham and Richard Gerry

Billings ----- Tafuna Tusi and Dylan Blackeagle

California ----- Jeffrey Turner and Daniel Redeagle

Great Plains ---- Sunny Colombe

Nashville ----- Theresa Cochran

Navajo ----- Dee Hutchison, Randall Morgan, Darlene Kirk, and Philene Tyler

Oklahoma ----- Melissa Gower and Melanie Fourkiller

Phoenix ----- Carey Tso and Arikah L. McClary

Portland ----- Laura Platero, Joe Finkbonner, Nichole Swanberg, CAPT Ann Arnett

Tucson ----- Rueben Howard, Lynnitia Hoffman, Mark Bigbey

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Appendix

HOT ISSUES BY IHS SERVICE AREA

ALASKA

1. PARITY AND SOCIAL JUSTICE ALASKA NATIVES AND AMERICAN INDIANS

Advance Appropriations

The recent partial government shutdown, which greatly affected the Indian Health Service, and chronically late funding under Continuing Resolutions have 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 Alaska Native and American Indian (AN/AI) 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 appropriation cycle so that Tribal health care providers, as well as the IHS, can know what their next year's funding will be in advance and thereby better plan their budgets and administer their programs.

EHR Conversion - RPMS & COTS

Across the Alaska Tribal Health System (ATHS), the use of Information Technology in maintenance of patient and provider records, as well as the actual delivery 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. Providing adequate financial resources to carry out these functions is critical to the ATHS and will support IHS in moving away from the antiquated RPMS system to 21st century solutions including commercial off the shelf options. IHS needs to provide an accurate estimate of cost for the Administration and Congress to consider. Tribes are striving for parity between other federal agencies and departments, particularly the Department of Veterans Affairs in its endeavors to implement a new EHR system. This a parity adjustment and should not come at the cost of current services and programs, but IHS should request appropriate levels similar to the VA.

Hepatitis C Virus (HCV) Treatment

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 due to the lack of funding. 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 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.

Best Treatment

Tribes and Tribal health organization in Alaska were initially excited when they were notified of “an opportunity to receive free HCV treatment for patients” that at closer look turned out to be an obsolete medication that was no longer a best practice and would not have worked for over 99% of HCV patients in Alaska, anyways. Treatment opportunities made available to IHS and Tribal programs should be on par with national best practices and on step with treatment modalities made available to the VA.

2. CLIMATE CHANGE

Climate change is an important issue to the health of our people and our communities. Over the past 60 years, the average temperature across Alaska has increased by approximately 3 degrees. Warming temperatures in the winter have increased by an average of 6 degrees. This increase is more than twice the warming seen in the rest of the U.S. In arctic regions of Alaska, communities are being damaged by powerful storm surges; shorelines that were originally protected by sea ice are being battered, and the long-term existence of these rural Alaska communities is being threatened. Permafrost is melting and large sinkholes are opening, causing damage to homes and infrastructure.

Delivery of service

The impacts of climate change are broad-reaching. Alaska Communities, their health and wellness programs are having to dedicate substantial resources to build their adaptive capacity, address food security (insecurity), cultural ecosystem services, research and assessments as climate change affects traditional harvest levels, receding ice sheets, altered growing seasons, invasive flora and fauna species, increased hazards, and compliance issues with state and federal mandates that may not consider the unique aspects of Alaska’s terrain, geography/demographics, and rapidly changing climate. The IHS is obligated to provide resources to tribal programs experiencing these challenges to delivery of service caused by the impacts of climate change and rising sea levels.

Village Relocation

The extreme impacts of climate change in Alaska are causing extreme needs. Many Alaska Native Coastal villages must contemplate relocation as the sea levels

rise. IHS needs to consider the costs associated with such required moves including requesting funds for collecting topographical data, design services for infrastructure needs, assessments and engineering plan development.

3. FACILITIES AND INFRASTRUCTURE

Sanitation – Self-determination

Our communities in Alaska are among the poorest in the nation, the percentage of our people living below poverty is twice that of the U.S. and three times that of the rest of Alaska. Additionally, unlike Tribal communities in the Lower 48, we lack a taxable land base from which to generate resources for infrastructure. Our People and Communities depend upon a subsistence lifestyle and there are no commercial enterprises or industries which contribute to our village economies. The sanitation facilities in our community are an essential part of our infrastructure, alongside our airport, school, and clinic. Keeping our sanitation infrastructure operating in our extreme climate conditions consumes a very large percentage of our very limited resources.

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.

Clinic Leases

It is essential to the budget development process that IHS estimates and adequately request funding in its budget request to Congress to cover 105(l) and Village-Built Clinic leases. The funding to support programs, functions, services, and activities—and associated inflation increases—should not be reprogrammed to cover these mandatory costs. IHS should request funding for these leases similar to how Contract Support Costs are appropriated. There should be a separate and specific request to adequately fund 105(l) and Village Built Clinics.

Joint Venture Construction Projects/Staffing Packages

Alaska Tribes request that IHS 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

Alaska Tribes recommend IHS request funding for the Small Ambulatory construction program. This program is very important to rural communities in Alaska, and for many rural Tribes across Indian Country. In many communities, the only access to health care is the Tribal Health Program. Congress recognized this fact when it authorized Section 306 of the Indian Health Care Improvement Act (IHCIA) to award grants to Tribes and 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.

Staff Housing

IHS must ask Congress to address and fund the shortage of staff housing associated with staffing Tribal health facilities. Adequate staff housing is essential for recruitment and retention of health professionals. The ability to provide safe housing for providers willing to work in isolated Tribal communities is a critical issue, and funding to maintain and replace the few existing houses has either not been available, or is extremely limited, over the past 20 years. Many Tribal 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.

4. INFORMATION TECHNOLOGY & REPORTING

First and foremost, IHS needs to support tribal sovereignty, and recognize that Tribes do not relinquish ownership of the data when they participate in data reporting. Tribes are partners with IHS the data we submit is co-owned and should be co-utilized. In the Alaska

Tribal Health System (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 because 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 and 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.

Data Reporting & Measures

Alaska Tribes have long requested that IHS collaborate with sister agencies on reporting requirements, the *ReImagine* HHS initiative shows promise of achieving efficiencies. To encourage this, 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." However, still today, Tribes continue to divert program funding to comply with the reporting requirements of both agencies, creating an unnecessary administrative burden and incurring unnecessary costs. 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. IHS needs to prioritize and budget for the alignment of these data and reporting requirements.

Telehealth

Telehealth is a critical component of care and is intricately paired with the CHAP program. The ATHIS is a true system of care that provides services to over 175,000 AN/AIs and is comprised of:

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

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

Additionally, increased funding for Tele-Behavioral Health: Tele-behavioral health capabilities (Video Teleconferencing—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.

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.

IDCS DM

On October 30, 2015 the Alaska Native Health Board submitted comments regarding IHS' Information Data Collection System Data Mart (IDCS DM). It was stated then that IHS needs to consider budgeting and continuing development of the IDCS DM. The design and budgeting

amounts should provide for mechanisms that allow Tribes and Tribal Health Organizations to have direct access to the raw data (not predesigned reports and not through an IHS employee). Secondly, IHS needs to budget Tribal participation as part of the design; that is, IHS should include and work in partnership with Tribes and THOs who have adopted a COTS EHR in the design and recognize the need for an IHS OIT standards allowing for self-validated information to be accepted and incorporated. Thirdly, as stated earlier, 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., and not a data/analytic platform tied to a single EHR technology (RPMS). IHS should align eCQMs whenever possible to facilitate this process. Finally, IHS would make available resources to support the standardizing nomenclatures needed to map multiple Electronic Health Records specific codes.

These issues are of particularly of 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/AIs).

Cerner

IHS and Tribes need to immediately begin to assess alternatives to RPMS – such as Cerner (this is of particular interest given the Veterans Administration's decision to use Cerner) or NextGen solutions. Multiple solutions may be necessary, but IHS needs 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 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.

The only progress to report is that IHS has agreed to decommission its uncertified RPMS Blood Bank Package. However, 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;
- Ask-at-Order Questions not passing from EHR to Lab Package.

5. CONTRACT SUPPORT COSTS

Alaska Tribes appreciate that Contract Support Costs (CSC) are provided indefinite year appropriations and cannot take from other programs or operational line items. Alaska Tribes still advocate that appropriations of CSC funds be transferred from discretionary to mandatory. Alaska Tribes also contend that IHS must amend its CSC policy to reflect the recent Cook Inlet Tribal Council (CITC) contract support cost court ruling that the ISDEAA’s duplication provision does not require IHS to apply a categorical approach for duplication, and rather must apply a dollar-for-dollar offset. IHS should also delete current footnotes suggesting this issue remains

in dispute. Similarly, IHS must amend its CSC policy to reflect the 2016 Navajo Health Found.-Sage Mem. (Sage) court ruling that the ISDEAA's contract support cost mandate extends to ISDEAA programs funded with third-party revenues, and should delete current footnotes suggesting this issue remains in dispute.

Finally, Alaska Tribes contend that current behavioral health grants, including but not limited to SASP, DVPI, and MSPI, should be allocated as Tribal shares to ensure that they are eligible to be paid CSC funding to support the administration of these programs.

6. GRANTS VS TRIBAL SHARES

The trend of IHS requesting grants to fund programs is inconsistent with the principles of self-governance and the ISDEAA. It is inefficient and does not support programs, workforce development, or 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 creating grant programs to be implemented separate from ISDEAA agreements.

Grant programs are an inefficient use of funds in that the grant program cannot adequately reach all Tribes, limits community-based approaches, does not create stability in programming, and is not flexible. Alaska Tribal 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 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.

7. ALCOHOL & SUBSTANCE AND MENTAL HEALTH

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. It contributes to adverse childhood experiences and trauma. 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.

Mental Health

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

Increase funding for Behavioral Health Workforce Development

Alaska has been progressive in replicating its highly successful CHAP training model by creating an innovative Behavioral Health Aide Model which focuses on

prevention, intervention, treatment, case management and aftercare services in our rural communities. The trained and certified BHAs are a critical component of our care teams providing 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.

8. LONG TERM CARE/ELDER CARE

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. Increases in life expectancy can also lead to a higher prevalence of chronic disease and with it increased incidence of disability and functional limitations. 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.

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

9. SPECIAL DIABETES PROGRAM FOR INDIANS

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

Alaska Tribes request 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.

10. TRAINING

CHAP

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 CHA/P 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 CHA's 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. As IHS advances on this plan, the additional amount of funding needed to expand and/or establish new CHAP training centers must be included in the agency's request to Congress.

Environmental Technicians

The Indian Health Service is responsible for the delivery of environmental engineering services and sanitation facilities to American Indians and Alaska Natives. This

responsibility is not limited to the construction of sanitation facilities, but also the maintenance and operations of these facilities. Having properly trained environmental technicians are critical to the safety of the communities and for protecting the longevity of those facilities. IHS must include proper requests for funds to provide this needed training.

ALBUQUERQUE

1. PERMANENT FUNDING FOR THE SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI).

Background: The SDPI program has become a bedrock prevention program in many Tribal Communities. Data show it has been effective in preventing Diabetes in Tribal Communities, which in turn reduces costs to I/T/U facilities spent on costly tertiary diabetes treatments. The program has been continuously funded since 1997, but the mechanism for funding—namely, the 2 or 5 year periods of funding and the constant need for reauthorization—makes long term program planning, staff retention, and continuity of services challenging.

Recommendation:

- SDPI has not received an increase since 2004, meaning that dollars are stretched even further when considering increased population growth and medical inflation. We strongly encourage an increase in funding for the SDPI program to at least match the inflationary and population growth increases. Additionally, because there is a return on investment for this program by the cost savings realized in prevention, we encourage this to be viewed as a cost saving measure, not necessarily an expenditure.
- Late renewals and/or two year renewals mean that SDPI programs lose staff that are very hard to replace in rural communities where Tribes are located. We are advocating for a permanent funding mechanism for Tribes in a way that continues the community driven programming, but creates permanency, security, and the ability for long term planning in this successful programming.

2. CONTINUED FUNDING OF THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

Background: In 2018, the funding for the Community Health Representative (CHR) program was eliminated from the President's proposed IHS Budget.

Recommendation: The Community Health Representative (CHR) program is a bedrock program for Public Health in Native communities. CHRs provide a wide variety of services, from health education to families to home visits for elders to community health promotion activities. They are a valued link between the medical providers and the community; often providing recommendations, solutions, and services that otherwise wouldn't be available to community members.

In many way, the Indian Health Services perspective on the CHR program in the best description. Quote:

"The Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs have demonstrated how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs are great advocates, in part, because they come from the communities they serve and have Tribal cultural competence. Their dedicated work has assisted many to meet their healthcare needs. The health promotion and disease prevention efforts that CHRs provide have also helped people from the community improve and maintain their health. By providing health education and reducing hospital readmissions, CHRs have contributed to lowering mortality rates. The demand for CHRs continues to grow." (<https://www.ihs.gov/chrl/>)

The CHR program faced elimination in the proposed President's FY 2019 budget. It was saved by congressional action, but we need to ensure not only the permanency of the CHR program, but also look at the shortage of CHRs in Tribal Community and how IHS might help alleviate this shortage. Data was presented as the reason for potential elimination, but data entry and the lack of ability for CHRs to enter data into the IHS system may have been the contributing factor to this data decrease; not a decrease in services.

Tribes should not have to worry about the elimination of this vital program, and we need IHS to advocate for the effectiveness and importance of this program.

3. EMS – RELIABLE AMBULANCE FOR COMMUNITY SERVICES

Zuni Pueblo EMS is in dire need of dependable ambulances to provide safe lifesaving emergency care. Presently Zuni Pueblo has 5 ambulances with 2 out of commission due to the high cost of repairable service needed. McKinley County provided 2 ambulances to the Tribe, Zuni Pueblo has 2 ambulances and Indian Health Service (IHS) provides one GSA ambulance.

Background: Zuni Pueblo EMS provides services to a population of over 13,000 community members that includes non-Zunis. They also provide services to communities outside of Zuni as needed.

When the Zuni Pueblo established the EMS Program separate from the CHR/EMS in 1995 the 638 IHS EMS base budgets was at \$106,403. The current 638 IHS base budget for FY 2018 is at \$343,846. The 638 budget funds seven (7) positions leaving only 3% for operational costs. Other eight (8) positions are paid by the Zuni Tribe's Third Party collections. To this date the Third Party reimbursements for FY 2018 is almost equal to the IHS 638 base budget. This again allows minimal funds for operational costs.

Zuni EMS transports emergent, critical and noncritical patients to IHS for medical care. An MOU is in place between Zuni Pueblo and IHS to collaboratively determine what and how services will be provided. In the MOU, Zuni will provide services for IHS within a 150 radius for transports to and from other medical facilities and IHS has obligated itself to provide a GSA ambulance to the Tribe.

The GSA ambulance that IHS provides to the Tribe has been out of commission 95% of the time to this date with a long wait period to replace with a new unit that is being built. On October 18, 2018, a major vehicular accident with four (4) occupants occurred with two (2) fatalities. The GSA ambulance lost power at the scene resulting in multiple patients transported by one other Tribal ambulance. This ambulance had been recently serviced for another problem. It has been very challenging for the Tribe to wait on IHS's to have the undependable ambulance replaced. A year of IHS's bureaucratic internal process is too long.

With the high volume of transports that have been occurring 3 ambulances is not sufficient. Priorities as to who receives services and at what time frame hinders the overall quality care of our community members. This should not even occur.

McKinley County has indicated they have limited funding to provide additional ambulances. And with the 3% operational costs from 638 Funding Zuni Pueblo is unable to purchase a new ambulance.

Recommendation: It is very apparent by the budget amounts throughout the years that there has been a slow progression for increases. For FY 2021 it would be 26 years that if the budget is allocated at the same yearly percentage, these allocation of dollars will not keep up with inflation costs to sustain operations. For this exact reason Zuni Pueblo is highly recommending the increase in the EMS budget to provide the quality and life sustaining care that every AI/NA community deserves.

4. ALCOHOL ABUSE AND IMPACT ON THE JICARILLA APACHE RESERVATION

The Jicarilla Apache Nation reservation is located in northern New Mexico in the rural town of Dulce, NM and is comprised of approximately 3,200 Tribal members. It is a known fact that alcohol abuse has a profound negative effect on the individual's health, the family, the children and the community as a whole. The costs of local services also increases especially with the time and effort from the EMS, Behavioral Health Services, Social Services, the Court System and the Police department responding to incidents that occur that are alcohol related. The costs from medical bills is high due to chronic and severe health related complications and even accident related injuries. Alcohol abuse is also a high contributor to the suicide rate in the community.

Background: The Nation has spent many years implementing programs and systems to address this issue but has not made a significant impact due lack of funding to continuously support effective programs. Many patients who seek treatment leave the reservation for services only to return to the same environment without access to community-based prevention strategies to avoid the patient from relapsing. The Nation has not invested in a rehabilitation center that could assist with the transition but funding remains an issue.

Recommendation: As noted on the Indian Health Service website, "in 2017, IHS received \$2,000,000 in grant and contracted funding to provide alcohol or drug treatments services to Indians, including detoxification services. IHS used the funds to focus on the provision of services in the Navajo and Great Plains IHS Areas to address alcohol-related deaths occurring in communities that were in need of urgent substance abuse treatment, residential services,

and detoxification services. Preventing Alcohol-Related Deaths (PARD) through Social Detoxification is an IHS cooperative agreement that serves to increase access to community-based prevention strategies to provide social detoxification, evaluation, stabilization, fostering patient readiness for and entry into treatment for alcohol use disorders and when appropriate, other substance use disorders."

The outcome of these Areas receiving this funding has contributed to implementing effective systems to manage the alcohol-related issues in their communities. The Jicarilla Apache Nation program leaders are prepared to identify a strong and relevant plan if future funding is made available to this community to further existing efforts.

BEMIDJI

1. ADVANCE APPROPRIATIONS

Indian Health Service is susceptible to lapse of appropriation funding which negatively effects budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts are significantly vulnerable.

Background: Since Fiscal Year 1998, there has been only one year (FY 2006), in which the Interior, Environment and Related Agencies Appropriations bill has been enacted before the beginning of the new fiscal year.

Recommendation: The Bemidji Area is requesting the IHS receive Advance Appropriation, which was done in FY 2010 for the Veterans Administration (VA) when medical care programs achieved advance appropriations. The fact Congress implemented advance appropriations for the VA medical programs demonstrates the importance of advance appropriations for direct health service agencies. Just as veterans groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of VA to properly plan and manage its resources, Tribes and Tribal organizations also have those concerns about the IHS health system.

2. UPGRADE OF THE IHS INFORMATION TECHNOLOGY (IT) SYSTEM

The Bemidji Tribes believe the IHS IT system is in need of a major upgrade, primarily the RPMS system.

Background: Tribes have been leaving the IHS RPMS because it is not meeting the needs of their clinics and services due to its out datedness. Because of the deficiencies in the IT systems, Tribes need to keep current with the private sector and they need to purchase very expensive commercial healthcare software. There are major issues surfacing with interfaces between the systems and causing reporting issues.

The branching out on their own, Tribes have to use much needed funding taken to obtain the new systems, which have a negative effect on patient care funding.

Recommendation: The Bemidji Area Tribes recommend the IHS provide major funding to upgrade the IHS IT system to which can compete with the private sector. By moving toward a modern IT system, the I/T/Us can be standardized for training, interfaces, cost savings, and reporting.

3. REPROGRAM CHEF FUNDS FOR OPIOID GRANT FUNDING

Additional funding is needed to combat the growing opioid epidemic.

Background: Unused CHEF funds should not be carryforward but should be made available health services in the year they are appropriated.

Recommendation: The Bemidji Area is recommending reprogramming unused CHEF funds to be used for opioid grant funding to Tribal substance abuse programs.

4. LOAN POOL FOR TRIBES TO BORROW FOR FACILITY CONSTRUCTION

Facility construction funding is very limited for Tribes to access.

Background: New and updating of existing health care facilities are needed throughout the reservations.

Recommendation: The Bemidji Area is recommending the IHS establish a revolving loan pool in which Tribes would be able to access for new construction or remodeling existing health care facilities.

5. EHR MODERNIZATION

Modernization of the RPMS EHR package is needed to keep pace with EHR packages of the private sector.

Background: The IHS RPMS EHR system is failing to keep up with the private sector. The underfunding of the IHS is causing a lack of modernization of the EHR system and Tribal health systems are struggling to keep up current technology. There is a very big concern about where the money will come from for this EHR modernization project and how it will meld with Tribes who have moved forward and gone to the private sector for their data processing needs.

Recommendation: The Bemidji Area is recommending increasing the level of funding to upgrade the RPMS EHR package to keep pace with similar packages in the private sector.

The upgrade costs are high and many Tribes have had to pull funding from other primary services offered at the healthcare facilities. There is a concern those costs associated with the upgrades will be discarded if they return to the IHS EHR system. There is also a concern Tribes will indirectly pay for the upgrades because of diversion of healthcare funds to the IT upgrade. The Tribes request equitable treatment for those Tribes who have purchased commercial packages.

IT upgrades are extremely important components in the IHS system, and need to be treated as such. The Bemidji Area also recommends IT upgrades should receive recurring funding and earmarked just for upgrading the IHS IT system.

6. SUBSTANCE ABUSE TREATMENT CENTERS

Background: The cost for treatment of alcohol and substance abuse is increasing at a rate, which exceeds availability of funding. Local Tribal treatment centers and alcohol and substance abuse programs are forced to priorities as a result. Studies show to be effective, Tribes need to provide 180 day inpatient treatment, as well as follow up care. To provide this effective care additional treatment centers need to be made available for AI/AN

patients. Tribes are active in this effort, but miniscule funding increases have made providing these additional centers are difficult.

Recommendation: The Bemidji Area is recommending additional funding be made available for substance abuse treatment centers.

7. STUDENT LOAN REPAYMENT

The annual HHS limit for student loan repayment is \$30,000. The private sector offers a much higher loan repayment level, which makes recruitment of quality healthcare providers for I/T/U facilities very difficult.

Background: The IHS is limited to \$30,000/year on the amount of student loan repayment it can offer to health care providers. Many providers graduate with school debt in the 6-digit range. The lower amount makes it very hard for IHS to compete with the private sector in recruiting and retention of quality health care providers.

Recommendation: The Bemidji Area is recommending increasing the annual level of student loan repayment for recruitment and retention of health care providers. This would enable the I/T/Us to be on a competitive level with other health care organizations.

8. NEW IHS SECURITY CLEARANCE REGULATIONS – RE: EHR & DATA SYSTEMS

The requirement for increased security level background checks for those Direct Service Tribal employees who need access to IHS computer systems (ie. EHR, Protected Health Information (PHI) and other Personal Identifiable Identification (PII) Data)

Background: Due to the increased security around PHI, PII, and IHS computer systems, all government employees are required to undergo a more intensive background check. Direct Service Tribal employees with access to IHS systems will also need a more intensive background check completed in order to maintain that access.

The security background checks results are not timely and retrieval of data is slow.

In addition, the increased cost for security clearances are an added financial burden on Tribes and with no additional funding, could hurt smaller facilities who comply with this requirement.

Recommendation: The Bemidji Area Tribes are recommending that either we lower the security level requirement for Direct Service Tribal employees who access IHS systems, offer background checks as a buyback or assist with the additional cost in the performing the increased background checks.

BILLINGS

1. ALCOHOL & SUBSTANCE ABUSE

Alcohol and Substance abuse issues plague our communities as a health care crisis and epidemic. The Billings Area sees the need for additional resources to continue to build capacity and provide quality treatment/recovery services. Methamphetamine use is a high concern and epidemic that plagues our communities in drastic fashion and there are no treatment facilities in the area that deal with its correction. The combined effect on our populations abusing alcohol and substance abuse is devastating. Mental health trauma can be seen as a catalyst for our people choosing alcohol and substance abuse as a means of coping.

2. MENTAL HEALTH

The Tribes of Montana and Wyoming see as a strong correlation between substance abuse and trauma issues stemming from mental health disorders and have expressed concern about the lack of mental health services and a need for more mental health clinicians and professionals.

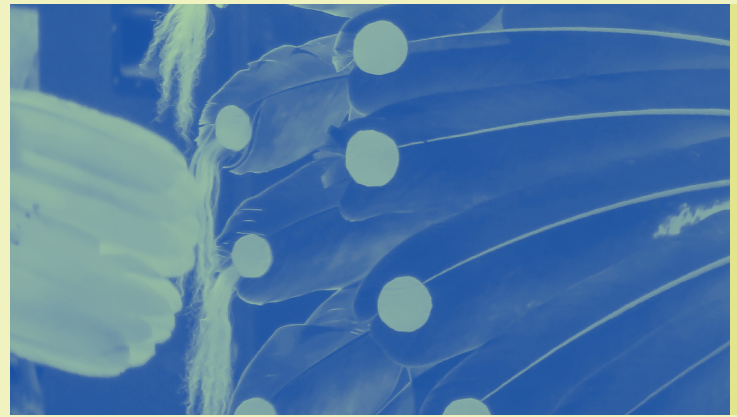
It is imperative that behavioral health and primary care services are coordinated between both the Indian Health Service and Tribes to overcome challenges with recruitment and retention of mental health clinicians and other providers such as social workers. Increased Mental Health dollars will assist with the Billings Areas ability to hire and retain quality professionals and provide improved mental health services to our patients. An increase in mental health funding for additional staff will also provide for more qualified people into the mental health workforce. Mental Health is the #2 priority for the Billings Area for the FY2021 Budget Formulation cycle for these reasons.

3. DENTAL SERVICES

Dental is a high priority for the Billings Area because it recognizes the medical and social effects of poor dental care for both elders and children. Adults utilize the IHS Dental Department for dental care and with the limited resources for basic dental procedures, acceptable operations and purchased referred care referrals, patients often go without proper dental care that in turn has a long-term negative impact on their overall health care and wellness. Dental health is persistently underfunded. Oral health services can be limited to emergency care services particularly when dentists are limited. Some of the Billings Area service units only have 2 dentists to serve entire Tribal populations. Dental assistants are also in dire need as properly trained ancillary personnel can greatly improve clinic flow and patient care. Preventive and restorative services, as well as health promotion, are often limited due to funding issues. This may be reflected in the higher prevalence of tooth loss in the American Indian populations. According to the Institutes of Medicine, tooth extraction is a common method for treating decay when financial resources are limited versus attempting to restorative services. Very few patients in the Billings Area are able to utilize private dental insurance to supplement their dental care. Pediatric care for children in the Billings Area is also very limited, but with additional funding and staffing the access can be increased. Preventive dental care in children can improve dental hygiene and decrease the need for future dental care. The budget increase can expand the dental programs further into the community and school systems with education and services. Additional funding for dental will increase access and expand the programs, which can improve patient health.

4. HOSPITALS AND CLINICS

The Billings Area understands it is important to continue to advocate for additional hospitals and clinics funding for our clinic and its staff. The operation and function of the clinic provides direct care for our Tribal members and by increasing resources for improving recruitment and retention of quality and qualified medical professionals. An increase in medical providers would help decrease patient visits in our Urgent Care and reduce long waiting time for medical appointments. Our clinics and Tribal programs are persistently underfunded. Tribal Program areas are also limited in the services they can provide every fiscal year, this is mostly due to stagnant budgets that do not increase with inflation and cost of living in rural areas. 3rd party reimbursement is highly needed to



assist in fulfilling fiscal shortfalls and providing services that are not funded through the Indian Health Service or other federal funding, including programs such as suicide prevention and oral health intervention. Specialty services that were once provided by our service units such as nephrology, pediatrics, OBGYN or urology are no longer available at current funding levels, therefore, patients are forced to drive hundreds of miles in order to receive specialty care. With communities that have high unemployment rates, this makes accessing these services particularly difficult. Third party billing offered a pathway to providing these services, however, with the current cuts to Montana's DPHHS, these programs may be in jeopardy of continuing or not able to be realized at all.

Meaningful use of electronic health records is also a present issue. The current RPMS system is lacking with limited abilities. For example, needed preventive health services for patients are difficult to identify as this function is not available with the current charting system. The outdated EHR limits clinic flow and does not allow for efficiency in the clinical setting.

5. PURCHASED/REFERRED CARE (PRC)

Purchased Referred Care will always remain a top health care priority because of the constant and underfunded need for specialized care and emergency procedures that our local clinic is unable to provide. The need for preventative services and operations maintains important in order to better manage patient health care. Properly funding the PRC program is essential to assuring patients receive health care services that are not available at our service units and preventing minor illnesses or chronic illnesses from progressing into major complications? Research has shown that prevention helps to reduce overall costs for medical care for both the facilities and the patient. A budget increase in PRC will allow for patients to be treated in a timely manner for their current conditions improving their health and also at a lower cost to

the healthcare system. With the possibility of Medicaid Expansion sun setting in June for the Billings Area, increased funding to PRC is even more of an importance for health care funding.

6. PUBLIC HEALTH NURSING

The Public Health Nursing budget is currently utilized almost completely on wages which includes benefits to retain qualified nurses. By dedicating this amount to staff personnel it allows for the Public Health Nursing program to serve our communities. Increased funding is needed for supplies (i.e. dressings and durable medical equipment) and other medical items to carry out daily Public Health Nursing functions. 3rd party billing currently assists with providing increased services to the our communities, however, with the current political climate and ensuing Medicaid cuts, revenue which allows the Public Health Nursing program to provide these additional services may be affected. An increase in public health nursing is vital in order to keep these programs running.

7. COMMUNITY HEALTH REPRESENTATIVES (CHR)

Community Health Representatives was a high priority for the Billings Area because of the unknown status of the FY 2019 Presidents Budget potentially cutting CHR from the overall budget. Community Health Representatives is a vital program in the Billings Area. The CHR program is 100% Tribally operated and run. Without the CHR program, many patients within the Billings Area would not have access to health care.

8. URBAN HEALTH

The urban health centers in the Billings Area receive approximately \$3,057,109 dollars a year. The US Census Bureau reported in 2015 that there are 37,536 American Indian and Alaska Natives living in urban settings which is 47.3% of the total population of American Indians and Alaska Natives in the Billings Area. Funding levels throughout Indian Health Service for the urban centers is not adequate for the needs the urban population presents. Some of our urban centers see a user population similar to the size that one of our Indian Health Service facilities might see in the same year operating on only a \$607,000 yearly average budget. The Billings Area I/T/U group is advocating and in support of an increase to the Urban Health budget activity program line item for the FY 2021 Indian Health Service Budget.

9. HEALTH EDUCATION

Health education is the backbone of preventive health care. Numerous studies have shown correlations between low health literacy and poor health outcomes. The Tribal Health programs in the Billings Area currently offer Diabetes, Nutrition, WIC, Diabetes prevention and a formal Health Education program. Due to restrictive funding annually, community outreach to improve health literacy is not at the desired level. School based health education can also get a message out to our youth to reinforce health education at the earliest levels. Increased funding could offer more opportunity to properly provide additional community outreach activities in order to improve health education within the Billings Area, ultimately improving health disparities that may exist

10. INDIAN HEALTH CARE IMPROVEMENT FUND

The Indian Health Care Improvement Fund was voted the 10th priority by the Billings Area because of its importance in eliminating the inequities in funding for both direct care and purchased referred care programs at both the Tribal level and also the Service Unit level. With these funds becoming recurring to the Areas there is a high importance for continued and increased funding.

CALIFORNIA

1. ACCESS TO SPECIALTY CARE

Funding for additional resources to assist with access to specialty care.

Background: Problems with specialty care access for patients arise from a combination of factors: lack of specialists at the clinics themselves; the clinics' lack of specialty diagnostic tools and equipment; difficulty obtaining specialist consultations; absence of clear lines of communication between Tribal and Urban Indian health-care clinics and specialists; and, extensive wait times for patients to obtain specialty appointments and diagnostic services at other sites.

Given the increased number of individuals who are now accessing health care in California, the availability of providers does not meet the current demand. The

Affordable Care Act added hundreds of thousands of Medi-Cal enrollees that are now competing for the same specialty doctors. The proportion of doctors not accepting new Medi-Cal patients is up to 60%. Those that are able to offer an appointment often have wait times of over a month, despite state rules requiring patients obtain appointments within 10 business days. Lack of timely access to specialty care is a significant and growing challenge that can contribute to poorer health outcomes. Since many private sector health care specialists are not accepting Medi-Cal, it has become increasingly difficult for Tribal and Urban Indian healthcare organizations to find specialty providers that will bill at the lower rate. Due to the lack of specialists in some areas, California Tribes have resorted to using PRC and other funding to pay for patient travel to specialists. Some patients will not travel these distances and their chronic conditions worsen.

Access to specialty care, especially for our underserved population, is an issue of critical importance. As the population ages and demand for specialty resources continues to climb, it is important to expand primary care resources and to reserve PRC dollars for specialty resources for patients with complex or rare disorders.

Recommendation: The IHS/CAO recommends funding for the following activities:

- Assist clinics with recruitment and retention of specialty providers
- Obtain specialty diagnostic tools and equipment for Tribal and Urban Indian healthcare programs
- Provide supplemental funds to compete with specialty care costs
- Work collaboratively with clinics to develop relationships with local specialty care providers

2. AMBULANCE SERVICE

California Tribal healthcare programs located in isolated areas are 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). 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.

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.

During the FY 2019 and FY 2020 Budget Formulation sessions, 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 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.

During the FY 2021 Budget Formulation session, additional isolated Tribes requested line items to assist in the operating costs for ambulance services. For example, Tule River Indian Tribe is launching an ambulance service and the Iipay Nation of Santa Ysabel is looking into the logistics of this as well. Without an ambulance service, their PRC dollars are depleting at an alarming rate, and they are not able to provide services in a timely manner.

Recommendation: 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.



3. IHS FUNDING TRANSPARENCY

California Tribes notice a lack of transparency by IHS at a national level.

Background: California Tribes became aware that IHS received a rather substantial increase in funding in FY 2018, but California Tribes only received a minimal increase in funding.

Recommendation: A transparent and open budget process fosters trust and allows Tribal programs to plan and budget accordingly. Announced increases in agency funding would help offset medical inflation costs if distributed equally to all Areas, unfortunately increases appear earmarked to specific programs outside the California Area, resulting in little if any actual increases. The California Area is disproportionately impacted by these small increases in funding, specifically, the tremendous backlog of the building priority list and the lack of hospitals and subsequent over-reliance on PRC funding. California Tribes request that future budget increases be distributed equitably and a detailed and transparent explanation of budget increases occur.

4. 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.

5. RECRUITMENT AND RETENTION

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

Background: Personnel vacancy rates in critical health-care 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.

GREAT PLAINS

1. WORK REQUIREMENTS FOR MEDICAID

Career Connector a South Dakota 1115 Demonstration Proposal

Background: The South Dakota Career Connector 1115 demonstration proposal would impose work requirements for Medicaid beneficiaries in Pennington and Minnehaha Counties, the two largest populated counties in South Dakota. Without an exemption receive an exemption from state requirements, dual IHS/Medicaid eligible beneficiaries would be disproportionately negatively impacted. Approximately 30% of the Medicaid beneficiaries that would have work requirement imposed on them are AI/AN. Additionally, nearly 70% of users of the IHS Rapid City Service Unit, in Pennington County are Medicaid Eligible. The requirements imposed by the South Dakota 1115 Demonstration Proposal will have a devastating impact of the existing and potential enrollment of AI/ANs in Medicaid in Pennington County. The IHS budget for the RCSU is already less than half of the level of need, so any additional loss of Medicaid Revenue will have a drastic impact on the program.

Recommendation: CMS allows states flexibility and discretion to work with Tribes to try to help them achieve their goals and determine how to best apply community engagement to serve their populations. Therefore, we recommend the following are exempted from participation: 1.) Individuals already exempted from cost sharing requirements under CMS rules; 2.) Individuals dually eligible for Indian Health Services; and 3.) Individuals exempted from participation in any state Managed Care Plan.

2. SD/ND CHSDA

Sec. 192. Of the IHCI A 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.

Background: While statutory authority exists to implement a single PRC delivery area, IHS Headquarters has indicated they lack appropriations are required to expand the service delivery to include all counties in ND and SD, as required in the IHCI A. However, the complexities of the current multiple service delivery area have left numerous IHS beneficiaries either without needed service or with undue financial responsibility for care that

should be provided by the IHS. IHS must provide needed resources to implement the ND/SD as one Purchased and Referred Care Delivery area. The viability and sustainability of implementation is even greater with the adoption of Medicaid Expansion in North Dakota and with the broadening of 100% FMAP savings in South Dakota.

Recommendation: As in previous years, the Great Plains Area requests the IHS to do the following:

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

3. OTHER HOT ISSUE DISCUSSIONS INCLUDED;

- Advocacy for Medicaid Expansion in Nebraska
- Budget Formulation Process
- Advanced Appropriations
- Restructuring the GPAIHS
- Permanent Area Director
- Permanent CEO at Lower Brule and Pine Ridge
- Increased collaboration between IHS and the Great Plains Area Tribes
- Mitigate depletion of third-party revenue due to CMS issues in the GPA
- PRC funding for sponsorship by Tribes
- Integration with EHR system and long-term care
- Lease issue 105L
- Increase IT & telehealth support
- Housing to assist in recruitment
- Methodology TA for opioid set aside funds
- Increased funding Dialysis Unit for diabetes and end stage renal disease
- Training & resources to improve billing
- PRC level of funding, distribution and regulation
- Adherence to Medicare Like Rates
- Political Interference by Federal (IHS) Employees
- CSC- Appreciate & support full funding level

NASHVILLE

1. FUNDING OBLIGATION FOR 105 (L) LEASE AGREEMENTS

ISDEAA authorizes the IHS to enter into a lease with Tribal Nations for a facility used to administer and deliver PFSAs.

Background: Historically, the appropriations for facilities has been underfunded, so 105(l) lease agreements allow Tribal Nations to collect additional funds to maintain their facilities and frees up other resources that could be utilized to deliver health care services. To the disadvantage is that IHS doesn't receive separate appropriation for 105(l) lease agreement, though, if entered into, IHS has a binding obligation to pay these agreements, in accordance with regulatory criteria.

Recommendation: Nashville Area Tribal Nations believe that funding for 105(l) lease agreements should be funded similar to Contract Support Costs, as a separate appropriation account with an indefinite amount — “such sums as may be necessary.”

2. FUNDING FOR AFTERCARE AND HOUSING PROGRAMS

When surveyed, the Nashville Area Tribal Nations reported the need for additional funding to aid those returning from substance abuse treatment programs, 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 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. CONTINUED FUNDING FOR CHR PROGRAMS

Minimal Increases to support and sustain Community Health Representatives

Background: CHRs are critical to the Indian Health Delivery System, in their roles, they help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained community members. The CHR 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.

Recommendation: Additional funding is needed to sustain and expand the current CHR program. CHRs are a vital resource for the communities and healthcare facilities within the Nashville Area.

5. CONSTITUTIONALITY CHALLENGES

Failure to recognize that AI/ANs have a unique political status within the federal government that is not based on race and, in fact, obligates the federal government with a trust and legal responsibility to ensure the highest possible health status for Tribal Nations.

Background: Recent actions by the Administration have applied a fundamentally flawed interpretation to the relationship between Tribal Nations and the U.S. government, calling federal Indian programs and accommodations for American Indians and Alaska Natives (AI/AN) “race-based,” rather than political in nature. Under familiar principles of Indian law, the Constitution explicitly addresses AI/ANs and Tribal Nations based on their underlying political relationship with the United States.

The Centers for Medicare and Medicaid Services (CMS) are currently employing this critical misinterpretation in the 1115 waiver process, which allows states to propose different service delivery and payment methodologies for their Medicaid programs. Many states have proposed adding work requirements as a condition of participating in their Medicaid programs. Tribal Nations and organizations have consistently requested that CMS exempt AI/ANs from any state-imposed work requirements, as these and other barriers to healthcare access are counter to the execution of the federal trust responsibility and ignore Tribal sovereignty.

Recommendation: Indian Country must remain vigilant and continue to challenge and oppose any efforts within the federal government—executive, legislative, and judicial—that seek to undermine the constitutionality of our relationship. The federal government, including CMS, has ample legal authority to provide AI/ANs with accommodations in administering federal programs due to the unique federal trust responsibility to Indians. Even in the absence of statute, CMS has made regulatory accommodations for AI/ANs. For example, HHS regulations implementing Title VI of the Civil Rights Act recognize and implement this principle with respect to the Indian Health System (45 C.F.R. § 80.3(d)).

NAVAJO

1. ALCOHOL & SUBSTANCE ABUSE

Alcohol and Substance Abuse continues to remain a public health concern among American Indians and Alaska Natives. Statistically, AI/ANs have the highest rate of substance dependence according to the Substance Abuse and Mental Health Services Administration (SAMSHA, 2014). The use of Alcohol and Substances continues to affect AI/AN families and communities resulting in behavioral and mental health issues, domestic violence, social issues, unintentional injury and/or suicide.

Background: Prevention, counseling services, traditional and faith-based services, crisis response, and aftercare services are necessary to help decrease and control the rise of Alcohol and Substance use in AI/AN populations. Enhancing these types of services requires funding to sustain and improve outpatient, residential, and outreach services.

In 2017-2018, the Navajo Division of Behavioral and Mental Health Services (DBMHS) provided 32,899 clinical treatment hours for counseling, aftercare, group sessions and traditional and faith-based services and provided prevention and outreach to approximately 82,370 individuals. The issue of Alcohol and Substance Abuse has many effects on an individual, their family, the community and the Navajo Nation. Therefore, it is crucial that the issue continues to be addressed and improved to decrease alcohol and substance use and to begin to restore harmony and balance of the individual, family, and community.

Recommendation:

- Increase and continued funding for prevention, intervention, and aftercare services for Alcohol and Substance Use.
- Recruitment and retention of qualified and culturally competent personnel to provide direct services.
- Continue to support client preferred services.
- Continue to advocate for providers to be able to bill for traditional and faith based services.
- Enhancing data and data sharing regarding Alcohol and Substance Use.

2. LONG TERM CARE FACILITIES

Presently, The Navajo Nation has only one State and Federally Licensed/Certified 79 bed skilled facility Level I, II and III Long Term Care Nursing Home in Chinle,

Arizona. The Navajoland Nursing Home, Inc. (NNHI) opened in 1968 under the Navajo Nation Division of Health Department but later incorporated as a non-profit 501(c) (3) under the State of Arizona due to lack of funding from the Navajo Nation.

Background: On October 22, 2018, the Navajo Nation Health, Education, & Human Services Committee approved Legislation #HEHSCO-23-18 for NNHI to become PL93-638 facility starting fiscal year 2019 in October. The facility is open 7 days a week, 24 hours a day and provides employment to 91 State Licensed individuals, a Chief Executive Officer (CEO) and five (5) Board of Directors Members. The areas that dramatically impacted the nursing homes ability to provide care services is maintaining its revenue to a level that breaks even with all payables including payroll. There have been situations where funding received through reimbursement for direct care services was insufficient to cover all the expenses incurred. Especially, after the cost of utilities, medications, and food for elders which has doubled in the past 3 years. The cost of elder supplies and food are transported from as far away as Phoenix, Arizona which is 630 miles round trip. Second is the capacity and limitation of rooms, NNHI has been full to capacity for 8 months, there is another cost of hiring additional professional health care staff.

Recommendation: Congressional funding is needed for this unfunded IHCA mandate for the following: Assisted Living Services, Section 1602, Hospice Care & Long-term care services, Section, 7702B(C) of Title 26, 25 U.S.C. Section 162d. Therefore, these funds can be provided for Operating/Maintenance and Facility Construction Costs on the Navajo Nation for health care and to keep the elders in their communities, close to home and to their related cultural and traditional backgrounds. Keeping elders near their home would teach responsibility of communities and family members caring for their own elders. This would also alleviate cost/time for Tribal members from traveling long distances to visit their love ones off the reservation where they become lonely and do not receive visitation which decreases their quality of life.

3. MENTAL HEALTH

Background: Existing challenges and disparities remain within mental health programs and services for the Navajo Area and other Indian Tribes. Limited access to mental health treatment services continues to negatively impact native communities. Insufficient levels of funding results in unsuccessful attempts to cure the Navajo

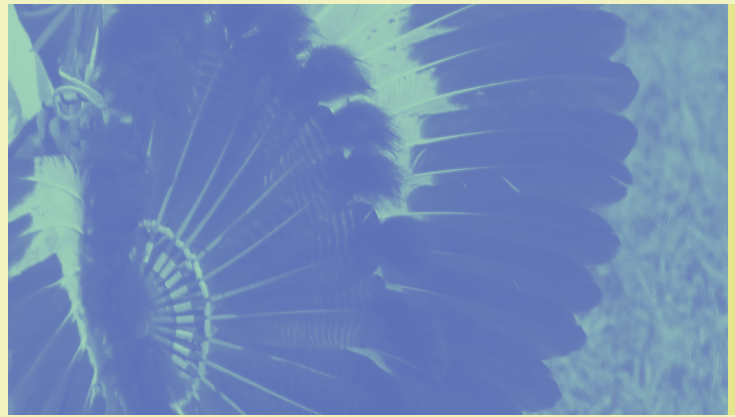
population of mental health co-morbidities, including those related to historical trauma. Navajo people and other Native American people continue to rely upon spiritual, cultural and traditional beliefs to treat mental illness. These practices are unique to Indian Tribes and are not consistently incorporated into current modern treatment methods for mental health.

Clinical research underlines a direct correlation between intergenerational trauma and mental health issues that leads to depression, violence, alcohol and substance use, generational poverty and neglect.

In many service areas, seven percent of IHS funds are allocated to mental health needs, despite the fact that mental health problems are estimated to comprise one-third of the demand for services in AI/AN populations. X Limited funding for mental health and behavioral health means that AI/ANs have few treatment options and are therefore more at risk for suicide or serious complications from mental health challenges. 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. X From 2010 to 2013, Suicide is the 8th leading cause of death for the Navajo Nation. X Currently, the Navajo Epidemiology Center is implementing a suicide surveillance system that will collect data on self-directed violence throughout the Navajo Nation. Self-directed violence includes suicide ideations, attempts, and death. The anticipated date of completion is September 30, 2020.

In 2011, the United States Department of Health and Human Services, Office of Minority Health developed an Action Plan to Reduce Racial and Ethnic Disparities. The 2011-2014 Implementation Progress Report states its commitment to the Action Plan. X It is commendable that the Secretarial Priorities state goals to improve the quality and access to care to alleviate disparities however, increased funding is needed to improve access to, and improvements to, the quality and unique development of resources for mental health treatment and alcohol and substance abuse.

Behavioral health issues also influence the physical health of individuals. Therefore, leading to ongoing and expensive treatment of co-morbidities and symptoms but, not the treatment of underlying causes of mental health issues. This places an economic burden on the monetary resources and more importantly, places a tremendous ongoing societal burden on the communities.



Recommendation: Continued and increased federal resources will enable innovative partnerships with Tribal leaders, traditional healers, community stakeholders such as churches and schools and clinicians of modern medicine to assist in the development and incorporation of traditional philosophy to the modalities of modern medicine to effectively treat the disparity of AI/ANs who suffer from mental illness. It is also a recommendation to increase funding which will enable the implementation of telemedicine utilizing culturally competent practitioners.

OKLAHOMA CITY

1. WORKFORCE DEVELOPMENT

Closely connected with quality of care issues, are workforce challenges within the Indian health system. The IHS, Tribal health providers, and Tribal public health programs continue to struggle to find qualified medical and public health professionals to work in facilities or programs serving Indian Country.

According to the Government Accountability Office (GAO) IHS has an “average vacancy rate for physicians, nurses, and other care providers of 25%. Current vacancy rates make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners is at an all-time high, the situation is unlikely to improve in the near future. What we do know, is that the IHS has been unable to meet the workforce needs with the current strategy and IHS must improve its ability to address workforce challenges if the care needs of AI/ANs are going to be met.

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 2018, 848 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, is inconsistent with the National Health Service Corp (NHSC) programs, 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 (ADA), 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.

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 direct funding and support for Tribal medical residency programs.
- 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.
- NHSC waived the scores for their loan repayment and made Tribes automatically eligible. The IHS should do the same as NHSC and waive the scores for their loan repayment and make Tribes automatically eligible.

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.

2. ESTABLISHMENT OF A SPECIAL CANCER PROGRAM FOR AMERICAN INDIANS AND ALASKA NATIVES

A large body of literature attests to the growing importance of cancer as a major cause of death and disability among AI/AN communities. Indian Health Service and other data collections indicate that cancer is now the second leading cause of death among AI/ANs, accounting for 17.3% of deaths in 2015, which is just behind the 17.9% figure for heart disease (Heron M. National Vital Statistics Report: Deaths: Leading Causes for 2016. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System; 2018.). Cancer is the leading cause of death of AI/AN women. Further, AI/ANs experience several cancer disparities when compared to US Whites. For example, cancer death rates for AI/AN men and women increased between 1990 and 2009, compared to a decrease among White men and women during approximately the same time period (White, MC. Disparities in Cancer Mortality and Incidence Among American Indians and Alaska Natives in the United States. *AJPH* 104:s376-s387; Supplement 3, 2014). These investigators reported an especially troubling disparity. The mortality to incidence ratio (MIR) for AI/AN for most of the common cancers was higher than that for US Whites. For all cancers, the MIR for AI/ANs was 0.49 compared to 0.39 for Whites. These data mean that, regardless of incidence rates, mortality rates from cancer after diagnosis are higher for AI/ANs than

are those for US Whites (White MC et alii). This disparity results primarily from late cancer diagnosis among AI/ANs, which in turn results primarily from inadequate screening programs.

The overall situation regarding cancer among AI/ANs is summarized by Guadagnolo, Petereit and Coleman (Guadagnolo BA, Petereit DG, Coleman CN. Cancer Care Access and Outcomes for American Indian Populations in the United States: Challenges and Models for Progress. *Semin Radiat Oncol.* 2017 Apr.27(2):143-149.). These authors, after an extensive review, concluded that AI/AN communities experience “poorer cancer outcomes, suboptimal cancer screening, and high-risk cancer behaviors”. Further, “AI/AN cancer patients are less likely to undergo recommended cancer surgeries, adjuvant chemotherapy, and radiation therapy than their White counterparts”. Situations in which these disparities occur include “cancer prevention, access to cancer treatment, and access to effective supportive and palliative care”. The authors also noted that “culturally tailored programs in targeted communities have been shown to mitigate the observed cancer-related health disparities among AI/AN communities.”

Recent experience with the Special Diabetes Program for Indians (SDPI) established in the Balanced Budget Act of 1997 (P.L. 105-33, Section 4922), illustrates that significant improvements can be achieved through a specially targeted program. Some of the improvements include: decrease in the rate of rise of the prevalence of diabetes from a yearly average of approximately 2.2%/yr. in 2001-2005 to 0.8%/yr. in 2006-2013; decrease in hemoglobin a1c among diabetes patients from 9.0% in 1996 to 8.1% in 2015; decrease of average LDL cholesterol levels among patients with diabetes from 118 mg/dL in 1998 to 94 mg/dL in 2015. Of special importance, from 2000 to 2011, the rate of new cases of kidney failure associated with diabetes leading to dialysis declined 43%, a larger decline than observed in any other US racial group (Justification of Estimates for Appropriations Committees; Indian Health Service, Fiscal Year 2017, Rockville, MD 20857; January 11, 2016).

These, and other experiences, clearly illustrate that challenges of cancer diagnosis and management among AI/ANs have become acute and require greater efforts at several points. The time has arrived for the establishment of a Special Cancer Program for Indians.

In Summary;

- Cancer is now second leading cause of death of AI/AN, virtually the same as for the number one killer, heart diseases.

- Cancer is leading cause of death of AI/AN women.
- The many challenges associated with diagnosis and management of cancer are enormous, especially for AI/AN.
- Disparities experienced by AI/ANs exist in all phases of cancer detection, diagnosis, treatment and aftercare.
- Much of the progress being made in cancer diagnosis and therapy is not experienced by AI/AN communities.
- Several local programs have shown the benefits of devoting special attention to problems of cancer experienced by AI/AN.
- Operation of the SDPI over the past two decades has well illustrated that improvements can be made by such a special program.
- The time has arrived for establishment of the “Special Cancer Program for Indians”, adequately funded.

3. JOINT VENTURE CONSTRUCTION PROGRAM

The OCA voices continued support for the use of the Joint Venture Construction Program (JVCP). As a partnership between Tribes and IHS, the JVCP program is cost-effective as 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 (T/TO) in JVCP projects where a Tribe 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. 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 (~\$110 million/annually), a new facility in 2017 would not be replaced for 300-400 years.
- To replace IHS facilities every 60 years (twice a 30-year design life), would need HCFC appropriations of ~\$500 million/annually.
- The IHS would need HCFC appropriations of ~\$1 billion/annually to reduce the need by 95% by 2040.
- 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 is unsustainable. IHS has been given approximately 110 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.

It is urgent and necessary that the Joint Venture Construction Program be opened for competition on a regular bi-annual cycle with no queue creation, because unfortunately since its inception, the JVCP has only solicited project applications a handful of times. Therefore, as long as Tribes have an interest and ability to pay for facilities and equipment with their own funding, the OCA requests that IHS announce a new cycle for the Joint Venture Construction Program applications bi-annually. The JVCP is a cost-effective investment, and a true partnership; most importantly, it will increase access to care in the OCA.

4. FUND CONTRACT SUPPORT COSTS FOR GRANT PROGRAMS AND CONCLUDE THE PRACTICE OF GRANT MAKING

There are four reasons the OCA supports the funding of CSC for grant programs in addition to that which is awarded for each grant project. First, Congress is appropriating indefinite appropriations for CSC based on estimated need and therefore IHS is no longer in a Contract Support Costs “shortfall” funding environment. Second, statutes do not exempt special initiative projects or grant funding from the CSC mandate. Third, regularly preparing competitive and non-competitive continuing grant applications and managing grant programs and reports is administratively burdensome. Last, when CSC is not awarded, indirect costs are taken from within a grant award, resulting in less funding to provide direct services. The OCA applied an average indirect cost rate of 25% to special initiative grants and estimates that the proposed unmet need for CSC is roughly \$13 million – just a fraction of the total CSC need identified in previous presidential budget requests.

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. 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 health programs and services cannot be effectively and efficiently operated if they are forced to operate on grant funding. Therefore, OCA recommends that the practice of grant making be concluded and a permanent recurring base be developed for Tribally-determined programs and services.

5. FUNDING FLEXIBILITIES TO HELP DIRECT SERVICE TRIBES

Fundamental changes in the organization of health services for American Indians and Alaska Natives during the past thirty years have resulted in disparities impacting the Direct Service Tribes (DST) to include:

- Limited funding by Continued Resolutions impacting the quality of care provided by the Service Units

- Inability to reprogram funds between one line account to another enforcing limited funds for specific programs
- Inadequate administrative funding and personnel which leads to restrictive salaries for medical professionals and inadequate support in offices such as procurement, human resources, finance, etc.
- In order for Indian Health Service (IHS) to reduce these disparities among the DST organizations, IHS must be granted the following authorities.
- Receipt of funds in a single allocation at the beginning of the fiscal year so that Direct Service Tribes are able to receive quality, timely care unrestricted of limited funding (Continued Resolution)
- The ability to reprogram funds between account lines to better serve direct service Tribes in the programs requiring an increased support in funding
- IHS to receive 2- year authority rather than 1-year authority to be able to serve and support direct service Tribes in the highest quality

6. DEVELOPING A REGIONAL TREATMENT CENTER

Indian youth in the Oklahoma City 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
- 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

Three 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 regional residential (inpatient) treatment for substance abuse/dual diagnosis youth.

The Oklahoma City 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 in Tahlequah, which is in the extreme northeastern portion of the state. 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 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 regional treatment center would improve the overall outlook for youth who are in need of said treatment.

A regional 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.

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: The actions requested by Tribal Leaders in the Phoenix Area that support full funding for the IHS include the following:

- Secure advanced appropriations (2-year funding cycles) for the IHS.
- Enact mandatory appropriations for the IHS.
- Provide additional funding in FY 2021 for three Phoenix Area priorities in the Indian Health Care Improvement Act (IHCIA) that was permanently reauthorized in 2010:
 - » A program increase is recommended for the Health Care Facility Construction line item for HCFC projects on the current priority list of which funds are

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 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 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.

- Provide additional funding in FY 2021 to the Dental line item to reduce oral health disparities. 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 2021 to the Maintenance & Improvement line item to reduce the backlog of deferred maintenance that's reported by IHS.
- Provide additional funding in FY 2021 to the medical Equipment line item to address needs at new facilities and the replacement and repair of older equipment. 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. Increase program funding to replace equipment on a 7 year cycle.
- 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 (+\$46 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 CHRs.

Recommendations: Tribes in the lower 48 states recommend that the FY 2021 budget include the necessary resources to extend CHAP, including Dental Health Aide Therapy to the lower 48 states. The Phoenix Area recommends program increases.

4. 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 the IHS nor the Bureau of Indian Affairs receive an appropriation for this purpose, nor 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 receiving information about state initiatives to address prescription drug abuse and the opioid epidemic. SAMHSA Opioid Abuse Grants were provided to the states 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 2021 that an increase be added to the Hospitals & Clinics line item to address opioid high risk infant care and an increase 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. 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 2021 for EMS in the Hospitals & Clinics line as these programs have not received a substantial increase to their base funding for years.

7. 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 to the Indian Health Professions line item in FY 2021 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.

8. 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.

9. FUND IHCA FOR LONG-TERM ELDER CARE CENTERS & HOSPICE

There is a high need for our Tribal elders to have a Tribal facility to meet their aging needs. Most elders do not have family members who are either living and/or are not able to care for them due to incarceration, drug addiction or the family members are currently in a medical or rehabilitation facility themselves.

Background: Our PRC funds do not currently cover the cost for these services. Elders also have an issue signing over their monthly benefits to qualify for Medicaid/Facility benefits. Right now our Tribal elders are being helped as much as possible but there is a very high need here on our reservation/colony. Clinic's budget does not allow for a full time caregiver, and the clinic is very short staffed and the rate of pay is very low for retaining employees and recruitment. Risk of abuse in all forms but, financial, and emotional, are among the highest on our YPT reservation. If our elders had a care facility to meet their individual cultural needs they would feel better about living in a facility with familiar faces, close inter-generational visits, nutrition choices, and a traditional environment.

Recommendation: Tribes recommend that the concerns of the Yerington Paiute Tribe and other Tribes affected by the unfunded IHCA authority for long-term Elder Care Centers and Hospice be addressed by funded for \$50 million in Hospitals and Clinics.

PORTLAND

1. ADVANCED APPROPRIATIONS & EXEMPTION FROM SEQUESTRATION

Background: Indian Health Service is currently funded through annual appropriations. Incremental funding received through Continuing Resolutions makes it difficult for Indian Health Service, Tribal and Urban (I/T/U) health programs to plan, budget 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. Additionally, sequestration in 2013 resulted in an approximate 5% reduction in recurring funds. This loss of funding eroded the purchasing power of an already underfunded system.

Recommendation: Provide advanced appropriations to the Indian Health Service. This has 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: Value Based Payment (VBP) models are being adopted by states to reform how health care is delivered and paid under Medicaid. 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: Assist in educating tribes on VBP models, including metrics, expected outcomes, incentives and penalties to ensure Tribes can maximize collection revenue.

3. ELECTRONIC HEALTH RECORD REPLACEMENT & INFORMATION TECHNOLOGY

Background: The Veterans Administration's (VA) transition to Cerner 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. Limited broadband access in rural areas is also a concern as patient portals under a new system and telemedicine require high speed internet access.

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 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. Some Tribes have already purchased and transitioned to a new electronic health record (EHR) system. Portland Area Tribes, who have already transitioned, request consultation to ensure integration and inclusion. Portland Area Tribes also request increased broadband access in rural areas to allow patient access to patient portals and for telemedicine.

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 and support 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 USE DISORDER

Background: AI/AN people have 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 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. Traditional healing among AI/ANs is a powerful cultural practice associated with relief from distress. It strengthens ethno cultural identity, community support systems, and political empowerment, all of which have been identified as pathways to resilience for indigenous populations.

Up to 74% of AI/AN youth have experienced at least one traumatic event during childhood. AI/ANs are 2-3 times more likely to meet PTSD criteria compared to the US adult population. AI/ANs are 2.5 greater risk than the national average of experiencing physical, emotional,



and/or sexual abuse. In addition, AI/AN communities experience a layering effect of these conditions along with historical trauma. Many health care organizations and federal agencies are moving to a trauma informed care (TIC) approach to address these adversities. TIC assists in building a safe and trustworthy health care system for both patients and employees, increases collaboration and choice of care, and empowers individuals.

A survey of over 1,000 U.S. adults by the American Psychiatric Association (APA) found that anxious feelings increased the most over the past year among baby boomers (between 54 and 72 years of age) in comparison to Generation Xers (38 to 53), and Millennials (20 to 37). However, Millennials continued to be the most anxious overall. Individuals aged from 20 to 29 years in developed nations are three to four times more likely to die due to opioid use disorders than they were 20 years ago, as per the data from the Institute for Health Metrics and Evaluation. In face of genetic predisposition, a significant self-medication hypothesis is often overshadowed in understanding the cause of addiction. Self-medication is the use of mind-altering substances to find relief from anxiety or depression. What further complicates matters is if self-medication is the cause of substance abuse, the underlying anxiety or depression is often overshadowed. In such cases, it is crucial to acknowledge that substance abuse is the result of a mental health disorder, not just an independent entity. We know that AI/AN individuals have disproportional deaths from over-dosage of prescription and non-prescription medications.

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 (TBHA) in December 2016 (see <http://store.samhsa.gov/product/PEP16-NTBH-AGENDA>). Portland Area Tribes recommend increased funding to implement the TBHA to improve the behavioral health of AI/AN with inclusion of traditional healing practices. Fully fund IHICIA 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. Due to wide spread incidence of trauma in the AI/AN population, Portland Area Tribes request that a trauma-informed approach be implemented in any type of service setting. Funding is needed to address trauma informed care across all tribal programs. The issue of millennials self-medicating for anxiety warrants immediate action.

6. FOCUS ON PREVENTION

Background: Funding distributed by Indian Health Service is heavily 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.

Many leading causes of mortality among AI/ANs are preventable through early intervention, including prevention of obesity and encouragement of physical activity and overall wellness. It is important to ensure that the I/T/U health care system are able to address health promotion activities in addition to addressing high priority illnesses. 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.

Recommendation: Portland Area Tribes recommend funding increases to health promotion, disease prevention programs, and data collection to include monitoring and efficacy of prevention activities. They also recommend expansion of programmatic funding to incorporate traditional practices. It has been shown that incorporation of traditional medicine and ceremonies greatly enhances health and well-being and AI/ANs.

7. COMMUNITY HEALTH AIDE PROGRAM (CHAP)

Background: Portland Area Tribes would like full implementation of Alaska's model Community Health Aide Program (CHAP) in the Portland Area. Some Oregon and Washington Tribes have already integrated Dental Health Aide Therapists (DHATs) into their clinics. IHS has convened a CHAP Workgroup focused on expansion of

the CHAP in the lower 48. It would increase the number of AI/AN health, oral health, and behavioral health care providers available to tribal communities, increase access to culturally competent care into tribal communities, create more efficient and effective health, oral health, and behavioral health teams that can meet the needs of the tribal communities, establish cost effective solutions to the health, oral health, and behavioral health challenges into Tribal communities, and bring care where it is needed most.

Recommendation: Expand the CHAP program, allowing for certification at the Area level. Portland Area Tribes are further along than tribes in other areas in their implementation of DHATs and wish to continue expansion of CHAP to include DHATs, Behavioral Health Aides/Practitioners and Community Health Aides/Practitioners. Authorities need to be established to ensure that the services provided by these providers are authorized to be billed through Medicaid or Medicare reimbursements.

8. ACCESS TO TREATMENT FOR HEPATITIS C

Background: American Indian & Alaska Native populations have the highest incidence of acute hepatitis C virus (HCV) and the highest rate of HCV-related mortality relative to other racial and ethnic groups. CDC data show a slight decline in HCV-related mortality rates in all races, although among AI/AN it remains more than double the national rate, which in turn has led HHS to declare AI/AN a priority population in the National Viral Hepatitis Action Plan. Current HCV treatments are highly effective and greatly reduce liver disease, hepatocellular carcinoma and mortality. HCV treatment is highly successful at the primary care level. Unfortunately, HCV treatments remain costly to I/T/U facilities, which has been a barrier to many receiving treatment. The lack of access to acceptable treatment has increased 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: Portland Area Tribes recommend expanded HCV programming with emphasis on screening and access to care for HCV positive patients. 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. Portland Area Tribes also recommend additional funding for Indian Health Service to implement a similar policy as the Veterans Administration (VA) to ensure all patients with HCV are treated and to eliminate HCV from AI/AN communities.

9. PUBLIC HEALTH

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, negatively impacting smaller and geographically dispersed tribes. Portland Area Tribes request funding to address detrimental consequences that could result from public health emergencies.

Mutual aid agreements (MAAs) and other types of assistance agreements facilitate the rapid sharing of emergency aid and resources among governments and organizations at all levels. Identifying MAAs and cooperation agreements, through which the tribe and its agencies can receive or provide aid, can be a daunting task for small tribes. Portland Area Tribes are also interested in obtaining public health accreditation and need technical assistance and resources to attain accreditation (e.g., model Tribal public health codes).

IHCIA, Sec. 130. Epidemiology Centers, confers to epidemiology centers the status of public health authorities for purposes of the Health Insurance Portability and Accountability Act of 1996. While this service is mandated in Federal Law, Portland Area Tribes do not feel it has been adequately funded.

Recommendation: Dedicated public health funding to address the development of MAA with states, counties, municipalities, other tribes and organizations. Additionally, there is a need for training to enhance understanding of how MAAs are operationalized by agencies and programs in with whom tribes have MAAs.

Model Tribal Public Health Codes should be developed and made available as templates to interested tribes. The tribes request technical assistance for effective implementation of these codes to allow them to obtain public health accreditation.

Portland Area Tribes request increased Public Health funding to cover expanded public health activities beyond immunization programs and public health nursing. The Tribes request additional budget line items and funding to better represent the broad public health needs among all AI/AN, including full funding for tribal epidemiology centers.

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 be available for a wide-range of emergencies and their overall impact within a community. Tribes request additional resources, training and support so that, if and when disasters occur, each tribe understands when and how to access emergency assistance.

10. REGIONAL REFERRAL CENTER

Background: Portland Area Indian Health Service does not have hospitals or specialty centers, which forces tribes to rely on Purchased and Referred Care (PRC). Additionally, Portland Area 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 per the IHCIA 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 is 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. With the expansion of Medicaid and Medicare and the new funding authorities for Veterans Administration (VA), tribes are concerned with the ability to be competitive in order to

attract 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.

Workforce training and professional development are essential for staff recruitment and retention. Staff need training in trauma informed care, medication assisted treatment, and also training to improve medical service delivery capacity. It is helpful to have funds to train staff who are committed to Tribal health organizations thus reducing turnover and the need for constant recruitment.

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 IHCIA section 112, 132 as well as 134 would 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.

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 increased ability for UIHO's to collect revenue and 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 experience 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: 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. Written Asthma Action Plans can assist individuals to better manage their disease. Portland Area Tribes recommend that Indian Health Service providers receive training in developing plans and work with patients to implement them. Additional funding for training and remediation for tribes dealing with housing contamination due to clandestine drug labs and substance abuse within homes. Indian Health Service has partnered with agencies such as Agency for Toxic Substances and Disease Registry (ATSDR) to train tribal housing staff. Additional funding needs to be devoted to these programs to ensure they can be delivered consistently to all tribes within the region. Increased Sanitation Facilities program funding could target evaluation and maintenance of current water systems to help mitigate or treat contamination from heavy metals such as lead and other harmful substances.

14. OB/GYN SERVICES THE CONFEDERATED TRIBES OF THE COLVILLE INDIAN RESERVATION

Background: There are no IHS hospitals or specialty clinics in the Portland Area. Of particular concern, to the Colville Tribe, is the potential closure of a regional hospital which provides labor and delivery services to Tribal members. Tribal members must then travel to the nearest labor and delivery hospital system, which conservatively is 140 miles, or almost a three hour drive during optimum conditions. This is not acceptable for women in active labor.

Recommendation: Confederated Tribes of the Colville Indian Reservation request access to labor and delivery services and funding for specialty services for OB/GYN services at Colville.

15. MISSING AND MURDERED AI/AN WOMEN

Background: AI/AN women are murdered on some reservations at a rate more than ten times the national average. Although data is limited, the number of missing and murdered AI/AN women and the lack of resources is a major concern to AI/AN women, tribal governments, and communities.

Recommendation: Portland Area tribes recommend partnering among IHS, Department of Interior, Department of Justice, and other federal agencies and local law enforcement to protect AI/AN women.

TUCSON

1. MENTAL HEALTH

Numerous barriers prevent access to care on the Tohono O’odham Nation (Nation), such as psychiatric services for mentally ill clients. The average time for a client to receive psychiatric services is at least two months and the majority of services are conducted outside of the Nation. Due to the rural location, clients must travel great distance to obtain services, which often leads to non-compliance. In addition, it is difficult to recruit and retain qualified mental health professionals.

The recent increases in behavioral health funding has only been allocated through limited time sensitive competitive grants. There are time constraints in the grant process to award funding which creates a barrier to address behavioral health crises and interventions.

The majority of Tribal members are Medicaid eligible and are enrolled with American Indian Health Plan (AIHP), under the state Medicaid Program, Arizona Health Care Cost Containment Services. Unfortunately, most providers do not accept AIHP due to contractual obligations and reimbursement rates creating a disconnection for members to receive behavioral health services.

Background: Approximately half of the 34,500 enrolled Tohono O'odham members live throughout (11) governmental districts on the vast reservation. Some of these villages are very remote, with no electricity, running water, telephone services, or internet access.

The unemployment rate for the population over 16 years of age is 55%. In 2010, 41% of the on-reservation population live below 100% of the Federal Poverty Level (FPL) and 40% have earned a high school diploma or equivalent. Due to limited services available, many individuals are not able to receive services for mental illness or emotional disorders and may use or abuse alcohol or drugs. According to the CDC, the following risk factors put the Nation at increased risk for numerous public health and social issues: young age, low income, low academic achievement, unemployment as well as a number of other factors.

Recommendation: Recommend direct funding to implement new specialized providers, therapists, clinicians and physicians to enhance services; which include developing interventions for pre/post suicidal preventive programming. An increased budget allocation will establish an after-hour on-call crisis team, recruit case managers and develop a referral system for inpatient treatment, medical detox, and psychiatric hospitalization. Lastly, to hire psychiatric providers and cover the cost of psychiatric mediation for uninsured individuals.

2. IT ELECTRONIC HEALTH RECORDS (EHR)

The need for on-going technical support and an Electronic Health Record system when RPMS is no longer supported by IHS.

Background: The Resource and Patient Management System (RPMS) is a suite of over 86 applications that allow data sharing, storage and evaluation covering the array of Health Information and Resource Management needed to provide comprehensive health care to Native American and Alaska native patients.

RPMS was developed with a joint collaboration with the Veterans Affairs Health Care Division. From its incitation in the late 1980's, RPMS has grown to be the most comprehensive Health Information system under one umbrella. Using one patient database, all applications, from Patient Registration, Pharmacy, Laboratory, Case Management and Inpatient and Outpatient Care Services are among the application suites can share data to provide a complete Medical Record.

Starting as a clinical based system, the ability to submit and obtain Three Party Resources (Medical Insures) was gained, and RPMS also became a Resources Management system. For almost 40 years RPMS has been the primary tool for Indian Health Service and Tribal Programs to conduct the need for Health Information Management.

With the passing of time, RPMS needed to have a more modern database approach. To this end, applications were adapted using Graphical User Interfaces (GUI's) to mirror displays of data more in line with presentations similar to application one would use at home. Examples, Windows products like Office application, others software as used in TurboTax and the like. This effort brought about IHS version of the Electronic Health Record. The EHR became the standard for collection and displaying a comprehensive picture of a complete patient record in electronic form. Several other GUI based RPMS application were generated, Laboratory Service, Icare, Patient Management and Behavioral Health. This process increase the efficiency of data collection and mining required by Congressional mandates for HIPPA and Meaningful Use. These changes were aligned with the Veterans Affairs efforts along the same lines.

From the onset, a goal predicated by Congress was to have Health Information Systems that would be able to easily commutate between all Health Care systems that Government Department used, Department of Defense (DOD), Veterans Affairs (VA) and Indian Health Services (IHS). Much effort in money, time and Human talents were expended in completing this task, with little success.

That lends us to a new task at hand, lend by DOD ongoing purchase of a commercial package to provide a comprehensive Health Information System. DOD has started this process with a goal to have it operational within ten (10) years. Following DOD's lead, the VA, has announced their coming switch to the same commercial package. The VA's target date in to begin in 2020 and implementation is estimated to take ten (10) years.

With a closely aligned system (RPMS) to the VA (VistaA) Health Information it, and support from the VA is high critical to the IHS, it is imperative that the VA can and would continue to support RPMS until they have completely instituted their switch to a commercial package. This has been agreed upon by the two parties.

With that in mind, the Pascua Yaqui Tribe, an ardent user of RPMS, needs to monitor the development of DOD, and VA endeavors closely. As ten years can slip by fast.

Recommendation:

- Begin the task of exploring an alternative Health Care system with a comprehensive approach to the Tribe's needs, including aligning with the commercial package DOD and VA are looking at, Cerner.
- Provide resources to research different packages such as funding to travisit Tribal sites and view systems that are not RPMS based.
- Expand contract with Cimarron Informatics to help in research of new systems.
- Formulate a team to research new products for Health Information Systems
- Continue to support Infrastructure improvements, increase bandwidth, as new system are highly likely to be cloud based. This does bring a single port of failure without redundant paths to the cloud.
- Know this, despite which way the PYT goes, some critical functions that are inherent in RPMS, will most likely not be available in a commercial package (example: NextGen (used by El Rio) without paying for them. DOD is not getting a specialized version of the commercial package, it is apt to be, off the shelf

3. CONTINUE FUNDING FOR THE CHR AND HEALTH EDUCATION PROGRAMS

To provide Tribe's continued and on-going funding for the Community Health Representative (CHR) and Health Education Programs (HE).

Background: "The Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs have demonstrated how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs are great advocates, in part, because they come from the communities they serve and have tribal cultural competence. Their dedicated work has assisted many to meet their healthcare needs. The health promotion and disease prevention efforts that CHRs provide have also helped people from the community improve and maintain their health. By providing health education and reducing hospital readmissions, CHRs have contributed to lowering mortality rates. The demand for CHRs continues to grow" (Indian Health Service (IHS). (n.d.). Retrieved December 28, 2018, from <https://www.ihs.gov/chr/>).

"The Health Education Program mission is to provide basic information about the Indian Health Service Health Education Program that encourages a partnership with



American Indian/Alaska Natives that results in American Indians and Alaskan Natives becoming active participants in the improvement of their health status. Believing that many of the health problems found in American Indian and Alaskan Native communities are the result of behavior and lifestyle choices, the Health Education program is committed to an emphasis on wellness through health promotion and disease prevention" (Indian Health Service (IHS). (n.d.). Retrieved December 28, 2018, from <https://www.ihs.gov/healthed/index.cfm?module=she>).

Recommendation: The Tucson Service Area allocated additional funding into the Community Based Services to support this Hot Issue.

4. PERMANENT DIRECTOR

Indian Health Service has not had a permanent Director since 2015.

Background: Since 2015, a permanent Indian Health Service Director has not been appointed by Congress. Four interim Directors have cycled in and out since then. Currently, there is an acting Director in this position.

Recommendation: A permanent IHS Director needs to be appointed to provide stable leadership to address the mounting attacks against Tribal sovereignty and IHCA.

Notes



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