



Indian Health Service

NIHB National Tribal Public Health Summit

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Indian Health Service Update

by

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Good morning. I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). It is a real pleasure to be here with you today at the annual National Indian Health Board (NIHB) Tribal Public Health Summit.

I am grateful for this summit's focus on public health because it's a fundamental part of restoring our communities to wellness. My public health training was really key to my realizing that health and wellness are more than just seeing patients in the clinic. While that is important, there is so much more that needs to be done in our communities to reduce health disparities.

So thank you to the NIHB for convening this important annual forum for public health.

I want to start with an update on the IHS budget, which is a huge factor in our ability to improve the IHS and address health disparities in Indian Country.

We've received increases in the IHS budget each of the last 4 years. Overall, the IHS budget authority has increased 29% since fiscal year (FY) 2008. Within this increase, there have been some significant targeted increases, such as the 46% increase in Contract Health Service (CHS) funding, that have really made a difference. More funding means more patients are getting the referrals they need. In fact, at some facilities, patients are having referrals paid for beyond Priority 1 – life or limb.

All of these increases were achieved in partnership with Tribes and with the support of this Administration and Congress. It shows that when we all work together on a common goal, significant progress can be made.

The text is the basis of Dr. Roubideaux's oral remarks at the annual NIHB Tribal Public Health Summit on June 18, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.

However, FY 2013 is a different story. We're working on implementing the IHS FY 2013 final budget authority of \$4.1 billion, which is lower than the FY 2012 budget of \$4.3 billion. The FY 2013 budget does include an increase of \$53 million for additional staffing for new health care facilities, which is great.

But it also includes rescission cuts of \$8 million and sequester cuts of \$220 million. This means IHS has a total of \$228 million in across-the-board budget cuts that are being made in the allocation of funds for the remainder of the fiscal year.

IHS is engaged in extensive planning and implementation efforts to absorb the cuts associated with sequestration on the federal side. Tribes should have received information by now about what to expect for their final base funding levels for FY 2013. Areas have been preparing and making payments to Tribes.

I know that the impact of sequestration is significant for Tribes – they are dealing with sequestration cuts to several funding sources across the federal government.

Although there is much budget uncertainty, I know we're all doing what we can to protect our core mission to the greatest extent possible.

IHS has posted its operating plan for how the across-the-board cuts impact the IHS budget and each line item. We have already implemented a number of cost-saving changes to the way we carry out our work, including many reductions in administrative functions such as travel reductions, new restrictions on conferences, delayed or reduced purchasing and contracting, hiring delays and lapsing of positions, and enhancement of third-party collections.

You may have also heard about the efficiency in spending initiatives that require federal reductions in travel and strict conference approvals and oversight. As a result, we're holding more virtual meetings to help reduce travel and training costs. We're noticing that these virtual conferences allow more Tribes and individuals to participate who otherwise would not have been able to travel, especially given the travel restrictions. So we're actually reaching more people.

Sequestration also means that there is a 2% reduction in Medicare payments to all facilities. However, we recently got good news on our calendar year 2013 Office of Management and Budget (OMB) all-inclusive rates, and the increases in Medicaid and Medicare visit rates will help offset that reduction. These rate increases are retroactive to January 1, so that's more resources for all of us. So there is at least some good news to report.

We're doing everything we can to eliminate the need for sequestration and to get the IHS budget back on track. That's why we're supporting the FY 2014 President's Budget Request, which was released on April 10. It has enough deficit reduction to replace sequestration entirely, but still protects important priorities such as IHS.

The FY 2014 President's Budget proposed a 2.9% increase in budget authority for the IHS from the FY 2012 enacted level, with a total budget request of \$4.4 billion, which helps get us back to where we need to be – continuing the upward trend of the IHS budget.

This adds \$124 million to the IHS appropriation compared to FY 2012, and includes increases of approximately:

- \$35 million for the CHS program, which is under proposal to be called the Purchased/Referred Care program;
- \$77.3 million for staffing at new and replacement facilities, which we believe will help us catch up on almost all the new staffing needs in FY 2014;
- \$6 million for pay increases for federal and tribal staff; and
- \$5.8 million to partially address the shortfall in Contract Support Costs.

If the proposed budget is enacted, the IHS discretionary budget will have increased 32% since FY 2008. We are so grateful that Secretary Sibelius and the Department of Health and Human Services (HHS) have made the IHS budget a priority.

In preparation for the FY 2015 budget, we held our FY 2015 national tribal budget work session in February, and the tribal workgroup presented their national recommendations at the HHS Tribal Budget Consultation that was held in March in Washington, D.C. The workgroup met again recently to finalize their recommendations, based on the outcome of the FY 2013 budget and the FY 2014 President's Budget Request. We are now in the middle of our internal budget formulation process with HHS. This work continues until the President's FY 2015 Budget Request is announced next spring.

Now I'd like to provide a progress update on our agency priorities.

Our first priority is to renew and strengthen our partnership with Tribes. Working to improve tribal consultation is an important part of this priority. We've seen evidence throughout our system that we accomplish more when we work in partnership with our communities. I appreciate our partnership with the NIHB; thank you all for your support and assistance.

We have done a lot to improve consultation at the national, Area, and local levels. We have held Area listening sessions with all 12 Areas each year since I became Director, either in person or by phone or videoconference. We have also held many tribal delegation meetings, regularly meet with tribal workgroups and advisory groups, and attend tribal meetings and conferences, such as this one. We hope to hold a "virtual" Tribal Consultation Summit this summer. We will be sending out details soon.

Meeting with tribes and tribal organizations, such as the NIHB, is a very important part of our consultation efforts. We need and appreciate our partnership with you as we work together to end health disparities in Indian Country. I value the time we take to discuss issues, share information, and consider options to make progress. As partners, your advocacy, together with mine within the administration, has resulted in many improvements over the past few years, and given all we're facing, our partnership has never been more important.

Area listening sessions are also an important venue for me to hear about Area and local issues. And I meet regularly with tribal advisory groups, including the Tribal Self-Governance Advisory Committee and the Direct Services Tribes Advisory Committee. And of course Tribal Delegation Meetings are a vital part of our efforts to partner with Tribes in addressing health issues in Indian Country.

We have conducted a number of tribal consultations in the past few years, and we have concluded or made decisions on many of these. I would like to highlight four of them today.

The first is the consultation that started in 2010 on improving the Contract Health Service (CHS) program, which is how we pay for referrals for services in the private sector. I recently sent out a letter with the Tribal CHS Workgroup's third set of recommendations, which included a recommendation to keep the funding distribution formula for new CHS increases the same, and to protect the base CHS funding.

We also have made significant progress on gathering better data on CHS denials and deferrals. For FY 2012, the shortfall for CHS was \$973 million – almost a billion dollars of need beyond our funding. That's why CHS is a priority in budget formulation, since this impacts all Tribes.

The second consultation is on Health Care Facility Construction – we initiated a consultation last July, and issued a call for nominations for the new Facilities Appropriations Advisory Board. We have finally selected members and will hold our first meeting by phone once the announcement of membership goes out – letters are being prepared.

The third consultation is with the Department of Veterans Affairs (VA) through a memorandum of agreement that was signed in 2010 and the recently signed VA-IHS National Reimbursement Agreement. The agreement implements Section 405 of the Indian Health Care Improvement Act, and serves as the agreement for all IHS federal facilities. Through this agreement, VA can reimburse IHS for direct care services to eligible American Indian and Alaska Native veterans. The VA announced in August 2012 that tribally-managed facilities can negotiate agreements with the VA directly, and this new national VA-IHS Reimbursement Agreement can be used by tribally-managed programs as well.

We are making progress in improving coordination of care for veterans eligible for IHS and VA. Tribal input was critical to ensuring that the final agreement contained the OMB all-inclusive rate for outpatient services, which helps so many of our programs. The initial 10 federal sites are now billing the VA, and I understand one of them has actually received a payment! That's more dollars for services for everyone served by the facility. We are proceeding with all other federal sites.

And the fourth consultation that has been ongoing since last year is the consultation on Contract Support Costs (CSC). This is an issue of great importance to tribal self-determination and self-governance. It started last year with a request to review the CSC policy; then the Supreme Court ruled last June in the Salazar vs. Ramah Navajo Chapter case. The decision impacts two areas – past CSC claims, and future appropriations. I will talk about that in a minute.

In terms of past CSC claims, the IHS goal is to resolve all claims for CSC as quickly as possible and through settlement wherever possible. We are making progress.

The usual process is that Tribes submit claims to IHS; we deny them; the Tribe appeals; and then a settlement is reached, which is paid out of the Judgment Fund. This is the process defined by the Contract Disputes Act. We do not have a class action like the Bureau of Indian Affairs (BIA).

While there are some differences between how tribal lawyers and how the Administration interpret the Ramah decision, the Office of General Council (OGC) has worked with tribal lawyers to develop a case management plan for appealed claims that prioritizes settlement discussions. This plan was approved by the Judge on April 16, 2013. We are working with the Department of Justice to establish a similar plan for cases appealed to federal court.

My tribal leader letter in March indicated a decision to extend the time for discussion of claims before the agency denies them, and even before they have been appealed, as was requested by tribal lawyers.

We've recently developed two options for settlements. This is based on input that each Tribe should have the right to decide for themselves how to settle their claims. Some Tribes, for instance, may decide that the paperwork involved is too burdensome and they just want to put these claims in the past.

So the first option, the traditional approach, is what we are already doing – having in-depth discussions and exchanging documentation to reach a number that we can agree upon for settlement. The second option, which is new, is a simpler, or alternative, approach. Upon request, we will offer a non-negotiable, lump sum for settlement based on our paperwork alone. If the Tribe likes it, we are done. If they don't, then we return to the in-depth discussions.

We're hoping this simple approach helps us get through some of the claims in a more efficient manner. We can try this for a few months and see how it goes. Again, if a Tribe is interested in exploring their options, they can contact our OGC through their lawyer, or schedule a headquarters level Tribal Delegation Meeting.

We hope this progress is good news and demonstrates our goal to resolve these claims quickly and efficiently, through settlement if possible. You can read the latest update on CSC in my June 12 tribal leader letter, which is posted on the IHS website.

In terms of CSC appropriations, we have heard that tribes are upset with the administration's proposal on new appropriations language. The administration considers this a short-term solution, and BIA and IHS are consulting with Tribes to determine a more long-term solution, in the context of the difficult budget climate we face and multiple competing budget priorities. Your input is welcome.

Our second IHS priority is "to bring reform to the IHS." This priority has two parts – the first part involves the Affordable Care Act (ACA) and the Indian Health Care Improvement Act. The second part is about internal IHS reform.

The benefits of the ACA for American Indians and Alaska Natives are significant. They can benefit from all the reforms, whether they have insurance now, want to purchase affordable insurance through the “Health Insurance Marketplace,” or can take advantage of the Medicaid expansion starting in 2014. Indian elders will benefit from how Medicare is being strengthened with more affordable prescriptions and free preventive services. We know that some states are not choosing to expand Medicaid, but we hope they change their minds soon.

And of course, we’re thrilled that the Indian Healthcare Improvement Act (IHICIA), our authorizing legislation, was made permanent by the ACA.

An important date is coming up soon – October 1, 2013 – that’s when enrollment begins for the ACA Health Insurance Marketplaces and the Medicaid Expansion. And the time to get ready is now.

IHS has developed a business planning template to help ensure our facilities have the opportunity to benefit from their patients’ increased access to affordable health coverage, as this could mean more resources through third-party collections. The template covers understanding the local health insurance market and the potential patients who might enroll; assessing the workload for the facility, including the business office and the CHS program; and looking at marketing for staff and patients to ensure they know what to do and that they want to continue to receive their care at the facility.

A copy of the planning template was sent to all IHS Service Units – it’s required for federal sites, and recommended for tribal and urban Indian health programs.

Another important item is the recent announcement about the Essential Community Provider (ECP) requirements. The Qualified Health Plans (QHP) that will offer insurance for purchase in the Health Insurance Marketplaces in 2014 are establishing networks and should be working with our local sites. The IHS/tribal/urban Indian health program (ITU) QHP Addendum is now available to help explain the special authorities for working with ITU facilities. We’re also working on Contracting Guidance for Service Units when they enter into agreements with QHPs, and we will share this guidance when it’s completed.

And HHS recently provided technical assistance to the Senate Finance Committee on an expanded definition of “Indian” in the ACA that aligns more closely with the IHS eligibility. We support a legislative change, and will continue to work with Congress on this issue. If the definition isn’t fixed, American Indians and Alaska Natives who are not members of Tribes but who otherwise meet IHS eligibility requirements will not be able to benefit from monthly enrollment periods and cost-sharing waivers if they want to purchase insurance, and they may be subject to the penalty for not having insurance coverage. We’re hoping this can be fixed soon.

We’re working on an update to our table that summarizes progress on implementation of the IHICIA. Of course there are many self-implementing provisions already in place. For example, health care professionals in tribal facilities are now allowed to work under a license from any State, and outside providers can’t go after patients for referral charges if the referral is authorized for

payment by the CHS program. And third-party reimbursements must remain at the Service Unit where they were received.

We continue consultation on implementation. You can submit input at any time at consultation@ihs.gov, and visit www.healthcare.gov and my Director's blog for general information and updates on the ACA.

We're also working with national and regional tribal organizations, including NIHB, to conduct outreach and education on the benefits of the ACA. Our National Indian Outreach and Education initiative partners from all IHS Areas have been conducting trainings and developing helpful materials, including a website, on the ACA. We appreciate all their help in getting information out to Indian Country on this very important health legislation.

There's also a website – www.tribalhealthcare.org – that was developed by the National Indian Outreach and Education partners. I encourage you to take a look at some of the helpful tools and information on this site. And we have a slide show, tailored to the American Indian and Alaska Native population, to help with outreach and education efforts in Indian communities. We posted it on our website so everyone can use it. We're updating it now.

I am so glad NIHB is holding an ACA training session at this conference. I hope you get a chance to attend.

We're also working on internal reform efforts in our federal programs. Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff, with an emphasis on customer service, ethics, professionalism, and performance management.

To improve the way we do business, we're working with HHS and our Area Directors to improve how we manage our budgets and to improve our financial management. And we're working to make our business practices more consistent and effective throughout the Indian healthcare system.

To improve how we lead and manage staff, we're working on specific activities to make the hiring process more efficient and proactive, and less time-consuming. We're using the new HHS supervisory training for our managers, and improving our performance management process to praise top performing employees and to better hold accountable those employees who are not performing well.

We're also working on improvements in pay systems and strategies to improve recruitment and retention. We know that recruitment and retention are a big issue in all of our sites. All these reforms are ongoing and are helping us change and improve the agency's business practices, which is fundamental to our reform efforts.

Our third priority is to improve the quality of and access to care. We have emphasized the importance of customer service, and I am now starting to see and hear about activities to improve customer service throughout the system. Customer service is even more important now that the ACA is going to give our patients more choices.

We're also working on a number of initiatives to help improve the quality of care and promote healthy Indian communities. One of the most important of these is our Improving Patient Care (IPC) program. The IPC is our patient-centered medical home initiative that is designed to improve the coordination of care for patients. This is about making changes that will result in measurable improvements in patient-centered care.

We plan to expand this initiative throughout the entire IHS system – currently we have 127 sites. Many of these sites are doing really outstanding work, including reducing waiting times, improving no-show rates, and arranging the system so that patients can see the same providers each time they come to the clinic, which results in better coordination of care.

This program is essential for us to be able to adapt to the new delivery system changes with the ACA, and to helping us improve customer service by making our care more patient-centered. The patient-centered medical home is a big focus of the changing health care system in the U.S. So if our sites get this recognition, they might be able to get better reimbursements in the future.

A few other initiatives are also helping us improve the quality of care. One of the most important of these is the Special Diabetes Program for Indians (SDPI). This program has shown that, in partnership with our communities, we can prevent and treat diabetes in Indian country with innovative and culturally appropriate activities. So we're very pleased that this program was recently reauthorized through 2014.

Last September I attended the SDPI Diabetes Prevention and Healthy Heart Initiatives Meeting in Denver, Colorado. I viewed posters from the grant programs that documented their successful prevention activities through photos, activity summaries, and client testimonials. It was very inspiring to see the innovation, enthusiasm, and expertise of our grant program activities. I am glad you get to see some of their posters at this meeting.

I hope you have seen the dramatic drop in the rate of end stage renal disease (ESRD) in American Indian and Alaska Native people with diabetes when compared with other racial and ethnic groups in the U.S. Between 1995 and 2006, the incident rate of ESRD in American Indian and Alaska Native people with diabetes fell by 28% – a greater decline than for any other racial or ethnic group. Given that the Medicare cost per year for one patient on hemodialysis was \$82,285 in 2009, this reduction in the rate of new cases of ESRD means a decrease in the number of patients who would have required dialysis—translating into millions of dollars in cost savings for Medicare, IHS, and other third-party payers.

All of this occurred while SDPI I has been implemented. While we cannot say cause and effective, I believe these efforts are making a difference.

We're also focusing on behavioral health issues, which are a top tribal priority. We're making progress on our National Behavioral Health Strategic Plan and our National Suicide Prevention Plan.

And the evaluation data from the Methamphetamine and Suicide Prevention and the Domestic Violence Prevention Initiatives are very promising. I recently sent out a letter to tribal leaders about

our completed consultation on the FY 2013 funding distribution for both of these initiatives. We have a recommendation from the National Tribal Advisory Committee on Behavioral Health to keep the distribution the same for one more year and then consult on whether it should be changed for FY 2014 funding. It only goes to some Tribes now, but there are others that want to have a chance for this funding in the future.

There are a few other quality initiatives we're working on to address health promotion and disease prevention in Indian communities. The IHS Healthy Weight for Life initiative unifies all our efforts to promote a healthy weight among American Indians and Alaska Natives. And our IHS Baby-Friendly Hospital Initiative, which is our contribution to the *First Lady's Let's Move! In Indian Country* initiative, is promoting breastfeeding to reduce childhood obesity. Congratulations to Rosebud, Pine Ridge, Belcourt, and Claremore Service Unites for achieving the Baby Friendly national designation!

Another initiative we're participating in the national Million Hearts Campaign, with its goal of preventing a million heart attacks and strokes over the next 5 years, by focusing on improvements in "ABCS" – aspirin, blood pressure, cholesterol, and smoking cessation.

And the new Partnership for Patients that was launched by HHS will help improve the quality of care by focusing on reducing harm and improving patient safety in our hospitals. And we're working under an agreement with the Centers for Medicare and Medicaid Services to establish a new hospital consortium to work on improving quality and meeting accreditation requirements in our hospitals. We plan to establish a system-wide business approach to accreditation.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. We've worked hard to improve transparency and communication about the work of the agency. This includes working with the media, sending more email messages and letters to tribal leaders, and holding regular internal meetings.

We're also emphasizing accountability and fairness in the way we do business – by evaluating our programs and focusing on areas of greatest benefit, and by always considering fairness when dealing with staff and making programmatic decisions.

Inclusiveness is a part of these priorities because the IHS has to ensure that our decisions consider the impact on all our patients, whether they are served in an IHS, tribal, or urban health facility. One area of interest here is that we're working on our final new urban confer policy. Instead of consultation, the IHCA authorizes IHS to "confer" with urban Indian organizations.

You may have recently noticed a new look for the IHS website, and a new location for my Director's blog – we launched a new www.IHS.gov website a few weeks ago that has been redesigned to be more focused on what our customers need, with a less cluttered look and easier navigation options. My "Director's Blog" is now in the "newsroom" section. I use this blog on the to post brief updates on our activities and the latest IHS news. This is one of many efforts to be more transparent about what we're doing as an agency. I regularly post updates to my blog, so I encourage you to keep checking them for the latest information on Indian health issues. You can also subscribe for updates and search the blog.

I will close now by just saying once again how I appreciate all your support as we work together to reform and improve the IHS. Again, I am thrilled about the focus on public health at this meeting.

Despite all the challenges we face, I am confident that by working together in partnership, we can secure a healthier future for all American Indian and Alaska Native people by ensuring that they get the health care and public health services that they need and deserve.

Thank you.