



Indian Health Service
Tribal Self-Governance Conference
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Indian Health Service Update

by

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Good morning. I am Dr. Yvette Roubideaux, Director of the Indian Health Service (IHS). It is a real pleasure to be here with you today at the annual Tribal Self-Governance Conference.

Thank you, Lynn Malerba, Chair of the IHS Tribal Self-Governance Advisory Committee (TSGAC), and Ron Allen, Vice Chair of the TSGAC, for your leadership. I believe that our partnership has grown stronger this year, and we are starting to work together on some of the issues that are most important to Self-Governance Tribes. Self-governance works, and we appreciate and value this partnership with you.

We are in the middle of travel restrictions and sequestration, and are cutting back on a lot. I have only traveled once this year so far, but when it came down to it, this conference is a major priority of the IHS. We have representatives from IHS headquarters and all 12 IHS Areas, and our colleagues from the Office of General Counsel, here to participate. Despite the challenges, we made it!

The Tribal Self-Governance Conference has become one of the most important conferences in Indian Country. This is a reflection of the strong ongoing interest in and support of tribal self-governance throughout Indian Country and the Indian health system.

I like the theme of this conference, which is to “Strengthen, Advance and Invest in Self-Governance.” This conference supports that goal by bringing together tribal leaders and federal officials to address important health and policy issues affecting Native communities.

The text is the basis of Dr. Roubideaux’s oral remarks at the Tribal Self-Governance Conference on April 29, 2013. It should be used with the understanding that some material may have been added or omitted during presentation.

This past September I selected Mr. Benjamin Smith, a member of the Navajo Nation, as the Director of the IHS Office of Tribal Self-Governance. He will be providing an update right after me. And I have to say, he is doing an outstanding job.

The trend toward tribal management of health services in American Indian and Alaska Native communities continues, as Tribes increasingly chose to contract or compact under the Indian Self-Determination and Education Assistance Act to administer these services.

In 1994, 14 Tribes exercised their option to enter into self-governance agreements that constituted approximately 2% of the IHS budget. Today, 338, or about 60%, of all federally recognized Tribes have negotiated self-governance compacts and funding agreements. Tribes now manage approximately 35% of the IHS budget under self-governance authority.

Now I want to give you a brief update on what we're doing to improve the IHS in partnership with Tribes and tribal organizations. This is information that is important to all of us as we work together to eliminate health disparities in Indian Country. We need and appreciate all your input and support as we move forward with these improvements.

I want to start with an update on the IHS budget, which is a huge factor in our ability to improve the IHS.

We've received increases in the IHS budget each of the last 4 years. Overall, the IHS budget authority has increased 29% since FY 2008. Within this increase, there have been some significant targeted increases:

- Contract Health Service (CHS) funding has increased 46%;
- Contract Support Costs (CSC) funding has increased 76%; and
- Health Care Facility Construction has increased 132%.

The increases in CHS funding have made a real difference; 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.

But fiscal year (FY) 2013 is a different story. The IHS is now working on implementing the FY 2013 final budget authority of \$4.1 billion, which is lower than the FY 2012 budget of \$4.3 billion. It does include an increase of \$53 million for additional staffing for new health care facilities, which is great. However, 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 will have to be 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. We have already implemented a number of cost-saving changes to the way we carry out our work, including travel reductions, new restrictions on conferences,

delayed or reduced purchasing and contracting, hiring delays and lapsing of positions, and work to enhance third-party collections activities.

By now you should have received information about your final base funding levels for FY 2013. We are on a 30-day apportionment, and likely will have to do another 30-day apportionment if we don't receive the full end of year apportionment from the Office of Management and Budget (OMB) by this week. We will get the funding out as soon as possible. We left our financial analysts back in Rockville this week to make sure we can get the funding out ASAP.

I know that the impact of sequestration is even worse for Tribes – you are dealing with sequestration cuts to several funding sources across the federal government. Although there is much budget uncertainty, I know we will all do what we can to protect our core mission to the greatest extent possible.

The FY 2014 President's Budget was released last month, and it 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. This adds \$124 million to the IHS appropriation, and includes increases of approximately \$35 million for CHS (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 CSC.

If the proposed budget is enacted, the IHS discretionary budget will have increased 32% since FY 2008.

If the entire FY 2014 President's Budget Request is enacted, it contains enough deficit reduction so that sequestration would be unnecessary. And priority programs like IHS can be protected. However, we are aware that Tribes are very upset about the Administration's proposed new appropriations language for CSC. Last week, Assistant Secretary of Indian Affairs Kevin Washburn, Charlie Galbraith, and I held a listening session with Tribes in Washington, D.C., and I know some tribal leaders had a good meeting with OMB. While the administration considers this a short-term solution, we are interested in consulting on a more long-term solution, and will be conducting consultation activities over the next few weeks – you will receive the proper notification of any calls or meetings.

In preparation for the FY 2015 budget, we recently held our FY 2015 national budget work session, and the tribal workgroup presented their national recommendations at the Department of Health and Human Services (HHS) Tribal Budget Consultation held last month in Washington, D.C. I know they are going to meet this week to finalize their recommendations now that they know the outcome of the FY 2013 budget and the FY 2014 President's Budget Request.

Sequestration also means that there is a 2% reduction in Medicare payments to all facilities. However, we just got the good news on our Calendar Year 2013 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 some good news.

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 Self-Governance Tribes, especially the IHS TSGAC. Thank you for your leadership and partnership. We have done a lot to improve consultation at the national, Area, and local levels. I have made it clear to all our senior leadership and our employees that we support self-governance in the IHS, and it is our job to work with you in partnership. This understanding is an important part of our reform activities.

We hope to hold a "virtual" Tribal Consultation Summit this summer. We will send you the details soon. We have conducted a number of tribal consultations in the past few years, many of which we have concluded or for which we have made decisions. I would like to highlight three of them today. The first is the consultation since 2010 on improving the CHS program, which is how we pay for referrals for services in the private sector.

I am sending a letter out this week with the Tribal CHS Workgroup's third set of recommendations, which includes 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, or FAAB. We have finally selected members and will hold our first meeting by phone once the announcement of membership goes out.

The third consultation is the consultation on the Department of Veterans Affairs (VA)-IHS memorandum of understanding that was signed in 2010 and the recently signed VA-IHS National Reimbursement Agreement. We are making progress in improving coordination of care for veterans eligible for IHS and VA. Your 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.

And the fourth consultation that has been ongoing since last year is the consultation on CSC. 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 mentioned the appropriations part already. I want to talk a little bit about the progress we are making on settling past CSC claims. Your input, and especially the input of the TSGAC, has helped us move forward to a more active phase of settling claims. And I have a significant announcement today.

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. The usual process is that Tribes submit claims to IHS, we

deny them, then the Tribe appeals, and then a settlement is reached that is paid out of the Judgment Fund. This is the process defined by the Contract Disputes Act.

While there are some differences between how tribal lawyers and the Administration interpret the Ramah decision, 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 recent tribal leader letter 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.

So contact us if you are ready to discuss your claims. We just have to find a number that works. In the spirit of finding a number that works, we also want to announce today that we have developed two options for settlements. This is based on input from the TSGAC that each Tribe needs to have the right to decide for themselves how to settle their claims; that the paperwork involved may be burdensome; and that some Tribes may just want to put these claims in the past.

So the first option is what we are doing now – having in-depth discussions along with exchanging documentation to come to a number that we can agree upon for settlement. I hope to continue to work with TSGAC to make this option more efficient.

The second option, which is new, is a more simple approach. Upon request, we will make a non-negotiable, lump sum offer for settlement based on our paperwork alone. If you like it, we are done. If you don't, then we return to the in-depth discussions. We are 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 you are interested in exploring your options, contact our OGC through your 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.

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 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 are thrilled that the Indian Healthcare Improvement Act (IHICA), our authorizing legislation, was made permanent by the ACA.

Everyone should be paying as much attention as possible to this date – October 1, 2013. That’s when the enrollment begins for the ACA Health Insurance Marketplaces and the Medicaid Expansion. Many of you are already doing a lot. But now is the time to get ready.

In order to make sure that our facilities benefit from their patients having access to affordable health coverage, which means that we may have more resources through third-party collections, IHS developed a business planning template with suggested areas for planning. It includes understanding the local health insurance market and the potential patients that 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 to ensure that they want to continue to receive their care at the facility. A copy of the planning template was sent to all Service Units – it’s required for federal sites, and recommended for tribal and urban Indian health programs.

Another important thing to call to your attention is the recent announcement about the Essential Community Provider (ECP) requirements. Qualified health plans (QHP) that plan to offer insurance for purchase in the Health Insurance Marketplaces in 2014 are now establishing their networks, and a list of tribal and urban sites that meet the statutory definition of an ECP was posted on the HHS website. These QHPs can benefit from including IHS, tribal, and urban Indian health (ITU) facilities in their networks, so we are recommending all sites contact the insurance companies they regularly work with and request to be in their network.

The ITU QHP Addendum is now released and available to be used as a way to explain the special provisions for Indians enrolled in plans. Congrats to the Tribal Technical Advisory Group and Tribes for getting this important document completed.

We are 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.

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.

We are working on an update to our table that summarizes progress on implementation of the IHClA. 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 are continuing our 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 are also working with national and regional tribal organizations to conduct outreach and education on the benefits of the ACA. Our National Indian Outreach and Education (NIHOE) initiative partners from all IHS Areas have been conducting

trainings and developing helpful materials. 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. I also encourage you to go to the website www.tribalhealthcare.org for other tools and materials developed by the NIHOE. HHS and the Centers for Medicare and Medicaid (CMS) are also starting some trainings and webinars – we'll forward the information on those as they are available.

If you are interested in negotiating specific provisions into your self-governance compacts and funding agreements as we move forward with implementation of the provisions of the ACA and IHCA, I encourage you to work with your Agency Lead Negotiators and the Office of Tribal Self-Governance staff during the negotiation process.

I just wanted to mention that we are 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 system, which will benefit all Tribes, including Self-Governance Tribes.

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.

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. 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 93 sites. And 23 self-governance sites have participated in IPC so far. Many of these IPC sites have been able to reduce waiting times, improve no-show rates, and arrange the system so that patients can see the same providers each time they come to the clinic, resulting in better coordination of care. The patient centered medical home is a big focus of the changing health care system in the U.S. and may be able to help us 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 the SDPI was recently reauthorized through 2014.

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 am sending out a letter this week to complete our consultation on the FY 2013 funding distribution for both MSPI and DVPI. 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 are working on. The IHS Healthy Weight for Life initiative unifies all our efforts to promote a healthy weight among American Indians and Alaska Natives. And we've joined the First Lady's *Let's Move! in Indian Country* initiative, which includes our IHS Baby-Friendly Hospital initiative to promote breastfeeding in all IHS hospitals, and we encourage tribal hospitals to join us.

We are 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. We are also working under an agreement with CMS 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 are working on our final new urban confer policy. Instead of consultation, the IHCA authorizes IHS to "confer" with urban Indian organizations.

I use the Director's Blog on the IHS website to post brief updates on our activities and the latest IHS news at least weekly. 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 please keep checking them for the latest information on Indian health issues.

And I will close now by just saying once again how I appreciate all your support as we work to reform and improve the IHS. I am looking forward to talking with you during the meeting and working to find solutions to the challenges we face. Our partnership with self-governance is growing, and despite the challenges we are facing, I look forward to working with you to ensure our patients get the health care they need and deserve.

Thank you.