



Indian Health Service

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*Indian Health Service Update*

by

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Good morning. I'm Dr. Yvette Roubideaux, Acting Director of the Indian Health Service (IHS). I'm really pleased to be here today and to be a part of the National Indian Health Board (NIHB) National Tribal Public Health Summit. Thank you to the NIHB and its Board of Directors for the invitation to speak today. We appreciate your partnership with the IHS.

I would also like to thank those of you who attended the IHS Listening Session yesterday. The feedback and recommendations that we receive during these Listening Sessions really helps us focus on tribal priorities and make sure we are hearing input from all Tribes. It is clear that while we have made progress, we also have much more to do to change and improve the IHS.

Today I will provide an update on how we are working hard, in partnership with Tribes and tribal organizations, to improve our ability to provide quality health care services to American Indians and Alaska Natives.

First, I would like to give you an update on the IHS budget, which is a huge factor in how we are able to provide services and work to improve the IHS.

Thanks in large part to tribal input and support, we have made a lot of progress on increasing the IHS budget. Compared to the fiscal year (FY) 2008 level, the budget

has increased every year during the Obama Administration except FY 2013, which is the year we were subject to an across-the-board rescission and sequestration. However, the FY 2014 budget included a 7.4% increase, getting us over the FY 2012 amount.

And the FY 2015 President's Budget Request was recently released, which proposes a \$4.6 billion level, which is a \$200 million, or 4.5%, increase in the IHS budget. If the FY 2015 President's Budget Request is enacted, the IHS budget will have increased 38% compared to the 2008 level.

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. However we do know that there more to do on the budget – that's why we will continue to fight hard for budget increases.

I would like to provide an overview of this year's budget. The Consolidated Appropriations Act of 2014 included a budget for IHS of \$4.4 billion, which includes a \$304 million increase that represents a 7.4% increase from FY 2013. The 2014 IHS budget includes:

- A \$33 million increase in the Facilities Account that restored most of the cuts from sequestration in those facilities line items. It provided funding to continue construction on the Kayenta Health Center and to complete construction on the San Carlos Health Center and the Southern California Youth Regional Treatment Center.

A \$271 million increase in the Services Account to fund the following three priorities: A \$77 million increases in Purchased/Referred Care (the new name for the Contract Health Service program); full funding for Contract Support Costs (CSC); and staffing for 8 new and expanded facilities.

Congress directed IHS to use this Service Account to fund these priorities even if it resulted in reducing other parts of the budget. This required a \$10 million decrease to other parts of the budget; after tribal input, the reductions were taken from parts of the budget that are not related to tribal shares: the Director's Emergency Fund, Indian Health Professions, Tribal Management Grants, and Self-Governance projects. Funding these three priorities also meant

that there was not enough funding to offset reductions from the rescission and sequestration in FY 2013.

Congress also directed the IHS and the Bureau of Indian Affairs (BIA) to consult with Tribes on a more long-term solution to CSC. This would involve simpler and more predictable CSC estimates in the appropriations process that would minimize the impact on the rest of the budget.

A work plan on how we will consult with Tribes on this long-term solution for CSC is due to Congress next month. We have already held a consultation session with the BIA on this issue and are discussing it with our IHS Contract Support Costs Workgroup and in other forums with Tribes over the next few months.

Of note, the Office of Management and Budget (OMB) has apportioned the funding to IHS, and recurring base funds have been allotted to all IHS Areas for distribution to Tribes. Otherwise appropriated or distributed funding is in progress and will be distributed soon.

Related to this is IHS' work to resolve all past claims for underpayment of CSC. IHS has heard the request from Tribes and Congress to accelerate the rate at which the Agency is resolving past claims. As a result, IHS has devoted additional resources and staff to resolving claims for unpaid CSC with a primary focus on speedy resolution through settlement whenever possible. IHS must analyze each claim individually and comply with the multi-step process required by the Contract Disputes Act.

IHS is working to resolve the claims expeditiously and also believes that the Agency and Tribes working together to resolve the claims will have the most benefit for our ongoing relationship. IHS is also improving internal business practices related to the CSC claims settlement process. IHS is also reviewing methods to enhance collaboration and streamline the process, and has offered an alternative claim resolution process that is less burdensome for Tribes but still is fair and consistent for all Tribes.

This work is showing results. As of March 18, 2014, IHS has analyzed, or is in the process of analyzing, over 550 claims. As of March 18, 2014, IHS has made settlement offers on over 200 claims for 31 Tribes. Of those claims, 34 claims have been formally settled with five Tribes, and an additional 68 offers have been

accepted by eight Tribes and are in the process of settlement. This is a considerable increase from the three settled claims reported as of November 2013.

The total settlement amount for the 102 claims that have been formally settled, or are in the process of settlement, totals over \$133 million. Our goal is to resolve the majority of currently pending claims with Tribes that are amenable to settlement and to extend settlement offers to as many Tribes as possible by the end of calendar year 2014. I personally have experienced the recent increased pace of our settlement process since I now receive emails almost every day from Agency attorneys requesting approval of settlement offers. So finally, some progress.

I also want to provide an overview of the FY 2015 President's Budget Request, which, as my first slide indicated, includes another increase for the IHS. The overall budget proposed for the IHS for FY 2015 is \$4.6 billion, which is a \$200 million, or 4.5%, increase over the FY 2014 final budget authority. Proposed increases include:

- \$50 million for Purchased/Referred Care;
- \$71 million to support staffing and operating costs at four new and expanded facilities;
- \$30 million to fully fund estimated CSC costs for new and expanded contracts and compacts in FY 2015;
- \$31 million to address medical inflation costs; and
- Additional funding for pay costs, partial funding for 5 new Tribes, and restoration of reductions in the FY 2014 operating plan.
- \$85 million in funding is also included to complete construction on the Kayenta Health Center, the Northern California YRTC, and the Ft. Yuma Health Center; and to continue construction on the Gila River Southeast Health Center.

The next step is for Congress to consider our budget request. The Administration is going to work with Congress on this budget. I encourage you to attend and take part in the discussions about budget priorities.

We are always working on three budgets – the current year, the President's Budget request for next year, and tribal budget formulation for the next year after that. The FY 2016 Tribal Budget Formulation Process is in progress, and Areas held have made recommendations that were considered by The National IHS Budget Formulation Workgroup at their national work session in February. They presented their budget recommendations during the Department of Health and

Human Services (HHS) Annual Tribal Budget Consultation session in March. Now the agency will begin its budget process with HHS and OMB.

We know that there are other tribal budget priorities, such as Advanced Appropriations. A bill was introduced to give IHS authority for Advanced Appropriations and the Senate Committee on Indian Affairs is holding a hearing on it with other bills this week. We also have heard that Tribes want IHS to be exempt from sequestration and the Administration is working with Congress to avoid sequestration. In order to avoid sequestration next year, Congress will need to find a way to meet its overall budget levels agreed upon last year.

I am so grateful that HHS makes the IHS budget a priority. IHS is proposed for an increase even as the rest of the HHS budget decreases. But even with all of this support for the IHS, it's still a difficult budget climate. So we need to continue to work together on ensuring continued progress on the IHS budget.

But funding is not the only answer, and at IHS, we remain committed to changing and improving the IHS, guided by our four agency priorities

Our first priority is to renew and strengthen our partnership with Tribes. While we have made a number of improvements in how we consult with Tribes, we want to continue to strengthen that partnership. We also realize that we have to continue to improve consultation at all levels of the organization – headquarters, Area Office, and local Service Units.

That's why I recently sent a letter to Tribes announcing that I would attend and conduct listening sessions in all IHS Areas this year. It's a chance to meet in person, especially with those Tribes that are unable to travel to Washington, D.C. We need to hear their concerns and issues also so that we can focus our improvements on tribal priorities.

We also hold individual meetings with Tribes, such as a recent Tribal Delegation Meeting at IHS Headquarters with the Crow Tribe of Montana. Tribes can schedule these meetings in person or by phone. It helps to hear local concerns so we can develop action steps together to address those concerns.

Another way of reaching out to Tribes includes our annual Tribal Consultation Summits, which began in 2011 as a way to hear about ongoing consultation

activities. We held our first Virtual Tribal Consultation Summit last year when travel restrictions were in place and people could not travel due to the cuts from sequestration.

We value our partnership with the NIHB on improving health care for tribal communities. IHS values tribal consultation to ensure that our services better meet the needs of the tribal communities we serve.

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 purpose of the ACA is to increase access to quality health coverage for all Americans, including our First Americans. I hope you already know that the ACA benefits those who have insurance now, want to purchase affordable insurance through the “Health Insurance Marketplaces,” or can take advantage of the Medicaid expansion. Indian elders can benefit from how Medicare is being strengthened with more affordable prescriptions and free preventive services.

And of course, we're thrilled that the Indian Health Care Improvement Act, our authorizing legislation, was made permanent by the ACA. So IHS is here to stay.

So even though the deadline for open enrollment for 2014 coverage was yesterday for most Americans, tribal members can enroll monthly as a special benefit of the ACA. And Medicaid enrollment continues throughout the year. So we still have more work to do to ensure everyone knows what benefits are available. And then there will be another open enrollment starting this fall for coverage for 2015 for those that missed the deadline yesterday and do not qualify as tribal members. So we continue to need your help.

The ACA is about options for health coverage in addition to access to the IHS health care system. Right now, about 23% of our patients have private insurance; about 38% of IHS patients are currently on Medicaid; and less than 10 % of our patients have coverage through Medicare and the Department of Veterans Affairs, so that leaves approximately 30% of our patients with no coverage other than IHS. This is the group that may benefit the most from the ACA.

We estimate that we could see up to an additional \$95 million in third-party collections in FY 2014, mostly from the Medicaid expansion. So making sure our

patients understand their choices related to these new benefits is critical. If more people who go to IHS are also covered by insurance, that will help stretch our limited dollars and give patients more choices around referred care and help us provide more services.

I was pleased to learn yesterday in a meeting with the urban Indian health programs in Montana that at least one of the programs has already seen increased collections/reimbursements from patients newly enrolled in insurance as a result of the ACA. Having more of our patients covered can really make a difference.

You may have also heard about the “definition of Indian” issues related to specific benefits of the ACA. First, let me make it clear that IHS eligibility is not affected by this and will remain the same.

The definition of Indian in the ACA impacts three areas of benefits – for those who purchase insurance through the Marketplaces, it affects who gets access to monthly enrollment and to waivers for cost-sharing, or co-pays. For those without insurance, it relates to the shared responsibility payment, or penalty, for not having minimum essential health coverage.

The challenge is that the ACA definitions of Indian are mostly based on membership in a federally recognized Tribe, which is a narrower definition than for IHS eligibility, which includes members and descendants of Tribes.

While we await the outcome of Congress’ efforts, HHS has worked to ensure that anyone who is eligible to receive services from IHS is exempt from the shared responsibility payment by creating an IHS eligibility exemption. A hardship application is available on [healthcare.gov](http://healthcare.gov), and tribal members can apply for the exemption on their tax forms.

But even though this waiver or exemption is available, we still want American Indians and Alaska Natives to understand their potential benefits because they might be newly eligible for Medicaid, or might find that insurance is now very affordable. And we continue to hope that the Medicaid Expansion will be adopted in more states.

As I mentioned before, the deadline for open enrollment for the ACA was March 31 for most people, and the White House sponsored a National Tribal Day of

Action on ACA enrollment on March 24. The purpose was to encourage Indian Country to rally with community health partners to organize ACA enrollment events. More than 60 IHS sites responded by holding outreach and enrollment events in their communities.

The week before, Vice President Biden and HHS Secretary Sebelius spoke directly to tribal leaders and community members on the benefits of the ACA for American Indians and Alaska Natives. The Vice President and the Secretary encouraged tribal leaders and community members to get themselves, their friends, and their relatives enrolled. So even though the national open enrollment deadline was yesterday, we still have a lot of work to do this year.

We realize there have been issues with HealthCare.gov website performance, but I assure you that these issues have been solved for the vast majority of users and that HHS is working continuously to improve the marketplace website. Please know that the website is just one place to enroll; patients can also enroll by phone, mail, or in person.

IHS has been working hard to ensure our patients are aware of their options. We've been offering weekly ACA question and answer calls; responding to inquiries received through the [ihs.gov](http://ihs.gov) website; sending messages via social media, including the Director's blog; and holding leadership briefings on important topics. We're also working with our colleagues at CMS to resolve issues that our staff and patients have encountered. If you have any questions or concerns, I encourage you to submit an email to [acainformation@ihs.gov](mailto:acainformation@ihs.gov).

A major focus over the last year has been on training for our staff, Tribes, and patients on the ACA. We're working with HHS and the Center for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight on training for our staff. In addition, the national tribal organizations are helping us with outreach and awareness training.

And we have a number of other resources for training. Our goal is that all staff will be able to respond to questions that patients have about the ACA, or will know where to refer the patients for further information.

Since the potential for the ACA to impact our bottom line is significant, 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, and more services for everyone we serve.

We're also working with the Qualified Health Plans (QHP) that offer insurance for purchase in the Health Insurance Marketplaces; they have established networks and should be working with our local sites that need to decide whether to contract with the QHPs. Section 206 of the Indian Health Care Improvement Act indicates that our facilities should get the highest reimbursement rate. The QHP Addendum for IHS, tribal, and urban Indian health programs is now available to help explain the special authorities for working with these facilities.

There is also a tribal website – <http://tribalhealthcare.org> – that was developed by our National Indian Outreach and Education partners. I encourage you to take a look at some of the helpful tools and information on this site. They even have a video about the marketplaces for showing in patient waiting rooms. IHS also has a webpage on our website that explains more about the ACA.

We're also working on internal reform efforts to change and improve the IHS, and to better prepare us to take advantage of the benefits of the ACA. Our internal reform efforts are focused on improving the way we do business and how we lead and manage our staff.

We are continuing to emphasize customer service, ethics, professionalism, and accountability. 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. We're also working to make our business practices more consistent and effective throughout the 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. We're also working on improvements in pay systems and other strategies to improve recruitment and retention, which are big issues at all of our sites.

These may sound like simple things, but they are fundamental to our agency efforts to improve service to our patients. And as we discussed yesterday, IHS is changing

its orientation to run more like a business in many ways. We are in the business of healthcare, and we need all of our Service Units to transition to that orientation.

Our third priority is to improve the quality of and access to care. We've emphasized the importance of customer service, which 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, which is our patient-centered medical home initiative that is designed to improve the coordination of care for patients.

The patient-centered medical home is a big focus of the changing health care system in the U.S. and the ACA. So if our sites get recognition as a "medical home," they might be able to get better reimbursements in the future. 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 initiative is making the improvements that our patients have requested.

And we're 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.

We're also implementing Meaningful Use with our Electronic Health Record, and are receiving incentive payments throughout the system. IHS is very close to receiving its certification for Meaningful Use stage 2.

We have also heard from Tribes that prevention is important. Obesity is a major cause of chronic diseases and mortality in our patient population, so we want to do everything we can to prevent and address it.

We have our Healthy Weight for Life initiative to unify all our efforts to promote a healthy weight among American Indians and Alaska Natives. We have a website with information on evidence-based, proven approaches to fighting the obesity epidemic that is threatening the health and well-being of Indian people.

And we've joined the First Lady's Let's Move! in Indian Country initiative, which includes our IHS Baby-Friendly Hospital initiative and a collaboration with the Notah Begay III Foundation.

We're promoting breastfeeding in all IHS hospitals because it has been shown that breastfeeding can reduce childhood obesity. We're also encouraging all tribally-managed hospitals to join us in this effort. So far, 7 of 13 IHS federal hospitals with obstetric services have achieved national designation as Baby Friendly, making the IHS system a leader across the entire U.S.

We also recently began collaborating with the Notah Begay III Foundation on activities aimed at preventing childhood obesity in American Indian and Alaska Native youth. The partnership will include sharing best practices in implementation of community-based activities directed at addressing childhood obesity in Indian Country.

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. We are currently consulting with Tribes on how to move forward with these initiatives.

And we are so grateful that the Special Diabetes Program for Indians (SDPI) is reauthorized for another year! Even though we would have preferred a multi-year reauthorization, we are glad now that our programs don't have to worry for another year about whether the funding will be available.

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.

Our recent report to congress showed outcomes and improvements in diabetes care throughout our system. And our recent outcomes paper for the SDPI Diabetes Prevention Program shows that these programs can reduce new cases of diabetes through lifestyle changes. So this is a successful program that needs to continue.

We have been consulting with Tribes and the Tribal Leaders Diabetes Committee on the distribution of FY 2015 SDPI funds, but they have said that with only year reauthorization, it is hard to make major changes. So more to come on the final decision for FY 2015.

We have updated data on one of the most important potential impacts of the SDPI's combined and sustained clinical improvements over time. Based on national data, between 1995 and 2011, the number of new cases of ESRD, or kidney failure, in American Indian and Alaska Native people with diabetes fell by nearly 39% – a greater decline than for any other racial or ethnic group. This data gives us hope that our efforts are making a difference.

We've accomplished a great deal as we work to meet our priorities, and this is reflected in our Government Performance and Results Act (GPRA) measures. In FY 2011, for the first time ever, we met all of our clinical GPRA measurement goals. In FY 2012, we did great again.

And the results are now in for 2013, and once again, we did great! We're very proud of all the IHS and tribal sites that worked so hard to make improvements in the quality of healthcare that we deliver.

So the increased funding we've received in the past few years, along with more accountability and a focus on improving the quality of care, are making a difference. But we know we still have more to do.

We are also working to increase transparency about what we are doing to change and improve the IHS, and presentations at conferences like this one help us spread the word and also hear input and recommendations on how to make further progress.

I hope you can take some time to look at the new format for our IHS website, which is much more customer friendly. So one of the first things you see now on the website homepage is how to find health care and how to find a job in IHS.

You can also see a link to my Director's blog. 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. So I hope you can check it regularly for updates

I will close now by just saying once again how much we need and appreciate your partnership as we work to change and improve the IHS.

Many of you in the audience have a great interest in both health care and public health, and we need your partnership more than ever to continue our progress. I also know that there are students attending the conference, and we are looking forward to you joining us in these efforts in the future.

So thank you to the National Indian Health Board and all the tribal representatives here at the meeting. I appreciate your partnership as we work together to ensure that all American Indian and Alaska Native people get the health care they need and deserve.

Thank you, and have a great rest of the conference.