



Indian Health Service

Tribal Self-Governance Consultation Conference

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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). I'm really pleased to be here today and to again be a part of the Annual Tribal Self-Governance Consultation Conference.

The theme of this conference, "Self-Governance – Nations with Choices and Voices," reminds us of our shared goal of promoting self-determination and self-governance in the government-to-government relationship between Tribal Nations and the United States. We appreciate all your input and assistance as we work together to advance health care services in Indian Country and to protect and honor tribal sovereignty.

The IHS supports Tribal Self-Determination and Tribal Self-Governance. I am grateful for the leadership and partnership of Chief Lynn Malerba, Chairman Ron Allen, and the entire Tribal Self-Governance Advisory Committee as they have helped us work through many important and challenging issues over the past few years. I appreciate their strong advocacy for self-governance, and value their advice, recommendations, and partnership.

IHS' partnership with Tribes to improve healthcare for American Indians and Alaska Natives is heavily impacted by the resources we have available to deliver services. The IHS budget 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. The budget has increased when compared to the fiscal year (FY) 2008 level every year during the Obama Administration, except in FY 2013, which is the year we were subject to an across-the-board rescission and sequestration.

The text is the basis of Dr. Roubideaux's oral remarks at the Tribal Self-Governance Consultation Conference on May 5, 2014. It should be used with the understanding that some material may have been added or omitted during presentation.

However, the FY 2014 budget included an increase to \$4.4 billion, getting us up over the FY 2012 amount. And the FY 2015 President's Budget Request that was recently released proposed to increase the IHS budget to the \$4.6 billion level. 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 is more to do on the budget – that's why we will continue to fight hard for budget increases as a top priority.

For this year, FY 2014, the Consolidated Appropriations Act of 2014 included a budget for IHS of \$4.4 billion, which includes a \$304 million, or 7.4%, increase from FY 2013. This includes a \$33 million increase in the Facilities Account, which restored most of the sequestration cuts in those line items and provided funding to continue construction on the Kayenta Health Center and complete construction on the San Carlos Health Center and the Southern California Youth Regional Treatment Center (YRTC). Also included was a \$271 million increase in the Services Account, which Congress directed IHS to use to fund three specific priorities, even if it resulted in reducing other parts of the budget. Those priorities include:

- A \$77 million increase for Purchased/Referred Care (PRC), which is the new name for the Contract Health Service program;
- Full funding for Contract Support Costs (CSC); and
- Staffing for 8 new and expanded facilities.

This was an unusual way for Congress to fund IHS. Funding these priorities in full required a \$10 million decrease to other parts of the budget. After tribal input, the reductions were taken from parts of the budget 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. So there is more work to do.

Congress directed the IHS and Bureau of Indian Affairs (BIA) to consult with Tribes on a more long-term solution to CSC that would involve simpler and more predictable CSC estimates 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 on May 17. We have held several phone calls and a listening session with the BIA, and have another one scheduled here for tomorrow afternoon.

Of note on the distribution of funding this year, 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. We are working on distributing other funding, such as those that are formula based, as soon as possible. Both the PRC increase and the remaining CSC need are being distributed now, so that is good news.

We also have had good news this year related to CSC, on both the appropriations and the past claims settlement. With regard to appropriations, the administration's decision to fully fund CSC in FY 2014 and FY 2015 represents the Administration's commitment to self-determination and self-governance.

The good news on the distribution of CSC funding this year is that we are fully funding the estimated CSC need for all Tribes, the funding has gone out to most Tribes, and there is time for discussion and reconciliation throughout the year. As I mentioned in the conference call with Tribes on Friday, if you have questions on the distribution, contact your Area Director.

The IHS CSC workgroup has met twice in person and on conference calls and has made progress on discussing areas of agreement on estimating CSC amounts in the pre-award or negotiations phase. This work and the areas of agreement we reached did help as we asked the CSC workgroup to make recommendations on the funding distribution this year.

The other good news on CSC that I am happy to report today is that we have made significant progress on the IHS CSC Claims Settlement! You may remember that in November, we only had three claims settled, with 60 offers on the table and 80 claims analyzed. Based on our data from May 2, we now have 729 claims that have analyses either completed or in progress, offers made on 310 claims, and 181 claims with settlement agreements or final settlements, for a total value for settled claims of \$289 million as of May 2, 2014.

So I hope you see this as very good news. We are settling the past claims, and this information shows that over the past 6 months, the pace of the settlement process is definitely increasing.

IHS has heard the request from Tribes and Congress to accelerate the resolution of past CSC claims. IHS is working to resolve the claims expeditiously, with a goal to settle where possible, and we believe that having the Agency and Tribes working together collaboratively to resolve the claims will have the most benefit for our ongoing relationship.

IHS has also been improving internal business practices related to the CSC claims settlement process. We want the process to be fair and consistent for all Tribes.

One major reason for the accelerated progress is a recent increase in resources and staff involved in the claims settlement process. I also can announce today that we have recently adopted a new streamlined approach to the settlement process that is helping us make further progress. This work is showing results.

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.

So the next steps are to make settlement offers on all pending claims as soon as possible, continue our new streamlined settlement approach and continue to accelerate the pace, and address claims

both before the Agency and courts as required; and we are even planning to have a focus at the IHS Area level by holding meetings to address claims for several Tribes over the course of a week. This worked well for us recently in Alaska, and we plan to extend this approach to other Areas soon. So the good news is that we have made significant progress, have now adopted a more streamlined approach, and are committed to putting these claims in the past as soon as possible.

I also want to provide an overview of the FY 2015 President's Budget Request, which 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 PRC, again formerly known as CHS;
- \$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.

The FY 2016 Tribal Budget Formulation Process is also in progress, and Areas have made recommendations that were considered by the National IHS Budget Formulation Workgroup at their national work session in February, and presented the 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 are also planning a Budget Summit this fall.

We know that there are other tribal budget priorities. For instance, funding for PRC is a top priority for Tribes. Again, the FY 2014 Budget changed the name of the Contract Health Service program to "Purchased and Referred Care." The PRC Workgroup has reviewed the distribution formula for new PRC funds and recommended keeping the formula the same for the current distribution, but will look at changing the hospital access piece of the formula to better reflect the capacity of the service units.

We have also heard that Tribes are advocating for Advanced Appropriations. A bill was introduced by the Senate Committee on Indian Affairs to give IHS authority for Advanced Appropriations, and the administration is reviewing this issue.

We also have heard that Tribes want IHS to be exempt from sequestration. The administration is working with Congress to avoid sequestration next year, which will require Congress finding a way to meet its overall budget levels agreed upon last year.

We had good news recently that the Special Diabetes Program for Indians was extended for another year! The Tribal Leaders Diabetes Committee met on the distribution funds for the FY 2015 Special Diabetes Program for Indians, but they have said that with only yearly reauthorizations, it is hard to make major changes, and recommended to keep the distribution the same. I should be sending you our final decision for FY 2015 soon.

Another tribal budget priority is seeking authority for Medicare-like rates for physician and non-hospital services. The Government Accountability Office (GAO) reported in 2013 that capping payment rates for nonhospital services could save millions of dollars for PRC. So I wrote to tribal leaders last December requesting input on seeking Medicare-like rates for health care professional services purchased by Indian health programs and medical charges associated with non-hospital based care. All comments received were in favor of IHS seeking Medicare-like rates for these services. Our FY 2015 President's budget supports a legislative solution, and we are working on options for an administrative solution as well.

Another priority that impacts the budget is the 2012 Department of Veteran Affairs (VA)-IHS National Reimbursement Agreement. So far, tribal and IHS facilities have collected over \$5 million in reimbursements from the VA. These collections are returned to the facility that provided the care, to support their health care delivery system. IHS has implemented the agreement in all its federal sites, and the VA is working to enter into agreements with tribal sites.

And my final update related to the budget is on the great need for health care facilities. IHS recently started meeting with the new Facilities Appropriation Advisory Board (FAAB), and Dr. Charles Grim from Oklahoma and Mr. Lincoln Bean from Alaska were named Chair and Vice-chair, respectively, at the meeting last week. So I am looking forward to their recommendations.

Also, I have good news – we have moved forward with the last three facilities approved during the last round of applications for the Joint Venture Construction Program, and I am happy to announce that we plan to open a new round of applications this summer. We heard from you how much you support this program, and now that we are getting caught up on new staffing funding, we feel comfortable moving forward with another round.

But funding is not the only answer. At IHS, we remain committed to continuing our work to change and improve 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 are working on more opportunities to consult in various forums, and to improve our responsiveness and follow up.

While we have been making improvements in our partnership with Tribes at the Headquarters, Area Office, and local Service Unit levels, the travel reductions and conference limits have resulted in less time together in person.

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 the concerns and issues of all the Tribes we serve so that we can focus our improvements on tribal priorities. Area listening sessions are an important venue for me to hear about Area and local issues. I met with the California Area in February and with the Billings Area last month. We are currently setting dates for other IHS Area Listening Sessions, so I hope to see you there.

We also are connecting with Tribes through tribal delegation meetings and conferences, and are holding more conference calls and webinars to extend our reach. Individual Tribal Delegation Meetings are a vital part of our efforts to partner with Tribes in addressing health issues in Indian Country. Tribes can schedule these meetings in person or by phone. It helps to hear local concerns so we can develop action steps together to resolve them.

I rely a lot on our Tribal Advisory Groups to help us work on tribal priority recommendations, especially lately with the Tribal Self-Governance Advisory Committee (TSGAC), the CSC Workgroup, the Budget Formulation workgroup, the Information Systems Advisory Committee, and the Contract Health Service Workgroup. For example, our TSGAC meetings have been particularly helpful on budget issues and CSC issues. They played a very important and significant role in recent progress on these issues.

You are also welcome to visit our tribal consultation webpage, check out our tribal leader letter website, or contact us at consultation@ihs.gov.

Our second IHS priority is "to bring reform to the IHS." This priority has two parts – the first part involves the Affordable Care Act and the Indian Health Care Improvement Act. The second part is about internal IHS reform. I won't discuss the internal reform activities today, but wanted to just mention that we are making progress on our work to make our business practices more consistent and effective throughout the entire system, which is helpful for our partnership and how we work with all Tribes, including Self-Governance Tribes.

So in terms of the Affordable Care Act, I want to thank all of you who helped us during open enrollment for the Health Insurance Marketplaces. We wanted every American Indian and Alaska Natives to see what benefits were available to them before the deadline for open enrollment on March 31. I know that some of you helped during the "Tribal Day of Action" that the White House sponsored, so thank you for helping assist with enrollment and outreach and education activities.

So even though the Marketplace deadline for open enrollment for 2014 coverage was March 31 for most Americans, we still need your help with three things: continuing to help tribal members who can enroll monthly as a special benefit of the Affordable Care Act; helping with Medicaid and Children's Health Insurance Program, or CHIP, enrollment throughout the year; and helping tribal members and those eligible for IHS with the application for an exemption or waiver from the tax penalty. So we still have more work to do. And there will be another open enrollment for everyone starting this fall for 2015 coverage. So we continue to need your help.

IHS continues to encourage outreach and enrollment activities at all of our facilities, and we are continuing to work with the National Indian Health Outreach and Education initiative on outreach, education, and enrollment in tribal communities.

IHS continues its focus on business planning around the Affordable Care Act at our Service Units, and is using the business office as a central point for information. We have recently worked on guidance for the business office, local contracting with Qualified Health Plans from the Marketplace, and training on how to incorporate the new plans and their requirements into our PRC program.

You may have also heard about the “definition of Indian” issues related to specific benefits of the Affordable Care Act, such as access to monthly enrollment and reduced cost sharing. We are still providing technical assistance to Congress on a legislative fix to broaden the definition of Indian to be similar to IHS eligibility, which includes both members and descendants.

While we await the outcome from Congress, HHS has worked to ensure that anyone who is eligible to receive services from IHS can also be exempt from the shared responsibility payment by creating an IHS eligibility exemption.

An exemption application is available on <https://www.healthcare.gov/> for use by both tribal members and those eligible for IHS. And tribal members can also apply for the exemption on their 2014 tax forms. But even though this exemption is available, we still want American Indians and Alaska Natives to understand their potential benefits on the Marketplace 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. If you have any questions about IHS and the Affordable Care Act, you can email acainformation@ihs.gov.

Our third priority is to improve the quality of and access to care. 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, or 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 Affordable Care Act. We plan to expand this initiative throughout the entire IHS system – currently we have 177 sites. We are encouraging our sites to become accredited as Patient-Centered Medical Homes.

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. Our IPC Quality and Innovation Learning Network will be the ongoing way to connect IPC programs and share best practices.

And we have worked with the Centers for Medicare and Medicaid (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 welcome any tribal hospitals that are interested in joining our consortium.

IHS also supports the CMS initiative for Meaningful Use of Electronic Health Records, and Indian country has benefited from nearly \$90 million in incentive payments to date. We've been working very hard on the 2014 certification requirements and expect to receive that certification soon. We are also continuing to focus on preparations for ICD-10, even though the deadline has been extended for a year by CMS.

And our Office of Information Technology is developing an Information Technology Service Catalog that will provide detailed information on the numerous IT services offered by the IHS to tribal and urban Indian health programs. The Service Catalog will provide tribal programs with important and accurate information on the services and value they receive when they retain IT Shares with the IHS. Thanks to the Information Systems Advisory Committee Meeting (ISAC) for helping with this important activity.

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 met all of our clinical GPRA targets! 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 much more to do.

Our partnership depends on good communication. I want to remind you that 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.

In closing, as I was recently sitting at the Rose Garden Ceremony hearing the President talk about Secretary Sebelius' accomplishments, I couldn't help but think how grateful I am for her leadership and strong support for the IHS and tribal issues. For her establishing the first Secretary's Tribal Advisory Committee for a Cabinet member; for her direction to states to consult with Tribes; for her encouraging all HHS agencies to improve funding and programs for Tribes; and of course for her strong support of IHS, especially as a budget priority, I am so grateful we have had the opportunity to work with her. She is still around, still supporting us every day, until confirmation of the new HHS Secretary.

I also have hope and confidence in our Secretary-designate Burwell. I know you agree that we still have more to do, and I appreciate your partnership on our shared goals to improve health care for American Indians and Alaska Natives.

Thank you, and I hope you enjoy the rest of the conference.