

# Phoenix Area IHS Tribal/Urban Budget Recommendations

Fiscal Year 2020

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Submitted on behalf of the Tribal Governments and the  
Urban Indian Health Programs served by the Phoenix Area  
Indian Health Service

**INDIAN HEALTH SERVICE  
FY 2020 PHOENIX AREA BUDGET FORMULATION SESSION  
BUDGET RECOMMENDATION NARRATIVE**

The Annual Phoenix Area Indian Health Service Budget Formulation Meeting was held in Tempe, Arizona on November 28, 2017. Tribal Leaders and Tribal health directors in the Phoenix Area met to develop the recommended budget for the fiscal year (FY) 2020 Indian Health Service (IHS) budget request. Several tasks were accomplished at the one-day meeting. Area staff provided an overview of the Indian Health Service (IHS) budget formulation process and last year's FY 2019 Tribal recommendations, the participants heard presentations on the 2017 National and Area budget, on the 2018 president's budget request and they had a significant discussion on hot topics and emerging issues. The principle activity was dedicated to engagement with the Tribal Leadership to develop the National and Area level FY2020 budget recommendations and the top ten budget line item priorities.

**SUMMARY OF RECOMMENDATIONS**

The amounts supported for the IHS national budget by the Tribes and urban Indian Health Programs in the Phoenix Area are summarized below. The detailed spreadsheet is attached to this report.

**PHOENIX AREA TRIBAL RECOMMENDATIONS FOR THE FY 2020 IHS BUDGET  
OVER THE FY 2017 ENACTED LEVEL\* (+36%)  
(Dollars in Thousands)**

Sub Sub Activity	FY 2017 IHS Enacted Level	FY 2018 IHS President's Budget Request	FY 2020 Current Services & Binding Obligations (Estimates)	FY 2020 Phoenix Area Program Increases (Totals)	FY 2020 Phoenix Area National Budget Recommendation (Totals)
Clinical Services	<b>3,359,038</b>	<b>3,252,542</b>	<b>227,106</b>	<b>1,013,359</b>	<b>4,372,397</b>
Preventive Health	<b>159,730</b>	<b>156,667</b>	<b>9,489</b>	<b>30,000</b>	<b>189,730</b>
Other Services	<b>175,694</b>	<b>165,156</b>	<b>5,018</b>	<b>65,000</b>	<b>240,694</b>
Contract Support Costs	<b>800,000</b>	<b>717,970</b>	<b>100,000</b>	<b>0</b>	<b>800,000</b>
Facilities	<b>545,424</b>	<b>446,956</b>	<b>122,511</b>	<b>418,000</b>	<b>963,424</b>
<b>TOTAL</b>	<b>4,239,886</b>	<b>4,021,321</b>	<b>464,124</b>	<b>1,526,359</b>	<b>5,766,245</b>

*\*See Deliverable 1 - FY 2020 Phoenix Area National Budget Worksheet (Addendum #1)*

## Fiscal Year 2020 IHS Budget Narrative (Deliverable #2)

Tribes in the Phoenix Area recommend a total Indian Health Service (IHS) budget of **\$5,766,245,000** for Fiscal Year (FY) 2020. This represents a program increase of **36 percent** above the FY 2017 IHS Enacted Budget of \$4.24 billion which served as the planning base for the FY 2020 formulation process. The top 10 budget line item priorities and the program increases were agreed upon by the participants at the meeting. They are based on last year's priorities and the current hot topics and emerging issues identified by the Tribes. They are:

1. **Purchased Referred Care (+\$135 million)**
2. **Hospitals & Clinics (+\$703.3 million – Includes \$101 million for New Staffing, \$20 million for EMS increase & \$5 million for Opioid High Risk Infant Care)**
3. **Mental Health (Behavioral Health) (+\$65 million)**
4. **Dental Services (+\$40 million)**
5. **Alcohol & Substance Abuse (+\$70 million – Includes \$5 million for Opioid abuse prevention and treatment)**
6. **Health Care Facilities Construction (+\$210 million – Includes \$25 million for Small Ambulatory Joint Venture Projects)**
7. **Maintenance & Improvement (+\$85 million)**
8. **Sanitation Facilities Construction (+\$75 million)**
9. **Urban Health (+\$35 million)**
10. **Community Health Representatives (+\$17.5 million)**

Several of the priorities connect to provisions of the Indian Health Care Improvement Act (IHCA) (25 U.S.C. Chapter 18) as well as to the specific line items. Tribes specified these line items because in their view they were inadequately funded neither in the enacted FY2017 Annualized Continuing Resolution (CR) or the FY2018 Budget Request.

**Current Services/Binding Obligations** – Tribal Leaders noted the importance of funding current services and the Federal government's binding obligations (fixed costs) in the FY 2020 IHS Budget Request. The IHS national estimate for Current Services and Binding Obligations in FY 2020 totals **\$464 million**. It is broken out as follows:

### Current Services:

- \$73.3 million for Population Growth
- \$75.3 million for Medical Inflation
- \$14.4 million for Non-medical Inflation
- \$15.8 million for Tribal Pay Costs (current staff)
- \$10.1 million in Federal Pay Costs (current staff)

### Binding Obligations:

- \$100 million for Health Care Facilities Construction (HCFC) projects (See additional program increase for HCFC)
- \$75 million for New Facility Staffing (See additional program increase for New Facility Staffing in the Hospitals & Clinics line item).

Binding Obligations are amounts that IHS commits to fund statutory requirements. The obligations of the agency include pending construction projects and New Staffing. The amount of \$100 million is the placeholder amount for construction and \$75 million is the placeholder amount for staffing at facilities that may be scheduled to open in any given year. Two facilities that have been on the HCFC priority list are scheduled to open in 2020. The amount identified in the IHS estimate for staffing is not sufficient for the Red Hawk clinic at the Gila River Indian Community and the Fort Yuma Indian Health Service Facility. Tribes in the Phoenix Area support an additional increase of \$101 million under the Hospitals & Clinics line item for this purpose.

FY 2020 Phoenix Area National IHS Budget Priorities

Tribes and urban Indian program representatives at the Phoenix Area meeting developed a 36 percent national budget request reflective of their agreed upon priorities. The issues and concerns surrounding the top 10 priorities are described below.

**1. Purchased Referred Care (PRC) (+\$135,000,000)**

The Tribes in the Phoenix Area recommend a program increase of **\$135 million** at the 36 percent level for the PRC line item. Because the IHS does not receive sufficient appropriations to provide some levels of tertiary care directly, the need to purchase specialty care from private providers is extremely important to patients served in our health care system. The increase is especially critical for Tribes and IHS Service Units in Nevada, Utah and rural areas of Arizona that are significantly more reliant on PRC funding. In FY 2017, the following top ten causes of inpatient PRC visits were reported by the Phoenix Area IHS:

Top Ten Causes of Inpatient PRC Visits (2017)

Arizona	Nevada	Utah
1. Sepsis	1. Sepsis	Sepsis
2. Pneumonia	2. Complications of Diabetes Mellitus	Fracture (unspecified)
3. Myocardial Infarction (Heart Attack)	3. COPD w/Acute Exacerbation	Complications of Diabetes Mellitus
4. Hypertensive Heart & Chronic Kidney Disease	4. Anemia	Alcohol Dependence
5. Renal Failure	5. Pneumonia	Hemorrhagic Stroke
6. Cerebral Infarction (Stroke)	6. Lower Back Pain	Gastro-Esophageal Reflux
7. Ulcer	7. Abnormal Fetal Heart Rate	Open Wound (unspecified)
8. Neoplasm (cancerous or non-cancerous).	8. Foot Ulcer	Traumatic Pneumothorax (Lung Collapse)
9. Osteoarthritis of Knee	9. Osteoarthritis	Acute Pancreatitis
10. Fluid Overload (unspecified)	10. Congestive Heart Failure	Poisoning by Tricyclic Antidepressants

Tribes are mindful of the important role of the PRC program and are encouraged that the President's Budget Request for FY 2018, did not include a reduction. Nevertheless, it's evident that a \$1.7 million increase above the FY 2017 Annualized Continuing Resolution level will be utilized quickly by our patients that meet the eligibility criteria and medical priority levels. Tribal Leaders brought to the attention of the Phoenix Area IHS that they support implementation of two PRC provisions in the Indian Health Care Improvement Act (IHCIA). They are;

Patient Travel Costs (25 U.S.C. §1621I) - Tribes noted that the ability to utilize their PRC allocations to cover these costs is crucial. Safe, coordinated and cost effective transportation for patients must be provided.

Arizona, North Dakota and South Dakota as Contract Health Service Delivery Area (CHSDA); Eligibility of California Indians (25 U.S.C. § 1678, §1678a, §1679) - IHS has not yet made concrete steps to implement these sections of the IHCIA to provide permanent designation of these states as PRC delivery areas otherwise known as CHSDA's. The delay in the implementation is a concern that existing appropriations would not be sufficient, but at the same time the Tribes realize that these measures would provide significant relief. In recent years, the Affordable Care Act provided alternative insurance options for individuals otherwise reliant on PRC to cover some of the costs of specialty care. Now policies that had shored up insurer participation in the Health Insurance Marketplace have been drastically altered under the current Administration to the extent that the number of insurance plans that will cover individuals with pre-existing conditions, which is an important requirement for many AI/AN seeking premium assistance and cost sharing reductions afforded through the Marketplace, have declined. Unfortunately, the relief that the ACA affords is tenuous and we could see a dramatic trend wherein PRC allocations have to be utilized in more situations because these alternative resources are dissipating. Tribes in the Phoenix Area request that IHS begin the process to consult with the Tribes in the region, to estimate the funding needed for implementation and to identify a feasible timeline to establish the statewide CHSDA in Arizona.

## 2. Hospitals & Clinics (+\$703,359,000)

Tribes in the Phoenix Area recommend a program increase of **\$703.3 million** at the 36 percent level for the Hospitals & Clinics (H&C) line item. Of this amount, Tribes in the Phoenix Area support an increase of **\$101 million** for New Staffing at ambulatory clinics scheduled to open in FY 2020, specifically for the Red Hawk facility at the Gila River Indian Community and the Fort Yuma Health Care Facility. **\$20 million** is sought to provide an across the board increase to Tribal Emergency Medical Services programs. Tribal Leaders value the life-saving work conducted by Paramedics, Emergency Medical Technicians and Emergency Department staff. Their ability to be ready to provide critically needed care on a 24 hour basis does not go unnoticed. Also supported is a **\$5 million** request for Opioid Specialized High Risk Infant Care. H&C provides the greatest source of funds for the IHS and Tribes to provide medical care and the request addresses needed improvements to increase access to health care to address chronic diseases and health risks such as cancer, heart disease, unintentional injury, liver disease and cirrhosis and diabetes which nationally are the leading causes of death among AI/AN.

The regional mortality rates in 2013 in Arizona, Nevada, and Utah for AI/AN reflect similar patterns to what is seen on a national level according to the Arizona Department of Health Services, the Nevada State Health Division and the Utah Department of Health. Heart disease and cancer were the leading causes of death among AI/AN in the three states in 2013. Nevada and Utah AI/AN populations also had a high burden of respiratory disease deaths. The table below lists the information by state.

American Indian/Alaska Native Mortality Rates by State, 2013\*

Arizona	Nevada	Utah
Heart Disease (123)	Heart Disease (142)	Cancer (122)
Cancer (101)	Cancer (100)	Heart Disease (103)
Unintentional Injury (95)	Unintentional Injury (40)	Respiratory Disease (85)
Diabetes (80)	Chronic Liver Disease/Cirrhosis (59)	Influenza/ Pneumonia (32)
Chronic Liver Disease/Cirrhosis (59)	Influenza/ Pneumonia (22)	Alcohol-Induced (30)

(per 100,000 population)

*\*Inter Tribal Council of Arizona, Inc. Tribal Epidemiology Center.  
Community Health Profile: IHS Phoenix & Tucson Service Areas. November 2016.*

In an era of uncertain funding for the Indian Health Service, Tribes are concerned about the need to sustain and enhance services. IHS/Tribal hospitals and clinics need to meet the projected workload. These facilities rely on appropriations as well as third party resources that our patients access, such as Medicaid, Medicare and Health Insurance Marketplace plans. For the moment it appears that the Patient Protection and Affordable Care Act (ACA) is still the law of the land, but potential budget cuts and policy re-direction that reduce the effectiveness of the ACA is damaging. Tribal Leaders fought hard in 2017 to inform the policy makers that any reduction in the resources that states have relied on to expand Medicaid up to 133% of the federal poverty level or to provide subsidies for individuals up to 400% FPL to obtain Marketplace coverage will put Indian health care in jeopardy. The significant program increase for the Hospitals & Clinics line item put forth by the Tribes in the Phoenix Area takes this uncertainty of discretionary funding and health insurance access into consideration. While the Administration sought an increase of \$16.7 million for this line item in FY 2018, it is primarily dedicated for New Staffing and the operations of the two facilities that are scheduled to open this year. These are the Choctaw Nation Regional Medical Center and the Flandreau Health Center. \$1 million is slated to fund the National Congress of American Indians (NCAI) Healthy Lifestyles for Youth grants, which leaves \$900,000, a minimal amount that will be quickly absorbed into clinical care.

Other Tribal recommendations were identified regarding overall the delivery of medical care. They include:

- The need to reduce long waits for medical appointments to prevent having to go to an Emergency Room or seek a PRC referral if the health issue is beyond care levels that IHS and Tribes are able to routinely provide.

- The need to keep pace with needed pharmaceutical services, including the types of medications that are required for patients seen through PRC referrals who fill their prescriptions at IHS or Tribal pharmacies.
- The need to provide the resources to upgrade Information Technology (IT) pertaining to the Electronic Health Record (EHR), to upgrade the Registration Patient Management System (RPMS) or compatible software to be utilized to maximize data collection and billing and third party insurance collections.

### **3. Mental Health (+\$65,000,000)**

Tribal Leaders in the Phoenix Area seek an overall increase of **\$65 million** dollars for the Mental Health line item. The Tribes seek to magnify the ability of mental health programs to continue their important work that includes providing outpatient counseling, psychiatric evaluations, crises response, case management and outreach and education. The resources requested in FY 2018, a \$710,000 is wholly inadequate to provide the level of screening treatment and therapy needed to reduce suicide and suicide attempts, depression, self-harm, violence and other emotional trauma. The increase is also needed so that IHS and Tribes may fully institute behavioral health integration with primary care. Additional concerns are noted below:

- The need for qualified mental health providers; in particular, Tribes voiced the difficulty in recruiting and retaining fulltime professionals to work in rural areas and adapt to Tribal settings. Tribal Leaders are aware of the need to grow our own Indian health professionals to fill this need.
- Significant numbers of youth and adults in Tribal communities that experience severe depression, suicidal thoughts, anxiety and other forms of mental illness, although prevention and treatment efforts, including Traditional Healing and Faith-Based counseling have been elevated that yield positive results.
- The need to access higher levels of psychiatric care as appropriate for AIAN patients within the IHS system and connecting patients to state services, including involuntary commitment orders processed by Tribal Courts or through state courts. A factor related to this is the difficulty obtaining necessary psychological evaluations for the Tribal Court process and knowledge of complex State requirements. Comprehensive case management of each patient's case and the provision of aftercare services for the individual in recovery are key.

There are numerous provisions in the Indian Health Care Improvement Act (IHCA) that pertain to behavioral health. Tribes in the Phoenix Area seek the new resources to enhance current services and to fund implementation of the following two provisions pertaining to mental health care and co-occurring disorders. These are;

Behavioral Health Prevention and Treatment Services (25 U.S.C. §1665, 25 U.S.C. §1665b, 25 U.S.C. §1665c). Establishes the authorities for comprehensive services and emphasizes collaboration among alcohol and substance abuse, social service and mental health programs.

Mental Health Technician Program (25 U.S.C. § 1665d). Comprehensive training of community mental health paraprofessionals, including Behavioral Health Aides under CHAP, to provide community based mental health care that includes identification, prevention, education and referral for treatment services and the use and promotion of traditional health care practices.

#### **4. Dental Services (+\$40,000,000)**

An increase of **\$40 million** to the Dental Services line item is requested. The need to improve oral health care delivery, workforce and prevention efforts cannot be understated. In 2015, the IHS conducted the Oral Health Survey that compares 1999 data to the current data. Key findings of the survey indicate the following for the Phoenix Area:

- 57% of AIAN dental patients 35+ years of age and older have untreated decay. AIAN adult dental patients are almost 3 times more likely to have untreated decay than whites. In the Phoenix Area the percent of dental patients 35+ years and older with untreated decay averages 63%.
- 17% of AIAN adult dental patients compared to 10% of the U.S. overall population have severe periodontal disease.
- 83% of AIAN adult dental patients (ages 40-64) have missing teeth compared to 66% of the U.S. overall population.

IHS reports that over 80 percent of AIAN children ages 6-9 and 13-15 years suffer from dental caries, while less than 50 percent of the U.S. population in the same age cohort has experienced cavities. Despite these high rates, the 2016-2017 IHS Oral Health Survey of AIAN elementary school children indicates that the caries rate has not increased significantly over the last 5 years. Encouraging results have been gained by widespread utilization of dental sealants and topical fluoride in our dental clinics. These applications have been made available to the youth at Tribal schools in many locations and some Tribes have increased prevention education efforts.

The FY 2018 budget request for Dental Health totaled a \$1.8 million increase above FY 2017. \$1.4 million of the increase is to be utilized at two new health facilities for dental staffing and operations. Without overall increases Tribes discussed the barriers to attracting dental professionals and paraprofessionals to work in Tribal communities. They believe that hiring Dental Therapists would be a viable addition to the Indian health care dental workforce. 25 U.S.C. §10221(d)(3)(A) requires that the use of Dental Therapy services or any mid-level dental health provider in the lower 48 states must be authorized under state law. Tribes in Arizona have begun to work with the Dental Care for Arizona Coalition to establish Dental Health Aide Therapy through the state's Sunrise Application process. On November 28, 2017, the Joint House & Senate Health Committee of Reference (COR) passed the application. This is positive recommendation by the COR which now gives the coalition the ability to move forward on the legislative process. It is believed that most of the reservations and rural areas of



the Arizona which are located in Dental Health Professional Shortage Areas with populations without dental insurance will benefit from Dental Therapy by increasing access to care.

The following IHCIA provision is a priority of the Tribes in the Phoenix Area.

Nationalization of the Community Health Aide Program 25 U.S.C. § 1616l (d)). CHAP would bring to the lower 48 states a program that's been successful in Alaska. It's comprised of highly trained paraprofessional workforce of Community Health Aides (CHAs), Behavioral Health Aides (BHAs) and Dental Health Aide Therapists (DHATs). Although the Dental Health Aide Therapy (DHAT) is excluded in the lower 48 states unless authorized by state law, Tribes are committed to overcoming barriers to implementation and seek a fully operational national Community Health Aide Program in the lower 48 states.

## **5. Alcohol & Substance Abuse (+\$70,000,000)**

Alcohol and substance abuse health risks in Tribal communities continue to be a major concern and correlates to two of the leading causes of death in the Phoenix Area, which are, unintentional injuries and chronic liver disease and cirrhosis. A **\$70 million** increase is needed to fund staffing and treatment costs, prevention efforts as well as coordination of care with behavioral health staff with regard to co-occurring mental health disorders. Of this amount **\$5 million** is requested to address opioid addiction and treatment. This concern is more fully discussed under the Phoenix Area Hot Topics section of this report.

The FY 2018 budget submission for Alcohol & Substance Abuse of \$205,593,000 is \$678,000 above the FY 2017 Annualized Continuing Resolution (CR) level. A major portion of the increase is needed for staffing and operations at two new health facilities. Tribes question how such an extremely low level of funding helps the agency to implement long sought behavioral health policies and programs in the Indian Health Care Improvement Act. Still the Tribes in the Phoenix Area continue to advocate for the resources needed to implement the two priority IHCIA provisions identified below. These should remain at the forefront of the agency's planning.

Comprehensive Behavioral Health Prevention and Treatment Program (25 U.S.C. §1665c). This section of the IHCIA expands the scope of American Indian/Alaska Native behavioral health care programs and services.

Indian Youth Program (25 U.S.C. §1665g). Expands the scope of treatment in Youth Regional Treatment Centers and would provide funds to construct and renovate existing health facilities to provide intermediate behavioral health services and professional staffing for intermediate adolescent services such as group homes, sober housing, youth shelters and psychiatric units.

## 6. Health Care Facilities Construction (+\$210,000,000 – Includes \$25,000,000 for Small Ambulatory Joint Venture Projects)

Tribes in the Phoenix Area support an additional Program Increase of **\$210 million** in FY2020 for the HCFC line item. The amount of **\$185 million** is to address projects on the HCFC priority list and the amount of **\$25 million** is specifically for Small Ambulatory Joint Venture and Demonstration Projects. Tribes have great need to alleviate lack of space and increase access to and improve patient health care. The current IHS HCFC Priority List, also known as the 5-year plan, was grandfathered into the new construction priority system established in the Indian Health Care Improvement Act in 2010. A new system includes the identification of priority projects at each IHS Area that the Congress will consider funding in the future.

As of June 2017, IHS reported that the amount needed to fund all of the current projects on the HCFC priority list, is \$2.9 billion. The amount specified under Binding Obligations at \$100 million is inadequate and will only be enough to potentially support phased construction of two or three projects listed on the 5-year plan that would be considered active in fiscal year 2020. There are six projects that should be considered in FY 2020. These include the hospital replacement projects at Gallup, New Mexico and the outpatient facilities planned for Dilkon, Arizona, Pueblo Pintado, New Mexico, Bodaway Gap, Arizona, Albuquerque West in New Mexico and Sells, Arizona. The amount identified by IHS to continue phased-in construction of these facilities in FY 2020 is \$214 million. It is uncertain whether or not IHS will request or if the Congress will appropriate sufficient dollars to the HCFC line item in FY 2018 and FY 2019 for all seven projects. The amount requested in the FY 2020 President's Request for Facilities Construction is a \$4.8 million cut.

The IHCIA provisions that require implementation and resources to address these Tribal concerns are:

Health Care Facility Priority System (25 U.S.C. §1631(c) (1) (A))

Priority of Certain Projects Protected (25 U.S.C. §1631(c)(1)(D), §1631(c)(2)(B), §1631(d)(1)(g))

Indian Health Care Delivery Demonstration Projects (25 U.S.C. §1637)

## 7. Maintenance & Improvement (+\$85,000,000 million)

Tribes in the Phoenix Area support an additional program increase of **\$85 million** in FY2020 for the Maintenance & Improvement (M&I) line item. M&I funds are the primary source of funding to maintain, repair and improve existing IHS and Tribal health care facilities. The FY 2018 IHS Congressional Justification states the importance of maintain reliable and efficient buildings to provide health care services, yet at the same time, the IHS Budget Request reflects a \$13.5 million cut below the FY 2017 enacted budget.

*“Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned health care facilities is approximately 37 years, whereas the average age, including recapitalization of*

*private-sector hospital plants, is 9 to 10 years. Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase.”*

This line item was identified as a hot topic by the Tribes in the Phoenix Area. Tribal Leaders are concerned that without proper maintenance of our facilities the staff will be hampered in their ability to deliver quality services. In terms of the need that IHS tracks, the backlog of deferred maintenance is now reported at \$500 million, therefore, a decrease in M&I cannot be justified by the Administration.

#### **8. Sanitation Facilities Construction (+\$75,000,000)**

Tribes in the Phoenix Area continue to prioritize the Sanitation Facilities Construction line item and request a **\$75 million** increase in FY 2020. As with other infrastructure issues in Tribal communities the need is great. The IHS reports that the sanitation project backlog is almost \$3.4 billion and affects several Areas of the IHS, including Alaska Area, Navajo Area, Oklahoma Area and the Phoenix Area. The FY 2018 President’s Budget, with a proposed cut of \$23.8 million to this line item cannot be justified as a marked increase is required to address water, wastewater and solid waste facilities for approximately 200,000 existing homes in communities across Indian Country. This request also considers the projected services that will be required for new Tribal housing in FY 2020.

#### **9. Urban Health (+\$35,000,000)**

Tribal Leaders in the Phoenix Area support a long overdue program increase for the Urban Health line item totaling **\$35 million**. They recognize that the health issues of the American Indian population whether they reside on or off-reservation are similar. Urban health programs, like the Tribes, have similar difficulty recruiting medical, dental, behavioral health and public health professionals that can uniquely respond to the health needs of the urban Indian population. It is recognized that access to health care is hampered by poverty in urban areas, limited and unreliable transportation, the lack of the full range of medical services in lower income areas and lack of optimal space at urban Indian health programs.

There is now a requirement in the IHClA that requires IHS confer with Urban Health programs (25 U.S.C. §1659). Other priority provisions of the IHClA that are relevant to this priority encompass all of Title 1 – Subtitle E. Health Services for Urban Indians, of which the following are of importance:

Facilities Renovation (25 U.S.C. § 1659)

Expand Program Authority for Sec. Urban Indian Organizations (25 U.S.C. § 1660e)

Community Health Representatives (25 U.S.C. § 1660f)

#### **10. Community Health Representatives (+\$17,500,000)**

Tribal Leaders in the Phoenix Area noted that the CHR line item has hovered at \$58 million since 2014. In recognition of the work CHRs do and the need to elevate and enhance their program efforts, a **\$17.5**

**million** increase is requested. Tribal leaders recognize the important role of CHR's as a paraprofessional member of the local IHS or Tribal clinical health care delivery team providing information on health issues, policies, procedures and basic preventative services to Tribal members. CHR's must comply with standards of practice and the training requirements. They are highly regarded in Tribal communities for the work they do. Tribes have struggled over the years to increase their salaries as well as hire additional CHR's to help with the workload. A program increase is sought to provide direct relief to these tribally operated programs.

The IHCIA provision that is associated with this priority is:

Community Health Representative Program (25 U.S.C. § 1616)

Under the authority of the IHCIA, the Secretary is required to maintain a Community Health Representative Program under which the Service that provides for the training of Indians as health paraprofessionals, and uses such paraprofessionals in the provision of health care, health promotion, and disease prevention services to Indian communities.

**INDIAN HEALTH SERVICE**  
**Phoenix Area FY 2020 Hot Issues (Deliverable #3)**

FULL FUNDING FOR THE INDIAN HEALTH SERVICE

**ISSUE**

Tribal Leaders in the Phoenix Area support a concrete commitment by the Administration to secure full funding for the Indian Health Service (\$32 billion) to be phased in over 12 years. The following actions described in this briefing paper, include requested policy changes and budgetary increases. These steps will notably increase access to health care, shore up the IHS system's operational efficiency and safety, and improve the overall quality of health care for the American Indian population

**BACKGROUND**

The funds necessary to eliminate the overwhelming health disparities of American Indian and Alaska Native people has never been properly appropriated. The IHS and the Tribes administering their own health programs have been forced to operate within a base budget which is historically inadequate. The true needs-based budget, which would bring health resources to parity with the rest of the nation, is now at \$32 billion. Compare this to an actual appropriation of less than \$5 billion. While the IHS has received marginal increases in more recent years, these certainly have not been enough to effectively target chronically underfunded health priorities.

**RECOMMENDATIONS**

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

- Secure advanced appropriations (2-year funding cycles) for the IHS.
- Enact mandatory appropriations for the IHS.
- Provide additional funding in FY 2020 for three Phoenix Area priorities in the Indian Health Care Improvement Act (IHCA) that was permanently reauthorized in 2010:
  - 1) A \$210 million program increase is recommended for the HCFC line item for Health Care Facility Construction projects on the current priority list of which \$25 million is requested to be designated for new grants for Joint Venture Small Ambulatory Projects.
  - 2) Without delaying progress on current priority projects, provide additional funding to institute the new HCFC priority system. A \$30 million program increase is recommended for the Office of Facilities and Environmental Health (OEHE) Support.
  - 3) Begin execution of the Arizona statewide Contract Health Services Delivery Area (CHSDA)/Purchased Referred Care (PRC) statutes. A \$135 million program increase is recommended for the Purchased/Referred Care line item from which a designated portion for planning, research and Tribal consultation on this statute should occur.

- Provide additional funding in FY 2020 to the Dental line item to reduce oral health disparities. (+\$40 million). Oral health care as a major need in the American Indian population. IHS has documented that the prevalence of tooth decay among American Indian children is at 76% by age 5, and American Indian adults suffer twice the prevalence of untreated tooth decay and/or periodontal diseases compared to the general U.S. population which is due to factors such as geographic isolation and lack of providers.
- Provide additional funding in FY 2020 to the Maintenance & Improvement line item (+\$85 million) to reduce the backlog of deferred maintenance that's reported by IHS at \$500 million.
- Provide additional funding in FY 2020 to the medical Equipment line item to address needs at new facilities and the replacement and repair of older equipment. (+\$18 million). Equipment funding has remained relatively flat and at the current rate of appropriations equipment would be replaced every 30 years rather than the recommended average lifespan of equipment at 7 years. To replace equipment on a 7 year cycle, it would require \$70 million annually.
- Increase the IHS annual requested estimate for New Staffing from \$75 million to \$125 million.
- Tribal Leaders support an infusion of resources to the IHS Urban Health line item (+\$35 million) and endorse Medicaid reimbursement at 100% FMAP for the American Indians and Alaska Natives that are served at these facilities. This may require amending the Social Security Act, which Tribes in the Phoenix Area fully support.
- The Indian health care system will be impacted by the Department of Veterans Affairs (VA) announcement on June 5, 2017, that it is ending use of the Veterans Health Information Systems and Technology Architecture (VistA) and purchasing a commercial off the shelf Electronic Health Record (EHR) product that is used by the Department of Defense. The IHS Resource Patient Management System (RPMS) is based on VistA, but has been upgraded over the years in coordination with the VA to meet IHS requirements. It's recommended that IHS seek new funding to cover the transition to an optimal EHR technology platform that can replace RPMS.

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SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI)

**ISSUE**

Tribes urgently request the U.S. Congress pass permanent reauthorization of the Special Diabetes Program for Indians (SDPI). The program was enacted into law in 1997 and without action by the U.S. Congress and the President, it is now set to expire on January 26, 2018.

**BACKGROUND**

The rates of ESRD have begun to decline among the American Indian population and can be attributed to the frontline prevention and educational activities that SDPI programs conduct in Tribal communities. Diabetes Mellitus (DM) is the 5th leading cause of death across all ages in the American

Indian population in the west. In the Phoenix Area IHS, it's the number one reason for an ambulatory visit among the Tribes in Arizona, Nevada and Utah and the second leading cause for an inpatient visit in the region.

### **RECOMMENDATION**

Increase SDPI funding to \$200 million per year with an inflation adjustment for the over 400 SDPI programs conducted in Tribal and urban Indian communities in 35 states.

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### **SUPPORT FOR COMMUNITY HEALTH REPRESENTATIVE (CHR) AND HEALTH EDUCATION FUNDING INCREASE AND IMPLEMENTATION OF THE NATIONAL COMMUNITY HEALTH AIDE PROGRAM (CHAP)**

#### **ISSUE**

CHAP implementation is one of the high priority policy and program issues under discussion by the Tribal Leaders. Implementation will involve coordination among the Mental Health, Dental Health, CHR and Health Education programs to prepare for the comprehensive roles of the new paraprofessionals in the lower 48 states. Community Health Representatives and Health Educators are currently the principle paraprofessionals that conduct health promotion and disease prevention activities in Tribal communities in the lower 48 states. These two line items are long overdue for a program increase.

#### **BACKGROUND**

IHS Headquarters has consulted with the Tribes and begun to methodically plan the national expansion of the program. Tribes in the Phoenix Area discussed the potential for incorporating Community Health Aides (CHA's), Behavioral Health Aides (BHA's) and Dental Health Aides (DHA's) in health care teams and tribally led health promotion disease prevention efforts. CHAP affords Tribes in the lower 48 states wide ranging opportunities, including career advancement for CHR's, Health Educators, Behavioral Health Technicians, Hygienists, Dental Assistants and others and the overall expansion of the public health workforce that is extremely needed in Tribal communities. Several states, including Arizona, are considering legislation to amplify the roles of Community Health Workers that are employed by community health clinics and other entities. The Arizona Community Health Outreach Workers Association (AzCHOW) is championing a voluntary certification process. CHR's have stayed apprised of this effort and provided input regarding how this process could be inclusive of the Tribes that employ the largest CHW workforce in the state, which are CHRs.

#### **RECOMMENDATIONS**

Tribes in the lower 48 states recommend that the FY2020 budget include the necessary resources to extend CHAP, including Dental Health Aide Therapy to the lower 48 states. The Phoenix Area recommends program increases in FY 2020 at \$17.5 million and \$7.5 million, respectively.

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## TRIBAL CORRECTIONAL HEALTH CARE SERVICES

### **ISSUE**

The U.S. Supreme Court has determined that correctional facilities are required to provide health care services to inmates in accordance with the Eighth Amendment of the Constitution, *Estelle, et. v. Gamble*, 429 U.S. 97 (1976), *Brown, et al. v. Plata*, 131 S.Ct. 1910 (2011). Since 2009, the U.S. Department of Justice and Bureau of Indian Affairs have invested in modernizing jails throughout Indian Country, constructing new facilities that are designed to accommodate large inmate populations. These new Tribal facilities operate without licensed medical personnel to provide correctional health care services. The Inter Tribal Association of Arizona has joined a coalition of Tribes and Tribal Organizations that has been led by the Tuba City Regional Health Care Corporation to address this concern.

### **BACKGROUND**

Neither IHS nor the Bureau of Indian Affairs receives appropriations for this purpose and incarcerated individuals have to be transferred by law enforcement officers to IHS and Tribal clinics for outpatient services. Tribes are generally unable to provide funds needed to support medical and behavioral health staff in correctional facilities because unlike off-reservation jurisdictions that utilize property tax revenue for this purpose, federal law prohibits tribal governments from imposing property taxes. Tribal jails built since 2009 have already experienced outbreaks of tuberculosis and other communicable diseases and many inmates have chronic disease conditions, experience traumatic injury and behavioral health issues that require attention.

In 2016, IHS and Health Services Resources Administration (HRSA) announced that 27 additional IHS and tribal hospitals are now eligible for selection by health care providers in both their outpatient and inpatient settings under the National Health Service Corps (NHSC). Prior to that, only 12 facilities were eligible for the NHSC loan repayment program. This announcement is applauded as it opens up recruitment opportunities at the approved outpatient care sites including some Tribal facilities. Going forward access to primary health services and should be expanded to inmates across Indian country, including individuals incarcerated at BIA facilities.

### **RECOMMENDATIONS**

Tribes recommend that the U.S. Public Health Service establish agreements with Tribes and/ or the Bureau of Indian Affairs to allow medical staff under the U.S. Public Health Service Corp to be assigned to provide services at these correctional facilities. The NHSC designation needs to be expanded to include Tribal and BIA correctional facility sites in addition to state and federal correctional facilities.

The Social Security Act prohibits Medicaid participation for any individual who's an inmate of a correctional institution. It's assumed that states and local jurisdictions pay for the cost of correctional healthcare. At the present time there is no "inmate exception" for IHS and Tribal health care facilities for outpatient services provided to tribal member inmates and the costs for these services are increasing. Tribes in the Phoenix Area recommend that Congress amend Medicaid's "Inmate exception" so that an "Indian exemption" authorizes Medicaid reimbursement for the outpatient



services provided to any individual who is an inmate of a tribal detention center. (See attached ITAA Correctional Healthcare Resolution. Addendum #2)

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BEHAVIORAL HEALTH (ALCOHOL & SUBSTANCE ABUSE, MENTAL HEALTH)

**ISSUE**

Tribal Leaders continue to advocate for the resources needed to address alcohol, substance abuse and mental health issues. Tribes experience crises that require professional behavioral response capacity as well as the need for psychological evaluation services in order for appropriate treatment to be accessed within Tribal communities or at state facilities that provide additional services not available in tribal communities. ITU's have not received direct resources to address prescription drug and opioid addiction treatment from the state or federal government. The states' comprehensive responses to the opioid epidemic have not widely involved measures to assist the Tribes. With this issue as well as the ongoing alcohol, cannabis dependence and methamphetamine use that effect tribal members, families and communities, efforts to heal our people must be continued in earnest.

**BACKGROUND**

While reported visits to Indian health treatment facilities remain high for alcohol, cannabis dependence and methamphetamine, now prescription drug abuse, including addiction to opioid pain killers and heroin is affecting Tribes. According to a U.S. HIDTA report in 2007-2009, the AI/AN drug-related death rate was 1.8 times greater than the U.S. all races rate of 12.6 for 2008. In Arizona, for example, the 2014 Arizona Youth Survey included a question on past 30 day prescription drug misuse among 3,871 American Indian youth. The statewide average rate among 48,244 8th, 10th and 12th grade students was 6.3 percent, however among American Indian youth the average rate was about 7.9 percent.

Tribes have begun to be informed of state initiatives to address prescription drug abuse and the opioid epidemic. SAMHSA Opioid Abuse Grants were provided to the states in April 2017, but did not include resources for the IHS or a Tribal set-aside. The awards included language that encouraged the states to work with Tribes and urban Indian populations. Prior to that CDC awarded grants to the states' to help them respond to the opioid crisis, but these resources were not made available to the Tribes.

In 2016, IHS required that providers attend mandatory training and check State Prescription Drug Monitoring databases before prescribing opioids. In May 2017, IHS apprised the Tribes of the establishment of the IHS National Committee on Heroin, Opioid and Pain Efforts (HOPE) through an official charter that is tasked to: 1. Establish IHS policies, 2. Develop training for providers, 3. Establish effective pain management, 4. Increase access to Naloxone, 5. Expand access to Medication Assisted Treatment and 6. Reduce inappropriate use of Methadone.

In 2017, to address prescription drug and opioid addiction treatment, IHS included plans to conduct Naloxone training to 500 BIA law enforcement officials and institute Medication Assisted Treatment (MAT) training through its Tele-Behavioral Health Center of Excellence (TBHCE) under the Behavioral Health Integration with Primary Care initiative. In the FY 2018 IHS Budget Request, a slight increase in

the national appropriation at \$678,000, allows IHS and tribal programs to maintain their current levels of activity, but is not sufficient to target prescription drug abuse and the opioid epidemic.

## **RECOMMENDATIONS**

Tribes advise that integrated physical health and behavioral health treatment teams work to affectively address these issues and concerns. High consideration should be given to incorporate Traditional Healers as members of these teams. Tribes also recommend in FY 2020 that an increase of \$5 million be added to the Hospitals & Clinics line item to address opioid high risk infant care and an increase of \$5 million to the Substance Abuse line item to continue ramping up and sustain program efforts to address prescription drug and opioid misuse prevention, education and treatment.

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### ENHANCE EMERGENCY MEDICAL SERVICES (EMS) OPERATED BY TRIBES

#### **ISSUE**

Emergency Medical Services (EMS) provided by Tribes through P.L. 93-638 contracts with the Indian Health Service in Arizona are reimbursed at capped fee-for-service rates established by the Arizona Health Care Cost Containment System (AHCCCS), the Medicaid state agency. These capped rates are currently up to three times less than the same services provided by ambulance companies certified by the Arizona Department of Health Services (ADHS).

#### **BACKGROUND**

A prior Arizona Health Care Cost Containment System (AHCCCS)/Tribal Workgroup met two years ago to evaluate the reimbursement methodology for Tribal EMS providers. As a result, there was a rural rate increase of 15% in October 2016, but it has not remedied the inequivalent rates that apply to Tribal and Federal agencies under Arizona law. A new Tribal workgroup has been established by the Arizona Department of Health Services (ADHS) to address concerns with regard to the state's certification process that employs a rate negotiation process for private ambulance companies.

Tribal governments report that 638 operated EMS agencies meet all the CMS required standards of care such as; 1) Emergency Medical Technicians and Paramedics maintain certification, 2) certified staff participates in continuing education, 3) medical oversight is provided by a medical director, and 4) following State of Arizona Red Book/Protocols. AHCCCS further requires Tribal EMS agencies to maintain a provider registration number and a National Provider Identification (NPI) which includes licenses, disclosures, and agreements in order to obtain third party reimbursement.

#### **RECOMMENDATION**

Tribes in Arizona seek direct agreements with ADHS and AHCCCS for rates that are comparable to non-Indian ambulance companies operating in these same regions of the state that have met state certification criteria to address the rate issue. Tribes in the Phoenix Area further recommend a program increase in FY 2020 for EMS in the Hospitals & Clinics line item totaling \$20 million as these programs have not received a substantial increase to their base funding for years.

## INCREASE RECRUITMENT & RETENTION OF INDIAN HEALTH PROFESSIONALS

### **ISSUE**

IHS and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: Physicians 34%; pharmacist 16%; nurse 24%; dentist 26%; physician's assistant 32% and advanced practice nurse 35%.

### **BACKGROUND**

IHS reported that a total of \$48.3 million was needed to fund all of the unfunded health professional loan applicants in FY 2016, but it was only able to fund 437 out of 939 applicants. The agency reported that only 456 of the new scholarship applicants were awarded this financial support out of 1,250 new online scholarship applications. An additional \$3.3 million in funding was needed to fund all of the qualified applicants.

### **RECOMMENDATION**

Tribes in the Phoenix Area recommend a program increase of \$15 million to the Indian Health Professions line item in FY 2020 to increase funding for scholarships and to expand loan forgiveness options to individuals that are seeking to work in Tribal communities. Tribes seek measures to increase the recruitment and retention of professionals that are seeking to work in Tribal communities and engage Tribes in comprehensive efforts to promote American Indian and Alaska Natives into health careers. For example, Tribes support amending Internal Revenue Service (IRS) statutes to fully exclude IHS scholarships and loans from an individual's taxable income. They also recommend updating clinical and administrative Grade Salary (GS) levels to enhance IHS salaries to make them competitive with the Veterans Administration. It is further recommended that IHS continue its efforts to assist Indian Health Care Providers obtain continuing education credits.

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## ROCKY MOUNTAIN SPOTTED FEVER (RMSF)

### **ISSUE**

Significant concerns were noted about the ongoing RMSF health impacts that continue to cause illness and death in Tribal communities. RMSF is a bacterial disease known as rickettsiosis spread through the bite of an infected brown tick. Symptoms include fever and headache, rash, nausea, vomiting, muscle pain and loss of appetite. It can rapidly progress to a serious illness that can lead to amputation due to damaged blood vessels, paralysis and mental disability; untreated cases can result in death.

### **BACKGROUND**

Some coordinated efforts occurred a few years ago and the Tribes, the state of Arizona and federal agencies at the time made available resources and instituted a priority coordination of effort to address this issue. However, those resources have diminished and the health issue has not subsided. The White Mountain Apache Tribe, the San Carlos Apache Tribe and other Tribes have continued to make efforts to address RMSF and indicated that they are seeking additional resources to assist in their prevention efforts.

The San Carlos Apache Tribal Council declared a RMSF Public Health Emergency on December 5, 2017 and is seeking assistance from the U.S. Department of Health and Human Services, notably CDC, IHS, as well as the Arizona Department of Health Services to find new options for supporting RMSF prevention. The Tribe reports that from the spring of 2017 to the present, there have been 12 RMSF cases with 2 fatalities. The Tribe is stepping up all efforts to quell the RMSF outbreak, including instituting quarantines of residences and mandatory treatment of dogs

#### **RECOMMENDATION**

Tribes recommend that the concerns of the San Carlos Apache Tribe and other Tribes affected by RMSF be heeded. The specific requests of the Tribe include that the U.S.HHS, including the Centers for Disease Control (CDC) and the Indian Health Service assist the Tribe with funding and technical assistance to quell the outbreak of RMSF on the reservation.

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#### Phoenix Area Report Slides (Deliverable #4)

See Addendum III.

#### Phoenix Area Tribal Leader Representatives (Deliverable #5)

See Addendum IV.

**ADDENDUM I – PHOENIX AREA IHS FY 2020 NATIONAL BUDGET SPREADSHEET**

**ADDENDUM II – HOT TOPICS (DELIVERABLE #3) – ADDITIONAL INFORMATION ON TRIBAL  
CORRECTIONAL HEALTH CARE ISSUES**

**ADDENDUM III – PHOENIX AREA REPORT SLIDES (DELIVERABLE #4)**

**ADDENDUM IV – PHOENIX AREA REPRESENTATIVES (DELIVERABLE #5)**



## ADDENDUM V - MAP OF THE PHOENIX AREA

**ADDENDUM VI - PHOENIX AREA IHS FY 2020 BUDGET FORMULATION MEETING - SAVE-THE-DATE/ANNOUNCEMENT/AGENDA**