USET
SOVEREIGNTY PROTECTION FUND

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Transmitted via IHCIFcomments@ihs.gov

December 15, 2017

Rear Admiral Michael Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane, Mail Stop 08E86
Rockville, MD 20857

Dear Acting Director Weahkee,

In response to the Dear Tribal Leader Letter published on November 13, 2017 by the Indian Health Service (IHS) requesting feedback and recommendations on topics for consideration by the IHS/Tribal Indian Health Care Improvement Fund (IHCIF) Workgroup, the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) offers the below recommendations. According to the letter, IHS will establish an IHS/Tribal IHCIF Workgroup which will be tasked with reviewing and assessing the existing IHCIF formula to submit recommended changes for future use. The formula must be updated to reflect considerable changes in the Indian Healthcare System since the 2010 Tribal Consultation on IHCIF.

USET SPF is a non-profit, inter-tribal organization representing 27 federally recognized Tribal Nations from Texas across to Florida and up to Maine[1]. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

In particular, the IHS/Tribal IHCIF Workgroup should consider the following:

- **Small Tribal Nation Add-on**
  - Due to the current formula, larger Tribal Nations receive a larger allocation of IHCIF resources because of their size and population. USET SPF recommends that the Workgroup consider maintaining a small Tribal Nation add-on within the formula. At times,

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

the allocation awarded to smaller Tribal Nations is too small to have a measurable impact on the health of the Tribal Nation.

- **Purchased Referred Care (PRC) Dependent Tribal Nations**
  - For a variety of reasons, including the underfunding of IHS, Tribal Nations, including many in the Nashville Area, often lack requisite healthcare infrastructure to deliver a full range of services to patients. In these situations, there is no other option except to purchase specialty care outside the Indian Health System. At current funding levels, most Nashville Area PRC programs are approving limited services beyond medical emergent referrals (to preserve life and limb), and less urgent, routine or preventive care must be deferred or denied pending additional appropriations. The circumstances of PRC dependent Tribal Nations must be taken into account, as the Workgroup reviews the formula.
- **Systems Efficiency Consideration**
  - With regard to Tribal and IHS health care infrastructure, USET SPF Tribal Nations have access to just two Tribally operated hospitals within the Nashville Area, with most of American Indian and Alaska Natives (AI/ANs) seeking care from small, rural health clinics offering limited services. In years past, the IHCIF Workgroup looked at a systems efficiency and accessibility factor. The upcoming convening of the Workgroup should also explore the impacts of health disparities for those Tribal Nations that can't readily access an IHS or Tribally-operated hospital.
- **Utilization of Tribal Epidemiology Centers**
  - USET SPF recommends the Workgroup consider the utilization of Tribal Epidemiology Centers (TECs) to provide mortality/morbidity data updates for IHS Areas and individual sites to correlate health care costs to the existing mortality index. This will help to determine if data pertaining to disease incidence or prevalence is sufficiently accurate to complete the health status indices for AIAN populations.

Thank you for the opportunity to provide recommendations on topics for consideration by the IHS/IHCIF Workgroup. USET SPF reminds IHS that updates and other changes to the IHCIF formula must be reflective of comprehensive Tribal Consultation before changes to the policy are finalized. This includes fully engaging with Tribal Leaders and Tribal Nations on an ongoing basis throughout the process. Should you have any questions or require further information, please contact Ms. Liz Malerba, USET SPF Director of Policy and Legislative Affairs, at LMalerba@usetinc.org or 202-624-3550.

Sincerely,

Kirk Francis
President

Kitcki A. Carroll
Executive Director