TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD

PRESENTED BY REX LEE JIM, NIHB BOARD AND EXECUTIVE COMMITTEE MEMBER AND VICE-PRESIDENT OF NAVAJO NATION

OVERSIGHT HEARING - INDIAN HEALTH
HOUSE APPROPRIATION SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES

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Chairman Simpson, Ranking Member Moran and Members of the Subcommittee, thank you for holding today's important hearing on Indian health. My name is Rex Lee Jim, and I serve as the Navajo Area Representative to the National Indian Health Board (NIHB) and as Vice President of the Navajo Nation.[1] The NIHB, in service to the 566 federally recognized Tribes, offers the following written comments regarding the Indian Health.

Honoring Trust Obligation

As you know, the federal trust responsibility is the foundation for the provision of federally funded health care to all members of the 566 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States. The provision of federal health care services to American Indians and Alaska Natives (AI/ANs) is the direct result of treaties that were made between the United States and Tribes and reaffirmed by Executive Orders, Congressional actions, and two centuries of Supreme Court case law. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples.

Health Disparities: Defining the Challenge

Significant health disparities exist within AI/AN communities. The current status of AI/ANs is grave, with the AI/AN age-adjusted death rates for all causes of death for years 2002-2003 at 1.2 times the rate of the U.S. population. Some areas see even greater disparities for AI/ANs compared to rates in the U.S. population; for example, tuberculosis rates are 8.5 times, chronic liver disease and cirrhosis, 4.2 times, diabetes, 2.9 times, unintentional injuries, 2.5 times and homicide, 2.0 times. AI/AN rates were below those of the U.S. population for Alzheimer's disease (0.5 times), and the recently-published CDC Report on HIV/AIDS in American indicates that AI/ANs had the 3rd and 4th highest (15.3 and 9.3) overall rate of new HIV infections per

[1] Established in 1972, the NIHB serves all federally recognized tribal governments by advocating for the improvement of health care delivery to AI/ANs, as well as upholding the federal government's trust responsibility to AI/ANs. We strive to advance the level and quality of health care and the adequacy of funding for health services that are operated by the IHS, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their Area. The NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of the Tribes.

100,000 respectively, among other races/ethnicities. However, while these rates have significantly changed since 2003, low rates are mostly likely due to the insufficient sampling data, reporting streams, racial misclassification, data ownership/management and under reporting. It is also critical to note that with diseases like HIV and AIDS, AI/ANs, among all American populations, have the shortest time between diagnosis and death.

Of all AI/AN people who died during 2002-2004, 26 % were under 45 years of age. These death rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates. This compared to 8% for the U.S. all-races population (2003).[2] Additional reduced age-adjusted mortality rates include: homicide (55%), cerebrovascular (49%), alcohol-induced (44 %), and heart disease (32 %).[3] Of all AI/AN people who died during 2002-2004, 26% were under 45 years of age. These death rates have been adjusted to compensate for misreporting of AI/AN race on the state death certificates. This is compared to 8% for the U.S. all-races population in 2003. Additional reduced age-adjusted mortality rates include: homicide (55%), cerebrovascular (49%), alcohol-induced (44%), and heart disease (32%).[4] Finally, the CDC reports that suicide remains the second leading cause of death of AI/AN youth.

The fact that the health status of AI/ANs has improved since 1972-1974 proves that with an increase in resources, health care providers, funding and other support it is possible to improve health inequities. Lowered mortality rates are among some of the positive changes in evidence. For example, tuberculosis mortality has declined 84% and deaths due to unintentional injuries have declined 58%. Although the AI/AN population suffers from among the worst chronic disease disparities in the nation, the leading cause of Years of Potential Life Lost is unintentional injuries. According to the Centers for Disease Control and Prevention (CDC) disparities data, the AI/AN population has the highest rate of death due to unintentional injuries of any race or ethnicity in the U.S, which is primarily prevented with the use of public health services, outreach, education, and public health law.

Preventable diseases affect AI/AN populations at a far greater rate than they do the rest of America. Death rates from preventable diseases among AI/ANs are significantly greater than among non-Indians. Significant regional differences exist in these disease patterns. Enhanced data gathering on a geographically-specific basis can yield information necessary to instruct policy development to appropriately address prevalence and incidence through more-informed approaches.

The Indian Health Care Delivery System

The Indian health care delivery system consists of services and programs provided directly by the Indian Health Service; Indian Tribes; and Tribal organizations who are exercising their rights of self-determination and self-governance; and services provided through urban organizations that receive IHS grants and contracts (collectively, the "Indian Health Care System" or I/T/U). The Indian Health Care System has a user population of 2.6 million individuals. This system is community-based and reflects a culturally appropriate approach to delivering health care to a

[2] Indian Health Service. Division of Program Statistics, "Trends in Indian Health," 2002-2003 edition.
[3] *Id.*
[4] *Id.*

population suffering severe health disparities and massive rates of poverty within the most remote and rural areas of America. The IHS has long been plagued by woefully inadequate funding in all areas, a circumstance which has made it impossible to supply Indian people with the level of care they need and deserve, and to which they are entitled by treaty obligation.

Gains for the Indian Health Care Delivery System

Thanks in no small part to the hard work and dedication of this Committee, in recent times, Congress and the Administration have demonstrated their desire to address commitments to Indian health and take steps toward the fulfillment of the federal trust responsibility by ensuring that the IHS receives annual increases. On behalf of NIHB, I thank this Committee for these increases in funding to IHS.

Over the past three fiscal years, the IHS budget has increased 29% and has a current budget of $4.3 billion. As a result, IHS has been able to keep up with inflationary costs and increase the access to primary care services, and IHS and Tribal programs have stretched these funds to make small, but real gains in health status such as with Diabetes. In light of the current economic climate, where many other budget accounts saw deep cuts, this increase acknowledges the critical health needs of our tribal communities and represents the continued commitment to honor the federal government's legal obligation and sacred responsibility to provide health care to AI/ANs. Despite the 44% funding deficit, the Indian Health Services was one of only several federal agencies, working in partnership with Tribes, to meet 100% of their Government Performance and Results Act (GPRA) performance measures in 2011 and continues to work to meet performance targets through innovative programs such as the Improving Patient Care Initiative (IPCI) which to helps improve the quality of care and use resources more efficiently. In addition, Tribes have expanded our Improving Patient Care initiative to 100 sites in the Indian health system. The IPCI is a patient-centered medical home initiative that is designed to improve the coordination of care for patients. This program is essential to facilitating adaptation to the new delivery system changes that come with the Affordable Care Act, and to helping improve customer service by making care more patient-centered.

Tribes are concerned that the severe lack of funding to address preventable diseases will keep the IHS from moving from a trauma system to a true public health model with a focus on prevention. Although the IHS budget has increase by an historic 29% since 2008, this equates to an average of 7.25% per year, barely enough to cover medical and non-medical inflation and the cost of contract health care for our growing population. Both serious budgetary increases and changes to resources supporting this health care system are necessary if we are going to effectively address the growing gap in health disparities, which has resulted in early death, and preventable, expensive chronic care costs for AI/ANs of all ages.

The value of a strong public health approach to American Indian and Alaska Native health

In addition to concerns over health care delivery, Tribes stress the absolute necessity of continued investments in public health initiatives. Catastrophic cuts to funding, coupled with preexisting underfunding of the IHS all but guarantee a dismantling of the public health programs tribes need and depend upon to address public health disparities. Public health is part of the health care delivery the federal government promised to the Tribes in treaties and

repeatedly affirmed though legislation, executive orders and Supreme Court case law. In some cases, public health initiatives were the primary focus of treaty health provisions.

In addition to a legal duty, the government must also recognize the moral responsibility it bears to continue funding for current public health initiatives. By creating initiatives that address substance abuse, depression, suicide, domestic violence, and a host of other multiple-trauma induced conditions, the federal government asked communities and individuals to begin conversations, open old wounds and start on the road to healing. Once begun, these processes require tenacity and commitment on the part of all parties. The work is generational. Abandoning those initiatives in the early stages actually results in poorer outcomes than neglecting the issues entirely.

Public health holds tremendous potential for the nation and special promise for Indian Country. Because Indian Country suffers from some of the highest rates of public health related disparities, including the high incidence and prevalence of completely preventable diseases, it also stands to make the greatest gains from the promised public health investments. Strong and sustained funding is necessary to address preventable diseases and allow IHS to move from a sick care system to a true public health model with a focus on prevention.

Successful Investment in Indian Health - Special Diabetes Program for Indians

The growing epidemic of Type 2 diabetes represents one of Indian Country's greatest public health challenges, as American Indians and Alaska Natives have the highest prevalence of diabetes amongst all U.S. racial and ethnic groups. In response to this epidemic, Congress established the Special Diabetes Program for Indians (SDPI) Congress in 1997. The recent Congressional reauthorization of SDPI through September 2014 through the *American Taxpayer Relief Act of 2012* at the current funding level of $150 million annually is a significant accomplishment for Tribal health care. SDPI programs established throughout Indian Country will continue to receive the needed funding and resources to continue the fight against diabetes.

While not every Tribe receives the SDPI grant, the program has become our nation's most strategic and effective federal effort in combating diabetes in Tribal communities. Today, SDPI provides grant funding to 404 diabetes treatment and prevention programs in thirty-five states. This federal investment in community-driven, culturally appropriate programs has led to significant advances in diabetes education, prevention, and treatment. SDPI is making a real difference in the lives of people who must manage diabetes on a daily basis and demonstrating remarkable outcomes.

The SDPI program is a mandatory funding program administered by the Indian Health Service (IHS). SDPI grantees follow specific reporting requirements that allow for assessment of grantee progress. These reporting requirements include: Attending and keeping track of required SDPI trainings; Improving the *IHS Diabetes Care and Outcomes Audit* items/elements; Collecting baseline data for required key measures of selected best practices; and Accomplishing objectives and planned activities from the grantee program plan. The SDPI grantee reports also includes information on diabetes prevalence for each target site and other diabetes-related measures such as amputations, End Stage Renal Disease rates, laser treatments, and obesity prevalence.

We have seen remarkable progress over the last several years from the data gathered from SDPI programs. The sharing of this information and expertise among health care professionals and Tribal communities has played a central role in improving accountability and excellence in the SDPI program. SDPI programs throughout Indian Country are clearly improving the way diabetes is addressed in Tribal communities as well as saving lives. As a result of intensive SDPI program data collection, sharing and analysis, we are able to demonstrate remarkable outcomes from SDPI programs, including a decrease in the average blood sugar level from 9.0% in 1996 to 8.1% in 2010; a 73% increase in primary prevention and a 56% increase in weight management activities targeting children and youth; and reduced risk of cardiovascular disease through reduced cholesterol levels.

The SDPI program can be used as a model of success because the SDPI program works in saving lives and the measurable health outcomes achieved so far are resulting in significant federal cost savings. From 1999-2006, the incidence rate of End Stage Renal Disease (ESRD) due to diabetes in American Indian and Alaska Native people decreased by 28%, which represents a greater decline than for any other racial or ethnic group in the country.

ESRD is the largest driver of Medicare costs in the United States. Medicare costs per year for one patient on hemodialysis exceeded $80,000 in 2009. The dramatic reduction in new cases of ESRD means a decrease in the number of new patients requiring dialysis and translates into millions of dollars in cost savings for Medicare, the Indian Health Service, and other third party payers. This data is significant and we can discuss the benefits of SDPI's impact beyond Indian Country as Congress focuses on ways to control Medicare spending. While it cannot be clearly claimed that this decline in the ESRD rates for American Indians and Alaska Natives is solely due to SDPI, the program has contributed to this downward trend.

SDPI has provided the funding, tools, training, support, and clinical data to help the Indian Health System make tremendous changes in the diabetes landscape in American Indian and Alaska Native communities. Guided by Congress' vision, scientific research, and community-driven priorities, SDPI funding has enabled the Indian Health system to build one of the most comprehensive and effective diabetes programs in the country. The challenges remain daunting, but as our understanding of diabetes continues to evolve, we will discover new directions and yet more hope for creating a healthier future for Indian Country. Together, we are beating diabetes for our ancestors, our communities, and future generations.

Recommendations

1. Create a long-term investment plan to fully fund IHS Total Need

Tribes have long asked for full funding of the IHS. Developing and implementing a plan to achieve funding parity is critical to the future of Indian health and to fulfilling the United Status's trust responsibility to AI/AN people. The funding disparities between the IHS and other federal health care expenditures programs still exist. In 2010, IHS spending for medical care was $2,741 per user in comparison to the average of federal health care expenditure of $7,239 per person.[5]

[5] IHS Fact Sheets: IHS Year 2012 Profile (January 2012) at: www.ihs.gov/PublicAffairs/IHSBrochure/Profile.asp

In 2003, IHS, Tribes, and urban programs worked together to develop for the first time a true Needs Based Budget (NBB) to address the shortfall of funding required to meet the health needs of AI/ANs. That Workgroup at that time proposed a 10-year phase-in plan, with substantial funding increases in the first two years and more moderate increases in the following years. In the intervening years and with failure to produce necessary funding to fulfill this 10-year plan, the health disparities between AI/ANs and other populations continue to widen, and the cost and amount of time required to close the funding disparity gap has grown.

Along with continued under-funding, IHS faces additional financial obstacles in its ability to provide care: inflation, both medical and non-medical, and population growth. Funding for IHS programs has not kept pace with inflation, while Medicaid and Medicare have accrued annual increases of 5% - 10%. The $59.9 million requested is needed to address the rising cost of providing health care and is based on the 1.5% non-medical inflation rate and 3.3% medical inflation rate identified by OMB. However, the actual inflation rate for different components of the IHS health delivery system is much greater. We recommended that the rates of inflation applied to Hospitals & Clinics, Dental Health, Mental Health and Contract Health Services in developing the IHS budget should correspond to the appropriate components in the CPI, and that there should be parity in the calculation of inflation among HHS operating divisions. The NIHB urges this Congress to consider the rates of inflation during the appropriations process and recommends an increase in funding to address these costs.

Additional funding is also needed to address the effects of population growth on IHS' ability to provide a continued level of care. IHS currently service population increases at an average rate of 1.9% annually.[6] The exclusion of population growth as a factor in the President's budget request puts the level of health care services into peril by reducing the availability of life-saving services for AI/ANs.

The NBB has been updated every year using the most current available population and per capita health care cost information. The IHS need-based funding aggregate cost estimate for FY 2015 is now $27.6 billion, based on the FY 2012 estimate of 2.6 million eligible AI/ANs served by IHS, Tribal and Urban health programs. Full funding of the NBB is a reasonable and achievable phased-in approach to begin to address the true health care needs in Indian Country. The Tribal NBB, if fully funded, would be less than three percent of the HHS $941 billion budget. Tribes and the NIHB will continue to ask the federal government to design and implement a true full funding plan for the IHS budget.

2. <u>Need for more data to understand true need</u>

Tribes need accurate, timely and accessible data to appropriately assess the health care needs for AI/AN. Tribes need this data to identify priority health needs, to plan health care delivery and public health programs, to implement those plans, and evaluate health activities. With this foundational knowledge, Tribes can make the best possible decisions for allocation of scare financial resources.

[6] IHS Fact Sheets: Indian Population (January 2012) at www.ihs.gov/PublicAffairs/IHSBrochure/Population.asp

At present, the data available for AI/AN populations fails to provide an accurate picture of AI/AN needs. Although there have been substantial and meaningful efforts on the part of Indian Health Service, the most comprehensive information available is from 2002-2003. Other federal agencies collecting health data often do not offer AI/AN statistics, or offer AI/AN statistics that are inaccurate. In these cases, inaccuracies may result from failing to correctly identify individuals as AI/AN or using survey methods that tend to minimize AI/AN participation.

Because effective health care and public health programs require this baseline data, the federal government's trust responsibility extends to health data collection, analysis and dissemination in addition to the provision of health care. Furthermore, the unique challenges in collecting AI/AN data, including geographic dispersion, racial misclassification, potentially excluding survey methods, and an inadequate collection of subgroup information, call for federal leadership and resources. Through the Indian Health Care Improvement Act, the Tribal Epi-Centers and Tribes have the right to access data kept by the States regarding the health of AI/ANs. Despite this legal assurance, acquiring data from the States remains costly and challenging. In addition, data available through the Indian Health Service, such as is collected through the RPMS system can also greatly enhance knowledge about AI/AN health status and progress. The establishment of electronic medical records throughout Indian Country, as is being achieved through the NIHB H Health Information Technology for Economic and Clinical Health (HITECH) Regional Extension Center, offers great promise in data creation about AI/ANs nationally. Data ownership and access issues must be addressed, however, before this potential can be realized.

3. Advanced funding to Indian Health Service Budget

Since FY 1998, appropriated funds for medical services and facilities through IHS have not been provided before the commencement of the new fiscal year, causing IHS and Tribal providers great challenges in planning and managing care for AI/ANs.

The lateness in enacting a final budget ranges from five days (FY 2002) to 197 days (FY 2011). Even after the enactment of an appropriations bill, there is an apportionment process involving OMB and then a process within IHS allocation of funds to IHS Area offices. In FY 2010, the Veterans Administration (VA) medical care programs achieved advance appropriations. The fact that Congress has implemented advance appropriations for the VA medical programs provides a compelling argument for Tribes and Tribal Organizations to be given equivalent status with regard to IHS funding. Both systems provide direct medical care and both are the result of federal policies. Just as the veterans groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of VA to properly plan and manage its resources, Tribes and Tribal Organizations have those concerns about the IHS health system. If IHS funding was on an advance appropriations cycle, Tribal health care providers, as well as the IHS, would know the funding a year earlier and would not be subject to continuing resolutions. Delayed funding significantly hampers Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts. Providing sufficient, timely and predictable funding is needed to ensure the federal government meets its obligation to provide health care for AI/ANs.

4. Protect IHS Budgetary Gains

The Tribes are extremely concerned about the consequences of sequestration. Unlike federal programs that serve the health of our nation's populations with the highest need, such as Social Security, Medicare, Medicaid, the Children's Health Insurance Program, and the Veterans Administration, the IHS is not exempt from the looming automatic across the board cuts. Although the recently passed American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2% to 5.1%, these cuts must be achieved over seven months instead of twelve, making the effective percentage of reductions approximately 9%. Even at that revised level, the IHS budget will suffer a devastating cut of $220 million.

As projected by the Administration, the IHS and Tribal hospitals and clinics would be forced to provide 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits. In addition, the billions in cut to funding for other key health agencies, such as Centers for Disease Control & Prevention, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration will further increase the blow to health of AI/ANs, as these programs have become critical to the Indian Health Care System. In total, this cut translates into lost funding for primary health care and disease prevention services for AI/ANs, which is certain to produce tremendous negative health impacts. Any budget cuts, in any form, will have harmful effects on the health care delivery to AI/ANs and its true cost will be measurable in lives as well as dollars. This must change. If this Congress cannot avoid sequestration through alternate methods of deficit reduction, the NIHB implores this Congress to make the IHS exempt from this process.

5. *Reform Contract Health Services*

The Contract Health Service (CHS) program serves a critical role in addressing the health care needs of Indian people. The CHS program exists because the IHS system lacks the capacity to provide onside and directly all the health care needed by the IHS service population. In theory, CHS should be an effective and efficient way to purchase needed care – especially specialty care – which Indian health facilities are not equipped or do not have the specialists required to provide needed services.

In reality, CHS is so grossly underfunded that Indian Country cannot purchase the quantity and types of care needed. Therefore, many of Indian patients are left with untreated and often painful and preventable conditions that, if addressed in a timely way, would improve quality of life, lower the cascading effect of requiring crisis medicine when prevention would have worked, and at lower cost. If this program expansion increase is not funded, or alternative methods of assuring access to care, equipment and services is not otherwise provided, AI/ANs will continue to live sicker and die younger than any other American citizens. In addition, the system will continue to drain existing available resources for costly urgent, emergent and chronic care at higher rates than other populations where prevention or immediate access to appropriate care is easily accessed. The prospect of a better future, the dream of healthy communities, and a fair shake at improving the health status of all AI/ANs will remain out of reach for most Tribal Nations.

One method that may alleviate some of the financial burden of accessing specialty care is extending the Federal Tort Claims Act to private physicians and other health care providers who

are willing to provide health care at Tribal and IHS sites on a voluntary, or pro-bono, basis. In partnership with NIHB, the American Academy of Orthopedic Surgeons explored the possibility of providing free health care services to American Indians in Montana and the lack of medical malpractice coverage to IHS and Tribal facilities was a main obstacle to advancing the effort. Charitable opportunities for physicians to provide free medical care are in evidence across the world and a well-planned and executed volunteerism program would provide for some relief. Likewise, establishing the presence of graduate medical education programs in Tribal and IHS facilities to ensure a constant presence of at least some medical specialists is also worthy of exploration.

Lastly, the IHS has a Tribal Workgroup reviewing this issue and is in the process of developing a set of tribal recommendations. We encourage the Committee to review these recommendations once released and we request that you assist with any legislative fixes if call for by the workgroup.

6. *Ensure Access to health care and services in 2014*

As this country's health care system will be evolving in the coming year, AI/ANs must be able to access the new benefits offered under the Affordable Care Act (ACA). The ACA contains numerous favorable procedural rules, cost-sharing protections, and mandatory enrollment exemptions that apply specifically to AI/ANs, referred to generally as "Indians" in the ACA. However, the ACA uses substantially similar but not exactly the same language to define "Indian" in every instance and in many cases does not include any definition at all. This creates enormous potential for confusion and inefficiency in the implementation of the ACA and makes it likely that AI/ANs will not receive the benefits and special protections intended for them in the law. Despite efforts by Tribal advocates, the only remaining remedy to this issue remains a legislative fix.

We are recommending that the definition of "Indian" adopted by CMS (at 42 C.F.R. § 447.50 and effective on July 1, 2010) in its implementation of the Medicaid cost-sharing protections should be adopted uniformly in implementation of the ACA for both Exchange plans and the Medicaid expansion as this definition is consistent with the substantially similar language used in the various definitions of Indian contained in the ACA. The use of the CMS regulatory definition has been endorsed by the National Indian Health Board, National Congress of American Indians, and the CMS' Tribal Technical Advisory Group.

The CMS definition conforms to the IHS eligibility regulations; thus, it is administratively efficient for I/T/U programs and state Medicaid plans to administer that are currently in place. Doing so will avoid bureaucratic confusion, fulfill the federal government's special trust responsibilities toward AI/ANs, promote the ACA's objectives of achieving nearly universal health coverage, and address the alarmingly inadequate access to health services by AI/ANs due to underfunding of the IHS.

9. Invest in the American Indian and Alaska Native Public Health System

It is proven that effective public health strategies save money and lives. Indian Country suffers from the highest rates of preventable illnesses and diseases and for every dollar spent in public health and prevention, $5 can be saved in the direct treatment of illness. Let's build on disease prevention and health promotion programs that work, like the Special Diabetes Program for

Indians, vaccinations, outreach and education and many other public health initiatives that will save money and lives.

Conclusion

Although our nation has been faced with a new budget reality, its recommendations remain relevant. NIHB asks that this Subcommittee give deep consideration to the true needs of the IHS, as well as Indian Country, and the federal trust responsibility to AI/ANs. The nation's debt is a pressing issue, but a solution must not be achieved through broken promises and the duty of this nation to honor trust responsibilities to it First Americans. Full funding for the Indian Health Services of $27.6 Billion would represent less than 3% of the HHS budget. We ask that this Congress take the honorable path of restoring the funding needed to end needless suffering and death of our Alaskan Native/American Indian Peoples.

I thank the Subcommittee for its time and for the opportunity to present this testimony. I am happy to answer any questions.