National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
LESTER SECATERO, CHAIRPERSON
AMERICAN INDIAN & ALASKAN NATIVE PUBLIC AND OUTSIDE WITNESS HEARING
HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON INTERIOR
MARCH 25, 2015, 3:00PM

Chairman Calvert, Ranking Member McCollum and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board and the 566 federally-recognized Tribes we serve, I submit this testimony on the Indian Health Service FY 2016 budget.

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives (AI/ANs). The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people. In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to AI/ANs, declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." [1]

Devastating consequences from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. AI/ANs have a life expectancy 4.1 years less than other Americans and suffer significantly higher mortality rates from suicide, type 2 diabetes, and heart disease than other Americans. According to CDC data, 45.9 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. American Indian / Alaska Native children have an average of six decayed teeth, when other US children have only one. These health statistics are no surprise when you compare the per capita spending of the IHS and other federal health care programs. In 2014, the IHS per capita expenditures for patient health services were just $3,107, compared to $8,097 per person for health care spending nationally.

The following recommendations follow the recommendations of the Tribal Budget Formulation workgroup for FY 2016.[2] Tribes recommend **$28.7 billion** to fully fund IHS. This includes amounts for personal health services, wrap-around community health services and facility capital investments. Within this $28.7 billion is: **$14.9 billion** for Medical Services; **$1.5 billion** for Dental and Vision Services; **$3.5 billion** for Community and Public Health Services; **$8.8 billion** for facility upgrades and upfront costs (non-recurring investments)

FY 2016 President's Budget Request – The administration has proposed $5.1 billion for IHS for FY 2016. This is $460.6 million above the FY 2015 level and as pointed out by the administration, a 53% increase over the FY 2008 Enacted budget. Overall, we believe that the current request contains many provisions that will be beneficial for Tribes. However, we must point out that the recent increases have

[1] Indian Health Care Improvement Act, §103(2009).
[2] The full FY 2016 Tribal Budget Request is available at http://nihb.org/legislative/budget_formulation.php

not allowed for program expansion. When considering staffing for new facilities, inflation, medical inflation, population growth, and Contract Support Cost obligations, the effective increase is minimal. This would explain why the reported net effect of these increases on the actual level of need, as calculated by IHS, is still hovering at a flat 56-59%. Instead of comparing appropriations levels, a better measure would compare the President's proposed FY 2016 budget of $5.1 billion and the Tribal recommended full funding level of **$28.7 billion**. The proposed budget amount is actually 17% of the total needed to adequately fund the Tribal Health System in a manner which would bring parity with the rest of the nation.

For FY 2016, to begin the 12 year phase-in of the full $28.7 billion request, Tribes recommend **$5.4 billion.** Within the $5.4 billion, Tribes have several priorities including *Purchased/Referred Care (PRC)*; *Hospitals and Clinics; Mental Health*; *Alcohol & Substance Abuse Services;* and *Health Care Facilities Construction.*

Purchased/Referred Care (PRC) – In FY 2016, Tribes recommend **$1.1 billion** for the Purchased/Referred Care (PRC) program. This is $142.8 million over the FY 2016 request and $213.2 million above the FY 2015 level. The PRC budget supports essential health care services from non-IHS or non-Tribal providers and includes inpatient and outpatient care, emergency care, transportation, and medical support services such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. These funds are critical to securing the care needed to treat injuries, cardiovascular and heart disease, diabetes, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. In FY 2013, PRC denied over $760 million for an estimated 146,928 services needed. Tribal providers are not required to report denials, so the actual shortfall is likely to be far higher. It is critical that this account continue to be prioritized by Congress.

Hospitals and Clinics – In FY 2016, Tribes recommend **$2.1 billion** for Hospitals and Clinics (H&C) which is $194 million over the FY 2016 President's request and $293 million over the FY 2015 enacted level. This core budget line item provides for the direct service delivery to AI/ANs. IHS/Tribal/Urban Indian (I/T/U)-managed facilities are often located in rural settings with service at many locations limited to primary care, due to inadequate funding. IHS H&C face tremendous challenges. Some of these factors include: an increased demand for services related to trends in significant population growth, an increased rate of chronic diseases, rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment. For many AI/ANs, IHS represents the health care access in its entirety, both in terms of monetary resources but also facility access. Consequently, any underfunding of H&C equates to *no health care*. For many in Indian Country, there are no alternatives.

Despite a proposed increase by the Administration, the FY 2016 budget request leaves out any increases for Tribal Epidemiology Centers (funded via H&C). These organizations work in partnership with the local Tribes to improve the health and well-being of their Tribal community members by offering culturally-competent approaches that work toward eliminating health disparities that are faced by AI/AN populations. In short, the Epi-centers serve as the public health authorities for Indian Country. This work is critical in reducing health disparities for AI/ANs. Yet, the agency continues to ask for level funding for this program meaning each center receives only $360,000 each year. This is not nearly enough to do this important work.

Mental Health – In FY 2016, Tribes are recommending **$136.3 million**. This is $51.8 million above FY 2015 and $55.1 million above the President's FY 2016 request. Expansion of mental health services are critically needed. In 2007, the National Center for Health Statistics noted that AI/ANs experience serious psychological distress 1½ times more than the general population. AI/ANs has the highest rates of suicide of any group in the U.S. for all ages. An eleven-year study (1999-2010) by Dr. Jacqueline Gray, University of North Dakota, reveals the suicide rate for AI adolescents and young adults from 15-34 is 2.5 times the national average for that age group. According to the American Foundation for Suicide Prevention, "90% of individuals who die by suicide had a diagnosable psychiatric disorder at the time of their death…" However, without adequate resources to address mental health needs, suicide rates for AI/ANs will continue its current trend.

Access to adequate care, from local paraprofessional providers to contracted specialty care providers, is critical to address the vast mental health needs for American Indians and Alaskan Natives who seek care from their Tribal health and direct service facilities. While the proposed $3.3 million increase appears to be substantial, it is important to note that there is little room for program expansion within the mental health budget. Within this increase, $1 million is for inflation; $1.3 million is for population growth; $616,000 is for pay costs; and $433,000 is for staffing of new facilities. What the administration shows as a 4% increase, is really not a program increase at all. We urge the Committee to carefully consider this as it proposes IHS budget priorities for FY 2016.

Alcohol and Substance Abuse – In FY 2016, Tribes recommend **$243.3 million** for the alcohol and substance abuse line. This is $16.3 million above the President's request and $52.3 million above the FY 2015 enacted level. Of the challenges facing AI/AN communities and people, no challenge is more far reaching than the epidemic of alcohol and other substance abuse. Now that Tribes manage a majority of alcohol and substance abuse programs, IHS is in a supportive role to assist the Tribes plan, develop, and implement a variety of treatment modalities. The collaboration has resulted in more consistent evidenced-based and best practice approaches to address substance abuse disorders and addictions. Successful treatment approaches include traditional healing techniques that link the services provided to traditional cultural practices and spiritual support.

NIHB is encouraged by the $25 million investment for the Methamphetamine Suicide Prevention Initiative in the FY 2016 request in order to hire additional "behavioral health staff positions focused on child, adolescent, and family services" (CJ-93). The FY 2016 request also includes $25 million in the Substance Abuse Mental Health Service Administration (SAMSHA) budget to develop community- or system-level infrastructure and service linkages and provide support for suicide and substance abuse prevention activities. These proposed investments are important. Tribes encourage the Committee to provide oversight to ensure that funds are coordinated across agencies. While the IHS is often the primary health provider for Indian Country, the federal trust responsibility is not limited to one agency or federal department. Tribes have asked that the Administration develop a plan of action, led by HHS that will demonstrate how programs for mental health and substance abuse, serving AI/ANs, are coordinated across agencies.

Health Care Facilities Construction – Health Care Facilities Construction funds support construction of functional, modern IHS and Tribally operated facilities and staff quarters. IHS utilizes a priority list to construct new facilities. According to the IHS, there was a $2 billion backlog on this list as of April 2014. Dedicated resources for construction should be one of the highest priorities of the federal

government and is necessary to improve quality of health care for hundreds of thousands of American Indians and Alaska Natives. The Administration's recommended $100 million increase in FY 2016 is much-needed and Tribes are pleased to see this proposed investment in the FY 2016 request.

Contract Support Costs – The FY 2016 Budget request also proposed that Contract Support Costs are funded on a mandatory basis starting in FY 2017. NIHB supports this request, and encourages Congress to work to enact this change as soon as FY 2016. This legislative change will guarantee legal compliance to fully pay Contract Support Costs, while ensuring that these payments do not take limited funds from other areas of IHS services budget. Creating a mandatory funding pathway for CSC must hold harmless other areas of the IHS budget. Taking allocations from other discretionary areas of the IHS budget to fund CSC will continue to widen the existing funding disparity, and the health of our people will suffer.

Other Recommendations – Tribes have also proposed other budget-related recommendations for IHS in FY 2016. One of these priorities is support for **advance appropriations for IHS** which would allow Tribes to have predictability on the IHS budget and place IHS on parity with other federal health providers. This Committee had a hearing on related legislation last year, and we hope to continue this progress in the 114th Congress.

Tribes continue to call for legislation that would require that purchased/referred care reimbursements to non-hospital providers are made at "**Medicare Like Rates** (MLR)." In December 2014, the IHS issued a proposed rule that would require Medicare-Like Rate payments for non-hospital based services, but we believe the enactment of legislation will make this provision stronger and more effective. NIHB and Tribes encourage Congress to swiftly enact the legislative change to make PRC subject to Medicare Like Rates for all non-hospital providers and suppliers which would result in millions of dollars in savings each year.

The **implementation of the IHCIA** remains a top priority for Indian Country. IHCIA provides new authorities for Indian health care, however additional funding is needed to fully implement the Act. The recommendations are to improve and enhance the services that IHS already provides; however, at least an additional $300 million is needed in order to begin to implement and fund the new authorities. Tribes fought for over 10 years to renew the Act, and Congress should act to fulfill the promises in the 2010 law.

As noted above, the trust responsibility for health extends beyond the IHS. We also encourage this Subcommittee to work with **other agencies at the Department of Health and Human Services to ensure that funds reach Tribal communities**. These agencies include, but are not limited to, the Centers for Disease Control and Prevention, SAMHSA, the Health Resources and Services Administration, and the Administration for Children and Families. Specific funding "set asides" for Tribes or language directing the HHS to fund Tribal communities specifically could be ways to ensure that appropriated dollars reach Tribes.

Thank you for the opportunity to offer this statement. We look forward to working with the Appropriations Committee as Congress considers FY 2016 Appropriations. If you have any questions, please do not hesitate to contact the National Indian Health Board.