National Indian
Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD – VINTON HALWLEY, CHAIRMAN
AMERICAN INDIAN & ALASKAN NATIVE PUBLIC AND OUTSIDE WITNESS HEARING
HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON INTERIOR
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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 567 federally-recognized Tribes we serve, I submit this testimony on the Indian Health Service FY 2018 budget.

The federal government has yet to live up to the trust responsibility to provide adequate health services to our nation's indigenous peoples. Historical trauma, poverty, lack of access to healthy foods, loss of culture and many other social, economic and environmental determinants of health as well as lack of a developed public health infrastructure in Indian Country all contribute to the poor state of American Indian and Alaska Native (AI/AN) health. AI/ANs suffer some of the worst health disparities of all Americans. We live 4.5 years less than other Americans. In some states, life expectancy is 20 years less, and in some counties, the disparity is even more severe. Our suicide rates for AI/ANs are four times the national average, and suicide is the second leading cause of death for Tribal youth between the ages of 15 and 24.[1] Our populations are approximately twice as likely to die of alcohol-related causes as the general population.[2] According to CDC data, 45.4 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. AI/AN children have an average of 6 decayed teeth, when other US children have only one.[3] But, none of these challenges, alone, is as damaging as starving the Indian Health systems. All of these determinants of health and poor health status could be dramatically improved with stronger investments in the health, public health and health delivery systems in Indian Country. In 2016, the IHS per capita expenditures for patient health services were just $2,834, compared to $9,990 per person for health care spending nationally. It is not much more complicated than that – America needs to keep its promises to American Indians and Alaska Natives and fully fund the IHS.

Tribes are grateful for the recent increases to the IHS Appropriation over the last several years, but note that the increases have not allowed for expanded services or improvements in equipment, buildings or staffing. While the IHS annual appropriated budget has increased by $1.2 billion (about 25%) since FY 2008 much of this increases simply covers needs associated with population growth, inflation, full funding of Contract Support Costs and maintaining current services. This leaves little extra money for making actual improvements in health services or to build public health infrastructure for American Indians and Alaska Natives. We are only 2% of the population. Congress, please take the courageous and ethical step of adequately funding health care for this country's first peoples. The following testimony reflects the IHS Tribal Budget Formulation Workgroup recommendations for FY 2018.[4] The Tribal workgroup is comprised of American Indian and Alaska Native Tribal leaders, technicians and researchers, nationwide, who come together each year form Indian Country's priorities as they relate to IHS. Through this process and product, this testimony reflects, therefore, the national Tribal voice.

Tribes recommend **$30.8 billion** to fully fund IHS. This includes amounts for personal health services, wrap-around community health services, facilities, and capital investments. Within this $30 billion is:

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[1] United States. Department of Health and Human Services, Indian Health Service. (n.d.). Trends in Indian health, 2002-2003. Rockville, MD: Indian Health Service

[2] Centers for Disease Control and Prevention. (2008). Alcohol-attributable deaths and years of potential life lost among American Indians and Alaska Natives—United States, 2001-2005. MMWR. Morbidity and Mortality Weekly Reports. Available online at: https://www.cds.gov/mmwr/preview/mmwrhtml/mm5734a3.htm

[3] Indian Health Service FY 2016 Budget Request to Congress, p. 78.

[4] The full FY 2017 Tribal Budget Request is available at http://nihb.org/legislative/budget_formulation.php

$16.45 billion for Medical Services; **$1.72 billion** for Dental and Vision Services; **$3.86 billion** for Community and Public Health Services; **$8.77 billion** for facility upgrades and upfront costs (non-recurring investments). While we have not seen the full FY 2018 President's Budget Request, we are encouraged by statements in the public blueprint that includes IHS among the "highest priorities" at the Department of Health and Human Services (HHS). We thank the Appropriations Committee for prioritizing CHR funding in the FY 2017 enacted budget. However, Tribes were dismayed to see a recommended $25 million cut in FY 2017 to the Health Education and Community Health Representative (CHR) programs at IHS. Both of these programs are critical to ensuring healthy Native communities. IHS receives little funding for preventative efforts, and these programs represent one of the few consistent investments in an essential public health service – helping to provide education efforts to community members in remote areas who may never otherwise encounter a health professional.

To begin the 12 year phase-in of the full $30 billion request, Tribes recommend a **$7.1 billion appropriation** in FY 2018. All areas of the IHS budget are important, and we hope to see a strong increase across the IHS budget FY 2018. We ultimately would like to see IHS have the ability to lead the way in innovative health care delivery, rather than struggle with technology and methods decades behind the trends. For example, IHS could expand telehealth, utilize online health portals and mobile technology to increase patient communication and transparency, and further integrate public health into clinical practice. We hope the Congress will entertain these possibilities as well as those captured in this testimony. The Tribes have identified several priorities including *Purchased/Referred Care (PRC)*; *Hospitals & Clinics; Mental Health*; *Alcohol & Substance Abuse Services;* and *Dental Services.*

<u>Purchased/Referred Care</u> – In FY 2018, Tribes recommend **$1.4 billion** for the Purchased/Referred Care (PRC) program. This is $507.9 million above the FY 2017 enacted level. The PRC budget supports essential health care services from non-IHS or non-Tribal providers. In FY 2015, PRC denied over $645 million in services – that is 132,000 needed health care services that AI/ANs were denied from receiving. This core funding is still a top priority for the Tribes, as some service Areas rely heavily on PRC dollars, and we hope to see it continued as a priority in FY 2018. These deferrals are real lives. One patient from the Oklahoma City Area is reported to have had a ruptured appendix. She went to their nearest facility and PRC funding wasn't available to pay for the emergency procedure. Another patient from the same area reported that a 62-year-old grandmother needed 2 knees replaced but no funds were available. To this day, she is unable to work or be the grandmother that she wants to be because of her bad knees.

<u>Hospitals and Clinics</u> – In FY 2018, Tribes recommend **$2.5 billion** for Hospitals and Clinics (H&C) which is $600 million over the FY 2017 enacted level. Hospitals & Clinics provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. IHS H&C faces tremendous challenges. Some of these factors include: Increased demand for services related to trends in significant population growth; Increased rate of chronic diseases; Rising medical inflation; Difficulty in recruiting and retaining providers in rural health care settings; and Lack of adequate facilities and equipment. Increasing Hospitals and Clinics funding is necessary as it supports the following: All primary medical care services, including inpatient care; Routine ambulatory care; Medical support services, such as laboratory, pharmacy, medical records, information technology and other ancillary services. It also provides the <u>greatest flexibility</u> to support community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis.
Health IT: One area within the H&C line item is the area of Health Information Technology (HIT). IHS does not receive dedicated and sustainable funding for the agency to adequately support health IT

infrastructure, including full deployment of electronic health records (EHRs). The current Resource and Patient Management System (RPMS), is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most Tribal facilities. No new funds have been appropriated to support operations and maintenance for the RPMS suite. This has resulted in a mass exodus of Self Governance Tribes who have opted to withdraw their IT shares to seek other commercial HIT solutions which promise to more readily address their needs. In fact, this has caused a domino effect in that the IHS agency technology budget is decreasing more rapidly because of the withdrawal of these shares. Without a viable solution, IHS Health IT system will be left behind, and IHS patients will be put at risk.

<u>Mental Health</u> – In FY 2018, Tribes are recommending **$301.1 million**. This is $207 million above FY 2017 enacted. This significant increase is needed to enhance the capacity of Tribal communities to develop innovative and culturally relevant prevention programs that are greatly needed in Tribal communities. Research has shown that AI/ANs do not prefer to seek mental health services that rely solely upon Western models of care; which suggests that AI/ANs are not receiving the services they need.[5] For example, NIHB spoke with a young woman from the Pine Ridge Reservation who courageously shared her story about her multiple suicide attempts. She went to an inpatient psychiatric facility in Rapid City, but did not feel that she received healing. It wasn't until she attended a Lakota cultural healing camp that her life turned around. She said, "It made me feel powerful. I got to learn about my culture and it made me feel closer to who I am." But the camp operates through donations and community support. Congress should provide dedicated funding for these types of activities. The geographic remoteness of most Tribal communities demands unique and innovative treatment options to address comprehensive mental health, substance abuse and psychiatric services.

<u>Alcohol and Substance Abuse</u> – In FY 2018, Tribes recommend **$396.9 million** for the Alcohol and Substance Abuse budget. This is $178.5 million above the FY 2017 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. Too many of our people look around their families and communities and feel the impact that addiction – whether somebody is out of work, homeless, abusive, abused, incarcerated, or no longer with us. These are the impacts on which it is practically impossible to place a dollar amount on. 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. Successful treatment approaches include traditional healing techniques that link the services provided to cultural practices and spiritual support. However, we now know that inadequate funding for alcohol and substance abuse services has a ripple effect on other services, such as overloading the agency's outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections). One father from the Northern Cheyenne Tribe reported that his daughter was born prematurely due to her mother's struggle with methamphetamine. The child battled for its life, and caused trauma for the whole family and community. He said, "… meth abuse just doesn't affect one or two in our large extended Tribal families – it effects everybody…The services available on the reservation weren't helpful to my needs nor to my family…" Congress must provide sustainable funding to help families prevent and survive these challenges.

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[5] Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry, 162,* 1723-1732.

Walls, M. L., Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2006). Mental health and substance abuse services preferences among American Indian people of the northern Midwest. *Community Mental Health Journal, 42*, 521 -535.

Dental Health – For FY 2018, Tribes recommend **$273.7 million** for Dental Health. This is $91.1 million above the FY 2017 level. Over 80% of AI/AN children ages 6-9 suffer from dental caries, while less than 50% of the U.S. population ages 6-9 have experienced cavities. These critical funds are desperately needed to improve the oral health of AI/ANs. Half of AI/AN youth live in a dental shortage area. NIHB and the Tribes continue to support the expansion of Dental Therapists (DTs) to Tribes outside of Alaska as a safe, reliable, cost-effective means for Tribal members to access oral health services. Sadly, provisions in the Indian Healthcare Improvement Act (IHCIA)[6] make it difficult to use IHS programs to use these effective providers. People with healthy teeth and healthy smiles feels better about themselves and experience better overall health outcomes. Our communities need our people and especially our youth to smile again. We encourage the Committee to work with the relevant authorizing Committees to repeal this section of the law so that IHS and Tribes can utilize scarce discretionary dollars in the most cost-effective way possible.

Facilities: In FY 2018, Tribes recommend a total of **$842 million** for facilities appropriations which is an increase of $297.4 million over the FY 2017 enacted level. These increases will be used to increase maintenance and improvement on IHS facilities, speed up the funding of projects on the IHS Healthcare priority list, and improve sanitation conditions in Tribal communities. IHS facilities represent some the oldest health facilities in the nation and at current rates of funding, a new facility built today would not be replaced for another 400 years.[7] Investments in facilities will allow the care provided in our communities to be on par with other health systems in the United States. In Alaska, for example over 5,000 rural homes are considered unserved by running water and wastewater. Individuals, instead, must rely on "honey buckets" to dispose of waste. This is just unacceptable. Tribes recommend including at least $157.8 million for Sanitation Facilities Construction in FY 2018.

Other Sources of Indian Health Funding

While the above recommendations address the IHS budget, the federal trust responsibility for health extends beyond the IHS. For example, Medicaid represents roughly 67% of 3rd party revenue at the IHS, and 13% of overall IHS spending. Current proposed changes to the Medicaid program outlined in H.R. 1628 will mean less services for AI/ANs and increased pressure on the severely underfunded IHS. We encourage the Committee to work with those on the authorizing committees to ensure Tribes are protected under changes to the Medicaid program. 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**. 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.

In February 2016, Jerilyn Church, CEO of the Great Plains Tribal Chairmen's Health Board stated: "Congress needs to be willing to put that investment into [IHS]. It is not asking too much. We make up 2% of the entire population of this country. We are the genocide survivors. It is not a big ask for this country to fund schools, health, our judicial systems at a level that allows us to live functional healthy lives." In FY 2018, NIHB calls on Congress to fully commit to funding our health services by enacting a robust budget for IHS. You can find a more detailed FY 2018 Budget Request at www.nihb.org.

[6] 25 U.S.C. 1616l(d)

[7] *"Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare - The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2018 Budget."* June 2016. P. 64.