National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD –
FUNDING FOR THE INDIAN HEALTH SERVICE AND INDIAN HEALTH PROGRAMS
HOUSE INTERIOR APPROPRIATIONS AI/AN PUBLIC WITNESS HEARING
MAY 10, 2018, 9:55AM

Chairman Calvert, Ranking Member McCollum, and Members of the Committee, the National Indian Health Board (NIHB) thanks you for holding these American Indian/Alaska Native Public Witness Hearings. On behalf of NIHB and the 573 federally-recognized Tribes, I, Vinton Hawley, NIHB Chairman and Chairman of the Pyramid Lake Paiute Tribe of Nevada, submit this testimony for the record regarding our recommendation for $6.4 billion in the Fiscal Year (FY) 2019 Appropriations for the Indian Health Service (IHS). NIHB is a 501(c)3, not for profit, national Tribal organization founded in 1972 to serve as the unified, national voice for American Indian and Alaska Native (AI/AN) health in the policy-making arena. This testimony reflects the IHS Tribal Budget Formulation Workgroup recommendations for FY 2019.[1] The Tribal workgroup is comprised of Tribal leaders, technicians and researchers, nationwide, who each year form Indian Country's priorities as they relate to IHS. Through this process and product, this testimony reflects the national Tribal voice. We urge this Committee to hear that voice and fully fund IHS.

The Federal Trust Responsibility

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 unique trust relationship between the United States and Tribes. IHS is the primary agency by which the federal government meets the trust responsibility for direct health services. IHS provides services in a variety of ways: directly, through agency-operated programs and through Tribally-contracted and operated health programs; and indirectly through services purchased from private providers. Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are Tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are Tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care. It is important to note that Congress has funded IHS at a level far below patient need since the agency's creation in 1955. In FY 2017, national health spending was $9,207 per capita while IHS spending was only $3,332 per patient.

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 AI/AN health. This underfunding of the IHS is clearly visible when examining the health disparities for AI/ANs. Among AI/ANs, the rate of drug overdose deaths is twice that of the general population, according to the IHS. According to the Office of Minority Health, from 2009-2013, AI/AN men were almost twice as likely to have liver and inflammatory bowel disease (IBD) cancer as non-Hispanic White men and are 1.6 times as likely to have stomach cancer as non-Hispanic White men. In 2014, suicide was the second leading cause of death for AI/ANs between the ages of 10 and 34. Adolescent AI/AN females have death rates at almost four times the rate for White females in the same age groups.[2]

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[1] The full FY 2019 Tribal Budget Request is available at http://nihb.org/legislative/budget_formulation.php

[2] Office of Minority Health. Minority Population Profiles, American Indian and Alaska Natives. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39 . Accessed on March 21, 2018.

Tribes are grateful for the recent appropriated increases to IHS over the last several years, but the increases have not allowed for significantly expanded services or improvements in equipment, buildings or staffing. Much of the increase supplied by Congress 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.

Indian Health Service Budget

Tribes recommend **$32 billion** to fully fund IHS, to be phased in over 12 years, with a $6.4 appropriation in FY 2019. This includes amounts for personal health services, wrap-around community health services, facilities, and capital investments. Within this $32 billion is: **$17.37 billion** for Medical Services; **$1.82 billion** for Dental and Vision Services; **$4.07 billion** for Community and Public Health Services; **$8.77 billion** for facility upgrades and upfront costs. The top 5 areas for program expansion at IHS include: 1) Hospitals and Clinics; 2) Purchased/Referred Care; 3) Mental Health; 4) Alcohol and Substance Abuse; 5) Dental Services.

Hospitals and Clinics – In FY 2019, Tribes recommend **$2.3 billion** for Hospitals and Clinics (H&C) which is $246 million over the FY 2018 enacted level. Adequate funding for the H&C line item is the top priority for fiscal year 2019, as it provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the ***core funding*** that makes available direct medical care services to AI/ANs. Increasing H&C funding is necessary as it supports medical care services provided at IHS and Tribally-operated facilities, including emergency care, inpatient and outpatient care, medically necessary support services, such as laboratory, pharmacy, digital imaging, information technology, medical records and other ancillary services. In addition, H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs.

Health IT: One area within the H&C line item is Health Information Technology. 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 yet been appropriated to support operations and maintenance for the RPMS suite. Without a solution, IHS's Health IT system will be left behind, and IHS patients will be at risk. With the VA's announcement to move toward a commercial-off the shelf EHR, it is critical that IHS receive parallel appropriations to facilitate the replacement of RPMS, since our system is based on VA's VistA program.

Purchased/Referred Care – In FY 2019, Tribes recommend **$1.2 billion** for the Purchased/Referred Care (PRC) program. This is $282 million above the FY 2018 enacted level. The PRC budget supports essential health care services from non-IHS or non-Tribal providers. In FY 2015, PRC denied over $423.6 million in services – that is 92,354 needed health care services that AI/ANs were denied. The shortage of PRC funds directly contributes to the opioid crisis in Tribal communities. The deferral of care due to funding and workforce shortages has pushed Tribal members towards prescription opioids to treat health conditions that would otherwise successfully be treated with non-opioid therapies. This endless cycle of deferral and opioid dependency is a result of the underfunding of the IHS system, and must be stopped.

Mental Health – In FY 2018, Tribes are recommending **$207.8 million**. This is $107.9 million above FY 2018 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.[3] 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. But the camp operates through donations and community support. The geographic remoteness of most Tribal communities demands unique and innovative treatment options to address comprehensive mental health, substance abuse and psychiatric services.

Alcohol and Substance Abuse – In FY 2019, Tribes recommend **$207.8 million** for the Alcohol and Substance Abuse budget. This is $100 million above the FY 2018 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. For instance, the state of Minnesota reported that pregnant AI/AN women were 8.7 times more likely to be diagnosed with maternal opioid dependency, and that AI/AN infants were 7.4 times more likely to be born with neonatal abstinence syndrome (NAS). The current opioid and substance abuse epidemic has disproportionately impacted Tribes and has further strained the limited public health and healthcare resources available to Tribes. Successful treatment approaches include traditional healing techniques that link the services provided to cultural practices and spiritual support. However, 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).

Dental Health – For FY 2019, Tribes recommend **$251.9 million** for Dental Health. This is $56.6 million above the FY 2018 enacted level. In the general U.S. population, there is one dentist for every 1,500 people, but in Indian Country, there is only one dentist for every 2,800 people. It is not uncommon for elderly patients to wait out in the cold for one of just a few dental appointments available. This delayed or deferred care has long-term impacts over a patient's overall health. 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. Some Tribes in the lower 48 have created programs outside of IHS funding to allow them to utilize DTs, but provisions in the Indian Healthcare Improvement Act[4] make it difficult to use IHS resources to use these effective providers. We encourage the Committee to work with the other relevant authorizing Committees to repeal this section of the law.

FY 2019 President's Budget Request

The FY 2019 President's Budget Request includes $5.4 billion for IHS discretionary spending in FY 2019, $113.7 million below the FY 2018 enacted budget. While we appreciate the emphasis on direct care and substance abuse, certain items in the FY 2019 request are of particular concern for NIHB and the Tribes.

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[3] Beals, J., et al. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations. *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.

[4] 25 U.S.C. 1616l(d)

Facilities – Increases in facilities funding in FY 2019will 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.[5] The FY 2019 Budget Request proposes a ***decrease*** of $361.7 million from the FY 2018 enacted facilities budget. NIHB emphatically opposes this decrease.

Community Health Representatives/ Health Education – The FY 2019 request eliminates funding for the Community Health Representative and Health Education programs. Tribes are unambiguously opposed to this cut. While the budget notes that the cut was proposed in order to "prioritize direct health care services," it is important to note that CHRs ***are*** direct care. CHRs provide services like in-home patient assessment of medical conditions, providing glucose testing or blood pressure tests to determine if the patient should seek further care, and providing transportation for medical care. They also help interpret prescriptions which is critical to patient safety. There are more than 1,600 CHRs representing over 250 tribes in all 12 IHS Areas and CHR program data in FY 2016 demonstrated that CHRs conducted 340,270 home visits and provided 1,102,164 patient contacts/services on a variety of health related conditions. In FY 2019, the TBFWG recommends CHRs are funded at **$92.2 million**, which is $29.3 million above the FY 2018 enacted level. The group recommends that Health Education is funded at $35.9 million, an increase of $16 million from FY 2018 enacted budget.

Opioid Funding and Use of Competitive Grants – The FY 2019 President's Budget Request also proposes $150 million in competitive grants to "combat the opioid epidemic and address serious mental illness." This is part of the total $10 billion that the Department of Health and Human Services would receive. Firstly, this funding is a mere 1.5% set aside for AI/ANs despite the disproportionate disease burden in Tribal communities and the federal trust responsibility to Indian Country. Instead, the budget should set aside at least 10% for Tribes across all opioid related programs. Secondly, Tribes are universally opposed to this funding being distributed in the form of competitive grants. Grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes receive assistance and benefit from somewhat consistent increases, while other Tribes do not. This creates two pools of Tribes – those that have technical experience and financial resources receive funding, while many others without this capacity see no benefit. Instead of project or disease specific grant funds, the IHS needs to prioritize flexible, recurring base funds. Grants create a "disease de jour" approach, where the funding is tied only to an identified hot topic issue. Under the grant making process, Tribes cannot redesign the available programs and services to meet their needs. As such, ***IHS should never use a grant program to fund ongoing critical Indian Health needs.***

Conclusion Thank you again for the opportunity to offer this testimony for the record. You can find a more detailed FY 2019 IHS Budget Request at www.nihb.org. Please contact Stacy A. Bohlen, CEO of NIHB, at sbohlen@nihb.org, with any questions.

[5] *"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.