STATEMENT OF WILLIAM SMITH
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INTERIOR, ENVIRONMENT, AND RELATED AGENCIES, NATIONAL TRIBAL ORGANIZATIONS PUBLIC WITNESS HEARING FOR FY23

On behalf of the 574 federally-recognized Tribal nations and the member organizations the National Indian Health Board serves, thank you for the opportunity to testify on the Fiscal Year (FY) 2023 Appropriations for the Indian Health Service. My name is William F. Smith, Jr. and I am the Chairman of the NIHB and the Alaska Area Representative to the NIHB. I also serve as the Vice-President of the Valdez Native Tribe in Alaska. As a Vietnam war veteran and retired Army Sergeant, I am proud to have served my country and to continue in public service by serving Tribal nations through the NIHB.

Our testimony reflects NIHB's concurrence with the Indian Health Service (IHS) Tribal Budget Formulation Workgroup (the Workgroup) recommendations for FY 2023. Comprised of Tribal leaders, technicians, and researchers, the Workgroup develops Indian Country's priorities relative to IHS each year. The full slate of funding and policy recommendations can be found in the publication "Building Health Equity with Tribal Nations". We urge Congress to implement these recommendations by fully funding the IHS.

Background

The U.S. Constitution recognized the political and government-to-government relationship between the U.S. and Tribal nations. As sovereign nations, the U.S. and Tribal governments entered treaties - which exist in perpetuity - in which the Tribes exchanged millions of acres of land for the federal obligations and responsibilities, including the obligation for the provision of comprehensive health care from the federal government.

The U.S. Supreme Court decisions acknowledged this relationship while also recognizing a trust relationship and obligation to Tribes existed to honor these agreements, among other duties. This trust and treaty obligation extends and applies throughout the federal government, including all agencies. These responsibilities are carried out, in part, by the primary agency, IHS, within the Department of Health and Human Services (HHS). This agency provides ***both*** direct care and resources for health care services to AI/AN people. Among all federal health care-related agencies, the IHS and the Indian health care delivery system are unique in this regard.

The IHS provides health care services either directly to AI/AN people, or through contracts or compacts with Tribal nations which provide the services. The IHS may also enter contracts with urban Indian organizations to provide health care services to AI/AN people in certain urban locations.

Principled Funding Approaches

Mandatory Funding. Because health care for Tribal nations is a trust obligation of the federal government, Tribes have proposed that Indian health care be secured through mandatory federal funding, rather than through the discretionary, annual appropriations process. The budgetary instability which arises from Continuing Resolutions or shutdowns and budgetary authority limitations diminish the ability of the Indian health care system to reduce health disparities. The

President recognized this problem and proposed in his FY 2023 Budget Request a shift in Indian health care funding from discretionary to mandatory in the amount of $9.1 Billion in the first year, with automatic increases to $36.7 Billion in FY 2032. We look forward to working with Congress to see this shift occur.

Direct Funding. Providing funding through grants to Tribes is inconsistent with the federal trust obligations. Grants provide only short-term funding for a few Tribes and generally impose cumbersome administrative burdens. These limitations prevent continuity of care and long-term services necessary to reverse decades of health disparities of AI/AN people. For these reasons, Tribes recommend the grants[1] in agency funding be available for *Indian Self-Determination and Education Assistance Act* contracts and compacts.

Full Funding. ***Tribes have recommended full funding of the Indian health care system at $49.8 Billion beginning in FY 2023***. The fundamental responsibilities of IHS to deliver excellent health care cannot happen without the appropriate support and resources from Congress. The Indian health system is underfunded by nearly 50% of levels necessary to address the existing health care disparities. In FY 2020, the national health expenditure was $12,530 per capita which was also accounted for COVID-19 relief spending. In FY 2019, the national health expenditure was $11,582 per capita. In FY 2019, based on the latest information provided by the IHS, the IHS expenditure was only $4,078 per user population. As funding gaps grow and the IHS funding increases cannot close those gaps, the AI/AN people suffer.

The persistent chronic underfunding of the IHS, historical trauma, and other social and economic conditions contribute to the unacceptable health conditions. The AI/AN people often face the most significant health disparities among all populations in the United States, including diabetes, suicides, behavioral health challenges, and COVID-19 infections, hospitalizations, and deaths.

According to the Office of Minority Health, in 2019, suicide was the second leading cause of death for AI/ANs between the ages of 10 and 34.[2] "Likewise, the U.S Surgeon General report found […] [t]he effects of the COVID-19 pandemic can further compound the effects of historical trauma and disparities that are linked to higher rates of suicides of AI/AN youth and adults."[3] For AI/AN adults, the overall death rate from suicide is about 20% higher as compared to the non-Hispanic white population.[4]

Every year, the IHS funding increases by roughly 2-3%. Most of the increases are directed toward binding obligations, current services, and fully funding the contract support costs and Section 105(l) leases. Court decisions mandate full funding of contract support costs and more Tribes enter these leases, so costs increase. These are essential costs which support the administration of health

[1] Some of these programs are 1) Substance Abuse and Suicide Prevention, 2) Opioid Prevention, Treatment and Recovery Services, 3) Domestic Violence Prevention, 4) Zero Suicide Initiative, 5) Aftercare Pilot Programs at Youth Regional Treatment Centers, 6) modernization costs of the Electronic Health Record system, and 7) to improve collections from public and private insurance.

[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.

[3] Office of the Surgeon General. (2021). The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention.

[4] 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.

care for Tribal nations and are statutory and legal obligations to Tribal nations. Without fully funding the IHS, these mandatory obligations may displace these incremental "increases that could be provided to medical services, facilities, sanitation, and other needs."[5]

Partial incremental funding is not working. Critical investments are necessary to achieve health equity and reverse these problems. Since 2003, Tribal leaders have been working on solutions and national healthcare priorities enabling them to develop a fully funding for the IHS. After assessment and evaluation, the Tribal leaders, through the Workgroup, determined the full funding figure of $49.8 Billion would more "comprehensively account" for the services and facility construction, including those authorized by the IHCIA.[6] Tribal leaders recommend that moving toward full and mandatory funding are necessary actions to moving the Indian health care system to health equity.

Recommended Investments

We highlight the following key programs Tribes have recommended for increases and program expansion include 1) Hospitals and Clinics, 2) Purchased Referred Care, 3) Health Care Facilities Construction and other Authorized Facility Construction, 4) Mental Health, and 5) Alcohol and Substance Abuse.

Hospitals and Clinics. For FY 2023, Tribes recommend $13.03 Billion for Hospitals and Clinics (H&C) which is $10.63 Billion over the FY 2022 enacted level. The top priority, the H&C account funds the 650 hospitals, clinics, and health programs operating on Indian reservations, primarily in rural and frontier settings. This is the core funding for direct medical care services and other 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.

Purchased Referred Care. For FY 2023, Tribes recommend $7.27 billion for the Purchased Referred Care (PRC) program, $6.289 Billion above the FY 2022 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 greater health crises in Tribal communities. The deferral of care due to funding and workforce shortages has denied Tribal members specialty care they need, making their conditions worse.

Health Care and Other Authorized Facility Construction. For FY 2023, Tribes recommend $4.41 Billion for health care and other authorized facility construction,[7] an increase of $4.16 Billion over the FY 2022 enacted amount. The IHS has estimated a total need of up to approximately $22 Billion.[8] These facilities include hospitals, clinics, joint ventures, small ambulatory clinics, staff

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[5] "Building Health Equity With Tribal Nations." The National Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2023 Budget. At 19. (May, 2021).

[6] *See* Id.

[7] 25 U.S.C. §1631(f).

[8] *See* The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress. Indian Health Service, 2016. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

quarters, inpatient and outpatient behavioral health facilities, dialysis centers, and long-term care facilities.

The IHS hospitals average 40 years of age, 4 times more than other U.S. hospitals. A 40-year-old facility is nearly 26% more expensive to maintain than a 10-year-old facility. Current health care facilities are grossly undersized—about 52%—for patient populations, creating crowded, even unsafe, conditions among staff, patients, and visitors. If a new facility was built today, it would not be replaced for ***400 years***. The absence of adequate facilities frequently results in no treatment, worsening symptoms, and much higher health care costs for the patient.

Mental Health. For FY 2023, Tribes recommend $3.95 Billion, an increase of $3.82 Billion over the FY 2022 enacted amount. This increase is critical to address mental health challenges compounded by the COVID-19 pandemic.[9] It would also 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,[10] suggesting that AI/ANs are not receiving the services they need. The geographic remoteness of most Tribal communities demands unique and innovative treatment options to address comprehensive mental health, and psychiatric services.

Alcohol and Substance Abuse. For FY 2023, Tribes recommend $3.1 Billion for the Alcohol and Substance Abuse account, $2.84 Billion above the FY 2022 enacted level. Of the challenges facing AI/AN people, no challenge is more far reaching than the epidemic of alcohol and other substance abuse. Inadequate funding for alcohol and substance abuse services overloads other services by burdening outpatient clinics, urgent care and emergency departments with visits that may have been prevented.

Unfunded IHCIA authorities. For FY 2023, Tribes recommend at least $100 million for "those new authorities and provisions of the *Indian Health Care Improvement Act* (IHCIA) which have not yet been implemented and funded."[11] Permanently reauthorized in 2010, the IHCIA establishes new authorities for a wide-range of programs and services. These new authorities have not been funded adequately, or at all. Most notably, those programs include Comprehensive Behavioral Health Prevention and Treatment Programs, Fetal Alcohol Spectrum Disorders, Child Sexual Abuse and Prevention Treatment Programs, Behavioral Health Research, and Indian Youth Tele-Mental Health Demonstration Project. Moreover, these programs relate to securing the mental well-being of Native children. Investing in these programs are an opportunity to enhance and fulfill the trust responsibility by protecting and securing the future of Tribal nations.

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[9] For example, the U.S. Surgeon General reported, for Native youth, an increase in mental health challenges compounded by the COVID-19 pandemic. [cite]

[10] 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.

[11] "Building Health Equity With Tribal Nations." The National Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2023 Budget. (May, 2021).