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Oversight Hearing

Reviewing the Broken Promises Report: Examining the Chronic Federal Funding Shortfalls for Native Americans

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Good afternoon, Chairman Gallego, Ranking Member Cook, and Members of the Subcommittee. I am RADM Chris Buchanan, Deputy Director of the Indian Health Service (IHS). Thank you for the opportunity to discuss the U.S. Commission on Civil Rights (USCCR) 2018 report, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*. The IHS mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. As an agency within the Department of Health and Human Services (Department), the IHS provides Federal health services to approximately 2.6 million American Indians and Alaska Natives from 573 federally recognized tribes in 37 states, through a network of over 605 health care facilities, including hospitals, clinics, health stations, and other facility types.

The USCCR 2018 report is an update to the USCCR 2003 report, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*, which evaluated Federal agencies', including the Department, use of funds for Native American programs. This testimony only addresses the 2018 report, which found that the Federal Government continues to fall short of supporting adequately the social and economic wellbeing of Native Americans.[1]

The IHS is committed to improving health care delivery and enhancing critical public health services throughout the health system to strengthen the health status of American Indian and Alaska Native people. Earlier this year, the IHS released its Strategic Plan for Fiscal Years 2019-2023. The IHS Strategic Plan describes what the agency hopes to achieve over the next 5 years, based on the participation and feedback received from tribes, tribal organizations, Urban

[1] U.S. Commission on Civil Rights. Broken Promises: Continuing Federal Funding Shortfall for Native Americans (December 2018) Available at https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.

Indian Organizations, IHS staff, and other stakeholders. The Indian health care system faces several challenges related to access, quality, management, and operations, and the IHS Strategic Plan aims to address these challenges and build on progress already made. The plan details how the IHS will achieve its mission through three strategic goals, which are each supported by objectives and strategies.

- Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.
- Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.
- Goal 3: To strengthen IHS program management and operations.

Advance Appropriations

Through the IHS's robust annual Tribal Budget Consultation process, tribal and Urban Indian Organization leaders have repeatedly and strongly recommended advance appropriations for the IHS as an essential means for ensuring continued access to critical health care services. The Department continues to hear directly from tribes advocating support for legislative language that would provide the authority of advance appropriations for the IHS. The issues that tribes have identified present real challenges in Indian Country, and we are eager to work with Congress on a variety of solutions.

Purchased/Referred Care

IHS continues to improve and increase access to care for our beneficiaries through outreach, education, and enrollment activities. The U.S. Government Accountability Office's (GAO)

recent analysis of IHS data shows that from fiscal year (FY) 2013 through FY 2018, the percent of patients at federally operated IHS hospitals and health centers that reported having health insurance coverage increased an average of 14 percentage points.[2] As GAO reported, this increased coverage and collections has allowed for an expansion in the complexity of services provided offsite through the Purchased/Referred Care (PRC) program, allowed some patients to access care offsite using their coverage, and has reduced the need for some patients to access PRC.

The national PRC program set targets for local programs to ensure that IHS is able to provide access to our patients in the most cost effective manner. Since implementation of the PRC rates regulations (42 CFR §§ 136.201-204) in October 2016, the PRC program has realized a $1.43 billion increase in purchasing power according to the fiscal intermediary. This purchasing power has allowed PRC programs to pay for additional services and fund more medical priority levels than ever before, which improves access to care for our patients.

Increasing Services

Consistent with the 2010 Indian Health Care Improvement Act amendments, 25 U.S.C. §§ 1616l(d)(l)-(3), IHS is moving forward to establish a national Community Health Aide Program (CHAP) outside of Alaska to allow for this community-based, culturally responsive, and efficient model of health care to be expanded nationally. CHAP is an IHS unique multidisciplinary system of mid-level professionals referred to as behavioral, community, and dental health aides

[2] U.S. Government Accountability Office. Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections (GAO-19-612). Available at https://www.gao.gov/products/GAO-19-612.

working alongside and under the long-distance clinical supervision of licensed providers to offer patients increased access to quality care.

The CHAP has become a model for efficient and high quality health care delivery in rural Alaska providing approximately 300,000 patient encounters per year and responding to emergencies twenty-four hours a day, seven days a week. Through a national CHAP, IHS will provide a network of health aides trained to support other health professionals while providing direct health care, health promotion, and disease prevention services. The CHAP allows for care and follow up services from a community health aide, behavioral health aide, or dental health aide to be provided more conveniently for patients who may otherwise need to travel far distances to obtain in person care from other licensed practitioners, such as physicians and nurse practitioners.

Special Diabetes Program for Indians

American Indian and Alaska Native people have the highest prevalence of diabetes of any U.S. racial/ethnic group.[3] However, significant improvements have been made in a variety of diabetes-related outcomes, including reductions by at least one-half in the rates of new cases of diabetes-related kidney failure[4] and eye disease.[5] Between 1996 and 2013, there was a 54 percent decrease in the incidence of diabetes-related end-stage renal disease (ESRD-DM) in

[3] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017. Available at https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.
[4] Bullock A, Burrows NR, Narva AS, Sheff K, et al. Vital Signs: Decrease in Incidence of Diabetes-related End-stage Renal Disease among American Indians/Alaska Natives—United States, 1996-2013. MMWR 2017;66(1):26-32.
[5] Bursell SE, Fonda SJ, Lewis DG, Horton MB. Prevalence of Diabetic Retinopathy and Diabetic Macular Edema in a Primary Care-based Teleophthalmology Program for American Indians and Alaska Natives. PLoS ONE 2018;13(6):e0198551.

American Indian and Alaska Native populations.[6] In the Department's Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief titled, "The Special Diabetes Program for Indians: Estimates of Medicare Savings," ASPE estimated that the decrease in ESRD-DM incidence resulted in 2,200 to 2,600 fewer cases and $436 to $520 million of savings to Medicare over a ten-year period. In addition, hospitalizations for uncontrolled diabetes decreased by 84 percent between 2000 and 2016.[7]

The years of increases in the prevalence of diabetes[8] and childhood obesity[9] have stopped and the rates for both have been stable for several years. Although it is not possible to determine how much of these improvements can be attributed to the Special Diabetes Program for Indians (SDPI), it has been a critical factor in making them possible. The SDPI currently provides grants to 301 IHS, tribal, and urban Indian organizations in 35 states.

Sanitation Facilities Construction

Since 1959, the IHS Sanitation Facilities Construction (SFC) Program has worked in partnership with tribal governments and other Federal agencies to construct essential sanitation facilities and provide technical assistance that supports the operation and maintenance of those facilities. The

[6] Office of the Assistant Secretary for Planning and Evaluation (ASPE), The Special Diabetes Program for Indians: Estimates of Medicare Savings. ASPE Issue Brief. Department of Health and Human Services, May 10, 2019. Available at https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings.
[7] Agency for Healthcare Research and Quality. Data Spotlight: Hospital Admissions for Uncontrolled Diabetes Improving among American Indians and Alaska Natives. AHRQ Publication No. 18(19)-0033-7-EF. December 2018. Available at https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/dataspotlight-aian-diabetes.pdf.
[8] Indian Health Service. Statement by the IHS Acting Director before the Senate Committee on Indian Affairs. March 29, 2017. Available at https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/testimony/115/115th-March-29-2017.pdf.
[9] Bullock A, Sheff K, Moore K, Manson S. Obesity and Overweight in American Indian and Alaska Native Children, 2006-2015. Am J Public Health 2017;107:1502-1507.

SFC Program employs a cooperative approach for planning, designing and constructing sanitation facilities serving American Indian and Alaska Native communities. Each project is initiated at the request of a tribe or tribal organization, and coordination is maintained throughout project planning, design and construction. The SFC Program works to ensure that tribal utilities and homeowners have the necessary training to appropriately operate and maintain their facilities.

In FY 2019, the IHS revised its internal guidance on how it collects sanitation deficiency data to further ensure that sanitation deficiency reporting follows the governing statutes, and resources used to address these deficiencies are allocated to projects on an equitable needs basis. The revised guidance also addresses concerns raised by tribes and the GAO for improving the allocation of project funding toward infrastructure projects that address the most serious public health risks affecting American Indian and Alaska Native homes and communities. As a result of this guidance, it is anticipated that more funding will be allocated towards projects to serve homes lacking piped water supply and waste water disposal systems, which at the end of FY 2019 included a total of 6,626 American Indian and Alaska Native homes, or 1.6 percent of all American Indian and Alaska Native homes tracked in the IHS data system.

In FY 2019, the SFC Program received $192 million in appropriated project funding and over $120 million in contributed project funding from other Federal, state, and tribal entities. With these funds, 424 new projects were funded in 2019 that benefited 206 Tribes and served over 43,471 tribal homes.

The Indian Health Care Improvement Act requires IHS to provide a report estimating the full funding need for health care facilities construction every five years. The last report, submitted to Congress in July 2016, estimated the full need at $14.5 billion.

I can promise you that IHS will continue our efforts to ensure safe and quality care for our patients. We are committed to doing whatever it takes and will continue to work closely with our tribal and urban Indian partners in transforming health care for American Indians and Alaska Natives across the Country. We appreciate your efforts in helping us provide the best possible health care services to American Indians and Alaska Natives we serve. Thank you, and I am happy to answer your questions.