National Indian Health Board

September 9, 2021

The President
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Re: Indian Health Care in the Budget Reconciliation

Dear Mr. President:

On behalf of the 574 Tribal nations and Member Organizations the National Indian Health Board (NIHB) represents, we write to you regarding Indian health care in the Budget Reconciliation measure being prepared by Congress. We respectfully request your assistance in ensuring that this legislation provide specific set asides for Tribal nations health programs and sufficient funding for Indian Health Service (IHS) within the Department of Health and Human Services (DHHS) and Tribal nation health care facilities and services.

Overview

The United States has a treaty and trust responsibility to Tribal nations which, in part, involves the provision of health care to Indians by all Federal agencies. Historic underfunding has created significant needs and contributed to disparities in the health care status of Indians. The Budget Reconciliation creates a unique opportunity to reverse decades of underfunding.

We appreciate the inclusion of Indian programs in the Budget Resolution, S.Con.Res. 14. This Resolution provided instructions to different Committees relating to health care programs.

For example, the Resolution instructed the House of Representatives Energy and Commerce Committee, which governs most health care programs and Medicaid, to increase the deficit by not more than $486 Billion. It is troubling that Tribal nations are not afforded set asides in these health care measures, but despite being separate sovereigns, must compete with other governmental entities for these funds.

The Resolution also included instructions to increase the deficit by $20.5 Billion for certain Senate Committee on Indian Affairs programs and provided $25.6 Billion for House of Representatives Natural Resources Committee to allocate among 8 subcommittees and programs, including certain Indian health facilities. However, the Indian health care needs far exceed that total amount.

Facilities

According to the IHS, "early drafts [of the 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress] report an increase in the need up to approximately $22 billion…."[1] The needed

[1] *Examining Federal Facilities in Indian Country Hearing Before the H. Subcomm. For Indigenous Peoples of the U.S.*, 117th Cong. 1 (2021) (statement of Randy Grinnell, Deputy Director for Management Operations, Indian Health Service, Department of Health and Human Services) (emphasis added).

facilities include hospitals and clinics (including the related equipment, EHR, and health IT), inpatient behavioral health (including substance abuse) treatment, dialysis, and long-term care facilities.

With sufficient funding, many more Tribal communities would benefit:

- To illustrate, the attached graph shows that for facilities construction for "Active Authorities" (e.g., hospitals, joint ventures, and small ambulatory clinics), Tribal communities in ***33 states*** could be served if that account (including the related equipment, EHR, and health IT) were fully funded.

- In addition, the preliminary estimates on the attached table show that ***every IHS Area*** could benefit if the "Expanded Authorities" (e.g., long-term care, inpatient substance abuse, and dialysis facilities) were fully funded.

On average, IHS hospitals are 40 years old, nearly four times the average age of other U.S. hospitals of 10.6 years. A 40-year old facility is about 26 percent more expensive to maintain than a 10-year old facility. The facilities are grossly undersized–about 52%–for the identified user populations creating crowded conditions for staff and patients, unacceptable during this pandemic.

Many tribal communities have not received any facilities and never will at the current level of appropriations. For those that have, at the current rate of funding, these facilities would not be replaced for ***400 years***.

Services

Likewise, substantial investments–most notably in the IHS funding and from set asides in other DHHS funding-for health care and prevention services would also benefit these communities. The IHS National Tribal Budget Formulation Workgroup indicated that in FY 2018, IHS spending equaled $3,779 compared to $13,257 in Medicare spending per capita, $9,574 in Veterans Health Administration spending per capita, and $9,409 per capita for the national health spending - ***an astonishing 60% difference***.

Increasing the access to these critical services would save lives by helping to increase the life expectancy of American Indians and Alaska Natives which is currently "5.5 years less than the U.S. all races population, [of] 73.0 years to 78.5 years, respectively."[2]

Workforce

The entire Indian health system is vulnerable without a sufficient workforce to deliver the services. The Government Accountability Office in its August 15, 2018 report, GAO-18-580, found IHS data which showed an average vacancy rate for physicians, nurses, and other care providers of 25 percent. With competition for primary care physicians and other practitioners at an all-time high, the situation is unlikely to improve soon. The IHS cannot meet workforce needs with the current strategy.

Innovative and significant investments are needed to address these vacancies, both immediately and in the long-term. These approaches include sets asides in Public Health Service programs and scholarships, tax-exemptions for the IHS scholarship and loan programs, and expanding tribal graduate medical education under the Health

[2] Department of Health and Human Services, FY 2022, Indian Health Service. *Justification of Estimates for Appropriations Committees*.

Resources & Services Administration (HRSA). To strengthen the healthcare workforce, Congress must invest in IHS and Tribal programs – to educate, to recruit, and to expand their pool of qualified medical professionals.

These requests are consistent with the President's American Jobs Plan and American Families Plan in which he stated that health care is a foundation of middle-class prosperity. Nowhere is this needed more than in Indian Country where the poverty levels can be staggering and the health disparities stark. This health care foundation, if fully funded, would serve to build stronger, healthier Tribal communities.

The President's American Families Plan set forth its mission of investing in families so that "when American families do well, our Nation thrives." Likewise, when Tribal nations do well, our Nation thrives.

We understand the Budget Reconciliation measure continues to move forward quickly. We strongly urge you to support Indian Country by securing specific set asides for Tribes and much more robust investments in Indian health care to help build better Tribal communities.

NIHB stands ready to work with you in securing appropriate funding levels for Indian health care. Indian Country is also united in requesting adequate funding for the many health care needs as outlined in our letter dated June 21, 2021 and the Interorganizational letters dated April 13, 2021 and August 19, 2021.

Please contact Stacy Bohlen, CEO, or our Congressional Relations staff, Rhonda Harjo at rharjo@nihb.org (cell/text at 202-830-6148) and Erin Morris at emorris@nihb.org for any questions or for further information. Thank you for your attention and consideration in this matter.

Sincerely,

William Smith, *Valdez Native Tribe*
Chairman and Alaska Area Representative
National Indian Health Board

Stacy A. Bohlen, *Sault Ste. Marie Chippewa*
Chief Executive Office
National Indian Health Board

ATTN: Ms. Elizabeth "Libby" Washburn
White House Domestic Policy Council
Eisenhower Executive Office Building
1650 Pennsylvania Avenue, N.W.
Washington, DC 20502

ATTACHMENTS

IHS Facility Need by State		
State	New Construction and Replacement Space (ft^2)	Total Need ($)
Alabama	30,000	$10,760,000
Alaska	2,270,000	$2,164,970,000
Arizona	3,220,000	$2,084,800,000
California	1,080,000	$528,620,000
Colorado	100,000	$38,680,000
Connecticut	50,000	$19,790,000
Florida	60,000	$25,440,000
Idaho	160,000	$69,150,000
Iowa	10,000	$5,660,000
Kansas	110,000	$43,920,000
Louisiana	30,000	$10,490,000
Maine	110,000	$42,130,000
Massachusetts	20,000	$12,370,000
Michigan	140,000	$65,460,000
Minnesota	460,000	$238,620,000
Mississippi	180,000	$8,1070,000
Montana	730,000	$328,780,000
Nebraska	20,000	$16,940,000
Nevada	210,000	$91,030,000
New Mexico	2,140,000	$1,219,220,000
New York	200,000	$83,030,000
North Carolina	160,000	$77,250,000
North Dakota	300,000	$145,160,000
Oklahoma	3,950,000	$1,744,730,000
Oregon	370,000	$156,340,000
Rhode Island	10,000	$5,750,000
South Carolina	40,000	$13,850,000
South Dakota	570,000	$305,010,000
Texas	60,000	$20,420,000
Utah	90,000	$32,090,000
Washington	970,000	$414,990,000
Wisconsin	290,000	$126,370,000
Wyoming	160,000	$58,730,000
TOTALS	**18,310,000**	**$10,281,610,000**

Expanded Authorities – IHS Facilities

IHS Area	Inpatient MHBH/ASAP	Long-Term Care (LTC)	LTC Non-Clinical	Specialty Care Centers	Dialysis Centers	Estimated Cost
Alaska	$178,400,000	$109,600,000	$71,500,000	$179,400,000	97,100,000	$636,000,000
Albuquerque	$52,300,000	$32,100,000	$20,900,000	$ 52,600,000	$28,500,000	$186,400,000
Bemidji	$87,000,000	$53,400,000	$34,800,000	$87,500,000	$47,400,000	$310,100,000
Billings	$51,000,000	$31,300,000	$20,400,000	$51,300,000	$ 7,800,000	$ 181,800,000
California	$76,800,000	$47,200,000	$30,800,000	$77,200,000	$41,800,000	$273,800,000
Great Plains	$75,200,000	$46,200,000	$30,100,000	$75,600,000	$41,000,000	$268,100,000
Nashville	$37,500,000	$23,000,000	$5,000,000	$ 37,700,000	$20,400,000	$ 33,600,000
Navajo	$169,200,000	$103,900,000	$67,800,000	$170,100,000	$92,100,000	$ 603,100,000
Oklahoma City	$235,300,000	$144,500,000	$94,200,000	$236,600,000	$128,100,000	$838,700,000
Phoenix	$129,200,000	$79,400,000	$51,800,000	$130,000,000	$70,400,000	$460,800,000
Portland	$ 86,400,000	$53,100,000	34,600,000	$ 86,900,000	$47,000,000	$308,000,000
Tucson	$17,000,000	$10,400,000	$6,800,000	$17,100,000	$ 9,300,000	$ 60,600,000
TOTALS	**$1,195,300,000**	**$734,100,000**	**$478,700,000**	**$1,202,000,000**	**$650,900,000**	**$4,261,000,000**

SOURCE: The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress (Report). Please note that the 2021 Report has not been released yet, so most likely all of these figures will have increased.
Found at:
https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf.