

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD – VICTORIA KITCHEYAN, CHAIRMAN
AMERICAN INDIAN & ALASKA NATIVE PUBLIC AND OUTSIDE WITNESS HEARING
HOUSE APPROPRIATIONS SUBCOMMITTEE ON INTERIOR
FEBRUARY 11, 2020, 9:40AM

Chairwoman McCollum, Ranking Member Joyce, and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board and the 574 federally-recognized Tribes we serve, I submit this testimony on the Indian Health Service (IHS) Fiscal Year (FY) 2021 budget.

Congress established the IHS in 1955 as a step toward fulfilling the federal government's treaty and trust obligations for health services for all American Indians and Alaska Natives (AI/AN). But since its inception, IHS has suffered chronic and pervasive funding shortages that continue to adversely impact the quality and consistency of health services delivered to AI/AN Peoples. In FY 2017, per capita medical expenditures within the Indian health system amounted to just \$4,078 compared to \$9,726 in national per capita health spending that same year. Compared to all federal health care programs, IHS remains the most neglected and insufficiently funded. Yet, it is the only federal health program that exists because of federal treaty and trust obligations to Tribal Nations.

The repercussions of continued underfunding of IHS are measurable and quantifiable. Let's look at life expectancy. An American Indian born today has a life expectancy that is 5.5 years less than the national average, while in certain states our people are dying as much as two decades earlier than Caucasians. Health outcomes among AI/ANs have either remained stagnant or become worse as Tribal communities endure higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. Overall, AI/ANs face significantly higher death rates than the general population for chronic diseases such as cancer, diabetes mellitus, liver disease and cirrhosis, addiction and overdose, and chronic respiratory disease.

For instance, from 1999 to 2015 our people encountered a 519 percent increase in drug overdose deaths, the highest rate increase of any demographic nationwide. Approximately 75 percent of AI/AN adults are overweight or obese, thus increasing risk of heart disease, stroke, some cancers and hypertension. Rates of chronic liver disease and cirrhosis deaths among AI/ANs are 2.3 times the rate for Caucasians. Most if not all of these health conditions are preventable; however, chronic underfunding of the Indian health system forces limited resources to be allocated towards treatment as opposed to prevention. Investments in public health systems in Indian Country remain nonexistent. This state of affairs means higher expenditures for direct health care for preventable disease, in a grossly underfunded health system.

While Tribes are grateful for the recent increases to the IHS budget, note that those increases have not been enough to expand health services or improvements in equipment, facilities or staffing. In fact, while the IHS annual appropriated budget has increased by roughly 2-3% each year since FY 2008, much of those increases are only enough to cover needs associated with population growth, medical inflation, the rightful full funding of Contract Support Costs, and maintenance of current services. As a result, dollars are scarce for making marked improvements in the quality and accessibility of health services, or to build Tribal public health infrastructure.

Full Funding of IHS at Level of Need

The only long term solution to challenges with the Indian health system is for Congress to fulfill its constitutional obligations by first, fully funding IHS, and then transitioning the agency to mandatory funding. Each year, Tribes, Tribal organizations, and urban Indian organizations from across Indian Country come together to put forth national recommendations towards establishing a needs-based and fully funded IHS budget. Known as the IHS National Tribal Budget Formulation Workgroup, it is comprised of Tribal leaders, policy and budget analysts, technicians, and researchers from all twelve IHS Areas. Their recommendations reflect the collective national voice and policy priorities of all Tribal Nations. The Workgroup provides a roadmap towards fulfillment of the federal trust responsibility for the health of all American Indian and Alaska Native people.

In 2018, the Workgroup first recommended transitioning to a new methodology for calculating a full needs-based IHS budget. Starting with the FY 2021 recommendations, the Workgroup replaced the Federal Employee Health Plans (FEHP) per user cost benchmark with a benchmark based on national health expenditures (NHE). The NHE classification presents a more accurate and complete picture of need, and allows for better comparison among categories over time. It is also more useful in analyzing a changing mix of medical services and products. To that end, the Workgroup recommends a needs-based and fully funded budget of **\$37.61 billion** for IHS, phased in over twelve years.¹ This total includes recommended amounts for all IHS accounts and line item expenditures, including for binding obligations such as Contract Support Costs, funding for newly recognized Tribes, and 105(l) lease expenditures, among others.

Advance Appropriations

Tribes and NIHB are grateful for the bipartisan support for advance appropriations for the IHS. In particular, Tribes and NIHB wish to recognize Chairwoman McCollum's leadership in introducing H.R. 1128, the Indian Programs Advance Appropriations Act. This bill seeks to authorize advance appropriations for IHS Services and Contract Support Costs, in addition to the Bureau of Indian Affairs. The Indian health system faces many chronic challenges that are made worse by endless use of continuing resolutions (CRs) and the persistent threat of government shutdowns. In fact, of the four federal healthcare programs, IHS is the only one not protected from government shutdowns and CRs. This is because Medicare and Medicaid receive mandatory appropriations, and the Veterans Health Administration (VHA) has received advance appropriations for nearly a decade. In September 2018, the Government Accountability Office (GAO) issued a report (GAO-18-652) that noted that "uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs."

While Tribes and NIHB are pleased that the Bipartisan Budget Act of 2019 put an end to sequestration, the protection only lasts through the end of FY 2021. Once again, during last year's 35-day government shutdown, IHS was the only federal healthcare program directly harmed. The impact was devastating, yet entirely avoidable. Tribal facilities lost physicians because they couldn't keep working without pay. Doctor visits couldn't be scheduled because administrative staff were furloughed. Tribal members took out *private loans* to be able to help pay to keep the lights on at their clinic. Contracts with private entities for sanitation services and facilities upgrades went weeks without payments, threatening Tribe's credit and putting patient's health at risk. Some

¹ The full FY 2021 IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF

Tribal leaders even shared how administrative staff volunteered to go unpaid so that the Tribe had resources to keep physicians on the payroll. These are just a few examples of the everyday sacrifices that widen the chasm between the health services afforded to AI/ANs and to the nation at large.

Access to healthcare is a matter of life and death – our people should not have to face the risk of their local hospital shutting its doors if lawmakers fail to pass a budget on time each year. Only our people’s healthcare is directly threatened during government shutdowns and CRs – no other population has to live under that painful and constant threat. That is outrageous and unacceptable. Over the past two decades, only once has Congress passed the Interior budget on time – in FY 2006. Every other year, IHS has been subject to either short-term or full-year CRs or faced a government shutdown. When you compound the impact of chronic underfunding and endless use of CRs, the inevitable result are the chronic and pervasive health disparities across Indian Country. Advance appropriations for IHS is a necessity to ensure patient health isn’t comprised in the event of Congress’s failure to enact a budget each year. It is long past due.

FY 2021 Funding Recommendations

To begin the twelve-year phase in of the full needs-based IHS budget, Tribes recommend increasing FY 2021 IHS appropriations to **\$9.1 billion**. All areas of the IHS budget are critically important, and we hope to see strong increases across the board for FY 2021. However, Tribes have identified several top priorities including *Hospitals & Clinics*; *Purchased/Referred Care (PRC)*; *Mental Health*; *Alcohol and Substance Abuse*; and *Dental Services*.

Hospitals and Clinics – For FY 2021, Tribes request **\$2.87 billion** for Hospitals and Clinics (H&C), which is roughly \$552 million above the FY 2020 enacted level. The H&C line item provides the base funding for the 605 hospitals, clinics, and health stations operating on Tribal lands and reservations, predominantly in rural settings. H&C funding supports primary medical care services, including inpatient care; routine ambulatory care; medical support services; support for Tribal Epidemiology Centers; and other significant medical needs. However, the H&C line item faces reoccurring challenges such as a lack of sufficient funding increases matched to population growth and medical inflation; chronic and pervasive provider shortages across the Indian health system; and higher disease burdens among AI/ANs overall that create added strains on an already underfunded budget.

Purchased/Referred Care (PRC) – For FY 2021, Tribes recommend **\$1.5 billion** for the PRC program, which is \$485.7 million above the FY 2020 enacted level. PRC was established to allow for IHS and Tribally operated facilities to secure essential health care services from private sector providers when such services, especially emergent and specialty care services, are not available within the Indian Healthcare Delivery System. In FY 2018 alone, PRC denied over \$676 million in services for an estimated 163,058 AI/AN health care service requests. Inadequate funding for the Indian Healthcare Delivery System and PRC forces IHS and Tribal Nations to ration health care based on an antiquated ranked medical priority system.

Health Information Technology (IT) – For FY 2021, Tribes request **\$25 million** for the newly created Electronic Health Records (EHR) line item. Tribes were very pleased to see a new \$8 million line item for modernization of EHRs created under the final FY 2020 spending package,

and would like to see this line item increased in FY 2021. IHS uses the Resource and Patient Management System (RPMS), which is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most Tribal facilities, from patient registration to billing. The RPMS system is partly reliant on the health IT system used by the Veterans Health Administration (VHA), known as the Veterans Information Systems and Technology Architecture (VistA). With the VHA transitioning to a commercial off the shelf system, and more and more Tribes electing to do the same, it creates serious interoperability concerns that directly impact patient care. Congress must ensure parity between IHS and the VHA in modernization of their health IT systems so as to not compromise patient care and health.

105(l) lease expenditures – Section 105(l) of the Indian Self-Determination and Education Assistance Act mandates payment of leasing costs to Tribal facilities when used to operate IHS programs through contracting and compacting agreements. With more and more Tribes electing to apply for 105(l) lease contracts, IHS has indicated that costs are anticipated to increase exponentially over time. Currently, IHS has no other mechanism but to pay for 105(l) leases through the Services Account. In 2019, IHS reported a roughly \$72 million shortfall in funds available for existing lease agreements, forcing the agency to reprogram dollars from other critical needs. While Tribes are grateful for the \$89 million increase to 105(l) leases included in the FY 2020 enacted budget, it remains clear that growing 105(l) expenses place IHS in a similar quagmire as existed with Contract Support Costs several years ago. As such, Tribes strongly request that Congress **enact an indefinite appropriation and separate line item for 105(l) leases.**

Mental Health and Alcohol/Substance Abuse – For FY 2021, Tribes request **\$398.4 million for Mental Health**, which is \$289.4 million above the FY 2020 enacted level; and **\$503.9 million for Alcohol and Substance Abuse**, which is \$258.2 million above the FY 2020 enacted level. AI/AN people continue to experience alarming rates of mental health issues including higher rates of suicide, post-traumatic stress disorder, and depression. However, inadequate funding resources limit Tribes ability to implement asset-based approaches to address these issues. Similarly, Tribal communities are disproportionately impacted by substance use issues including higher rates of youth substance use, overdose, and addiction. The significant increases for both line items are needed to assist Tribal communities in further developing innovative and culturally appropriate prevention and treatment programs that build upon the resiliency factors and inherent strengths that already exist in Tribal communities.

Facilities – For FY 2021, Tribes request roughly **\$1.25 billion** for the Facilities Account. This includes marked increases for Maintenance and Improvement, Sanitation Facilities Construction, Health Care Facilities Construction, Equipment, and Facilities and Environmental Health Support. The Indian health system operates 45 hospitals and 531 outpatient facilities including health centers, Alaskan Village clinics, and health stations. In 2018 alone, these facilities had an estimated 39,367 inpatient admissions and 13.8 million outpatient visits. On average, IHS hospitals are 40 years of age, which is almost four times more than other U.S. hospitals with an average age of 10.6 years. A 40 year old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized – about 52% – for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. Significantly increased funding is needed to update and modernize health facilities in Indian Country in order to improve patient care and attract highly qualified providers.