

**Testimony of the National Indian Health Board  
Full Committee Hearing: Addressing the Urgent Needs of Our Tribal Communities  
United States House of Representatives  
Energy and Commerce Committee  
July 8, 2020**

Chairman Pallone, Ranking Member Walden, and Members of the Committee, thank you for holding this critical hearing *Addressing the Urgent Needs of Our Tribal Communities*. On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

**Recommendations**

The health policy recommendations outlined in this letter represent the collective national voice of all 574 federally recognized sovereign Tribal Nations. We urge the Committee to rapidly consider and pass these critical Tribal health priorities.

**1. Hold a legislative hearing to consider and then swiftly pass H.R. 1128 and H.R. 1135, which would authorize advance appropriations for Indian Health Service (IHS) and Bureau of Indian Affairs (BIA)**

- IHS is the only federal healthcare delivery system created in partial fulfillment of treaty obligations, yet is also the only federal healthcare delivery system not exempt from continuing resolutions or government shutdowns. Each previous government shutdown, especially the most recent 35-day shutdown in 2019, has severely destabilized Indian health and cost lives. In fact, over the past two decades, only once has the Interior, Environment, and Related Agencies appropriations bill with jurisdiction over IHS and BIA passed on time – in FY 2006. In every other year, the agencies have been subject to stopgap measures that hinder progress and fail to account for rising medical and non-medical inflation costs.
  - Congress recognized the inherent challenges of subjecting a federal healthcare delivery system to the volatile annual appropriations process when it authorized the Veterans Health Administration (VHA) to receive advance appropriations a decade ago. Yet Congress failed to establish parity with IHS then, and the Indian health system continues to suffer as a result.
- Advance appropriations would further the fulfillment of the federal trust responsibility by providing greater fiscal security for IHS, Tribal, and urban Indian (I/T/U) health systems, and affording more flexibility to engage in long-term healthcare planning without the concern of not having an enacted budget each year.
  - **H.R. 1128** from Rep. McCollum and **H.R. 1135** from Rep. Young are two strongly bipartisan bills that would achieve the goal of enacting advance appropriations for Indian programs. We strongly urge the Committee to quickly schedule a legislative hearing to consider these bills, and move to pass them speedily thereafter.

**2. Pass the bipartisan H.R 2680 – Special Diabetes Program for Indians Reauthorization Act of 2019 – with the addition of new “Delivery of Funds” language to ensure Tribes and Tribal organizations are able to receive awards through P.L. 93-638 self-determination and self-governance contracts and compacts**

- According to the CDC, diabetes is one of the strongest risk factors for a more serious COVID-19 infection. AI/AN communities are diagnosed with diabetes at more than double the rate for Whites, and higher than any other population nationwide.
- The Special Diabetes Program for Indians (SDPI) is the only program that has effectively reduced incidence and prevalence of diabetes, and is responsible for a 54% reduction in rates of End Stage Renal Disease and a 50% reduction in diabetic eye disease. In a 2019 federal report, SDPI was found to be largely responsible for \$52 million in savings in Medicare expenditures per year.
  - Despite its documented success, since September 30, 2019, SDPI has gone through four short-term extensions, with the most recent extension occurring under the CARES Act. SDPI is currently set to expire on November 30, 2020.
- The bipartisan H.R. 2680 introduced by Rep. O'Halleran would provide 5-years of guaranteed funding for SDPI at an increase to \$200 million per year overall. **This represents the first increase to SDPI in over sixteen years, and the longest reauthorization in over a decade.**
- However, we urge that H.R. 2680 include language authorizing Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 self-determination and self-governance contracting and compacting agreements, thus allowing for greater local Tribal control over the life-saving program. We urge the Committee to pass H.R. 2680 with the requested changes below.

***“(2) DELIVERY OF FUNDS.— On request from an Indian tribe or tribal organization, the Secretary shall award diabetes program funds made available to the requesting tribe or tribal organization under this section as amounts provided under Subsections 106(a)(1) and Subsection 508(c) of the Indian Self-Determination Act, 25 U.S.C. § 5325(a)(1) and § 5388(c), as appropriate.”***

### **3. Make significant investments in water and sanitation development across IHS and Tribal facilities**

- Roughly 6% of AI/AN households lack running water, compared to less than half a percent of White households nationwide.<sup>1</sup> Especially during the present COVID-19 pandemic, lack of running water in thousands of AI/AN households is an unconscionable barrier to health that must be immediately addressed.
  - In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of “honey buckets” that are disposed in environmentally hazardous sewage lagoons.
  - Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households *roughly 71 times higher* than the cost of water in urban areas with municipal water access.<sup>2</sup>

<sup>1</sup> US Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from [http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States\\_DIGITAL.pdf](http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States_DIGITAL.pdf)

<sup>2</sup> Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. *Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society*, 38(3),

- We appreciate that the Committee passed the bipartisan **H.R. 7056** from Rep. O’Halloran and Rep. Young which would ensure that all IHS and Tribal facilities have the critical funding resources to modernize and construct essential water and sanitation projects.
  - According to the 2018 IHS Sanitation Facilities Infrastructure Report, roughly \$2.67 billion is needed to bring all IHS and Tribal sanitation facilities to a Deficiency Level 1 designation.

#### **4. Provide direct funding to I/T/U facilities for broadband, telehealth, electronic health records and health information technology (IT) infrastructure development**

- Tribal populations are disproportionately underserved in broadband connectivity. According to a 2019 Federal Communications Commission (FCC) report, only 46.6% of homes on Tribal lands have access to fixed terrestrial broadband at standard speeds.<sup>3</sup> Lack of sufficient broadband not only hinders use of virtual technologies for healthcare delivery, it also creates significant challenges towards modernizing IHS’s dilapidated health IT system. In turn, this limits disease surveillance efforts, streamlined access to patient health records for providers, and widespread quality of care issues for I/T/U patients.
  - Limitations in the availability of AI/AN specific COVID-19 data are contributing to the invisibility of the adverse impacts of the pandemic in Indian Country within the general public. Senior IHS officials, including Chief Medical Officer Dr. Michael Toedt, have stated publicly that existing deficiencies with the IHS health IT system are inhibiting the agency’s ability to adequately conduct COVID-19 disease surveillance and reporting efforts.
  - Lack of health IT infrastructure has also seriously hampered the ability of IHS and Tribal sites to transition to a telehealth-based care delivery system. While mainstream hospitals have been able to take advantage of new flexibilities under Medicare for use of telehealth during the COVID-19 pandemic, IHS and Tribal facilities have not because of insufficient broadband deployment and health IT capabilities.
- The TBFWG has previously outlined the need for a roughly \$3 billion investment to fully equip the Indian health system with an interoperable and modern health IT system. It is critical that Congress provide meaningful investments in health IT technologies for the Indian health system to ensure accurate assessment of AI/AN COVID-19 health disparities and equip Indian Health Care Providers with the tools to seamlessly provide telehealth-based health services.
  - In addition, Congress must guarantee direct Tribal access to all FCC broadband proceedings, and ensure that the agency is not restricting Tribal access to 2.5 GHz Band TPW to a limited definition of “rural” which excludes Tribal lands held in trust that are deemed “off” a Tribal reservation.

#### **5. Make permanent the legislative fix to the “four walls” Medicaid billing restriction and extension of 100% FMAP to urban Indian organizations; Clarify the four walls language to ensure that the fix to the billing restriction is made both for services provided by an**

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031003. <https://doi.org/10.1116/1.5142283>

<sup>3</sup> Federal Communications Commission, Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018, 5 (May 2019).

### **Indian Health Care Provider outside the four walls, and those services on the basis of a referral**

- Currently, IHS and Tribal providers are largely restricted from billing for medical services outside the four walls of a clinic. This means that home visits, school-based care, and other critical healthcare services delivered *by* Indian Health Care Providers (IHCPs) outside the four walls, or those services provided on the basis of a *referral* to a non I/T/U provider, are largely not being reimbursed by Medicaid, leading to serious gaps in accessibility of care. This has been a longstanding issue that has gained heightened urgency during the COVID-19 pandemic.
- In March 2020, in an effort to improve access to services during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) announced that it would not review claims for compliance with the four walls restriction before January 30, 2021.
  - This means that if Section 30106 of the HEROES Act were to be enacted as is, the fix to the four walls restriction would only be in effect for five months. In addition, the four walls language under Section 30106 only fixes the four walls billing restriction for services on the basis of a referral, not those services provided by IHCPs outside the four walls. **Not only is it critical that the four walls fix be made permanent, it is equally critical that the fix to the four walls billing restriction be made for both services provided by IHCPs outside the four walls, and those services on the basis of a referral.**
- Delaying the four walls issue does not solve it. In addition, there is very little incentive for states to work with Tribes to amend their Medicaid programs for only a five month fix to the four walls issue, especially given the resources that go into that process.
  - **However, Tribes and NIHB are vehemently opposed to extending 100% FMAP to non-Indian Health Care Providers as part of the legislative fix to the four walls restriction.**

### **6. Authorize Indian Health Care Providers (IHCPs) to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act (IHCIA) – called “Qualified Indian Provider Services” – when delivered to Medicaid-eligible American Indians and Alaska Natives**

- Currently, IHCPs only receive reimbursement for health services authorized for all providers in a state. Therefore, although IHCIA authorizes medical services such as long-term care and mental/behavioral services, an I/T/U site will not be reimbursed for these services if they are not covered by the state Medicaid program. This runs afoul of the government to government relationship that exists solely between Tribes and the federal government, and denies I/T/U systems from delivering essential health services already authorized under federal law.
- Because of chronic underfunding of IHS, many Tribes utilize third party collections from payers like Medicaid to constitute up to 60% of their healthcare operating budgets. But without the authority to bill for services already authorized under federal law, it is further straining Tribal COVID response efforts.
  - This provision reinforces the direct relationship between Tribes and the federal government by ensuring that IHCPs are reimbursed at 100% FMAP for all services authorized under IHCIA, at no cost to the states.

- During the current COVID-19 pandemic, lack of Medicaid reimbursement for the full suite of medical services authorized under federal Indian law are contributing to even more gaps in healthcare access for AI/ANs.

## **7. Enact Certain Sections of the Bipartisan CONNECT to Health Act**

- The bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (S. 2741) was introduced in October 2019 and has the broad support of over 100 health organizations.
  - Section 3 of the CONNECT to Health Act would provide the U.S. Department of Health and Human Services (HHS) with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on provider types, technology, geographic area, and services. These are critical authorities to ensure flexibility in delivery of mental and behavioral care.
  - Section 8 of the CONNECT to Health Act would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization which make it very difficult to deliver mental and behavioral health care.
- Originating site requirements currently mandate that a patient be in a particular location such as a physician's office, hospital, or other specified clinical setting. These requirements prevent patients from being able to receive mental and behavioral health services from their homes, community centers, or other non-clinical locations.
  - In addition, Sections 4, 5, 7, and 14 of the CONNECT Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expands the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian health system.

### **Treaty and Trust Obligations for Healthcare and Public Health**

Over the course of a century, sovereign Tribal Nations and the United States signed over 300 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises – which have no expiration date - collectively form the basis for what we now refer to as the federal trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared that, “...it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”<sup>4</sup>

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations. But at no point since the founding of IHS has Congress fully funded the agency at the level of need. Although the IHS budget has nominally increased by 2-3% each year, these increases are not sufficient to keep up with rising medical and non-medical inflation,

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<sup>4</sup> 25 U.S.C. § 1602

population growth, facility maintenance costs, construction of new facilities, and other expenses. The effective result is, year after year, the Indian health system is unable to make meaningful improvements towards reducing the significant health disparities experienced by AI/AN Peoples. In 2003 the US Commission on Civil Rights issued a report called *A Quiet Crisis Federal: Funding and Unmet Needs in Indian Country*. The report brought to light how the current dire needs found across Indian Country, whether in infrastructure, employment, economies or in our health and judicial systems, are a result of centuries of the federal government's underfunding Indian Country.

The current unmet needs in Indian Country demonstrate that with the publishing of the Commission's 2018 follow up report, *Broken Promises*, only marginal progress has been made. As the Commission observes, despite some progress, the "*crisis the Commission found in 2003 remains, and the federal government continues to fail to support adequately the social and economic wellbeing of Native Americans.*"<sup>5</sup> As valuable as both reports are, one truth can be clearly drawn from them: incremental change is not working. Incremental improvements are not effective. Rather, Congress must make a comprehensive, long term commitment to work with Tribal Nations to restore AI/AN People to health, safety, functionality and opportunity. Congress must found such plans in the form of a significant investment. As stated in the *Broken Promises* report transmittal letter to President Trump, "*The United States Expects All Nations to Live up to their treaty obligations; it should live up to its own.*"

### **Chronic Health Funding and Resource Shortages**

The solemn legacy of colonization is epitomized by the severe health inequities facing Tribal Nations and AI/AN Peoples. When you compound the impact of destructive federal policies towards AI/ANs over time, including through acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and outlawing of traditional ways of life, religion and language, the inevitable result are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country.

Despite improvements in federal Indian policy and the government-to-government relationship in recent decades, necessary resources to address these issues remain in short supply. **The repercussions of such historically destructive federal policy towards the Tribes coupled with the severe underfunding of Indian health care and public health sustains the chronic and pervasive health disparities Native people face.** For example, IHS continues to be the most underfunded federal healthcare delivery system, and the ONLY federal healthcare delivery system not exempt from continuing resolutions or government shutdowns. Over the past two decades, only once – in FY 2006 – has the Interior budget, which has jurisdiction over IHS funding, been passed on time. In every other year there have been delays that have cost lives and worsened health outcomes. In FY 2018, per capita medical expenditures at IHS were at only 40% of national health spending (\$3,779 vs \$9,409).

In 2018 the Government Accountability Office (GAO-19-74R) reported that from 2013 to 2017, IHS annual spending increased by roughly 18% overall, and roughly 12% per capita. In comparison, annual spending at the Veterans Health Administration (VHA), which has a similar

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<sup>5</sup> *Broken Promises: Continuing Federal Funding Shortfalls for Native Americans*, US Commission on Civil Rights Report, December 2018

charge to IHS, increased by 32% overall, with a 25% per capita increase during the same time period. Similarly, spending under Medicare and Medicaid increased by 22% and 31% respectively. In fact, even though the VHA service population is only three times that of IHS, their annual appropriations are *roughly thirteen times higher*. In short, despite the fact that IHS is the *only* federal health entity created in partial fulfillment of federal treaty obligations, it is the *most* chronically underfunded and underresourced federal health entity.

Chronic and pervasive health staffing shortages – for everything from physicians to nurses to behavioral health practitioners – stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 GAO report found an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two-thirds of IHS Areas (GAO 18-580). In addition, many Tribes do not have adequate housing for health care professionals, which further complicate recruitment efforts. Numerous reports from GAO and the HHS Office of Inspector General (OIG) have documented how IHS and Tribal facilities struggle to keep providers when competing with mainstream healthcare entities that can easily offer higher wages and better working conditions. It should then come as no surprise that the Indian health system has largely failed to make meaningful strides towards reducing provider vacancies.

For instance, as reported by the HHS OIG, IHS and Tribal administrators have noted that staffing shortages have forced IHS hospitals and clinics to turn patients away due to limited capacity.<sup>6</sup> In other instances, staff shortages have caused facilities to fail to meet compliance standards for waiting rooms and medical transfers. These issues reduce staff's ability to meet performance standards, lowers staff morale, and ultimately leads to less quality patient care. Chronic underfunding of the Indian health system means that hospitals and clinics have less money to hire qualified physicians at competitive salaries. Further, limited funding for personnel can delay the physician hiring process as overburdened staff juggle multiple competing priorities and responsibilities. At the end of the day, these challenges harm the patient most – many of whom encounter long delays in scheduling appointments and are potentially traveling hundreds of miles just to access their closest health center.

Lack of providers also force IHS and Tribal facilities to rely on contracted providers, which can be more costly and less effective. Relying on contracted care reduces consistency in care for patients as many contracted providers have limited tenure and are unlikely to be available for subsequent patient visits. Further, because of how often IHS and Tribal facilities cycle through contracted providers, it also raises concerns around provider oversight and accountability.

Limited funding and access to specialty care resulted in nearly 80,000 Purchased/Referred Care (PRC) services (an estimated total of \$371 million) being denied in FY 2016 alone.<sup>7</sup> Deferral of care is particularly consequential when it applies to pain treatment. Moreover, lack of access to non-opioid therapies for pain such as traditional medicine and other alternatives leaves IHS and Tribal providers and patients with few options. In fact, rates of prescription opioid deaths increased

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<sup>6</sup> Ibid

<sup>7</sup> National Tribal Budget Formulation Workgroup. Recommendations on the Indian Health Service Fiscal Year 2020 Budget. Retrieved from <https://www.nihb.org/docs/03012018/TBFWG%20FY%202020%20Recommendations%20Brief.pdf>

10.8% among AI/ANs from 2016-2017 – the highest percentage increase of any demographic.<sup>8</sup> Lack of access to providers and limited funding for health services reinforces the endless cycle of deferral of care and lower health outcomes in Tribal communities.

Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that – at 37 years.<sup>9</sup> In 2013 alone, funding shortfalls for facilities maintenance and upgrades created a \$166 million backlog. Basic medical devices and equipment are largely outdated, as hospital administrators express strong concerns that use of the equipment *may increase one's risk for hospital-acquired infections*. A 2016 OIG report found IHS and Tribal trauma centers lacking necessary computerized tomography (CT) scans, or missing essential medicines. Use of antiquated equipment also deters new medical graduates from working in the Indian health system, most of whom are trained on advanced technologies and thus unable or unwilling to use outdated equipment.

In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care. The OIG noted that more than two-thirds of IHS hospitals have insufficient space including for exam rooms, diagnostic services, and even pharmacies. Similarly, water and sanitation infrastructure in Indian Country is significantly underdeveloped. Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.<sup>10</sup> In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of “honey buckets” that are disposed in environmentally hazardous sewage lagoons.

Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households *roughly 71 times higher* than the cost of water in urban areas with municipal water access.<sup>11</sup> In a 2018 report to Congress, IHS estimated that in order to bring all IHS and Tribal sanitation systems to a Deficiency Level 1 criteria, the agency would need \$2.67 billion.

In addition, the Indian health system continues to face immense challenges in health IT modernization, with very little dedicated funding within the IHS budget to meet this need. In fact, the FY 2020 IHS budget included \$8 million for Electronic Health Records (EHR) – the first time

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<sup>8</sup> Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. *MMWR Morb Mortal Wkly Rep* 2019;67:1419–1427. DOI: <http://dx.doi.org/10.15585/mmwr.mm675152e1>

<sup>9</sup> AHA, Chartbook: Trends Affecting Hospitals and Health Systems, ch. 4, Chart 4.10, Median Average Age of Plant 1993-2013. Accessed at <http://www.aha.org/research/reports/tw/chartbook/ch4.shtm>

<sup>10</sup> US Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from [http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States\\_DIGITAL.pdf](http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States_DIGITAL.pdf)

<sup>11</sup> Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. *Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society*, 38(3), 031003. <https://doi.org/10.1116/1.5142283>

the IHS had dedicated funding for this need. The Resource and Patient Management System (RPMS) – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and is partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA).

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribal governments have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system which are negatively impacting interoperability and continuity of care for AI/ANs. When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue.

However, Congress has largely failed to ensure parity in funding between VHA and IHS for health IT, despite the reliance of RPMS on the VA system. For example, while Congress gave IHS \$8 million for health IT in the FY 2020 enacted budget, the VHA received roughly \$1.5 billion. Similarly, Congress has not provided comparable emergency funding to IHS compared to VHA in response to the COVID-19 pandemic. For instance, the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act invested \$15.85 billion into medical care at the VHA, including \$3.1 billion specifically for health information technology (HIT) and telemedicine; but only \$1.032 billion for IHS, of which only \$65 million was allocated for HIT support.

Tribal Nations are also severely underfunded for public health, and were largely left behind during the nation's development of its public health infrastructure. As a result, large swaths of Tribal lands lack basic emergency preparedness and response protocols, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response. And despite the fact that Tribal governments and all twelve Tribal Epidemiology Centers (TECs) are designated as public health authorities in statute, they continue to encounter severe barriers in exercising these authorities due to lack of enforcement and education. Currently, Tribes and TECs are being routinely denied access to CDC public health surveillance systems, and are actively thwarted from receiving Tribal data from state health departments. Both CDC and state officials have incorrectly cited potential HIPAA violations if they were to share data with the Tribes and TECs, while states have imposed pay-to-play restrictions for Tribal access to public health data, or have limited the type of data Tribes and TECs can receive to only certain diseases. These measures infringe on Tribal sovereignty, run contrary to federal law, and further deny Tribes the ability to build their public health infrastructure.

Unlike state and local governments, Tribes do not have a local tax base to supplement public health funding. In addition, Tribes are routinely left out of larger public health funding streams, partly because it is erroneously assumed that Tribes will receive adequate state funding. Not only is this factually inaccurate, it runs afoul of the federal obligation to fully fund health services in Indian Country, and the government to government relationship that exists in perpetuity between Tribal Nations and the United States. In fact, up until the passage of the Coronavirus Preparedness and

Response Supplemental Appropriations Act, the Good Health and Wellness in Indian Country program – funded at only \$21 million in FY 2020 – was the ONLY Tribally-specific funding stream available at the agency. It is important to note that Tribes receive hardly any public health funding from IHS, because IHS is primarily a health care delivery system. This means that the small pools of federal public health funds Tribes receive represent the vast majority of available Tribal public health funds.

All federal public health programs should not only include Tribes as eligible entities, but also include direct Tribal funding set-asides. Tribal set-asides further the fulfilment of the federal trust obligation for health; but also, without a set-aside, Tribes will more than likely not receive meaningful public health funding. Many Tribal public health departments do not have the capacity to compete with state and local governments for competitive public health grants. The consequence is that Tribes are routinely left behind in development of public health infrastructure.

For instance, a 2019 U.S. Department of Health and Human Services report found that, from FY 2014 to FY 2018, Tribes received 0.06% of funds under the Preventive Health and Health Services Block Grant (\$0.5 million out of \$729.2 million). During that same time period, Tribes received only 0.03% of all Substance Abuse Prevention and Treatment Block Grant dollars (\$3 million out of \$8.8 billion). These are just two examples of how Tribes are largely left behind when direct Tribal set-asides do not exist in statute.

### **Continuing Resolutions and Government Shutdowns**

Unfortunately, the challenges do not end with chronic underfunding. Of the four major federal healthcare entities, IHS is the only one subject to the devastating impacts of government shutdowns and continuing resolutions (CRs). This is because Medicare and Medicaid receive mandatory appropriations, and Congress authorized the VHA to receive advance appropriations a decade ago. It is true that no section of our economy and government are spared from the negative consequences of government shutdowns and endless CRs – but the repercussions are neither equal nor generalizable across all entities.

For instance, during the 2013 federal budget sequester, the IHS budget was slashed by 5.1% - or \$221 million. This was levied on top of the damage elicited by that year's government shutdown. In fact, IHS was the only federally funded healthcare entity that was subject to full sequestration, as Congress had already exempted entities such as the VHA when it authorized it to receive advance appropriations in 2009. While Tribes and NIHB were glad to hear that the Bipartisan Budget Act of 2019 finally put an end to sequestration, the protection only lasts through the expiration of the Budget Control Act of 2011, which currently sunsets at the end of FY 2021. Indeed, should Congress seek to enact a similar law that reestablishes budget sequesters in the future, it would be incumbent upon Congress to ensure that IHS is exempt.

Once again, during the most recent 35-day government shutdown – the nation's longest and most economically disastrous – IHS was the only federal healthcare entity to be shut down. While direct care services remained non-exempt, providers were not receiving pay. Administrative and technical support staff – responsible for scheduling patient visits, conducting referrals, and processing health records – were furloughed. Contracts with private entities for sanitation services and facilities upgrades went weeks without payments, prompting many Tribes to exhaust

alternative resources to stay current on bills. Several Tribes shared that they lost physicians to other hospitals and clinics not impacted by the shutdown. Some 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 and ongoing struggles that widen the chasm between the health services afforded to AI/ANs and to the nation at large.

With the Bureau of Indian Affairs (BIA) also shutdown, roads were not cleared after heavy snowfalls, leaving our Tribal citizens stranded for hours if not days. Public safety was heavily compromised, as BIA officers were furloughed and thus unauthorized to respond to emergency calls. Tragically, closure of vital services led to deaths in some of our Tribal communities. While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear – Indian Country was both unequivocally and disproportionately impacted.

In 2018, GAO released a seminal report examining the benefits of authorizing advance appropriations for the IHS and thus establishing parity between IHS and the VHA (GAO-18-652). The report outlined how Congress has been forced to use short-term or full-year CRs in all but four of the last 40 years. In fact, only once over the past two decades – in FY 2006 – has the Interior, Environment, and Related Agencies Appropriations bill been passed on time. Because of the budget authority constraints under a CR, agencies are prohibited from initiating any new activities or projects that were not expressly authorized or appropriated in the previous fiscal year. In addition, agencies are required to exercise significant precautions around expenditures, and are generally limited to simply maintaining operations in “autopilot” as opposed to improving them. Even more troubling is that CRs do not account for increases in medical or non-medical inflation. In essence, then, the Indian health system has been operating on autopilot for decades. Healthcare systems cannot operate effectively on autopilot. Congress recognized this when it authorized advance appropriations for the VHA, yet failed to enact the same for IHS.

### **Health and Social Disparities in Indian Country**

When you compound the impact of broken treaty promises, chronic underfunding, and endless use of CRs, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. Indeed, AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.<sup>12</sup>

In 2016, 26.2% of AI/ANs were estimated to be living in poverty, compared to the national average of 14.0%. Just under a fifth of AI/ANs lacked health coverage in the same year, while nationally only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is marred by undercounting of AI/ANs in the U.S. Census, rates of overcrowded housing clearly indicate a significant shortage of available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally.<sup>13</sup>

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<sup>12</sup> South Dakota Department of Health. Mortality Overview. Retrieved from <https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf>

<sup>13</sup> U.S. Department of Housing and Urban Development. 2017. Housing Needs of American Indians and Alaska Natives in Tribal

AI/AN communities also face high rates of food insecurity, which can increase risk for future chronic diseases such as diabetes, obesity, and other ailments. While majority-AI/AN counties represent less than 1% of counties nationwide, as high as 60% of them are classified as food insecure.<sup>14</sup> In California, just under 40% of AI/AN families with incomes under 200% of the federal poverty line (FPL) were food insecure<sup>15</sup>; in Oklahoma, 1 in 4 AI/ANs were reported to be food insecure in 2015<sup>16</sup>; and in Montana, an analysis of 187 AI/AN households found 43% to be food insecure.<sup>17</sup>

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.<sup>18</sup> In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)<sup>19</sup>; higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

Behavioral health outcomes are similarly much lower in Indian Country compared to the general population. Alarming, rates of prescription opioid deaths among AI/ANs increased 10.8% from 2016 to 2017 – the highest percentage increase of any demographic, and this happened despite national and IHS efforts to crack down on unnecessary opioid prescribing.<sup>20</sup> The opioid epidemic has also triggered significant increases in rates of infectious diseases such as Hepatitis C (HCV) among AI/ANs – raising from 1.8 to 3.1 acute cases per 100,000 from 2015 to 2016.<sup>21</sup> In 2014, 9% of AI/ANs over the age of 18 had a co-occurring mental health and substance use disorder – more than 3 times the rate of the general population.<sup>22</sup> Studies have also demonstrated that AI/ANs have a younger age of initiation of drug and alcohol use than the general population.<sup>23</sup>

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Areas: A Report From the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs. Retrieved from <https://www.huduser.gov/portal/sites/default/files/pdf/HNAIHousingNeeds.pdf>

<sup>14</sup> Feeding America. 2017. Map the Meal Gap: Highlights for Overall and Child Food Insecurity. Retrieved from <https://www.feedingamerica.org/sites/default/files/research/map-the-meal-gap/2015/2015-mapthemealgap-exec-summary.pdf>

<sup>15</sup> Iue Bird Jernigan V, Garrouette E, Krantz E, Buchwald D. Food insecurity and obesity among American Indians and Alaska Natives and whites in California. *J Hunger Environ Nutr.* 2013;8:458–471

<sup>16</sup> Blue Bird Jernigan V. Healthy makeovers in rural tribal convenience stores as part of the Tribal Health and Resilience in Vulnerable Environments (THRIVE) Study. Paper presented at: 143rd APHA Annual Meeting and Exposition; October 31–November 4; New Orleans, LA. Washington, DC: American Public Health Association; 2015.

<sup>17</sup> Brown B, Noonan C, Nord M. Prevalence of food insecurity and health-associated outcomes and food characteristics of Northern Plains Indian households. *J Hunger Environ Nutr.* 2007;1(4):37–53.

<sup>18</sup> Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. *National Vital Statistics Reports*; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.

<sup>19</sup> Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

<sup>20</sup> Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. *MMWR Morb Mortal Wkly Rep* 2019;67:1419–1427. DOI: <http://dx.doi.org/10.15585/mmwr.mm675152e1>

<sup>21</sup> Centers for Disease Control and Prevention. Surveillance for Viral Hepatitis: United States, 2016. Retrieved from <https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm>

<sup>22</sup> Whitesell NR, Beals J, Crow CB, Mitchell CM, Novins DK. Epidemiology and etiology of substance use among American Indians and Alaska Natives: risk, protection, and implications for prevention. *Am J Drug Alcohol Abuse.* 2012;38(5):376-82. doi: 10.3109/00952990.2012.694527. PubMed PMID: 22931069; PubMed Central PMCID: PMC34436971.

<sup>23</sup> Heart MY, Chase J, Elkins J, Altschul DB. Historical trauma among Indigenous Peoples of the Americas: concepts, research, and clinical considerations. *J Psychoactive Drugs.* 2011;43(4):282-90. doi: 10.1080/02791072.2011.628913. PubMed PMID: 22400458.

Approximately 75 percent of AI/AN adults are classified as being overweight or obese<sup>24</sup>, thus increasing their risk of heart disease, stroke, hypertension, and numerous other ailments. Nearly 36% of suicide deaths occurred among AI/ANs aged 10-24 year olds, compared to 11.1% among Whites in the same age group.<sup>25</sup> In 2015, suicide rates among AI/ANs in 18 states were more than 3.5 times higher than the lowest rates recorded. All of these determinants of health and poor health status could be dramatically improved with sufficient and sustainable federal investment into the health systems, health care, public health systems, and infrastructure in Indian Country in accordance with federal treaty obligations.

The devastating impact of COVID-19 in Indian Country is a sobering example of how lack of sufficient investment into Indian healthcare and public health has left AI/AN communities at significantly higher risk of infection and economic turmoil. According to data analysis by APM Research Lab, AI/ANs are experiencing the second highest aggregated COVID-19 death rate at 36 deaths per 100,000.<sup>26</sup> The CDC reported that from March through June 13, 2020 age-adjusted COVID-19 hospitalization rates among AI/ANs were higher than any other ethnicity, at 221.2 per 100,000.<sup>27</sup> Most poignantly, in a data visualization of COVID-19 case rates per 100,000 by Tribal Nation created by the American Indian Studies Center at the University of California Los Angeles, it was found that if Tribes were states, the top five infection rates nationwide would all be Tribal Nations.<sup>28</sup>

Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS<sup>29</sup>, Tribal governments have innovatively found ways of maximizing third party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third party collections can constitute up to 60% of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third party reimbursement shortfalls ranging from \$800,000 to \$5 million per Tribe, per month. In a hearing before House Interior Appropriations on June 11, 2020, IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30-80% below last year's collections levels, and that it would likely take years to recoup these losses.

These funding shortfalls have forced Tribes across the lower 48 and Alaska to furlough hundreds of workers, curtail available healthcare services, or close down clinics entirely. For example, Tribes in the Bemidji Area reported that nearly 20% of their healthcare system and 35% of their

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<sup>24</sup> Centers for Disease Control and Prevention. 2017. Summary Health Statistics: National Health Interview Survey: 2015. Table A-15 <http://www.cdc.gov/nchs/nhis/shs/tables.html>

<sup>25</sup> Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. *MMWR Morb Mortal Wkly Rep* 2018;67:237–242. DOI: <http://dx.doi.org/10.15585/mmwr.mm6708a1>

<sup>26</sup> APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. <https://www.apmresearchlab.org/covid/deaths-by-race>

<sup>27</sup> Centers for Disease Control and Prevention. COVID-19 Data Visualization. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>

<sup>28</sup> University of California Los Angeles. American Indian Studies Center. Coronavirus in Indian Country: Latest Case Counts. Retrieved from [https://www.aisc.ucla.edu/progression\\_charts.aspx](https://www.aisc.ucla.edu/progression_charts.aspx)

<sup>29</sup> Per capita spending at IHS in FY 2018 equaled \$3,779 compared to \$9,409 in national health spending per capita; \$9,574 in Veterans Health Administration spending per capita; and \$13,257 per capita spending under Medicare.

government services staff were forced to be furloughed due to revenue shortfalls. Meanwhile, Tribal business closures have compounded the devastation of the COVID pandemic in Indian Country. According to the Harvard Project on American Indian Economic Development (HPAIED), before COVID-19 hit, Tribal governments and businesses employed 1.1 million people and supported over \$49.5 billion in wages, with Tribal gaming enterprises alone responsible for injecting \$12.5 billion annually into Tribal programs. During the six week period (through May 4, 2020) whereby all 500 Tribal casinos were closed in response to COVID-19 guidelines, Tribal communities lost \$4.4 billion in economic activity, with 296,000 individuals out of work and nearly \$1 billion in lost wages.<sup>30</sup>

Extrapolated across the entire U.S. economy, collectively \$13.1 billion in economic activity was lost during the same time period, in addition to \$1.9 billion in lost tax revenue across federal, state and local governments. In a new visualization created by NIHB, over 193,000 AI/ANs have become uninsured as a result of COVID-19 job losses, with the vast majority of these individuals (72%) lacking access to IHS as well.<sup>31</sup> Such astronomical losses in Tribal healthcare and business revenue are exacerbating the already disproportionate impact of COVID-19 infections in Indian Country, and are further reducing available resources for Tribes to stabilize their health systems and provide critical COVID-19 and related health services to their communities.

### **Conclusion**

The only certain solution to health challenges in Indian Country is for Congress to fully and sustainably meet its constitutional obligations to Tribal Nations for quality health infrastructure, resources and services. Specifically for healthcare, Congress can achieve this goal by enacting an IHS budget that is reflective of the priorities of the IHS National Tribal Budget Formulation Workgroup. Each year, Tribes, Tribal organizations, and urban Indian organizations from across Indian Country come together to put forth national recommendations towards establishing a fully funded IHS budget. The Workgroup 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.

Using a benchmark based on national health expenditures (NHE), and based on current inflation rates and population levels, the Workgroup has outlined that in order for IHS to be fully funded, agency appropriations must reach **\$48 billion**.<sup>32</sup> 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. In order to phase in this level of funding over several years, the Tribes recommended that the IHS budget reach **\$9.1 billion in FY 2021**.

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<sup>30</sup> Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from <http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming>

<sup>31</sup> National Indian Health Board. Estimating Covid-19 caused increases in Uninsured AIANs due to job loss. <https://public.tableau.com/profile/edward.fox#!/vizhome/EstimatingCovid-19causedincreasesinUninsuredAIANsduetojobloss/EstimatingIncreaseinAIANUninsuredduetoCOVID-19JobLoss>

<sup>32</sup> The full FY 2022 IHS Tribal Budget Formulation Workgroup Recommendations are available at [https://www.nihb.org/docs/05042020/FINAL\\_FY22%20IHS%20Budget%20Book.pdf](https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf)

We thank the Committee for holding this important hearing. The treaty obligations of the entire federal government to Tribal Nations and AI/AN People exist in perpetuity. They represent a solemn promise to our nation's First People. Congress must act swiftly and comprehensively to make systemic, long term policy changes and investments into Indian health care and public health infrastructures and systems in ways directed and informed by the voices of Tribal leaders and officials. To that end, we urge the Committee to prioritize consideration and passage of urgent Tribal bills, such as by holding a legislative hearing on pending bills that would authorize advance appropriations for Indian Country. As always, NIHB remains committed to working with Congress in a bipartisan fashion to advance Tribal health.