



**TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD  
LISA ELGIN, SECRETARY  
AMERICAN INDIAN & ALASKAN NATIVE PUBLIC AND OUTSIDE WITNESS HEARING  
HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON INTERIOR  
MARCH 17, 2016, 10:40AM**

Chairman Calvert, Ranking Member McCollum and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board and the 567 federally-recognized Tribes we serve, I submit this testimony on the Indian Health Service FY 2017 budget.

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives (AI/ANs). The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people. In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to AI/ANs, declaring 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>1</sup>

Devastating consequences from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. AI/ANs have a life expectancy 4.2 years less than other Americans, but in some areas, the life expectancy is far worse. For instance, in Montana, "white men ...lived 19 years longer than American Indian men, and white women lived 20 years longer than American Indian women."<sup>2</sup> In South Dakota, in 2014, "for white residents the median age [at death] was 81, compared to 58 for American Indians."<sup>3</sup> AI/ANs also suffer significantly higher mortality rates from suicide, type 2 diabetes, and heart disease than other Americans. According to CDC data, 45.9 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. American Indian / Alaska Native children have an average of six decayed teeth, when other US children have only one. These health statistics are no surprise when you compare the per capita spending of the IHS and other federal health care programs. In 2015, the IHS per capita expenditures for patient health services were just \$3,136, compared to \$8,097 per person for health care spending nationally.

The following testimony reflects the IHS Tribal Budget Formulation Workgroup recommendations for FY 2017.<sup>4</sup> Tribes recommend **\$30 billion** to fully fund IHS. This includes amounts for personal health services, wrap-around community health services and facility capital investments. Within this \$30 billion is: **\$15.82 billion** for Medical Services; **\$1.66 billion** for Dental and Vision Services; **\$3.71**

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<sup>1</sup> Indian Health Care Improvement Act, §103(2009).

<sup>2</sup> "The State of the State's Health: A Report on the Health of Montanans." Montana Department of Public Health and Human Services. 2013. p. 11.

<sup>3</sup> "2014 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators." South Dakota Department of Health. 2014. P. 62.

<sup>4</sup> The full FY 2017 Tribal Budget Request is available at [http://nihb.org/legislative/budget\\_formulation.php](http://nihb.org/legislative/budget_formulation.php)

**billion** for Community and Public Health Services; **\$8.77 billion** for facility upgrades and upfront costs (non-recurring investments).

FY 2017 President's Budget Request – The administration has proposed \$5.2 billion for IHS for FY 2017. This is \$377 million (7.28%) above the FY 2016 level. NIHB appreciates the bipartisan work this Committee has undertaken since FY 2008 to ensure that meaningful increases have been awarded to the IHS. However, when considering staffing for new facilities, inflation, medical inflation, population growth, and Contract Support Cost obligations, the effective increase is minimal. For example, of the \$377 discretionary increase requested for IHS, almost half (\$159 million) is just what is needed to maintain current services, and \$82 million is for Contract Support Costs, leaving actual program expansion with just \$136 million. We implore this Committee, to take the courageous step forward and recommend a budget for Indian Health that truly lives up to the federal trust responsibility and gives AI/ANs a chance at achieving better health outcomes.

To begin the 12 year phase-in of the full \$30 billion request, Tribes recommend **\$6.2 billion** in FY 2017. All areas of the IHS budget are important, and we hope to see a strong increase across the IHS budget FY 2017. However, the Tribes have identified several priorities including *Purchased/Referred Care (PRC)*; *Hospitals & Clinics*; *Alcohol & Substance Abuse Services*; *Mental Health*; and *Dental Services*.

Purchased/Referred Care (PRC) – In FY 2017, Tribes recommend **\$1.2 billion** for the Purchased/Referred Care (PRC) program. This is \$270.4 million over the FY 2017 President's request and \$318.6 million above the FY 2016 enacted level. The PRC budget supports essential health care services from non-IHS or non-Tribal providers and includes inpatient and outpatient care, emergency care, transportation, and medical support services such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services. In FY 2015, PRC denied over \$645 million for an estimated 132,000 services needed. It is critical that this account continue to be prioritized by Congress. Tribal leaders have voiced concern that PRC was flat-funded in FY 2016. This core funding is still a top priority for the Tribes, as some areas rely heavily on PRC dollars, and we hope to see continued prioritization by the Committee in FY 2017.

Hospitals and Clinics – In FY 2017, Tribes recommend **\$2.3 billion** for Hospitals and Clinics (H&C) which is \$300 million over the FY 2016 President's request and \$422.8 million over the FY 2016 enacted level. This core budget line item provides for the direct service delivery to AI/ANs. IHS/Tribal/Urban Indian (I/T/U)-managed facilities are often located in rural settings with service at many locations limited to primary care, due to inadequate funding. IHS H&C faces tremendous challenges. Some of these factors include: an increased demand for services related to trends in significant population growth, an increased rate of chronic diseases, rising medical inflation, difficulty in recruiting and retaining providers in rural health care settings, and the lack of adequate facilities and equipment. For many AI/ANs, IHS represents the health care access in its entirety, both in terms of monetary resources but also facility access. Consequently, any underfunding of H&C equates to *no health care*. For many in Indian Country, there are no alternatives.

Quality of Care Issues – Direct Service Facilities: Perhaps even more disturbing than the severe lack of resources at IHS, is recent findings by the Centers of Medicare and Medicaid Services (CMS) at several hospitals in the Great Plains Area of IHS. In the last year, three hospitals serving Tribes in the region have lost, (or received threats of revocation) their ability to bill CMS. This not only severely hampers

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the critical 3<sup>rd</sup> Party Revenue on which these facilities depend, but more importantly these findings raise serious questions about the quality of health care provided by IHS. At the Winnebago Indian Hospital, Pine Ridge Indian Hospital and the Rosebud Indian Hospital the deficiencies in question are simply unacceptable and more must be done to ensure that IHS management never allows this to happen again. Just last week, NIHB learned that Rosebud Indian Hospital was told it will lose this CMS certification on March 16, despite the fact that an IHS team has been on the ground for the last several months trying to prevent this. While it is our understanding that the agency has recently reached an agreement with CMS to keep the accreditation until at least May 16, we are continued to be troubled by the situation on the ground. NIHB believes that IHS should certainly be held to task by Congress for the poor management of these facilities, but it is also incumbent on Congress to provide IHS with sufficient funding so that the Service is able to safely and effectively carry out its mission. As one Tribal leader stated at a Senate hearing on February 3, 2016: “[IHS] is all we have to count on. We don't go there because they have superior health care. We go there because it is our treaty right. And we go there because many of us lack the resources to go elsewhere. We're literally at the mercy of IHS.”

Mental Health – In FY 2017, Tribes are recommending **\$154.9 million**. This is \$43.75 million above the President’s FY 2017 request and \$72.8 million above FY 2016. Expansion of mental health services are critically needed. Nowhere is the issue of poor coordination perhaps more acute than when it comes to mental and behavioral health services. AI/AN children and communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma.<sup>5</sup> But access to behavioral health services is limited. In a study of 514 IHS and Tribal facilities, 82% report providing some type of mental health service such as psychiatric services, behavioral health services, substance abuse treatment, or traditional healing practices, and to improve access 17% (87) have implemented telemedicine for mental health services.<sup>6</sup> However, none provide inpatient psychiatric services.<sup>7</sup> Without access to care, persons in psychiatric distress often end up at the hospital emergency room.<sup>8</sup> We support the Administration’s request for \$21.4 million in behavioral health integration as well as the \$3.6 million for the Zero Suicide Initiative. We also support the Administration’s mandatory funding requests for the Behavioral Health Professions Expansion Fund (\$10 million) and the Tribal Crisis Response Fund (\$15 million).

Alcohol and Substance Abuse – In FY 2017, Tribes recommend **\$312.3 million** for the Alcohol and Substance Abuse budget. This is \$79 million above the President’s request and \$107 million above the FY 2016 enacted level. Of the challenges facing AI/AN communities and people, no challenge is more far reaching than the epidemic of alcohol and other substance abuse. Now that Tribes manage a majority of alcohol and substance abuse programs, IHS is in a supportive role to assist the Tribes plan, develop, and implement a variety of treatment modalities. The collaboration has resulted in more consistent evidenced-based and best practice approaches to address substance abuse disorders and addictions.

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<sup>5</sup> Braveheart, M. Y. A., & DeBruyn, I. M. (1998). The American Indian Holocaust: healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, 8(2).

<sup>6</sup> Urban Indian Health Institute. (2012). Addressing depression among American Indians and Alaska Natives: A literature review. Seattle, WA: Urban Indian Health Institute.

<sup>7</sup> Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from [http://www.ihs.gov/newsroom/includes/themes/newihstheme/display\\_objects/documents/FINAL\\_IHCIA\\_InpatientMH\\_Assessment\\_Final.pdf](http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf)

<sup>8</sup> *Ibid*

Successful treatment approaches include traditional healing techniques that link the services provided to traditional cultural practices and spiritual support. NIHB strongly supports the Administration's request for an extra \$15 million for the Substance Use and Suicide Prevention Program.

Dental Health – For FY 2017, Tribes recommend **\$218.6 million** for Dental Health. This is \$31.8 more than the President's Request and \$40.3 million above the FY 2016 level. These critical funds are desperately needed to improve the oral health of AI/ANs. Over 80 percent of AI/AN children ages 6-9 suffer from dental caries, while less than 50 percent of the U.S. population ages 6-9 have experienced cavities. The IHS Dental program supports clinic-based treatment and prevention services, oral health promotion and disease prevention activities. However, access is one of the key issues in improving oral health for Tribal communities. Half of AI/AN youth live in a dental shortage area. NIHB and the Tribes continue to support the expansion of Dental Therapists (DTs) to Tribes outside of Alaska as a safe, reliable, cost-effective means for Tribal members to access oral health services. Sadly, provisions in the Indian Healthcare Improvement Act (IHICIA)<sup>9</sup> have made it difficult to use IHS programs to use these effective midlevel providers. We encourage the Committee to work with the relevant authorizing Committees to repeal this prohibitive section of the law so that IHS and Tribes can utilize scarce discretionary dollars in the most cost-effective way possible.

Contract Support Costs – NIHB and Tribes were pleased to see the separate funding account for contract support costs (CSC) that was created in FY 2016. However, we continue to support the Administration's request for mandatory CSC and encourage Congress to work to enact this change as soon as FY 2017.

Other Recommendations – Tribes have also proposed other budget-related recommendations for IHS in FY 2017. One of these priorities is support for **advance appropriations for IHS** which would allow Tribes to have predictability on the IHS budget and place IHS on parity with other federal health providers.

The **implementation of the IHICIA** remains a top priority for Indian Country. IHICIA provides new authorities for Indian health care, however additional funding is needed to fully implement the Act. This year, Tribes have set priorities for funding the additional provisions of IHICIA as follows: Section 205: Funding for Long-term Care Services (\$37 million); Section 704: Comprehensive Behavioral Health Prevention and Treatment Program (\$20 million); Section 204: Diabetes Prevention, Treatment, and Control (\$20 million); Section 123: Health Professional Chronic Shortage Demonstration Project (\$15 million); Section 705: Mental Health Technician Program (\$5 million).

As noted above, the trust responsibility for health extends beyond the IHS. We also encourage this Subcommittee to work with **other agencies at the Department of Health and Human Services to ensure that funds reach Tribal communities**. Specific funding "set asides" for Tribes or language directing the HHS to fund Tribal communities specifically could be ways to ensure that appropriated dollars reach Tribes.

Thank you for the opportunity to offer this statement. We look forward to working with the Appropriations Committee as Congress considers FY 2017 Appropriations. If you have any questions, please do not hesitate to contact the National Indian Health Board.

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<sup>9</sup> 25 U.S.C. 1616(d)