National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
AMERICAN INDIAN & ALASKA NATIVE PUBLIC AND OUTSIDE WITNESS HEARING
HOUSE APPROPRIATIONS SUBCOMMITTEE ON INTERIOR
April 16, 2021

Chairwoman Pingree, Ranking Member Joyce, and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized Tribes we serve, I submit this testimony on the Indian Health Service (IHS) Fiscal Year (FY) 2022 budget.

Congress established 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). Since its inception, IHS has suffered chronic and perverse funding shortages that continue to adversely impact the quality and consistency of health services delivered to AI/AN Peoples. In 2018, per capita medical expenditures within the Indian health system amounted to just $3,779 compared to $9,409 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.

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 health care coverage, and less socioeconomic mobility than the general population. For instance, from 1999 to 2015 our people encountered a 519% increase in drug overdose deaths, the highest rate increase of any demographic nationwide. Approximately 75% 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 toward treatment as opposed to prevention. Investments in public health systems in Indian Country remain nonexistent. This means higher expenditures for direct health care for preventable disease, in an already underfunded health system.

Tribes are grateful for the recent increases to the IHS budget, but those increases are not enough to expand health services or improvements in equipment, facilities, or staffing. While the IHS annual budget has increased by roughly 2-3% each year since FY 2008, much of those increases are only enough to cover costs associated with population growth, medical inflation, the rightful full funding of Contract Support Costs (CSC), 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 fully funding IHS, and then transitioning the agency to mandatory funding. Tribes, Tribal organizations, and urban Indian organizations from across Indian Country come together each year to put forth national recommendations towards establishing a needs-based and fully funded IHS budget. Known as the IHS National Tribal Budget Formulation Workgroup (TBFWG), 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. TBFWG provides a roadmap towards fulfillment of the federal trust responsibility for the health of all AI/AN people.

In 2018, the TBFWG first recommended transitioning to a new methodology for calculating a full needs-based IHS budget. Starting with the FY 2021 recommendations, the TBFWG 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 TBFWG recommends a needs-based and fully funded budget of **$48 billion** for IHS.[1] This total includes recommended amounts for all IHS accounts and line item expenditures, including for binding obligations such as CSCs, funding for newly recognized Tribes, and 105(l) lease expenditures, etc.

The FY 2022 recommendations from the TBFWG were crafted in April 2020, one month into the COVID-19 pandemic. This was before we fully understood the devastating impacts COVID-19 would have on our Tribal communities. When you compound the impact of broken treaty promises, chronic underfunding, and endless use of continuing resolutions, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do. We will honor the Workgroup's recommendation for FY 2022 and request the subcommittee begin the ten-year phase in of the full needs-based IHS budget of **$12.759 billion**; however, for future appropriation bills, we will request the subcommittee provide IHS with a fully funded budget of **$48 billion**.

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 Congresswoman McCollum's leadership in introducing H.R. 1128, the Indian Programs Advance Appropriations Act, in the 116th Congress. This bill sought to authorize advance appropriations for IHS Services and CSCs, in addition to the Bureau of Indian Affairs (BIA). We look forward to the reintroduction of this bill this Congress. NIHB is pleased to see, for the first time ever, advance appropriations were included in the President's discretionary funding request. We urge this subcommittee to follow the President's request and include advance appropriations for IHS in this fiscal year's appropriations bill. The Indian health system faces chronic challenges that are made worse by endless use of continuing resolutions (CRs) and the persistent threat of government shutdowns. Of the four federal health care programs, IHS is the only one not protected from government shutdowns and CRs. This is because Medicare/Medicaid receive mandatory appropriations, and the Veterans Health Administration (VHA) receive advance appropriations starting a decade ago. In September 2018, the Government Accountability Office (GAO) issued a report (GAO-18-652) that noted "uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs."

We are pleased the Bipartisan Budget Act of 2019 put an end to sequestration; however, the protection only lasts through the end of FY 2021 and once again is subject to this rule starting FY 2022. During the most recent government shutdown in 2019, which lasted 35 days, IHS was the only federal health care program directly harmed. The impact was devastating, yet entirely avoidable. Tribal facilities lost physicians because they could not keep working without pay. Doctor visits could not be scheduled because administrative staff were furloughed. Tribes took out *private loans* to be able to help pay to keep

[1] 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

the lights on at their clinic. Contracts with private entities for sanitation services and facilities upgrades went weeks without payment, threatening Tribes' credit and putting patients' health at risk. Tribal leaders shared how administrative staff volunteered to go unpaid so their 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 the nation at large.

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. The inevitable results are the chronic and perverse health disparities across Indian Country. Advance appropriations for IHS is a necessity to ensure patient health is not comprised in the event of Congress's failure to enact a budget each year. It is long past due.

FY 2022 Funding Recommendations

To begin the ten-year phase in of the full needs-based IHS budget, Tribes recommend increasing FY 2022 IHS appropriations to **$12.759 billion**. All areas of the IHS budget are critically important, and we hope to see strong increases across the board for FY 2022. However, Tribes have identified several top priorities including *Hospitals & Clinics*; *Purchased/Referred Care (PRC)*; *Mental Health*; *Alcohol and Substance Abuse*; and *Facilities*.

Hospitals and Clinics – For FY 2022, Tribes request **$4.2 billion** for Hospitals and Clinics (H&C), which is roughly $1.8 billion above the FY 2021 enacted level. Sufficient funding for H&C remains the top priority for FY 2022, as it provides the base funding for 605 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the core funding that provides direct medical care services to AI/ANs. Increasing H&C funding is critical as it supports medical care services provided at IHS and Tribally-operated facilities, including emergency care, inpatient and outpatient care, and specialized care, including for diabetes prevention, maternal/child health, youth services, communicable and infectious disease treatment. Rarely do the 2-3% increases to the annual appropriated IHS budget adequately account for rising medical inflation year to year. This effectively means that, over time, IHS and Tribal health systems are losing funding over time. Medical inflation particularly impacts the H&C line item as IHS and Tribal sites fail to keep up with rising medical costs. Underfunding of H&C translates to rationed care that is less accessible and of lower quality, further limiting efforts towards making meaningful improvements to AI/AN health disparities.

Purchased/Referred Care (PRC) – For FY 2022, Tribes recommend **$2.02 billion** for the PRC program, which is nearly $1 billion above the FY 2021 enacted level. PRC was established for IHS and Tribally-operated facilities to secure health care services from private sector providers when such services are not available within the Indian health 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 health 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 2022, Tribes request **$95.3 million** for the Electronic Health Records (EHR) line item, which is $34.3 million above the FY 2021 enacted level. IHS uses the Resource and Patient Management System (RPMS), which 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 VHA, known as the Veterans Information Systems and Technology Architecture (VistA). With the VHA transitioning to a commercial off the shelf system, 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 in order to not compromise patient care and health. This request for EHR systems for FY 2022 is part of the request to fully fund HIT under the HIT Modernization Project. Full funding for HIT is based on the outcomes of the HHS/IHS HIT Modernization and amounts to $3 billion based on current data. However, this amount is expected to be adjusted to reflect a more accurate cost once the final HHS/IHS recommendations for HIT are finalized.

105(l) lease expenditures – For FY 2022, Tribes request **$138 million** for Section 105(l) lease agreements, which is $37 million above the FY 2021 enacted level. The Tribes are grateful that in FY 2021 our request was granted, and Section 105(l) lease agreements were enacted as indefinite appropriations and has a separate line item for the funding. The final appropriations package of 2020 requires that lease agreements "...commence no earlier than the date of receipt of the lease proposal." This would end the IHS practice of back-paying lease costs to the start of the fiscal year, which contribute to the unpredictability of lease costs and issues in estimating future costs associated with the lease. There is a crucial need to develop policy guidelines around lease costs and a permanent solution for 105(l) lease agreements. The court decisions under Maniilaq "...appear[s] to create an entitlement to compensation for 105(l) leases that is typically not funded under discretionary appropriations." While the FY 2021 HIS budget increased by roughly $189 million overall, **over half of the increase - 53% - goes towards the indefinite appropriation for 105(l) alone.** Given the strict spending caps associated with the Interior budget, creation of the indefinite appropriation for 105(l) divests funds from other important line items.

Mental Health and Alcohol/Substance Abuse – For FY 2022, Tribes request **$714.9 million** for Mental Health, which is $582.16 million above the FY 2021 enacted level; and **$778.5 million** for Alcohol and Substance Abuse, which is $518.6 million above the FY 2021 enacted level. Both budget items have only increased in urgency and priority since the start of the COVID-19 pandemic. Funding increases would be used to implement previously unfunded sections of IHCIA that are desperately needed. Additional funds would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs. Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities continue to be afflicted with the epidemic of alcohol and other drug abuse including opioid addiction.

Facilities – For FY 2022, Tribes request roughly **$2.02 billion** for Facilities. This includes marked increases for Maintenance & Improvement, Sanitation Facilities Construction, Health Care Facilities Construction, Equipment, and Facilities & 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 old, 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. At the current rate of funding, if a new facility were built today, it would not be replaced for 400 years.