National Indian Health Board

June 21, 2021

The Honorable Charles Schumer
Majority Leader
U.S. Senate
S-221 U.S. Capitol Building
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
H-232 Capitol Building
Washington, D.C. 20515

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
S-230 U.S. Capitol Building
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
H-204 Capitol Building
Washington, D.C. 20515

RE: Healthcare Infrastructure Funding for Indian Country

Dear Leader Schumer, Leader McConnell, Speaker Pelosi, and Leader McCarthy:

On behalf of the National Indian Health Board (NIHB), and the more than 574 federally recognized American Indian and Alaska Native (AI/AN) Tribal Nations that we serve, the requests outlined in this letter address the extraordinarily poor infrastructure conditions that require improvement to meet the health, safety, welfare, and development needs of AI/AN communities.

As the U.S. shapes its infrastructure package, it must prioritize the honoring of its trust and treaty obligations to Tribal Nations. The 2018 Broken Promises Report conclude that the U.S. has failed to honor its trust and treaty obligations to Tribal Nations. As a result, Tribal Nations and AI/ANs suffer from some of the highest health and social well-being disparities found in the Unites States. A new and modern approach must be included with the understanding that purposeful domestic investment into the recovery and success of Tribal Nations is in the best interests of the United States.

Over the last several decades, Tribal Nations have seen incremental improvements in the federal government's efforts to support Tribal sovereignty and honor the trust responsibility regarding health; however, the Indian health system remains critically underfunded with medical services funded at only 48 percent of need. AI/ANs experience some of the poorest health outcomes when compared to all other groups. Strategic investment in health infrastructure is necessary to build a health system that will improve the health of all AI/ANs and prevent and prepare for public health emergencies. Outlined below are the current infrastructure needs in Indian Country related to the Indian, Tribal, and Urban Indian (I/T/U) Health Systems.

Health Care Facilities Construction

On average, Indian Health Service (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 nearly 26 percent more expensive to maintain than a 10-year facility. Further, about 52 percent of current health care facilities are grossly undersized for patient populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors.[1] At current rates of funding, if a new facility was built today, it would not be replaced for 400 years.[2] The absence of adequate facilities frequently results in either treatment not being sought, or sought later, prompted by worsening symptoms, and/or referral of patients to outside communities. To address these needs, we request the following:

- At least $21 billion for Healthcare Facilities Construction, including but not be limited to, support for new and current planned projects, the Small Ambulatory Health Center Program, UIOs, the Joint Venture Construction Program, and innovative approaches to addressing unmet construction needs for health facilities as described in 25 U.S.C. §1631(f).
- At least $10 billion in facilities construction funding that is available outside of the current Healthcare Facilities Construction Priority System (HFCPS) as a new, equitable source of funding that will provide access to construction funds and demonstration project funds for Tribes that do not qualify under HFCPS criteria.
- At least $2.9 billion for Sanitation Facilities Construction.
- At least $2 billion for behavioral health facilities.
- At least $1.8 billion for equipment.
- At least $750 million for maintenance and improvement of IHS and Tribal Facilities.
- At least $580 million devoted to incorporating sustainability features into construction projects (new and existing facilities).

Public Health Infrastructure

Public health infrastructure in Indian Country is one of the most severely underfunded and underdeveloped areas of the health service delivery system. The majority of the health disparities Tribal communities currently face, such as obesity, diabetes, heart disease, and cancer are largely preventable chronic conditions. Treating these chronic health conditions imposes unnecessary challenges on Tribal health systems and IHS. Presently, full funding for the IHS is at least $48 billion to address unmet service needs, that are not inclusive of the infrastructure asks outlined below. A significant federal investment must be made to improve the Tribal public health system

[1] The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress. Indian Health Service, (2016).
https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

[2] House Committee on Natural Resources, Oversight Hearing on Improving and Expanding Infrastructure in Tribal and Insular Communities, Remarks by Congressman Doug LaMalfa (R-CA), March 9, 2017.
https://republicans naturalresources.house.gov/newsroom/documentsingle.aspx?DocumentID=401671

to begin to make meaningful reductions in chronic and infectious disease disparities experienced by AI/AN people. Accordingly, we request full funding for the IHS and the following:

- Full funding for the Indian Health Service at $48 billion.
- At least $3 billion for Electronic Health Records and Health IT Modernization.
- Allow I/T/U providers to be reimbursed for services provided outside of the four walls of their clinic, just as they would if they were provided in the clinic.
- At least $1 billion for an Inter-Tribal (interoperability between Tribes) public health infectious disease surveillance systems with mobile capabilities to accommodate rural/mobile public health professionals.
- At least $2.3 billion for Tribes and Tribal Epidemiology Centers (TECs) to build and strengthen Tribal public health infrastructure and capacity.
- Codify a permanent Tribal set-aside in the Strategic National Stockpile at a minimum of five percent.
- Reauthorize the Special Diabetes Program for Indians (SDPI) through FY26 and increase funding to $250 million annually, with annual increases for medical inflation and funding available through contracts/compacts for Title I and Title V Tribes.
- Establish a Native Behavioral Health Program for I/T/U and fund through FY26 at $200 million annually with annual increases for medical inflation, and funding available through contracts/compacts for Title I and Title V Tribes.
- Authorize advance appropriations to insulate Indian health care providers from government shutdowns and allow for long-term planning.

Tribal Health Workforce Development

IHS and Tribal health providers continue to struggle to find qualified medical professionals. Currently, IHS sites' estimated vacancy rates stand at: 34 percent for physicians; 16 percent for pharmacists; 24 percent for nurses; 26 percent for dentists; 32 percent for physician's assistants; and 35 percent for advanced practice nurses.[3] Current vacancy rates make it nearly impossible to operate a quality healthcare program. With competition for primary care physicians and other practitioners/administrators at an all-time high, the situation is unlikely to improve soon. IHS cannot meet workforce needs with the current strategy. To strengthen the healthcare workforce at I/T/Us, Indian Country needs investment from the federal government to educate, recruit, and expand its pool of qualified medical and healthcare administration professionals. To accomplish this goal, we request the following:

- Establish a non-competitive tribal program for Graduate Medical Education (GME) with $10 billion in funding, removing administrative barriers and allowing all reasonable costs for GME funding by Indian operated hospitals.
- Establish a Tribal set-aside of $6 billion for Tribal medical residency programs under the HRSA Teaching Health Centers program.
- Make IHS and Tribal Loan Repayment Program tax-exempt.

[3] U.S. Government Accountability Office, Indian Health Service, Agency Faces Ongoing Challenges Filling Provider Vacancies, GAO-18-580. (2018). https://www.gao.gov/assets/gao-18-580.pdf

- Establish a Tribal set-aside in Public Health Scholarships.
- At least $2 billion for improved housing options and long-term livable standards for IHS and Tribal health workforce.
- Fully fund the Community Health Aide Program for implementation in all states and for UIOs.

Unfunded Provisions of the Indian Health Care Improvement Act

Various portions of the Indian Health Care Improvement Act (IHCIA) have either been partially, or not at all, funded or implemented since the law was permanently reauthorized in 2010. All of the programs included in the law were meant to fulfill the trust and treaty responsibility owed to Tribal Nations by the federal government and provide high quality healthcare to AI/ANs. Until all of these programs are fully funded and implemented, Indian health will continue to lack the resources needed to fulfill these obligations. We request the following programs, authorized in IHCIA, be fully funded and implemented:

- Community Health Aide Program.
- Health Professional Chronic Shortage Demonstration Project.
- Indian Health Care Delivery Demonstration Projects (IHCIA Section 143).
- Indian Country Modular Component Facilities Demonstration Program.
- Mobile Health Stations Demonstration Program.
- Services for Community Based Long-Term Care.
- Inpatient and Community Health Facilities Design, Construction, and Staffing for at least one inpatient mental healthcare facility per IHS Area.

In closing, the Tribes must be included in any effort to make meaningful infrastructure investments in the United States and health care infrastructure must be a key consideration in that effort. On behalf of the nation's 574 federally recognized Tribes, both American Indian and Alaska Native, NIHB looks forward to working with you to address the structural and practical challenges that the Indian/Tribal/Urban health system faces and the opportunities to address these challenges in the American Jobs Act.

Thank you for your continued commitment to Indian Country.

Sincerely,

William Smith
Valdez Native Tribe
Chairman
National Indian Health Board