National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
AMERICAN INDIAN AND ALASKAN NATIVE PUBLIC AND OUTSIDE WITNESS HEARING
HOUSE APPROPRIATIONS COMMITTEE, Subcommittee on Interior
April 8, 2014, 8:30am

Chairman Calvert, Ranking Member Moran and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board and the 566 federally-recognized Tribes we serve, I submit this testimony.

First, I would like to start by thanking the members of this committee for their determination in advocating for the rights of American Indian and Alaska Native (AI/AN) peoples. Consistently, this committee has been willing and ready to stand up for the trust obligations the federal government has toward American Indians and Alaska Natives. Thanks to your bipartisan work, we have seen historic increases for the Indian Health Service (IHS), and this is making a real difference in the health of our people.

Health Discrepancies for American Indians and Alaska Natives: Despite these much-needed increases, the health of AI/ANs continues to fall far short of the health status of all other Americans. The AI/AN life expectancy is 4.2 years less than the rate for the U.S. all races population. AI/ANs suffer disproportionally from a variety of diseases including alcoholism, diabetes; unintentional injuries, and suicide. According to IHS data, 39 percent of AI/AN women experience intimate partner violence, which is the highest rate of any ethnic group in the United States. One in three women in AI/AN communities will be sexually assaulted in her lifetime. Additionally, public health risks due to alcohol and substance abuse are widespread in many Tribal communities, leading to other health disparities such as poverty, mental illness, and increased mortality from liver disease, unintentional injuries and suicide. Our children ages 2 to 5 have an average of six decayed teeth, when children in the US all races population have only one.

When considering the level of funding appropriated to IHS, these statistics are not surprising. In 2013, the IHS per capita expenditures for patient health services were just $2,849, compared to $7,717 per person for health care spending nationally. The First People of this nation should not be last when it comes to health. Let's change that now.

Sequestration in FY 2013 and the FY 2014 Budget: As the Committee is well aware, the IHS budget lost $220 million due to sequestration in FY 2013. This, combined with the two week long government shutdown at the start of FY 2014 was devastating many Tribal health programs. Many sites cut patient visits, furloughed staff and delayed or denied needed medical procedures. The tragedy of sequestration in Indian Country is a clear denial of the federal trust responsibility to Tribes. Our communities become, yet again, casualties of unrelated and bitter political battles in Washington.

The Congress, in the FY 2014 budget did make a commitment to replace some of the funding lost due to sequestration in the previous year. However, due to priorities outlined by Congress and the rightful funding of Contract Support Costs, the IHS was not able to alleviate sequestration across most accounts and provided only nominal increases for those where the funding was restored. This, combined with medical inflation and additional staffing costs, have not really allowed these budgets to move forward. For FY 2015, Congress, at a bare minimum *must* truly restore these sequestration cuts, and adjust for inflation and population growth. We also urge this committee to continue to advocate with your colleagues

in Congress to create a permanent, full exemption from sequestration, as well as rescissions, for Tribal programs for FY 2016 and beyond.

FY 2015 Budget Request: NIHB echoes the recommendations of the Tribal Budget Formulation Workgroup for FY 2015. The Tribal Budget request continues to be full funding of the Total Tribal Needs base budget of 28.7 Billion dollars over a 12 year period. This includes amounts for personal health services, wrap-around community health services and facility capital investments. For FY 2015, Tribes request total funding amount of **$5.3 billion**.

Contract Support Costs: Importantly, the FY 2015 President's budget request fully funds Contract Support Costs (CSC). This represents a historic shift in a decades-long battle. NIHB would like to again, thank this committee for the work it did to not only elevate the issue, but also to change the position of the Administration. However, as noted above, this CSC funding obligation should not have been achieved at the expense of other Tribal programs. Funding CSC at the expense of other direct services is a continuation of the injustice, and is simply "robbing Peter to pay Paul." The increases provided in the FY 2014 budget to fund CSC only restored obligations to the federal government has already made to Tribes, and did not provide a true increase to the overall budget in terms of real health dollars. For FY 2015, we urge the full funding of CSC without harming other IHS accounts.

Purchased/Referred Care: Over the last several years both Congress and the Administration have heard the call of Tribes to increase funding for Purchased/Referred Care (PRC). Purchased/Referred Care dollars fund for IHS patients health care services that cannot be directly provided by an IHS or Tribal health facility. This dearth of funding creates an emergency "life or limb" scenario (Priority I) where an amputation will be paid for when the preventative care that could prevent the amputation will not – or where painkillers will be paid for when orthopedic surgery is needed. This has to stop. Tribes are grateful that since FY 2009 PRC has increased by 38%. However, funding is so short for this program that Tribes have requested **$1.1 billion** for PRC in FY 2015, which is $22 million above the FY 2014 enacted level and $17 million above the FY 2015 request. Through lack of funding and de-prioritizing preventative opportunities, this cycle creates increased costs for needed health care by increasing costs to the PRC programs specifically, and to the IHS health delivery system overall.

Medicare Like Rates for PRC: In addition to providing additional funding for PRC, one common-sense solution to enable these funds to go further is for Congress to enact legislation that would require that PRC reimbursements to non-hospital providers are made at "Medicare Like Rates." In April 2013, the Government Accountability Office issued a report that concluded "Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's CHS program that is consistent with the rate paid by other federal agencies." We agree: these savings would result in IHS being able to provide approximately 253,000 additional physician services annually. NIHB and Tribes encourage Congress to swiftly enact the legislative change to make PRC subject to Medicare Like Rates.

Hospitals and Clinics: In FY 2015, Tribes request **$2.1 billion** for Hospitals and Clinics (H&C) in order to better provide health services for 2.1 million AI/ANs. This represents an increase of $297 million, or 16 percent over the FY 2014 enacted level. H&C includes medical and surgical inpatient care, routine and emergency ambulatory care, and other medical support services. H&C funds also support community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, and elder health. The services provided

by H&C are constantly being challenged by many factors including inflation, population growth and an increased rates of chronic diseases. If the health status of AI/ANs is ever going to improve, Congress must prioritize this core program now.

Mental Health: For FY 2015, NIHB recommends **$130 million** for mental health services. Failure to treat mental health conditions and providing appropriate and timely interventions and care, effectively results in community-wide public health risks both on and off reservations for AI/ANs. For example, the Navajo Area suicide rate that is four times greater than the US all races rate for youth aged 5-14. In 2010, in one town with a population of only 8,000, there were 15 suicides. The trauma and emotional injury stemming from a suicide in Tribal communities impacts elders, mothers and fathers, sons and daughters, friends and destabilizes the cultural and community fabric of our Nations. Treating these issues among AI/ANs must utilize a comprehensive approach that targets early intervention and engages all aspects of life. Services that IHS currently provides, when resources are available, include crisis response services, prevention programming, collaborative treatment planning with alcohol and substance abuse treatment providers, group therapies, and traditional healing methodologies. Overall, these solutions are more reactive than they are proactive.

One of the most critical problems Tribal communities face is the recruitment and retention of qualified fulltime psychiatrists and psychiatric nurse practitioners. This is one of the many reasons NIHB supports a legislative fix that would enable IHS Student Loan Repayment Program to have tax exempt status. It would enable IHS to fund an addition 105 new repayment awards to combat the 1,550 vacancies for health care professionals in the IHS system. In the House of Representatives (H.R. 3391), bipartisan legislation has been introduced to address this concern.

Alcohol and Substance Abuse: Closely linked with mental health issues are chronic problems stemming not only from historical trauma, but from emotional injuries related to domestic violence as well as alcohol and substance abuse in Tribal communities. This leads to widespread health issues for individuals, families and entire communities. For FY 2015, we recommend **$236 million** for Alcohol and Substance Abuse, or $50 million above the FY 2014 enacted level. IHS programs and Tribally operated alcohol and substance abuse programs employ a variety of treatment modalities consistent with evidenced-based approaches to address substance abuse disorders and addictions through individual and group counseling, peer support, and inpatient and residential placement. However, it is essential that treatment approaches also include traditional healing techniques designed to improve outcomes and to tie services provided back to valuable cultural practices and the individual AI/AN's spiritual journey. Again, treatment for alcohol and substance abuse *must* be approached from a community-wide perspective and integrate not only health programs, but also Tribal justice, and education initiatives.

Fund IHCIA New Authorities: The adoption of the Affordable Care Act (ACA) (P.L. 110-148) renewed the Indian Health Care Improvement Act (IHCIA). The Act updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled. Adequate funding for the implementation of these long awaited provisions is needed now. Tribes recommend funding of **$300 million** in order to fully implement IHCIA in FY 2015.

Definition of Indian in the Affordable Act: As NIHB testified previously, we urge Congress to enact a legislative "fix" for the Definition of Indian in the Affordable Care Act. The "Definitions of Indian" in the ACA are not consistent with the definitions already used by the Indian Health Service (IHS), Medicaid

and the Children's Health Insurance Plan (CHIP) for services provided to American Indians and Alaska Natives. The ACA definitions, which currently require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act corporation, are narrower than those used by IHS, Medicaid and CHIP, thereby excluding a sizeable population of AI/ANs that the ACA was intended to benefit and protect. Unless the definition of Indian in the ACA is changed, many AI/ANs will not be eligible for the special protections and benefits intended for them in the law. NIHB requests that the committee use all methods at its disposal to resolve this issue.

Renewal of the Special Diabetes Program for Indians: According to the Centers for Disease Control and Prevention (CDC), AI/AN adults have the highest age-adjusted prevalence rate of diagnosed diabetes compared to other major racial and ethnic groups at 16.1 percent. By comparison, this is almost twice the rate for the total U.S. adult population. To combat this epidemic, Congress created the Special Diabetes Program for Indians (SDPI) in 1997. SDPI has become one of the nation's most strategic, successful and comprehensive effort to combat diabetes. Today, SDPI is funded at a level of $150 million per year and supports 404 diabetes treatment and prevention programs in 35 states. With funding for this critical program set to expire on September 30, 2015, Tribes are requesting a renewal of this program of **$200 million/ year for 5 years**. While we understand an increase in funds during this budgetary environment is difficult, SDPI has been level-funded since 2002. This represents an effective decrease. Calculating for inflation, $150 million in 2002 would be about $115 million in 2014 – or *23 percent less*. It is critical that Congress continue to invest in SDPI, which will save millions in preventative care over the long term.

Support for Advance Appropriations: In addition to the policy recommendations outlined by the Administration, NIHB would like to reiterate its support for Advance Appropriations for the Indian Health Service. Rep. Don Young (R-AK) has introduced legislation, H.R. 3229, to provide advance appropriations for the IHS. This measure will be an important first-step in ensuring that AI/ANs receive the health care they deserve. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. The need for advance appropriations was no more obvious during the federal government shutdown at the start FY 2014. Many Tribal health programs were forced to furlough employees, close their clinics and deny services during this period.

Conclusion

While we have made important gains in the IHS funding budget over the last several years, the scourge of sequestration has eliminated much of that progress. Tribal communities still continue to suffer greatly from chronic public health risks exacerbated by grossly underfunded health services in Indian Country. For FY 2015, Tribes are requesting: Begin implementation of a plan to achieve a Needs Based Budget for IHS at 28.7 billion; 2) Fund IHS at **$5.3 billion** for FY 2015; 3) Restore Cuts/Shortfalls in FY2013-15 resulting from sequestration, inadequate increases to cover Congressionally mandated budget categories, advocate that Tribes and Tribal programs be permanently exempted from any future sequestration; 4) Provide an additional $300 million to implement the provisions authorized in the IHCIA

It is a matter of justice and equity – failure to prioritize an IHS budget that makes a meaningful investment in the health of AI/ANs is a violation of the federal trust responsibility and denial of the sacrifices that our people have made to this country. Thank you for the opportunity to offer this testimony.