

National Indian Health Board



TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD OVERSIGHT HEARING ON THE PRESIDENT'S FISCAL YEAR 2015 BUDGET FOR TRIBAL PROGRAMS

SENATE COMMITTEE ON INDIAN AFFAIRS
March 26, 2014, 2:30pm

Chairman Tester, Vice Chairman Barrasso, and Members of the Committee, thank you for holding this important hearing on the FY 2015 President's Budget Request. 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 dogged 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. 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. To facilitate upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people.

In passing the Affordable Care Act, Congress also reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). In renewing the IHCIA, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives, 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."

Health Discrepancies for American Indians and Alaska Natives

Despite these promises, the health of AI/ANs continues to fall far short of the health status of all other Americans. The AI/AN life expectancy is 4.1 years less than the rate for the U.S. all races population. AI/ANs suffer disproportionately from a variety of diseases. According to IHS data from 2005-2007, AI/AN people die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher) and suicide (74% higher). Additionally, AI/ANs suffer from higher mortality rates from cervical cancer (1.2 times higher); pneumonia/influenza (1.4 times higher); and maternal deaths (1.4 times higher).

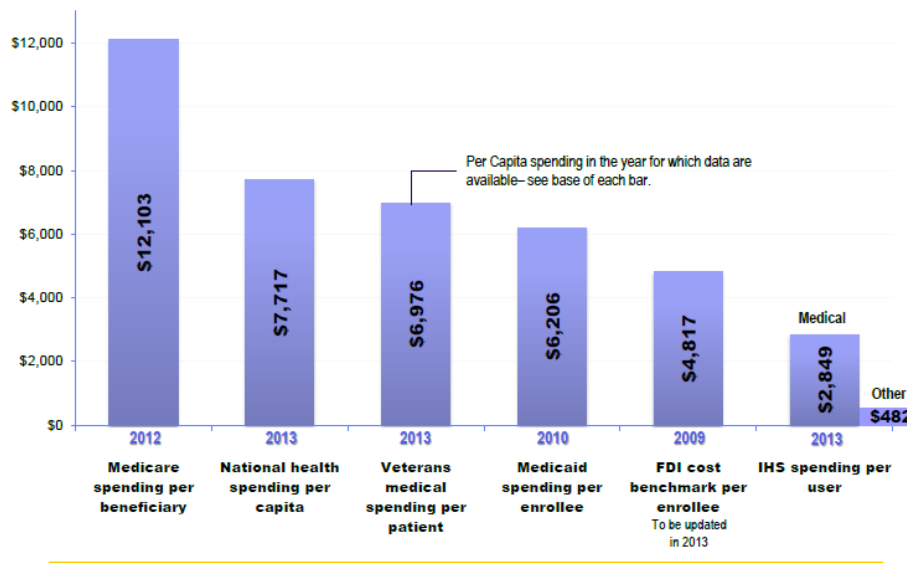
Devastating health risks from historical trauma, poverty and a lack of adequate treatment resources also continue to plague Tribal communities. According to IHS data, 39 percent of AI/AN women experience intimate partner violence, which is the highest rate of any ethnic group in the United States. One in three women in AI/AN communities will be sexually assaulted in her lifetime. AI/ANs suffer at higher rates

from psychological distress; feelings of sadness, hopelessness and worthlessness; feelings of nervousness or restlessness and suicide. Additionally, public health risks due to alcohol and substance abuse are sadly 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. Dental health concerns also continue to affect AI/ANs at higher rates than other Americans. Ninety percent of AI/AN children suffer from dental caries by the age of eight, compared with 50 percent for the same age in the US all races population. Our children ages 2 to 5 have an average of six decayed teeth, when children in the US all races population have only one.

Clearly, more must be done to alleviate these health risks for our people and to fulfill the trust obligations to AI/ANs. 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. Despite the historic increases that Congress has given to the IHS budget over the last several years, funding discrepancies unambiguously remain. The First People of this nation should not be last when it comes to health. Let's change that now.



2013 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



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 was a clear denial of the federal trust responsibility to Tribes and our communities became, yet again, an unfortunate victim of unrelated political battles in Washington. As then Senate Committee on Indian Affairs Chairwoman Maria Cantwell stated on November 14, 2013, “Our country’s financial troubles are not really stemming from our obligations to Indian Country, and frankly, we’re not doing a good job in fulfilling those obligations.”

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. Some accounts even received cuts beyond the FY 2013 sequestration level in FY 2014. This, combined with medical inflation and additional staffing costs, have not really allowed these budgets to move forward. Despite receiving these urgently needed increases, we are once again losing ground in addressing health disparities suffered by our people.

For FY 2015, Congress, at a bare minimum must truly restore these sequestration cuts, and adjust for inflation and population growth. Otherwise, our people will continue to experience some of the worst health disparities in the nation and continue to experience loss of lives due to sequestration cuts. To that end, Tribes also request that Congress enact legislation to exempt IHS and all programs serving Indian Country from any future sequestration. While discretionary spending is not facing sequestration in FY 2015, we 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 President's 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. However, for FY 2015, Tribes request total funding amount of **\$5.3 billion**. This request would enable the funding of current services and include program expansion increases in several key areas including purchased/referred care; hospitals and clinics; mental health and alcohol and substance abuse.

The NIHB and Tribes believe that the President's FY 2015 request a positive step forward for Indian Country. The President's overall proposal restores the cuts caused by sequestration and the cuts made in the FY 2014 IHS operating plan. NIHB commends the Administration for including a \$63 million increase to account for medical inflation and an additional \$2.6 million for pay cost increases at both the IHS and Tribal level. However, other challenges still remain in the federal budget, such as a long-term solution on Contract Support Costs when a long-term commitment is required; increased funding for Purchased/Referred Care (formerly Contract Health Services); increase for Mental Health care, screenings and services; and alcohol and substance abuse.

Contract Support Costs

Importantly, the FY 2015 budget request also fully funds Contract Support Costs (CSC) in accordance with the U.S. Supreme Court decision in *Salazar v. Ramah Navajo Chapter*. The request includes a \$30 million increase in order to fund the increases requested for the IHS in FY 2015. This represents a historic shift in a decades-long battle. As you recall, in FY 2014, the Administration proposed capping CSC for individual contracts, which Indian Country unanimously pointed out was a violation of both the federal trust responsibility and the principles of *Ramah* decision. Congress rejected this proposal in FY 2014 and provided a pathway for the Administration to fund CSC in FY 2014. 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. It is unfair to force Tribes to choose between increased services and funding of costs already owed to us to operate our 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.

NIHB is encouraged by statements that the Administration recently made that it wants to continue to find a long-term solution for funding CSC. We urge Congress and the Administration to work together with Tribes in order to ensure that funding for CSC can be maintained without making sacrifices to other areas of the budget.

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) (formerly called Contract Health Services). Purchased/Referred Care dollars fund for IHS patients health care services that cannot be directly provided by an IHS or Tribal health facility. These dollars have historically been so scarce that many health programs run out of funding by June 1 of the fiscal year. 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 \$244.1 million, or 38 percent. Before sequestration, some clinics were actually able to start treating cases that were non-life threatening (Priority II). In FY 2015, the President’s request includes an \$18 million increase for PRC. 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. At current levels (and especially after sequestration), the IHS budget typically only covers Priority I or “Life or Limb” referrals. Through lack of funding and de-prioritizing preventative opportunities, this cycle creates increased costs for needed health care by increasing costs to the Purchased/Referred Care 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 2003, Congress amended the Medicare law to authorize the Secretary of Health and Human Services to establish a rate cap on the amount hospitals may charge IHS and Tribal health programs for care purchased from hospitals under the PRC program. However, hospital services represent only a fraction of the services provided through the PRC system. The IHS PRC program may be the only federal government entity that does so; neither the Veterans’ Administration nor the Department of Defense pay full billed charges for health care from outside providers.

On April 11, 2013, the Government Accountability Office (GAO) 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. This number will even be greater when you consider Tribally-run programs, which means that total savings are more likely to be around \$100 million 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. Additionally, IHS/Tribal/Urban-managed facilities often have great difficulty in recruiting and retaining medical staff meaning due to remote locations and funding difficulties. 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. This represents a \$52.7 million increase over the FY 2014 enacted level. As noted above, American Indians and Alaska Natives suffer from a high incidence of mental health disorder, illnesses and suicide rates; in fact, suicide is the second leading cause of death for AI/AN children and youth. 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. Sadly, many communities throughout Indian Country also experience this tragic story. 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. Our young people in Indian Country often experience a life filled with a variety of social problems such as substance abuse and poverty, and envision a future without promise or hope for a better life. For the sake of the next Seven Generations, we must all work together to find a serious, comprehensive solution to end this disturbing epidemic.

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 comprehensive outpatient mental health treatment, crisis response services, prevention programming, collaborative treatment planning with alcohol and substance abuse treatment providers, group therapies, and traditional healing methodologies, in addition to other evidence-based approaches to mental health treatment. Overall, these solutions are more reactive than they are proactive. Services generally not available at IHS or Tribally-operated facilities, but instead must be procured through third party contracts, include inpatient and residential treatment services, group homes, and independent living centers.

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 and Health Professions Scholarship 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. We urge the members of this committee to introduce a Senate companion bill to H.R. 3391 and swiftly pass it out of committee.

NIHB also urges this committee to seriously investigate the contributing factors to mental health and work with Tribes, federal agencies and other stakeholders to find a real solution to this difficult problem.

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. As mentioned above, AI/ANs are consistently overrepresented in statistics relating to alcohol and substance abuse disorders, leading to widespread health issues for individuals, families and even entire communities.

For FY 2015, we recommend **\$236 million** for Alcohol and Substance Abuse, or \$50 million above the FY 2014 enacted level and \$43 million above the FY 2015 President's request. 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.

IHS funding supports the operation of adult and youth residential facilities and placement contracts with third party agencies, but limited funding often results in placement decisions based on the availability of alternate resources and the providers' clinical recommendations. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, mental health and substance abuse services, and the exploration and development of partnerships and alliances with other community stakeholders.

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. Communities in Indian Country experience these tragic issues due to a large and complex list of contributing factors, so approaches to solve these problems must also address all aspects of society.

Fund IHCIA New Authorities

The adoption of the Patient Protection and Affordable Care Act (ACA) (P.L. 110-148) in 2010 was historic for Tribes in many ways. Most importantly, it renewed the Indian Health Care Improvement Act (IHCIA). The effort to renew IHCIA took 10 years and represents a true victory for Indian health. 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. It also establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

However, many of these provisions remain unfunded, which again, represents another failure to follow through on promises to our people. All provisions of the IHCIA are critical to advancing the health care

of American Indian and Alaska Native people and should be implemented immediately. 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 (ANCSA) 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. On October 16, 2013, Senator Mark Begich (D-AK) introduced S. 1575 which would address this issue. NIHB encourages the committee to swiftly consider and favorably report S. 1575 to ensure that all AI/ANs are eligible for the benefits intended for them in the ACA.

Other Policy Recommendations

The Administration’s FY 2015 Budget Request Contains three legislative policy provisions: 1) Provide Tax Exempt Status for the Indian Health Service Health Professions Scholarship Program and the Health Professions Loan Repayment Program; 2) Renew the Special Diabetes Program for Indians at \$150 million for three years. NIHB supports these legislative priorities, in addition to Advance Appropriations for the Indian Health Service.

Renewal of the Special Diabetes Program for Indians

As part of the Balanced Budget Act of 1997, Congress established the Special Diabetes Program for Indians (SDPI) to address the growing epidemic of Type II diabetes in American Indian and Alaska Native (AI/AN) communities. The Special Diabetes Program for Type 1 Diabetes (SDP) was established at the same time to address the serious limitations in Type 1 diabetes research resources. Together, these programs have become the nation’s most strategic, successful and comprehensive effort to combat diabetes. SDPI is transforming lives and changing the diabetes landscape in America.

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. Some regions of Indian Country have diabetes rates as high as 33.5 percent, with specific communities having Type II diabetes reach a level as high as 60 percent.

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, 2014, 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*. In order to keep the momentum of this important program alive, it is critical that Congress continue to invest in SDPI, which will save millions in preventative care over the long term. When taking into account additional Tribes that have gained federal recognition since 2002, the dollars are even scarcer.

NIHB wishes to express its gratitude for the work that members of this committee have done so far to support renewal of SDPI. With the deadline of September 30th in mind, I urge you to support a multi-year reauthorization of the SDPI by March 31st of this year. We have a critical opportunity to see the program renewed by March 31, when Congress must renew the Medicare Extender legislation – and that legislative vehicle is typically the legislative vehicle for SDPI renewals. Without an immediate, long-term reauthorization, critical infrastructure that the Tribes have built to address the Diabetes epidemic in Indian Country has greatly contributed to the success of SDPI. A delay in renewal will mean loss of SDPI staff – loss of jobs – that will severely impact tribal health: both in terms of patient health and community economic health. Also, because SDPI is a grant program, the Indian Health Service requires four months to advertise and complete the grant process – so please actively shepherd through the reauthorization of SDPI by March 31, 2014.

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. On October 10, 2013, Senator Lisa Murkowski (R-AK) introduced legislation, S. 1570, to provide advance appropriations for the IHS. While this measure will not solve the complex budget issues at IHS, it 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.

This change in the appropriations schedule will help the federal government meet its trust obligation to Tribal governments and bring parity to the federal health care system. Adopting advance appropriations for IHS would result in the ability for health administrators to continue treating patients without wondering if –or when– they would have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution.

At the Department of Health and Human Services Budget FY 2016 Tribal Budget Consultation on March 7, 2014, agency officials noted that they are seriously considering this issue with the Office of Management and Budget. They are also engaged in conversations with the Veterans' Administration to learn how they implemented advance appropriations when they received this status in 2010. NIHB is highly encouraged by these statements and urges this Committee to quickly consider S. 1570 and report the bill favorably to ensure that Tribes can move forward to a more stable funding mechanism.

Conclusion

On behalf of the National Indian Health Board and the 566 federally recognized Tribes we serve, thank you to the Committee for holding this important hearing on the FY 2015 budget. 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:

- 1) 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, and no provision for inflation for Continuing Services & Binding Obligations and 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 Indian Health Care Improvement Act (IHCA)

State and local governments have the power to tax in order to fund government services. Tribes do not have that option. In many remote Tribal communities, economic development is also unfeasible. Tribal governments depend more heavily on federal government sources, thereby making the need to fund Tribal programs at a sustainable level even greater. 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.