



HEALTHCARE

REDUCING DISPARITIES IN THE FEDERAL HEALTH CARE BUDGET

The federal promise to provide Indian health services was received in good faith by our ancestral Tribal leaders to lay the foundation for peaceful co-existence of our great nations. By giving up Tribal lands, the United States was able to prosper and build great wealth, leaving First Americans to try to build a life within this new nation. The federal responsibility for health was prepaid by the Tribes. 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), removing responsibility for tribal healthcare from the War Department, and tasked the agency with providing health services to American Indians and Alaska Natives.

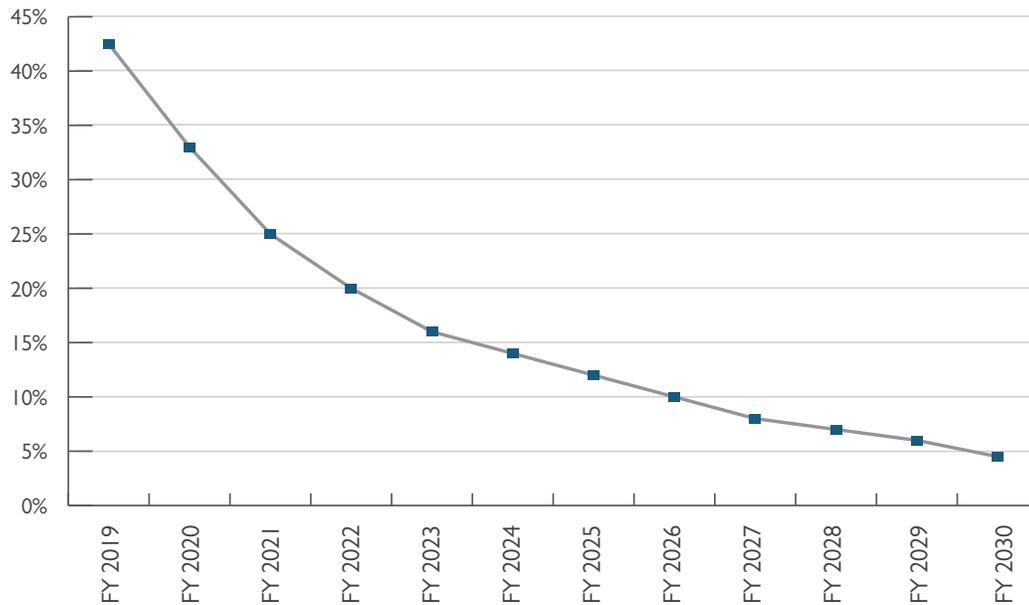
Yet, the federal government has never fully lived up to this responsibility. Appropriations for the IHS have never been adequate to meet basic patient needs, and health care is delivered in mostly third world conditions. The Indian health care delivery system faces significant funding disparities, notably in per capita spending between the IHS and other federal healthcare programs. The IHS has been and continues to be a critical institution in securing the health and wellness of tribal communities. In FY 2015, the IHS per capita expenditures for patient health services were just \$3,136, compared to \$8,760 per person for health care spending nationally. New health care insurance opportunities and expanded Medicaid in some states may expand health care resources available to AI/ANs. However, these new opportunities are no substitute for the fulfillment of the federal trust responsibility, and the budget gap will remain. The FY 2019 budget for the IHS should support tribal self-determination, uphold the trust relationship, and work to reduce health disparities for Indian people.

As recently as 2010, Congress permanently reauthorized and made permanent the Indian Healthcare Improvement Act (IHICA). In renewing the IHICA, 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.”²⁵ Yet, IHS has never received sufficient appropriations to fully honor the new authorities promised within the IHICA, and AI/ANs continue to live with health disparities that are far worse than the rest of the U.S. population.

Since FY 2009, tribes have seen moderate increases within the IHS budget and increased access to other funding opportunities within the Department of Health and Human Services. Though this has barely been enough to keep up with inflation and population growth, the increases have made important progress for IHS and Tribal health programs nationwide. However, the most recent FY 2018 President's budget Request proposed a shocking \$300 million cut from FY 2017 enacted levels. It is critical that the Indian health budget move forward in a way that honors and respects the federal trust obligations to the Tribes.

These decisions to underfund the Indian Health Service have created the crisis situation we now see in almost all Tribal communities and reservations. The failing infrastructure creates unsafe and unsanitary living conditions and severely compromises the quality of care which can be provided. While controlling TB was a successful effort in the 70's and 80's; it is now creeping back up again as a public health concern associated with rampant substance abuse and related behavioral health issues. Infant mortality, suicides and preventable deaths plague our Indian communities. Treatment of chronic diseases like diabetes, auto-immune deficiencies, cancer and heart disease quickly erode our limited resources leaving few dollars for prevention. Aging facilities and the lack of resources to modernize equipment and health information technology, has created a dire need for large investments in basic infrastructure, including housing for health professionals who want to work in our communities but have no place to stay.

Figure 5: FY 2019 Tribal Needs Based Budget
% of Increases Needed to Achieve Full Funding in 12 Years - \$32 billion



For the IHS budget to grow sufficiently to meet the true and documented needs of tribal nations over a twelve-year period will require the federal government to commit an additional \$2.25 billion per year. After a decade, the increase would fully fund the IHS at the \$32 billion amount required for Native peoples to achieve health care parity with the rest of American. This request has been put forward as part of the Indian Country Budget Request since FY 2005. Developing and implementing a plan to achieve parity is critical to the future of Indian health and to the fulfillment of the federal trust responsibility to tribal nations.

The requests listed below focus on specific increases to the IHS that reflect both the priorities of the Tribal Budget Formulation Workgroup which contains representatives from the 12 IHS Areas and the Agency-wide goals expressed by IHS.

Key Recommendations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Interior - Environment Appropriations Bill

Indian Health Service (IHS)

- Provide a total of \$6.4 billion for the Indian Health Service in FY 2019, a 33% increase over the FY 2016 planning base.
- Increases above the FY 16 enacted amount planning base of \$5.1 billion include:
 - an increase of \$421.2 million to maintain current services and other binding obligations (\$169.1 million for full funding of current services and \$252.1 million for binding fiscal obligations)
 - an increase of \$1.17 billion for program expansion

The FY 2019 tribal budget request above the FY 2016 enacted Budget addresses funding disparities between the IHS and other federal health programs (Figure 7) while still providing for current service costs (Table 1). About \$421.2 million is necessary simply to maintain current services, a top priority for tribes. The remainder of the requested budget increase is an increase to fund specific programs.

Figure 6: Diminished Purchasing Power: A thirty-year look at the IHS Health services Accounts: Actual expenditures adjusted for inflation and population growth

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A thirty-year look at the IHS Health services Accounts: Actual expenditures
adjusted for inflation and population growth**

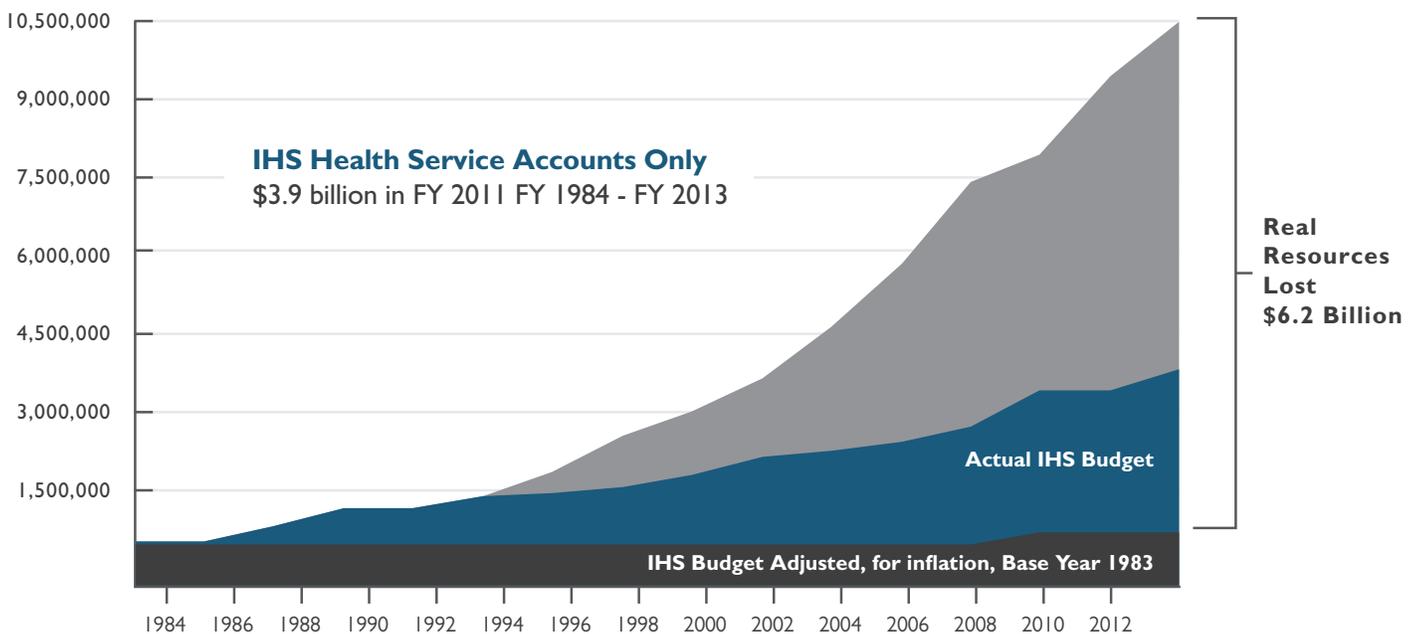
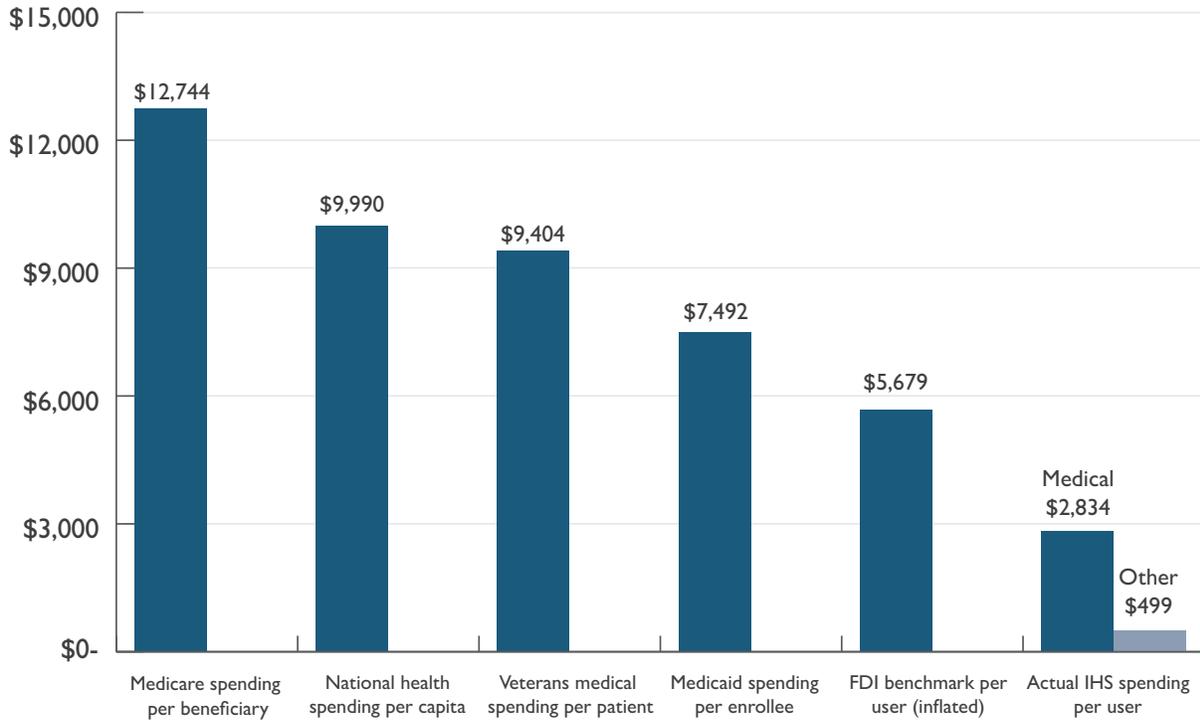


Figure 7: 2016 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

Note: “Other” refers to Indian Health Service expenditures for facilities.



Source: The National Tribal Budget Formulation Workgroup’s Recommendations on the Indian Health Service Fiscal Year 2019 Budget

CURRENT SERVICES

Maintaining current funding levels so that existing services can be provided is a fundamental budget requirement and a top priority for tribal leaders. These base costs, which are necessary to maintain the status quo, must be accurately estimated and fully funded before any real program expansion can begin. Any funding decreases would result in a significant reduction of health care services and prolong the state of emergency facing the IHS. To address this situation, the following budget increases are necessary.

Table 1 – FY 2019 Tribal Recommended Increases to Planning Base

FY 2019 NATIONAL TRIBAL RECOMMENDATION	
	Planning Base - FY 2016 Enacted
	\$4,807,589,000
CURRENT SERVICES & BINDING OBLIGATIONS	\$421,157,000
Current Services	\$169,074,000
Federal Pay Costs	7,964,000

Table 1 – FY 2019 Tribal Recommended Increases to Planning Base

FY 2019 NATIONAL TRIBAL RECOMMENDATION	
Tribal Pay Costs	11,946,000
Inflation (non-medical)	10,385,000
Inflation (medical)	70,068,000
Population Growth	68,711,000
BINDING OBLIGATIONS	\$252,083,000
New Staffing for New & Replacement Facilities	68,750,000
Contract Support Costs - Estimated Need	100,000,000
Health Care Facilities Construction (Planned)	83,333,000
Program Expansion - Services	\$985,131,526
Hospitals & Health Clinics	295,549,023
Dental Services	67,168,312
Mental Health	122,592,753
Alcohol and Substance Abuse	114,762,394
Purchased/Referred Care (formerly CHS)	278,594,524
Public Health Nursing	24,533,658
Health Education	16,662,830
Community Health Representatives	29,531,279
Alaska Immunization	0
Urban Indian Health	20,177,628
Indian Health Professions	13,301,447
Tribal Management Grants	0
Direct Operations	2,253,411
Self-Governance	4,267
Program Expansion - Contract Support Costs	\$0
Contract Support Costs - New and Expanded	0
PROGRAM EXPANSION - FACILITIES	\$180,215,767
Maintenance & Improvement	30,720,693
Sanitation Facilities Construction	44,839,660
Health Care Facilities Construction-Other Authorities	59,301,676

Table 1 – FY 2019 Tribal Recommended Increases to Planning Base

FY 2019 NATIONAL TRIBAL RECOMMENDATION	
Facilities & Environmental Health Support	12,988,643
Equipment	32,365,095
GRAND TOTAL	\$6,394,093,293
\$ CHANGE OVER PLANNING BASE	\$1,586,504,293
% CHANGE OVER PLANNING BASE	33.0%

PROGRAM SERVICES INCREASES

In addition to increased costs as part of maintaining Hospital and Clinic Program costs, including the Indian Health Care Improvement Fund, NCAI recommends the following Program Services increases. Included in these requested increases are the amounts for program expansion as well as increases to maintain current services.

HOSPITALS AND CLINICS: INCREASE OF \$295.5 MILLION

Adequate funding for Hospitals and Clinics (H&C) is the top priority for FY 2019, as this budget line provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations and Tribal communities, predominantly in rural and frontier settings. IHS and Tribal managed facilities continue to grapple with chronic and inadequate funding. Increasing H&C funding critically supports the following: all primary medical care services, including inpatient care, routine ambulatory care, and medical support services, such as laboratory, pharmacy, medical records, information technology, and other ancillary services and expenditures such as provider/staff housing. In addition, H&C funds provide the greatest flexibility to support community health initiatives targeting health conditions disproportionately affecting AI/ANs such as diabetes, morbidity and mortality relating to maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis.

Tribes have supported the IHS requests for program increases in the H&C line item to address Health Information Technology (HIT), hepatitis C virus (HCV) treatment funds, the Domestic Violence Prevention Program, Quality Improvement, Tribal Clinic Leases, Operations & Maintenance and Tribal Epidemiology Centers. These efforts will require continued support in FY 2019.

The demands on the IHS H&C are continuously challenged. All facilities experience constant and increased demand for services due to the significant population growth, increase in users who had not come to for services before because they knew services were not available, and the increased rate of chronic diseases. All these factors increase demands on already overworked staff. Add rising medical inflation, difficulty in recruiting and retaining providers in rural and frontier health care settings, and the lack of adequate facilities and equipment, these resources are overwhelmingly stretched. As a result, any underfunding of H&C equates to limited health care access, especially for patients that are not eligible for or who do not meet the medical criteria for referrals through Purchased/Referred Care that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the care provided directly at an IHS or Tribal administered facility. In a lot of cases, that means no access to care.

Tribes are determined to seek the commitment from IHS and the Secretary of HHS to provide resources, from whatever source, to provide meaningful improved health outcomes. This will be impossible to achieve if IHS continues to receive limited resources to address even just the basic primary and urgent care needs. Tribal communities clearly suffer from significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse. It is well known in the industry that preventative and primary care programs deter costly medical burdens. Yet, with funds primarily directed to cover fixed and inflationary costs, there is little left over to make significant, long-term progress toward improving the health of AI/ANs. This Administration can make a difference as well by targeting some of the funding increases to support infrastructure development and capacity building such as to support provider and staff housing, Health Information Technology, and long-term and elder care.

MEDICAID REFORM AND INDIAN COUNTRY

Over 40 years ago, Congress permanently authorized the IHS and tribal facilities to bill Medicaid for services provided to Medicaid-eligible American Indians and Alaska Natives to supplement inadequate IHS funding. The House Report stated: “These Medicaid payments are viewed as a much needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian.”

At the same time, Congress ensured that States would not have to bear any associated costs by reimbursing them at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and tribal facilities. As Congress and the Administration consider Medicaid reform, it is critical that AI/ANs are protected by ensuring that the federal government continues to fully fund Medicaid for Tribes. This ensures that much needed 3rd Party Revenue can reach IHS and Tribally operated health facilities, and guarantees access to health care for many AI/ANs.

Similarly, AI/ANs are afforded several critical protections that must be preserved including the right to continue to see the IHS or Tribal healthcare provider of their choice; an exemption from income for eligibility determinations of treaty and trust-related income; the right of Indian healthcare providers to be promptly paid by managed care entities at the network rate or the rate set out in the State plan; and the right of Indian healthcare providers to be paid a wraparound payment by the State in the event the managed care entities do not pay them the full amount under the State plan.

DENTAL SERVICES: INCREASE OF \$67.2 MILLION

Oral health care access is one of the greatest health challenges Tribal communities face. Tribal communities are struggling under the weight of devastating oral health disparities. In the general U.S. population, there is one dentist for every 1,500 people, but in Indian Country, there is only one dentist for every 2,800 people. Nationally, American Indian children have the highest rate of tooth decay than any population group in the country. On the Pine Ridge Reservation, the W.K. Kellogg Foundation found 40% of children and 60% of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. Nationally, 59% of AI/AN adult dental patients have untreated decay, this is almost three times as much as U.S Whites.

The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services, oral health promotion, and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the significant dental caries rate among AI/AN children. Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies, and equipment. These funds are needed primarily to improve preventive and basic dental care services, as over 90% of the dental services provided by I/T/Us are used to provide basic and emergency care services. Due to the overwhelming rate of oral health infection and disease

prevalent in AI/AN communities from children to elders, dentists are unable to work at the top of their scope and more complex rehabilitative care (such as root canals, crown and bridge, dentures, and surgical extractions) is extremely limited, but may be provided where resources allow.

It is clear why the Tribes have prioritized increased access to dental care year after year. Yet the state of oral health for American Indian and Alaska Natives has not been substantially improved. Tribal communities have pioneered an important part of the solution. In Alaska, the use of Dental Therapists (DTs) over the last decade has filled a gap where dentists are not available. Dental therapists are primary oral health providers and work as part of the dental team with a dentist to provide a limited scope of services to patients. DTs live and work in communities they serve providing routine care to patients so that the need for emergency services is minimized and patients are experiencing greater overall oral health outcomes. Alaska's DTs have expanded dental care to over 40,000 Alaska Natives and now, elementary schools in Alaska with relationships with DTs have started cavity free clubs.

Language in the 2010 IHCIA amendments has been interpreted to limit expansion of DTs in the lower 48 without state legislation authorizing DTs as a provider. This limitation has not deterred Tribes from advocating for and pursuing opportunities to incorporate DTs into their programs. In 2015, several Tribes in Washington and Oregon announced that they will use DTs as part of their dental team. Two tribes and the Urban Indian Health Program in Oregon are working through a state pilot project program. Their first student will return from training the summer of 2017 to offer services with more students in the pipeline for graduation in 2018 and 2019. The Swinomish Indian Tribal Community operates its own dental licensing board to license dental professionals at the Tribe, including a DT. Since introducing a DT to the dental team in January 2016, Swinomish dental clinic has increased their patient load by 20%, increased complex rehabilitative care by 50%, and the dental team is completing treatment plans more quickly and more often. In 2017, the state of Washington signed a bill into law authorizing DTs as a provider for the tribes in the state.

While these are remarkably positive steps for the Tribes in these states, all Tribes in Indian country should have access to DTs. NCAI continues to request that IHS use its dental services funds to expand DTs to tribes in the lower 48 within the existing law. In guidance issued by the agency in January 2014, IHS erroneously noted that any DT expansion in Tribal communities can only occur if a state legislature approves. However, as Swinomish has demonstrated, Tribes, as sovereign nations, do not need approval from the state to license and employ DTs. IHS should revise, update and re-issue guidance on the use of DTs in Tribal communities. The revised guidance should clarify that the limitation in IHCIA applies only to the proposed national expansion of the CHAP, and does not otherwise prevent Tribal health care programs from providing DT and other dental midlevel services in their communities.

MENTAL HEALTH: INCREASE OF \$122.6 MILLION:

Tribal leaders report Mental Health as a significant priority for FY 2019 and recommend a \$122.6 million increase above the FY 2016 budget enacted. This increase would mean a 153% increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of Tribal communities to develop innovative and culturally appropriate prevention programs that are so greatly needed in Tribal communities.

AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. However, tribal communities receive inadequate funding resources to address these issues. Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, suggesting that American Indians and Alaska Natives are not receiving the services they need to help reduce the disparate statistics.²⁶ Funds are needed to support infrastructure and capacity in tele-behavioral health, workforce development and

training, recruitment and staffing, integrated and trauma-informed care, long-term and after-care programs, screening, and community education programs. Mental Health program funding supports community-based clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities. After-hours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. Group homes, transitional living services and intensive case management are sometimes available, but generally not as IHS programs. The IHS Mental Health Program is currently focused on the integration of primary care and behavioral health services, suicide prevention, child and family protection programs, tele-behavioral health, and development and use of the RPMS Behavioral Health Management Information System.

Suicide continues to plague American Indians and Alaska Natives throughout Indian Country. Suicidality is often in combination with other behavioral and mental health issues including depression, feelings of hopelessness, history of trauma, substance abuse, domestic violence, sexual abuse and other negative social issues. Moreover, American Indian and Alaska Native people experience high rates of depression and psychological distress and higher suicide rates across the national average. Furthermore, one of the main risk factors known to contribute to such psychological distress and behavioral health concerns is historical trauma which continues to manifest through this population and specifically today's generations through intergenerational trauma.

Intergenerational effects of historical trauma on long-term health have been documented among American Indian and Alaska Native populations through adverse childhood events (ACEs) studies. These studies assess prevalence of personal experiences—physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect and family experiences—an alcoholic parent; a mother who has been a victim of domestic violence; a family member in jail; a family member with a mental illness; and the loss of a parent through divorce, death or abandonment. As generations of families transmit the damage of trauma throughout the years it becomes a cumulative, collective exposure to traumatic events that not only affect the individual exposed, but continue to affect the following generations, thus compounding the trauma even further.

The Attorney General's Advisory Committee on AI/AN Children Exposed to Violence, comprised of experts in the area of AI/AN children exposed to violence recently released its report. It describes the foundation that must be put in place to treat and heal AI/AN children who have experienced trauma: "We must transform the broken systems that re-traumatize children into systems where Tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed."

Another significant factor reinforcing these mental health concerns is economic. The poverty rate among American Indian and Alaska Natives was 29.1% in 2012, compared with 43% for whites. On many reservations, economic development is much lower than in surrounding cities. There are far fewer jobs, and unemployment is much higher in the reservation communities. On some reservations, unemployment is as high as 80 or 90%, leading to a sense of hopelessness and despair. The inability to provide for one's family often leads to a sense of loss of identity, despair, depression, anxiety and ultimately substance abuse or other social ills such as domestic violence.

ALCOHOL AND SUBSTANCE ABUSE: INCREASE OF \$114.5 MILLION

Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities and people continue to be afflicted with the epidemic of alcohol and other drug abuse. Tribal leaders agree that this topic remains a high priority for FY 2019. NCAI recommends a program increase of \$114.8 million above the FY 2016 budget enacted.

Alcohol and substance abuse has grave impacts that ripple across Tribal communities causing upheaval and adverse experiences that begin or perpetuate a cycle of abuse breaking the social fabric of our traditions and ties to one another. Stigmatization and lack of understanding of the disease of addiction make addressing the challenge even more difficult. The problems range from individual social and medical health loss to community distress, from unintentional injury to domestic violence to suicide and/or homicide. Increasing resources to combat Alcohol and Substance Abuse is needed to break the cycle and reduce the disease and cost burden currently experienced by our Tribal communities. The purpose of the Indian Health Service Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent.

Current alcohol and substance abuse treatment approaches (offered by both the IHS and Tribal facilities) employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, and inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming through the exploration and development of partnerships with stakeholder agencies and by establishing and supporting community alliances.

Breaking the cycle means that we must prevent and offer early intervention with our at-risk youth and expand the scope of treatment in Youth Regional Treatment Centers. Alcohol and Substance Abuse funds are needed to hire professionals and staff intermediate adolescent services such as group homes, sober housing, youth shelters and psychiatric units. Our communities need increased adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care.

Effects from historical trauma, poverty, lack of opportunity, and lack of patient resources compound this problem. AI/ANs have consistently higher rates relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues.

Additionally, we now know that inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources, such as overloading the agency's outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections).

OPIOID FUNDING

Addressing the opioid epidemic is a nationwide priority. American Indians and Alaska Natives (AI/AN) face opioid related fatalities three times the rate for Blacks and Hispanic Whites (Murphy et al., 2014). The Centers for Disease Control and Prevention (CDC) further reported an opioid overdose rate of 8.4 per 100,000 for AI/ANs, second only to Whites. As sovereigns, Tribal Nations are left out of statewide public health initiatives such as the prevention and intervention efforts created through the new opioid crisis grants.

Despite this, Tribal communities have been left out of major agency-wide funding decisions to states to treat and prevent opioid misuse. As recently as September 2017, the Prescription Drug Overdose: Prevention for States funded state governments but not Tribes to address this crisis. Without federally-supported infrastructure for prevention and response to the opioid epidemic in Indian Country, the impacts on American Indian and Alaska Native people will continue to be devastating.

Furthermore, failure to directly fund federally recognized Tribes and Tribal organizations could mean that large land areas of this country would be left out of prevention efforts which would impede the United States' efforts to combat the continued spread of opioid misuse.

Advance Appropriations for the Indian Health Service. In June 2014, NCAI passed a resolution supporting the enactment of Advance Appropriations for the Indian Health Service. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. Providing Advance Appropriations for the Indian Health Service Budget would be consistent with other federal programs that provide critical health care services to vulnerable populations.

Tribal health programs must make long-term decisions without the guarantee of sustained funding. Often programs must determine whether and how they can enter into contracts with outside vendors and suppliers, plan programmatic activities, or maintain current personnel. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. This change in the appropriations schedule will help the federal government meet its trust obligation to Tribal governments and bring parity to federal health care system. The Veterans Health Administration achieved this status in 2009. IHS, like the VHA, provides direct care to patients as a result of contractual obligations made by the federal government.

IHS FACILITIES INCREASE OF \$280.4 MILLION

The Indian Health Service system is comprised of 45 hospitals (26 IHS operated, 19 Tribal) and 612 outpatient facilities (83 IHS operated, 529 Tribal). At these facilities in 2016, there were an estimated 39,300 inpatient admission as 13.7 million outpatient visits.

On average, IHS hospitals are 40 years of age, which is almost four times as old as other U.S. hospitals with an average age of 10.6 years.²⁷ 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. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic and outdated design which makes it difficult for the agency to deliver modern services.²⁸ Improving healthcare facilities is essential for:

- Eliminating health disparities
- Increasing Access
- Improving patient outcomes
- Reducing operating and maintenance costs
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates
- Improving staff and operational efficiency
- Increasing patient and staff safety

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. This significantly increases the cost of patient care and causes travel hardships for many patients and their families. The amount of aging facilities escalates maintenance and

repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. AI/AN populations have substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited outdated facilities as direct threats to patient care. For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance” with the Medicare Hospital Conditions of Participation (CoPs).²⁹ “Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in backlogs totaling approximately \$166 million.”³⁰ In fact, over one third of all IHS hospitals” deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.³¹

For many AI/AN communities, these failing facilities are the only option that patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere.

SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI) REAUTHORIZATION AND EXPANSION

Few programs have proven to be as effective as the Special Diabetes Program for Indians (SDPI). Tribes are implementing evidence-based approaches that are attesting to the improvement of quality of life, lowering treatment costs, and yielding better health outcomes for tribal members. However, the disparities still exist. The progress made as a result of the SDPI is at risk due to shorter authorization periods, flat funding and more tribes needing access to SDPI funds, as reported in the Indian Health Service Special Diabetes Program for Indians 2011 Report to Congress. Tribes support permanent authorization of the SDPI program and request for a minimum increase of \$50 million for a new total of \$200 million. Current programs should be held harmless from inflation erosion, and the additional funds will allow for tribes not currently funded to develop programs which has been highly effective in reducing the devastating impact that diabetes has in Tribal communities.

PROVIDE DEDICATED FUNDING TO BEGIN IMPLEMENTING PROVISIONS OF THE INDIAN HEALTHCARE IMPROVEMENT ACT

The Indian Healthcare Improvement Act (IHCA) was permanently reauthorized as part of the Patient Protection and Affordable Care Act (ACA) in 2010. This historic law has opened up many new opportunities for the Indian health system, but not all provisions have been equally implemented - representing yet another broken promise to Indian Country. With the passage of the ACA, the American health care delivery system has been revolutionized while the Indian healthcare system still waits for the full implementation of the IHCA. For example, mainstream American healthcare increased its focus on

prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and is now a standard of practice. Replicating these same improvements for Tribes in the IHCA was a critical aspect of the reauthorization effort. Tribes fought for over a decade to renew IHCA and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized.

To provide context for how much of the law has not been implemented, the follow represent several categories of programs that have not been implemented and funded:

1. Health and Manpower – 67% of provisions not yet fully implemented.
 - *Includes: establishment of national Community Health Aide Program; demonstration programs for chronic health professions shortages*
2. Health Services – 47% of provisions not yet fully implemented
 - *Includes: authorization of dialysis programs; authorization hospice care, long term care, and home/community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment an office of men's health.*
3. Health Facilities – 43% of provisions not yet fully implemented
 - *Includes: demonstration program with at least 3 mobile health station projects; demonstration projects to test new models/ means of health care delivery*
4. Access to Health Services – 11% of provisions not yet fully implemented
 - *Includes: Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs*
5. Urban Indians – 67% of provisions not yet fully implemented
 - *Includes: funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health*
6. Behavioral Health – 57% of provisions not yet fully implemented
 - *Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants to for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides*
7. Miscellaneous – 9% of provisions not yet fully implemented
 - *Includes: Provision that North and South Dakota shall be designed as a contract health service delivery area*

Clearly, a plan must be put in place to ensure that the intended benefits of this law are actually realized.

DEPARTMENT OF HEALTH AND HUMAN SERVICE

Tribal Access to Health Programs

Much of the funding that supplements IHS resources for tribal health programs, including funding that supports public health programs in Indian Country, comes from agencies within HHS outside of the IHS. The federal government's trust responsibility extends to the whole federal government, not just the IHS or BIA. IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. This means that Indian Country continues to lag far behind other communities in basic resources and services. Our communities are therefore more vulnerable to increased health risks and sickness.

To that end, tribes support increased funding specifically dedicated to tribes at other HHS agencies. Tribes are eligible to apply for many federal grants that address public health issues, however, many of these programs have little penetration into Indian Country because tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even apply for the grants. NCAI recommends creating specific tribal funding set-asides for block grants such as Preventive Health and Health Services Block Grant; Community Mental Health Services Block Grant; Community Service Block Grant; and the Social Services Block Grant. Federal agencies should also create funding streams that parallel the state flagship grant system. These large flagship grants provide funds to organizations and efforts within the state, but also provide the funding to sustain the infrastructure within state health departments. Denying this stable source of funding to tribes, denies them a significant opportunity to create the infrastructure required to address their own public health priorities.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Labor, HHS, Education Appropriations Bill

Diabetes Prevention

- *Continue to provide \$1 million for the On the TRAIL (Together Raising Awareness for Indian Life) to Diabetes Prevention program.*

IHS has successfully funded the On the TRAIL program since 2003, serving nearly 12,000 Native American youth ages 7-11 in over 80 tribal communities. The program curriculum is an innovative combination of physical, educational, and nutritional activities that promote healthy lifestyles. The program also emphasizes the importance of teamwork and community service. Members apply decision-making and goal-setting skills when completing physical activities and engage in service projects to improve health lifestyles in their communities. Continued funding of this program sustains a tested program and represents one of the few national youth-oriented diabetes prevention initiatives.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Labor, HHS, Education Appropriations Bill

Health Resources and Services Administration (HRSA)

Native Hawaiian Health Care Systems Program

- *Provide \$14.4 million to fund the Native Hawaiian Health Care Systems Program.*

The Native Hawaiian Health Care Systems Program provides critically needed support for the health and well-being of Native Hawaiians. Since the Native Hawaiian Health Care Systems Program was first established in 1988, it has provided direct health services, screenings and health education to hundreds of thousands of Native Hawaiians, and supported hundreds of Native Hawaiians in becoming medical professionals, including physicians, nurses, and health research professionals. Allocating this funding would ensure the continuation of an already established and necessary resource for Native Hawaiians.