HEALTHCARE

Reducing Disparities in the Federal Healthcare Budget

The federal government's obligation to provide healthcare was prepaid by tribal nations. The United States assumed this responsibility through a series of treaties with tribal nations, exchanging compensation and benefits for tribal nations' land and resources, and to obtain peace. The Snyder Act of 1921 (25 U.S.C. § 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 (AI/ANs).

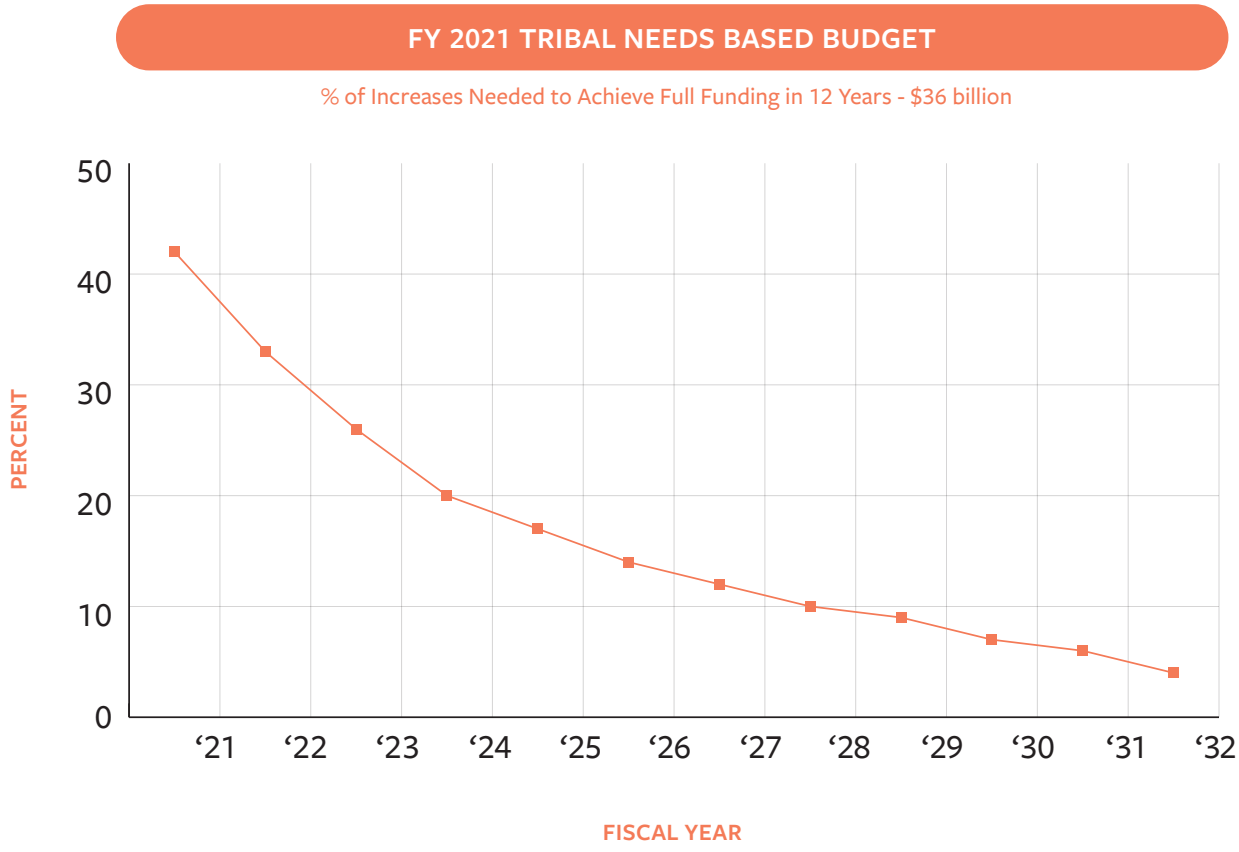
Yet, the federal government has never met this responsibility. Appropriations for IHS have never been adequate to meet basic patient needs, and healthcare is delivered in mostly third world conditions. The Indian healthcare delivery system faces significant funding disparities, notably in per capita spending between the IHS and other federal healthcare programs. IHS has been and continues to be a critical institution in securing the health and wellness of tribal communities. In FY 2017, IHS per capita expenditures for patient health services were just $4,079, compared to $9,726 per person for health care spending nationally.[30] New healthcare insurance opportunities and expanded Medicaid in some states may increase healthcare resources available to AI/ANs. However, these new opportunities are no substitute for fulfillment of the federal trust responsibility, and the budget gap will remain. The FY 2021 budget for IHS should support tribal self-determination, uphold the trust relationship, and work to reduce health disparities for Indian people.

The Indian Health Care Improvement Act's (P.L. 111-148) (IHCIA) enactment and permanent authorization in 2010 provided a foundation for tribal nations, tribal organizations, and Urban Indian Organizations (UIOs) to protect Indian health by advocating for appropriations for authorized programs. In renewing the IHCIA, Congress reaffirmed the duty of the federal government to AI/ANs declaring, "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians."[31] Presently, IHS has never received sufficient appropriations to fully honor the new authorities promised within the IHCIA, and AI/ANs continue to live with health disparities that are far worse than the rest of the U.S. population.

The underfunded status of the Indian healthcare system has resulted in a health crisis within tribal communities. Infant mortality, suicides, and preventable deaths plague tribal communities. Treatment of chronic diseases like diabetes, auto-immune

deficiencies, cancer, and heart disease quickly erode our limited resources leaving few dollars for prevention. Further, failing infrastructure creates unsafe and unsanitary living conditions and severely compromises the quality of care. 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 1



For the Indian Health Service (IHS) budget to grow sufficiently to meet the documented needs of tribal nations over a twelve-year period, the federal government must commit $37.6 billion based on the FY 2018 estimate of 2.9 million AI/ANs eligible to be served by IHS, Tribal, and Urban health programs. Given the lack of adequate budget increases over the past fourteen years, the amount of time to reasonably phase-in the Needs-Based Budget of $37.6 billion has been extended to twelve years.

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)

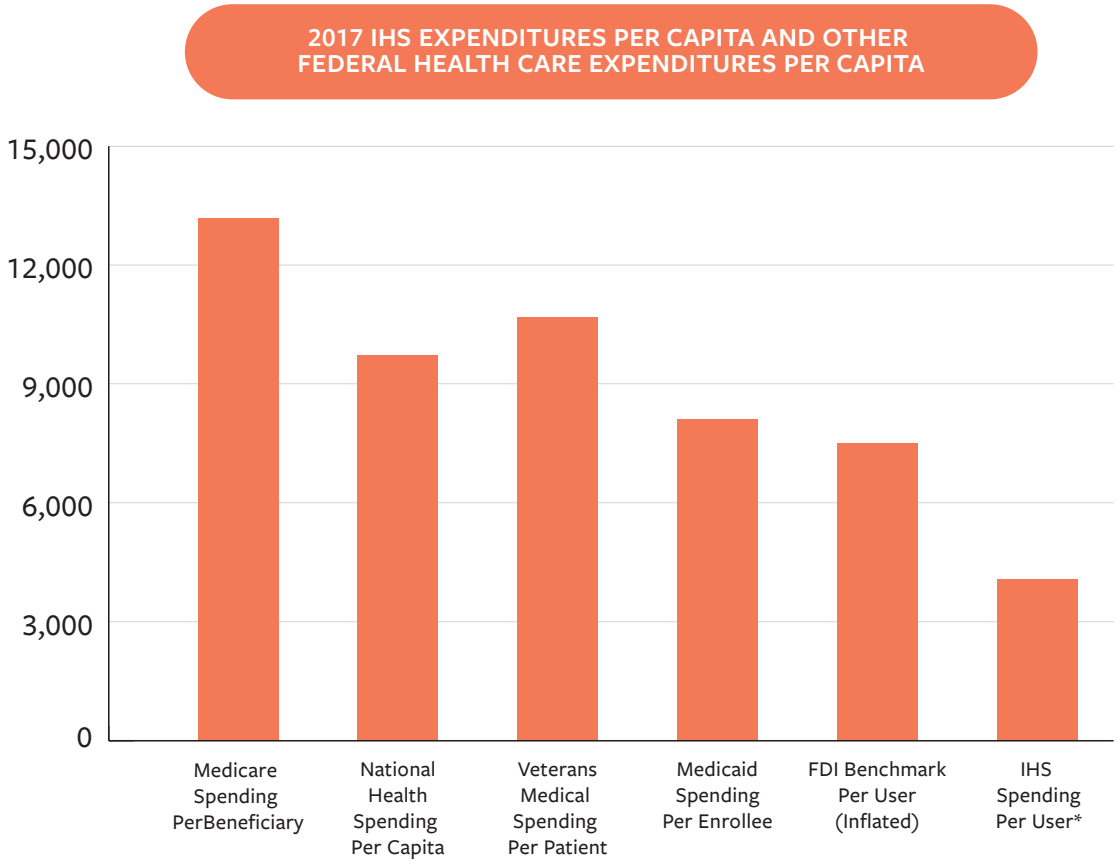
- *Provide a total of $9.145 billion for the IHS in FY 2021, a 46 percent increase over the FY 2019 enacted levels.*
- *Increases above the FY 2019 enacted amount planning base of $5.8 billion include:*
  - *an increase of $681.5 million to maintain current services and other binding obligations ($257 million for full funding of current services and $424.5 million for binding fiscal obligations); and an increase of $2.7 billion for program expansion.*

The FY 2021 tribal budget request addresses funding disparities between the IHS and other federal health programs (Figure 2) while still providing for current service costs.

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 in healthcare services and prolong the state of emergency facing IHS. To address this situation, the following budget increases are necessary.

FIGURE 2



Source: The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2021 Budget.

Table 1 – FY 2021 Summary of the National Tribal Budget Formulation Recommendation

FY 2021 NATIONAL TRIBAL BUDGET FORMULATION RECOMMENDATIONS	
SERVICES	
Hospitals and Health Clinics	$3,193,844,000
Dental Services	$427,467,000
Mental Health	$398,446,000
Alcohol & Substance Abuse	$503,928,000
Purchased/Referred Care	$1,507,362,000
Indian Health Care Improvement Fund	$168,507,000
Total, Clinical Services	**$6,199,522,000**
Public Health Nursing	$140,620,000
Health Education	$78,539,000
Community Health Reps	$136,579,000
Immunization AK	$2,331,000
Total, Preventative Health	**$358,069,000**
Urban Health	$105,905,000
Indian Health Professions	$77,459,000
Tribal Management	$2,691,000
Direct Operations	$74,514,000
Self-Governance	$6,118,000
Total, Other Services	**$266,687,000**
Total, Services	**$6,824,309,000**
FACILITIES	
Maintenance & Improvement	$316,559,000
Sanitation Facilities Construction	$228,104,000
Healthcare Facilities Construction	$467,646,000
Facilities & Environmental Health Supplement	$271,888,000
Equipment	$53,437,000
Total, Facilities	**$1,397,634,000**

Table 1 – FY 2021 Summary of the National Tribal Budget Formulation Recommendation

FY 2021 NATIONAL TRIBAL BUDGET FORMULATION RECOMMENDATIONS	
Total Services & Facilities	**$8,221,943,000**
Contract Support Costs	$922,227,000
Total, Contract Support Costs	**$922,227,000**
Total, IHS	**$9,144,170,000**

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: REQUEST INCREASE OF $729.5 MILLION

Adequate funding for Hospitals and Clinics (H&C) is the top priority for FY 2021, as this budget line provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations and within tribal communities, predominantly in rural and remote areas. This is the core funding that makes available direct medical care services to AI/ANs in the United States. Increasing H&C funding is necessary as it supports medical care services provided at IHS and tribally-operated facilities, including emergency care, inpatient and outpatient care, medically necessary support services, such as laboratory, pharmacy, digital imaging, information technology, medical records, and other ancillary services. In addition, H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs such as heart disease and diabetes, treatment and rehabilitation due to injuries, maternal and child healthcare and communicable diseases including influenza, HIV/AIDS, and hepatitis.

It also supports the Domestic Violence Prevention Program, the IHS Quality Consortium for Federal Hospitals, the Improving Patient Care Initiative, Trauma Care at a limited number of facilities, Facility Staffing and Operations, and Tribal Epidemiology Centers. Tribal nations support the continuation of investments in direct medical care; however, it should not be at the expense of reducing other line items that support the delivery of healthcare, such as public health infrastructure and preventative services. These issues are addressed elsewhere in this report.

The demands on direct care services are a continuous challenge in our facilities. Indian Country experiences constant and increased demand for services due to population growth and the increased rates of chronic diseases that result in growing patient workloads. Adding rising medical inflation, difficulty in recruiting and retaining providers in rural healthcare settings, and the lack of adequate facilities and equipment, these resources are stretched thin. As a result, any underfunding of H&C equates to limited healthcare access, especially for patients that are not eligible for or who do not meet the medical criteria for referrals through Purchased/Referred Care (PRC) to the private sector that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the direct care provided at an IHS or tribal facility. For these reasons and the numerous access to care issues that tribal citizens experience, an increase of $729.5 million is not exorbitant, but realistic (and reasonable) in terms of fulfilling unmet needs across Indian Country.

MEDICAID REFORM AND INDIAN COUNTRY

Over 40 years ago, Congress permanently authorized IHS and tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs 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."[32]

The Medicaid system is a critical lifeline in tribal communities. Efforts that decrease scarce Medicaid resources also jeopardize the ability to cover our cost of care, and further restrict the eligible patient population. This puts an unequal burden on the IHS budget which is dependent upon these resources to make up for funding shortfalls. The unique relationship between Medicaid and the Indian health system means that the Administration has the tools it needs to allow states to design Medicaid programs that best fit non-Indian populations while simultaneously respecting tribal sovereignty and maintaining Medicaid as a critical source of funds for the Indian health system. Like states, tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them.

Proposals in the President's FY 2020 Budget Request will have major fiscal impacts on IHS and tribal health reimbursements that would devastate tribal health. We urge the Administration to work with tribal nations and strengthen its tribal consultation practices on issues like Medicaid work requirements, and block grants, so that fiscal strain doesn't unintentionally fall back to IHS and tribal health programs.

DENTAL SERVICES: REQUEST INCREASE OF $210.4 MILLION

Oral healthcare access is one of the greatest health challenges tribal communities face. 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 of any population group in the country. On the Pine Ridge Reservation, the W.K. Kellogg Foundation found that 40 percent of children and 60 percent of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. Nationally, 59 percent of AI/AN adult dental patients have untreated decay, which is almost three times the rate of whites. It is not uncommon to hear stories of elderly patients waiting out in the cold for one of just a few dental appointments available in a day or for patients to wait for months to get an appointment. Patients get frustrated with this system and often abandon the search for care altogether. This delayed or deferred care has long-term impacts over a patient's overall health and wellbeing.

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 percent of the dental services provided by IHS/Tribal and Urban (I/T/U) health delivery systems 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 Tribal Budget Formulation Work Group has prioritized increased access to dental care year after year. Yet the state of oral health for AI/ANs has not been substantially improved and is failing tribal communities. Tribal nations as sovereign nations have been searching for innovative solutions to address the unique barriers that keep oral healthcare out of reach for many tribal citizens. Tribal communities have pioneered an important part of the solution. In Alaska, the use of Dental Health Aide Therapists (DHATs) over the last decade have 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. DHATs 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 DHATs have expanded dental care to more than 45,000 Alaska Natives, and elementary schools in Alaska with relationships with DHATs have started cavity-free clubs.

Language in the 2010 IHCIA amendments has been interpreted to limit expansion of DHATs in the lower 48 without state legislation authorizing DHATs as a provider. This limitation has not deterred tribal nations from advocating for and pursuing opportunities to incorporate DHATs into their programs. Several tribal nations in Washington and Oregon announced in 2015 that they would use DHATs as part of their dental care provision teams. Two Oregon tribal nations and the Urban Indian Health Program established DHAT programs under state pilot project legislation. The first Oregon student returned from training in the summer of 2017 and is providing services in her community. The Swinomish Indian Tribal Community in Washington operates its own dental licensing board to license dental professionals at the Tribe, including a DHAT. Since introducing a DHAT to the dental team in January 2016, Swinomish's dental clinic has increased its patient load by 20 percent, increased complex rehabilitative care by 50 percent, 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 DHATs as a provider for the tribal nations in the state. This prompted the Port Gamble S'Klallam Tribe to hire a DHAT at the end of the year. Notably, eight more students from Washington, Idaho, and Oregon are in the Alaska DHAT Training Program with anticipated graduations in 2020.

While these are positive steps for these tribal nations, all tribal nations in Indian country should have access to DHATs. The TBFWG continues to request that IHS use its dental service funds to expand DHATs to tribal nations in the lower 48 within the existing law. In guidance issued by the agency in January 2014, IHS erroneously noted that any DHAT expansion in tribal communities can only occur if a state legislature approves. However, as Swinomish has demonstrated, tribal nations, as sovereign nations, do not need approval from the state to license and employ DHATs. IHS should revise, update and re-issue guidance on the use of DHATs in tribal communities. The revised guidance should clarify that the limitation in IHCIA applies only to the proposed national expansion of the Community Health Aide Program (CHAP), and does not otherwise prevent tribal healthcare programs from providing DHAT and other dental midlevel services in their communities. With IHS's commitment to national expansion of the CHAP and the formation of the CHAP Technical Advisory Committee, IHS should issue a comprehensive report detailing the effects of DHATs on clinics in Alaska. Programs like Southeast Alaska Regional Health Consortium (SEARHC) could serve as an important example of what dental programs with a whole suite of dental health aide providers could look like. Finally, IHS should commend tribal nations in Idaho, Washington, and Oregon for being on the forefront of public health dentistry and taking the lead in their states at the cutting edge of health policy.

MENTAL HEALTH: REQUEST INCREASE OF $286.7 MILLION

Mental Healthcare is a significant priority for FY 2021. Tribal leaders recommend a $286.7 million increase above the FY 2019 enacted budget for total funding of $398.4 million. This increase would mean a 278 percent increase in funding for behavioral health services in Indian Country. This significant increase is needed to allow tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that build upon the resiliency factors and inherent strengths already existing in tribal communities. AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. However, inadequate funding resources limits the ability of tribal nations 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 their lack of cultural sensitivity. Furthermore, studies are suggesting that American Indians and Alaska Natives do not receive the services they need to help reduce the disparate statistics.[33] These health services include 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. The goal in the emergency setting is to stabilize patients and assess and refer them to the appropriate level of care. Many communities and areas lack a sufficient number of hospital beds for patients with mental health emergencies requiring further hospitalization, which puts pressure on emergency rooms and urgent care services to provide this care beyond initial stabilization.

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 Resource and Patient Management System (RPMS) Behavioral Health Management Information System. Proper funding levels would allow for earlier interventions reducing the need and therefore costs associated with these services, allowing for more efficient use of resources that are also associated with better outcomes and improved quality of life. Additionally, funding for protective transition center(s) is critically needed for homeless individuals and families as they lose employment due to illness or other compounding factors. Further, individuals and families fleeing domestic violence situations also need temporary shelter that offers safety and counseling services that will assist and support them in stabilizing their crises.

Suicide continues to plague AI/AN communities. 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. AI/ANs, more than any other racial or ethnic group, suffer the highest burden of suicide rates, which has been increasing since 2003. In the 18 states participating in the National Violent Death Reporting System (NVDRS), the suicide rate among AI/ANs in 2015 was 21.5 per 100,000, more than 3.5 times higher than those among ethnic groups with the lowest rates.[34]

Lack of behavioral health resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. The Centers for Disease Control and Prevention (CDC) reported in 2018 that from reviewing data from 2003-2014, approximately 70 percent of AI/AN decedents resided in non-metropolitan areas, including rural areas. The residential status can affect the circumstances surrounding suicide. For example, AI/AN decedents were less likely than white decedents of having received a mental health diagnosis or having a mental health treatment plan. The high rate of suicides among AI/AN youth highlights the need for early prevention. In addition, programs that focus on individual life skills development and interpersonal social-emotional learning programs to promote healthy relationships and conflict resolution might address the higher occurrence of intimate partner problems preceding AI/AN suicides. Also, the need for prevention, such as establishing survivor support groups, are key to interrupting or reducing the potential of suicide contagion. [35]

An increase in funding and subsequent staffing would allow a greater percentage of the population to be screened, seen by behavioral health specialists, and, most importantly, treated.

ALCOHOL AND SUBSTANCE ABUSE: REQUEST INCREASE OF $242.7 MILLION

Closely linked with the issue of mental health is that of alcohol and substance abuse in tribal communities. Indeed, AI/AN communities continue to be afflicted with the epidemic of alcohol and other drug abuse. Tribal leaders agree that this topic remains a high priority for FY 2021. NCAI recommends a program increase of $242.7 million above the FY 2019 enacted budget for a total of $503.9 million. 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 tribal traditions and community ties. 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 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. These approaches also incorporate traditional healing techniques designed to improve outcomes and align the services provided with 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. New approaches are also needed to reduce significant health disparities in motor vehicle death rates, suicide rates, rates of new HIV diagnoses, binge drinking and tobacco use. There is also a need for funds to provide alternative treatment modes such as physical therapy, behavioral health, and buy-in to pain treatment utilizing alternatives to overused and abused medications – along with development and support of regional treatment centers. Currently, waiting lists are indicative of our treatment programs for alcohol, illegal, and prescription drug use.

Individuals seeking alcohol abuse treatment are falling through the cracks when our programs are not able to intake more patients. We need these funds to increase the number of residential substance abuse treatment beds to increase access to care. Adult and youth residential facilities and placement contracts with third party agencies are funded through the IHS budget for alcohol and substance abuse treatment. Providing this treatment is costly to the community and program funding is not consistent or stable. While a number of tribal nations have been successful in finding grants and other non-IHS resources to manage alcohol and substance abuse outpatient programs, the long-term sustainability of these programs is tenuous. IHS is in a unique position to assist tribal nations to plan, develop, and implement a variety of culturally responsive treatment options to help individuals become and stay sober

Methamphetamine, opioid, and heroin use is high in many IHS regions, with limited treatment facilities available. Tribal nations and tribal entities are developing initiatives to combat the opiate epidemic. Tribal leaders in the Bemidji Area have declared a "state of emergency" with the growing epidemic of increased abuse of alcohol and drugs, including meth and opioids.[36] Tribal nations in Washington are taking a stand against opioid addictions, and tribal entities in Alaska have declared a "war on alcohol and drugs."[37] The combined effect of alcohol and drugs is devastating tribal communities.[38] The average age of death for those dying due to alcohol addictions at the Wind River reservation is 38; for those addicted to alcohol and drugs the average age of death is 33.[39]

In FY 2008, Congress appropriated $14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, that funding continues to be allocated through competitive grants, despite tribal objections. For over a decade, tribal nations and their leaders have noted that IHS reliance on grant programs is counter to the federal trust responsibility, undermining self-determination tenets. Some tribal nations receive some funding, others do not. Grants create a "disease du jour" approach, where funding is tied to only one identified hot topic issue. If an area, for example, is suffering more from alcohol addictions than from meth or opioids, that area cannot redesign the available programs to meet its needs.

Because grant funding is never guaranteed, vulnerable people and communities often regress when grant resources run out. The needed increase must be applied to IHS's funding base, and HHS and IHS must move away from the ineffective use of grants in order to stabilize programs and ensure the sustainability of care for our struggling tribal communities.

Breaking the cycle also 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. Alcoholism is a terminal disease. In fact, if left untreated, addiction places considerable burden on the health system through unintentional injuries, chronic liver disease, cirrhosis, and facilitates the transmission of communicable diseases such as HIV and Hepatitis C, both having catastrophic effects on the Indian health system and youth.

According to a study in 2009-2010, AI/ANs were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people.[40] The study found that AI/ANs needed treatment at a rate of 17.5 percent compared to the national average of 9.3 percent. 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). The increased number of patient visits to private sector emergency departments also puts an increased burden on PRC services.

In addition to the funding needed to support detox and rehabilitation services, tribal nations have reported a critical need for after-care services. Time and again, tribal citizens are re-entering the community or reservation without access to professional support services to prevent them from falling into the same behaviors that led to the past abuse. Additional funding would be directed to support groups, sober-living opportunities, job placement, and other resources to encourage a clean and drug-free lifestyle.

Smoking and smokeless tobacco is often the first drug that individuals experiment with and research demonstrates that it increases the risk of illegal drug use. Smoking rates are significantly higher among AI/ANs than those of non-AI/AN populations. Moreover, cigarette smoking is linked to approximately 90 percent of all lung cancers in the U.S., and it is a leading cause of death among AI/AN people. Such chronic illnesses exacerbate individuals' mental well-being and overall health and wellness. Increased funding will support the need for prevention and education on this topic and particularly target youth. As noted in the FY 2017 Tribal Budget report, domestic violence rates in tribal communities are alarming, with 39 percent of AI/AN women experiencing intimate partner violence – the highest rate in the U.S.[41] The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle. The National American Indian/Alaska Native Behavioral Health Strategic Plan provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts through IHS, tribal and urban Indian alcohol and substance abuse programs.

ADVANCE APPROPRIATIONS FOR IHS

With the ongoing polarization in Congress, passage of a timely budget has become increasingly difficult and Continuing Resolutions (CRs) have become the appropriators' solution of choice in an effort to avoid a government shutdown. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year.

The negative consequences for the Indian Health Service and tribal nations have been substantial. Under CRs, annual funding levels are uncertain and timing of payments are unknown. Health services must be limited to the funding in hand, new grant awards are put on hold, and provider recruitment grinds to a halt. In short, funding delays for health services can be measured in lives lost. Tribal health programs cannot enter into contracts with outside vendors and suppliers. In some cases, tribal health programs are forced to take out private loans to cover the costs of expenses between the start of the fiscal year and the time when Congress passes a full budget. All these inefficiencies take away funds from an already starved health system. Advance appropriations can help mitigate such catastrophic effects. For these same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts.

Advance appropriations would identify the level of funding available for IHS in the appropriations process one or more years before it is applicable. Thus, advance appropriation provides more certainty to operate the Indian healthcare delivery system. This change in the appropriations schedule will allow Indian health programs to effectively and efficiently manage budgets, coordinate care, enter into contracts, and improve health quality outcomes for AI/ANs. Advance appropriations for IHS would support the ongoing treatment of patients without the worry if – or when – the necessary funds would be available. Healthcare services require consistent funding to be effective. Advance appropriations will help the federal government meet its trust obligations to Indian Country and bring parity to this federal healthcare system at no additional cost.

NCAI has testified at several hearings during 2019 about the effects of the 2019 government shutdown and ongoing CRs. In addition to advocating for Congress and the Administration to uphold its treaty and trust obligations by providing full funding for tribal programs, NCAI continues to request that the Administration support Advance Appropriations for IHS in its FY 2021 Budget Request.

IHS FACILITIES: REQUEST INCREASE OF $377.107 MILLION

The Indian Health Service system is comprised of 45 hospitals (26 IHS-operated, 19 tribal) and 552 outpatient facilities (76-IHS operated, 476 tribal). At these facilities, there were an estimated 39,367 inpatient admissions and 13.8 million outpatient visits in 2018.

On average, IHS hospitals are 40 years of age, which is almost four times as old as other U.S. hospitals, whose average age is 10.6 years.[42] A 40-year-old facility is about 26 percent more expensive to maintain than a 10-year-old facility. IHS facilities are grossly undersized – about 52 percent – for the patient populations, which has created crowded, even unsafe conditions for patients, staff, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility, oftentimes to modular office units to provide additional space for primary healthcare services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and creates numerous inefficiencies within the healthcare system. Furthermore, these aging facilities are largely based on simplistic and outdated design, which makes it difficult for the agency to deliver modern services.[43] 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; and increasing patient and staff safety.

At current rates of funding, if a new facility was built today, it would not be replaced for 200 to 250 years. The absence of adequate facilities frequently results in either treatment avoidance, delayed treatment, 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 indicated that outdated facilities directly threaten a patient's 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). [44]

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."[45]

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). Tribal nations 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 citizens. However, disparities still exist. The progress made as a result of SDPI is at risk due to shorter authorization periods, flat funding, and more tribal nations needing access to SDPI funds, as reported in the Indian Health Service Special Diabetes Program for Indians 2011 Report to Congress. Tribal nations 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 tribal nations not currently funded to develop programs. SDPI 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 HEALTH CARE IMPROVEMENT ACT

IHCIA was permanently reauthorized as part of the Patient Protection and Affordable Care Act (P.L. 111-148) (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 healthcare delivery system has been revolutionized, while the Indian healthcare system still waits for the full implementation of the IHCIA. 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 that is now a standard of practice. Replicating these same improvements for tribal nations in the IHCIA was a critical focus of the reauthorization effort. Tribal nations fought for over a decade to renew IHCIA, and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized.

Presently, the certain IHCIA programs have not been fully implemented and funded. A plan must be put in place to ensure that the intended outcomes of IHCIA are actually realized. It is critical that additional funds are allocated so the full implementation of IHCIA.

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 IHS. The federal government's trust responsibility extends to the whole federal government, not just IHS or the 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 illnesses.

To that end, tribal nations support increased funding specifically dedicated to tribal nations at other HHS agencies. Tribal nations 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 tribal communities have difficulty meeting the service population requirements, match requirements, or lack adequate capacity or resources to even apply for the grants. Denying tribal nations this stable source of funding 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

- *Provide $1.5 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 more than 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 healthy 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

Native Hawaiian Health Care Systems Program

- *Provide $25 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.