Healthcare

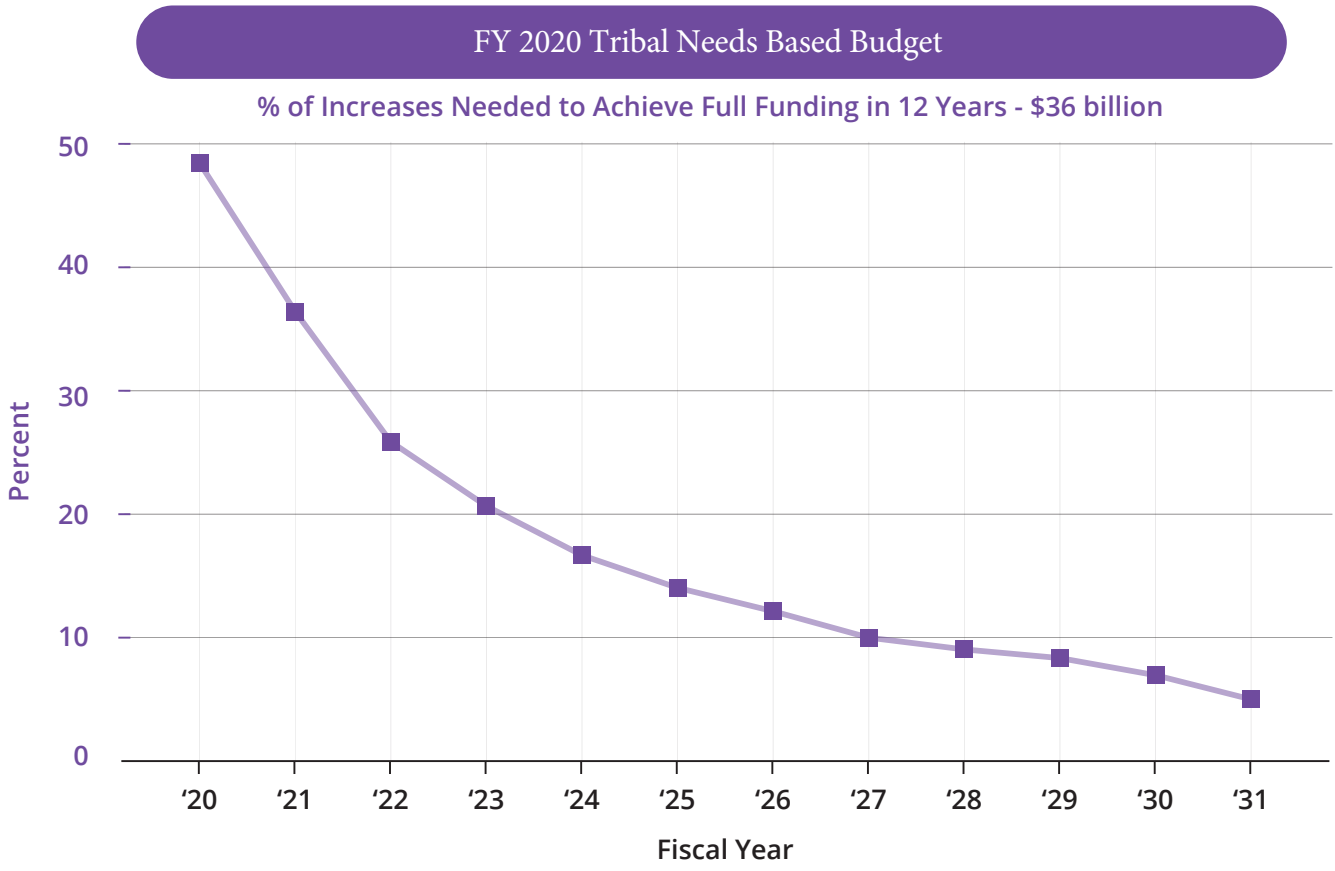
Reducing Disparities in the Federal Health Care Budget

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 health care programs. The IHS has been and continues to be a critical institution in securing the health and wellness of tribal communities. In FY 2017, the IHS per capita expenditures for patient health services were just $3,332, compared to $9,207 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 2020 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 Health Care Improvement Act (IHCIA). In renewing the IHCIA, Congress reaffirmed the duty of the federal government to American Indians and Alaska

FIGURE 1: FY 2020 Tribal Needs Based Budget Percentage Increases Needed to Achieve Full Funding in 12 Years - $36 billion



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." [38] Yet, 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.

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 that can be provided. While controlling Tuberculosis 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.

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 $36 billion based on the FY 2017 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 $36 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 $7.03 billion for the Indian Health Service in FY 2020, a 36 percent increase over the FY 2017 planning base.***
- ***Increases above the FY 17 enacted amount planning base of $5.03 billion include:***
  - ***An increase of $464.1 million to maintain current services and other binding obligations ($189.1 million for full funding of current services and $275 million for binding fiscal obligations)***
  - ***An increase of $1.5 billion for program expansion***

The FY 2020 tribal budget request addresses funding disparities between the IHS and other federal health programs (Figure 3) while still providing for current service costs (Table 1). About $464.1 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 2: **Diminished Purchasing Power:** A thirty-year look at the IHS Health services Accounts: Actual expenditures adjusted for inflation and population growth

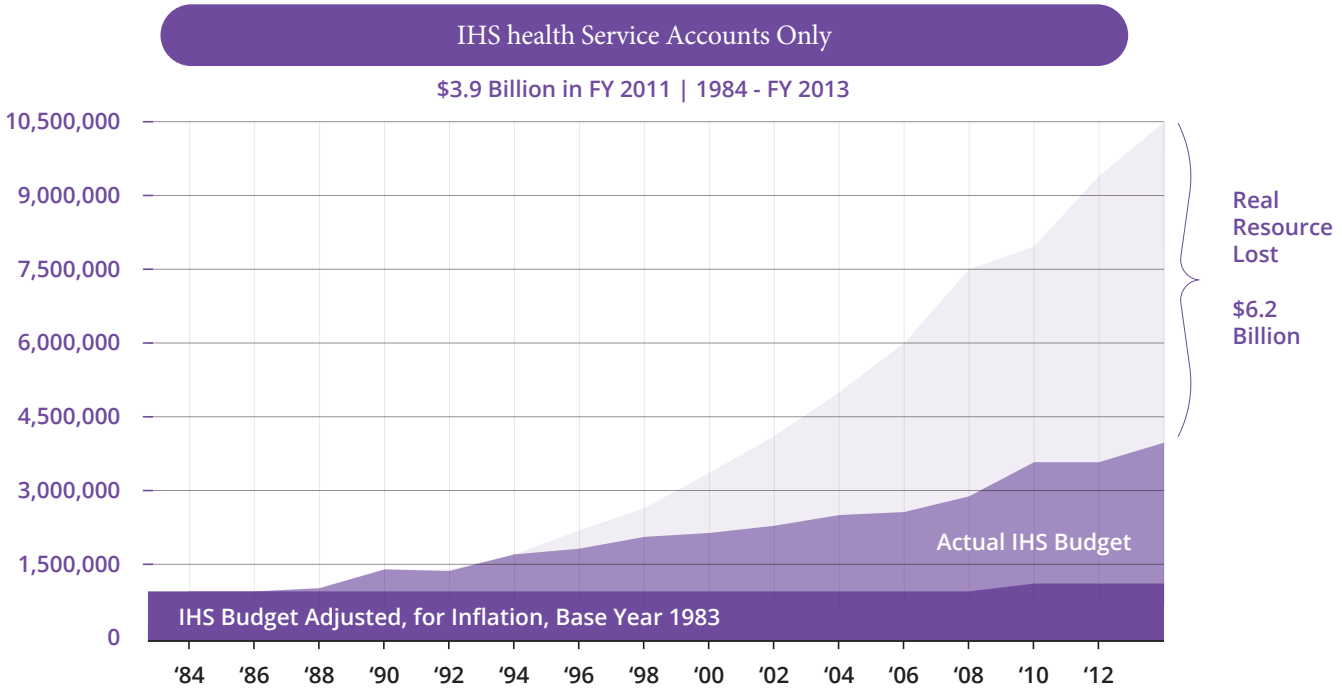
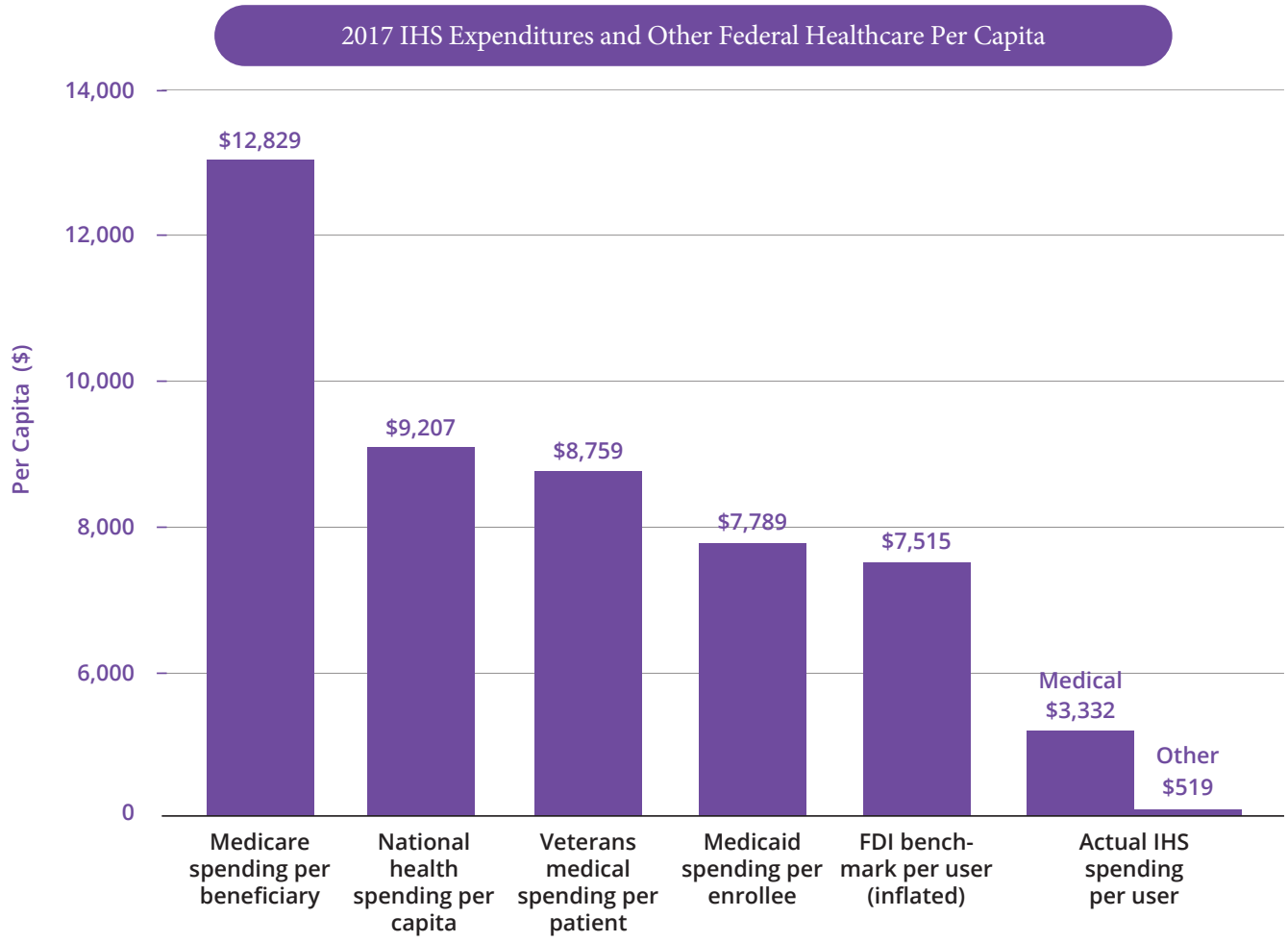


FIGURE 3: 2017 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita *(Note: "other" to Indian Health Service expenditures for facilities)*



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 as necessary.

Table 1 – FY 2020 Tribal Recommended Increases to Planning Base

FY 2020 NATIONAL TRIBAL RECOMMENDATION	
Planning Base - FY 2017 Enacted	$4,239,886,000
CURRENT SERVICES & BINDING OBLIGATIONS	**$1,264,124,000**
Current Services	$189,124,000
Federal Pay Costs	10,133,000
Tribal Pay Costs	15,850,000
Inflation (non-medical)	14,430,000
Inflation (medical)	75,359,000
Population Growth	73,352,000
BINDING OBLIGATIONS	**$1,075,000,000**
New Staffing for New & Replacement Facilities	75,000,000
Contract Support Costs - Estimated Need	900,000,000
Health Care Facilities Construction (Planned)	100,000,000
PROGRAM EXPANSION - SERVICES	**$985,131,526**
Hospitals & Health Clinics	$409,042,000
Dental Services	98,263,917
Mental Health	157,244,583
Alcohol and Substance Abuse	123,753,750
Purchased/Referred Care (formerly CHS)	406,993,000
Public Health Nursing	21,880,583
Health Education	19,951,083
Community Health Representatives	18,886,583
Alaska Immunization	0
Urban Indian Health	32,747,500
Indian Health Professions	16,196,883
Tribal Management Grants	416,667
Direct Operations	613,583
Self-Governance	421,500

Table 1 – FY 2020 Tribal Recommended Increases to Planning Base

FY 2020 NATIONAL TRIBAL RECOMMENDATION	
PROGRAM EXPANSION - FACILITIES	**$219,947,500**
Maintenance & Improvement	32,530,500
Sanitation Facilities Construction	72,543,917
Health Care Facilities Construction-Other Authorities	81,388,833
Facilities & Environmental Health Support	9,426,333
Equipment	24,057,917
PROGRAM EXPANSION SUB-TOTAL	**$1,526,359,083**
% Change over Planning Base	$36.0%
GRAND TOTAL	**$7,030,369,083**

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 $409.4 MILLION

Adequate funding for Hospitals and Clinics (H&C) is the top priority for FY 2020, 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. 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 health care 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. Tribes 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 health care, such as public health infrastructure and preventative services. These issues are addressed elsewhere in this report. It should be noted that the FY 2018 President's Budget Request for the Hospitals & Clinics line item, totaled a $16.7 million dollar increase over the FY 2017 Annualized Continuing Resolution. $14.7 million of the increase was targeted for staffing and operations at the two new health care facilities, one in Oklahoma and one in South Dakota. $1 million was made available for a limited cooperative agreement with the National Congress of American Indians to extend the Healthy Lifestyles in Youth Grant beyond August 2017. The focus on direct medical care continues by the Administration, which is evident in the proposed FY 2019 Budget Request for H&C at $268 million above the FY 2018

Continuing Resolution. Tribal leaders support the increase, but disagree with the decision to shift $123 million from important preventative services and flat lining other line items to help provide this increase.

The demands on direct care services are a continuous challenge in our facilities. We experience 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 health care settings, and the lack of adequate facilities and equipment, these resources are 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 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 $409 million is realistic in terms of fulfilling unmet needs across Indian country.

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."

Medicaid is a critical lifeline in tribal communities. Moving Medicaid to a block grant system, as proposed in the President's FY 2019 Budget Request, will have major fiscal impacts on tribal health reimbursements, and would devastate tribal health. Decreasing Medicaid decreases scarce resources available to cover our cost of care, and further restrict the eligible patient population. This puts an unequal burden on the IHS budget which is so reliant on these resources to make up our funding shortfalls. We urge the administration to ensure that American Indians and Alaska Natives are exempt from any burdens put on Medicaid like work requirements, so that fiscal strain doesn't unintentionally fall back to the IHS. American Indians and Alaska Natives already have access to health care through the IHS, so work requirements only serve to inhibit the use of Medicaid in Tribal communities.

Tribes are committed and seek the commitment of the Department of Health and Human Services (HHS) to make meaningful impacts in terms of improved health outcomes. This will be difficult to achieve if we continue to receive limited resources to address basic primary, secondary and urgent care needs. The AI/AN population suffers from significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse than other groups. Preventative and primary care programs deter costly medical burdens. Minimal increases that we've seen to date from the Administration are primarily directed to cover pay costs and inflation and staffing and operations at specific facilities. These are very important, but there is little left over to make significant, long-term progress and real gains in improving the health of AI/ANs.

A critical component of realizing the full potential of the Indian health care system is by funding new authorities in the Indian Health Care Improvement Act (IHCIA) under the H&C line item. The provisions in this law represent a national promise made by the federal government to significantly improve the health of AI/AN people, yet eight years after the IHCIA was reauthorized, most of the new authorities remain unfunded and not implemented. For tribes, this is a huge disappointment, more broken promises by the federal government. Tribes are especially concerned about Section 124 - Other Authority for Provision of Services (25 U.S.C. § 1621d) as it would provide our elders the hospice care, assisted living, long-term care and home-and community- based care and convenient care services that are long overdue. FY 2020 should be the year when the Administration commits to funding this new authority and other priority sections of the IHCIA that are further identified in this report. We must begin to see the positive impacts of a law that was over 20 years in the making and permanently reauthorized in 2010.

DENTAL SERVICES: INCREASE OF $98.2 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 among 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, this is almost three times as much as 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 one 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 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 not an exaggeration to say that the current dental care delivery system is failing Tribal communities. Tribes as sovereign nations have been searching for innovative solutions to address the unique barriers that keep oral health care 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 over 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 tribes from advocating for and pursuing opportunities to incorporate DHATs into their programs. Several tribes in Washington and Oregon announced in 2015 that they would use DHATs as part of their dental team. Two Oregon Tribes 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 dental clinic has increased their 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 tribes in the state. This prompted the Port Gamble S'Klallam Tribe to hire a DHAT at the end of the year. Notably, ten more students from Washington, Idaho and Oregon are in the Alaska DHAT Training Program with anticipated graduations in 2018 and 2019. Tribes in several other states including Idaho and Arizona are working on bills in the state legislature to authorize dental therapy in these states.

While these are remarkably positive steps for these tribes, all tribes in Indian country should have access to DHATs. NCAI continues to request that IHS use its dental services funds to expand DHATs to Tribes 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, tribes, 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 health care 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. Mature 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 the Tribes 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: INCREASE OF $157.245 MILLION:

Tribal leaders report mental health as a significant priority for FY 2020 and recommend a $157.245 million increase above the FY 2017 budget enacted. This increase would mean a 167 percent increase in funding for behavioral health services in Indian Country. This significant increase is needed to increase the ability of tribal communities to further develop innovative and culturally appropriate prevention and treatment 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, American Indians and Alaska Natives are not receiving the services they need to help reduce the disparate statistics.[39] 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.

Another significant factor reinforcing these mental health concerns is economic. The poverty rate among American Indian and Alaska Natives was 28.3 percent among single-race American Indians and Alaska Natives in 2014, the highest rate of any group. For the nation as a whole, the poverty rate was 15.5 percent, according to the Census Bureau. 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 percent, 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 $123.7 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 2020. NCAI recommends a program increase of $123.75 million above the FY 2017 enacted budget. 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. 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 the overused and abused medications along with development and support of regional treatment centers. Currently, waiting lists are are the norm for our treatment programs for alcohol, illegal and prescription drug use.

When our programs are not able to receive patients when an addict is ready, this is where he or she falls through the cracks. 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. However, as a result of diminishing resources, placement and treatment options, decisions are often attributed more to funding availability than to clinical findings. Providing this treatment is costly to the community and program funding is not consistent or stable. While a number of tribes 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 questionable. IHS is in a unique position to assist the tribes plan, develop and implement a variety of culturally responsive treatment options to help individuals become sober and prevent from relapse. Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability, several culturally responsive in-patient treatment centers have had to close their doors leaving a major gap in service availability and more specifically availability of detox beds with the rising number of heroin and opioid addictions.

Methamphetamine, opioid and heroin use is high in many IHS regions, with limited treatment facilities available. Tribes and tribal entities across the nation are developing initiatives to combat the epidemic that is causing harm and has a devastating impact on families and communities. 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; tribes in Washington are taking a stand against opioid addictions and tribal entities in Alaska have declared a 'war on alcohol and drugs'; The combined effect of alcohol and drugs is devastating. 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.

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, Tribes have noted that IHS's reliance on grant programs is counter to the federal trust responsibility, undermining self-determination tenets. Some tribes 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 the needs of that area.

And, because grant funding is never guaranteed, vulnerable people and communities often slip through the cracks and fall back into drug habits when grant resources run out. The needed increase must be applied to IHS funding base and HHS and IHS must move away from the inefficient use of grants, in order to stabilize programs and ensure the sustainability of care to our struggling tribal members and their families.

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. The science is starting to catch up, but there is a need for a paradigm shift in thinking in order to break down the stigmas that are a barrier to addressing the disease of addiction. In fact, if left untreated, addiction places considerable burden on the health system in unintentional injuries, chronic liver disease, cirrhosis, and facilitates the trans-mission of communicable diseases such as HIV and Hepatitis C, both having catastrophic effects on our health system. 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.

According to a study in 2009-2010, American Indian and Alaska Natives were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people. The study found that AI/ANs needed treatment at a rate of 17.5 percent compared to the national average of 9.3 percent. The Great Plains area has the highest alcohol-related death rate in the country. This death rate is 13.9 times the United States all-races rate and 1.3 times higher than the second highest rate, which is the Albuquerque Area (Indian Health Service, 2001). According to SAMHSA, South Dakota, North Dakota, Nebraska, and Iowa had the highest rates of underage (aged 12 to 20) binge alcohol use (29.5 percent) and binge alcohol use among persons 18 to 25 years (58 percent). These states had the highest percentage of persons with dependence on or abuse of alcohol and needing treatment services. National data indicates that Alaska and New Mexico have the largest percentage of AI/AN treatment admissions for illicit drug use in the country. 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). The increased number of patient visits to private sector emergency departments also puts an increased burden on Purchased/Referred Care Services.

In addition to funding needed to support detox and rehabilitation services, tribes have also reported a critical need for after-care services. Time and again, tribal members are re-entering the community or reservation without access to professional support services to prevent them from falling into the same crowds and 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 try; furthermore, research has demonstrated that it increases risk to using illegal drugs. Smoking rates are significantly higher among American Indian and Alaska Natives when compared to 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 challenge individuals' mental well-being and overall health and wellness. Increased funding will support the need for prevention and education on this topic and particularly targeting youth while promoting non-tobacco using adults as role models for establishing social norms in Indian communities. The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle. This is apparent in the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relationship to children's cognitive development. 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. IHS, tribal and urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture based prevention and treatment.

ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

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 lateness in enacting a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011).

The negative consequences for the Indian Health Service and tribes 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. Advanced appropriations can help mitigate such catastrophic effects. For the same reasons, Congress now provides advance appropriations for the Veterans Administration medical accounts.

Advanced appropriation identifies the level of funding available for the IHS in the appropriations process one or more years before it is applicable. Thus, advanced appropriation provides more certainty to operate the Indian health care 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. Advanced appropriations for IHS would support the ongoing treatment of patients without the worry if—or when—the necessary funds would be available. Health care services require consistent funding to be effective. Advanced appropriations will help the federal government meet its trust obligations to Indian Country and bring parity to this federal health care system at no additional cost.

As in past years, NCAI continues to request that the Administration support Advance Appropriations for IHS in its FY 2020 Budget Request.

IHS FACILITIES INCREASE OF $219.9 MILLION

The Indian Health Service system is comprised of 45 hospitals (26 IHS operated, 19 Tribal) and 529 outpatient facilities (125 IHS operated, 611 Tribal). At these facilities there were an estimated 39,300 inpatient admission and 13.7 million outpatient visits in 2016.

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.[40] 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 percent – 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.[41] 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).[42] "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."[43] 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 that are not equipped for a modern medical environment.[44]

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. As several tribal leaders have testified, all our patients' want is to feel comfortable and safe within the environment in which care is being provided; this is difficult to do when facilities are in disrepair, overcrowded, and medical equipment has outlived its useful life.

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.

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 $19 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.