

APRIL 2020

# Reclaiming Tribal Health:

## A National Budget Plan to Rise Above Failed Policies and Fulfill Trust Obligations to Tribal Nations

The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2022 Budget

### TRIBAL CO-CHAIRS

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# Executive Summary



**THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2022 BUDGET**



Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 13-14, 2020 to exercise their right to provide meaningful input into the Indian Health Service budget request for the FY 2022 budget year. Following a thorough discussion of the Area Tribal health care needs, the national Tribal FY 2022 budget priorities and recommendations were established, as highlighted below:

- Urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life-safety issues at IHS and Tribal Health facilities by implementing a budget which fully funds IHS at **\$48 billion**.
- Increase the President’s Budget Request to a total of \$12.759 billion for the IHS in FY 2022 by adding *at a minimum*:
  - » +\$337 million for full funding of current services
  - » +\$474.5 million for binding fiscal obligations<sup>1</sup>
  - » +\$2.7 billion for program increases for the most critical health issues (~30% above FY 2021 Recommendation). Top priorities for program expansion include:
    1. Hospital & Clinics .....+\$569.6 Million
    2. Purchased/Referred Care .....+\$460.3 Million
    3. Mental Health.....+\$308.8 Million
    4. Alcohol and Substance Abuse.....+\$255.0 Million
    5. Dental Services .....+\$207.2 Million
    6. Maintenance & Improvement ....+\$152.8 Million
    7. Health Care Facilities Construction/  
Other Authorities .....+\$152.3 Million
    8. Sanitation Facilities  
Construction .....+\$114.4 Million
    9. Indian Health Care  
Improvement Fund .....+\$104.1 Million
    10. Electronic Health Records  
System (New) ..... +\$95.2 Million
    11. Urban Indian Health .....+\$90.94 Million
    12. Community Health  
Representatives .....+\$107.2 Million
    13. Public Health Nursing.....+\$57.26 Million
    14. Equipment.....+\$44.33 Million
    15. Health Education ..... +\$32.9 Million
    16. Facilities and Environmental  
Health Support.....+\$6.498 Million
    17. Indian Health Professions.....+\$3.39 Million
    18. Direct Operations..... +\$352 Thousand
    19. Self-Governance .....+\$13.0 Thousand
    20. Tribal Management Grants .....+\$3.0 Thousand
    21. Alaska Immunization .....+\$2.0 Thousand
- Support the preservation of Medicaid, the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable Care Act (P.L. 111-148), or any subsequent replacement bill, and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act (IHCIA), which were passed almost a decade ago (~100 Million in FY 2022)

<sup>1</sup> Includes placeholder estimates for Contract Support Costs (CSC), 105(l) lease agreements, Health Care Facilities Construction Projects Priority List, and staffing for new facilities and new Tribes

- Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
  - » Health IT for full implementation of interoperable EHR systems & tele-health capacity at ~\$3 Billion estimate based on 25% of VA cost estimates for FY 2022. (Note: this estimate will be adjusted once the HHS/IHS HIT Modernization decisions are finalized):
  - » Support the efforts outlined in the HHS/IHS Modernization Project's *Roadmap* Report. The President's Budget request for FY 2022 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment.
  - » Health Facilities Construction Funding & Equipment (~\$15 Billion)
- Mandate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions
- Mandate Advance Appropriations for the Indian Health Service
- Authorize federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
- Authorize mandatory funding for Contract Support Costs (CSC) and 105(l) lease agreements
- Request \$337 million in FY 2022 for section 105(l) line item to ensure that growing 105(l) lease costs are fully paid without impacting increases to other critical IHS line items. Oppose IHS action to unilaterally restrict ISDEAA authorities in the absence of Tribal consultation.
- Permanently reauthorize the Special Diabetes Program for Indians and increase funding to \$200m per year, with built-in automatic annual inflationary increases.

Tribal Leaders put forward a national budget request each year which proposes to phase in funding increases and bring the federal government closer to fulfilling the treaty and trust obligations for health services. These requests are largely ignored and funding continues to fall short of what is needed to sustain a viable health system in Indian country. Tribal leaders request there be a meaningful investment in health infrastructure and services which

would eliminate untenable third world conditions. Tribal nations must be able to build a health system designed to raise the health status of all AI/ANs and to respond to public health emergencies. Tribal leaders strongly believe that it is time that this great country acknowledge this failure and take action immediately. The United States has the authority and resources to fulfil the treaty and trust obligations to the indigenous Tribal nations of these great United States. What we need is political will & commitment to close the deal.

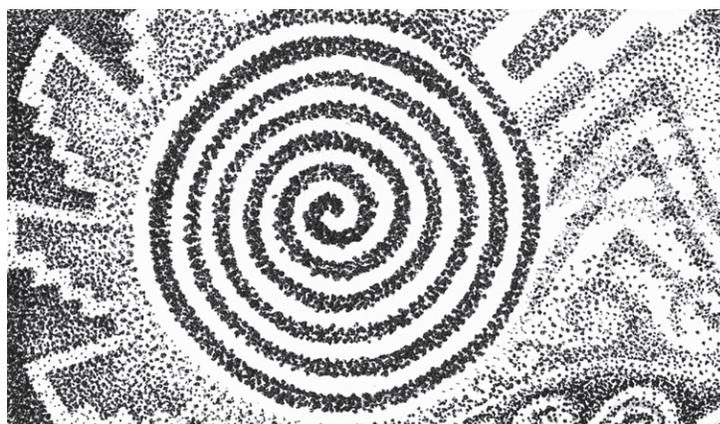
This duty to fulfill this Trust obligation is no less true today.

House Interior, Environment and Related Agencies Appropriations Subcommittee Chairwoman, Betty McCollum stated on March 6, 2019, "The Federal government entered into guaranteeing health care with their treaties to our Native American brothers and sisters. My visits to Tribal communities across the nation, has shown me how we are failing, and failing greatly, at meeting our treaty responsibilities. Congress must not take our Treaty and Trust Responsibilities lightly."

Unfortunately, as stated in the *Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans* which was released in December 2018 by the U.S. Commission on Civil Rights, "Due at least in part to the failure of the federal government to adequately address the wellbeing of Native Americans over the last two centuries, Native Americans continue to rank near the bottom of all Americans in health, education, and employment outcomes."

Specific to health, Tribal Nation communities continue to suffer the highest rates of health disparities than any other citizen group. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.

In 2018, 23.7% of AI/ANs were estimated to be living in poverty, compared to the national average of 11.0%. Just under one-fifth of AI/ANs lacked health coverage in the same year, while nationally only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is difficult to obtain due to undercounting of AI/ANs in the US Census, rates of overcrowded housing indicate a significant shortage of



available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally. According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population. In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

These unacceptable health conditions can be directly linked to the persistent chronic underfunding of the IHS and the other social and economic circumstances which exist in many Tribal reservations and villages. *The discretionary nature of the federal budget that systemically fails to fulfill Trust and Treaty obligation is a legal, ethical, and moral violation of the greatest order.* Unfulfilled Trust and Treaty obligations results in American Indian and Alaskan Native people *living sicker and dying younger* than other Americans. Bipartisan collaboration between Congress and the Administration, has allowed the Indian Health Service budget to minimally binding obligations such as for Contract Support Costs and current services, with some small targeted funding for certain programs. However, even with an overall increase of 50% from FY 2010 to FY 2020, this falls far short of even addressing medical inflation. The roughly 2-3% annual increase to the IHS budget does not keep pace with year to year increases in medical inflation, which are projected to

be 6.5% in 2020. Moreover, with the exception of FY 2006, in every other year the IHS budget has not passed on time, leading to a partial or full-year Continuing Resolution (CR). Because of the inherent budget constraints under a CR, which also do not account for medical inflation, the IHS budget is effectively *decreasing* over time in terms of its purchasing power and competitiveness with the mainstream healthcare system.

The Administration, with the support of Congress, must devise a plan to appropriate funds which go beyond just sustaining maintenance-level services which have been essential to cover expenses related to population growth and legal obligations for full funding of Contract Support Costs (CSC). Leaders of our Tribal Nations strongly urge that this Administration address the historic agreements which were essential to the power and growth of these United States by putting forth a real budget which will finally eradicate the atrocious health disparities which has overwhelmed Indian Country during these occupation decades. It will take a committed partnership between the United States and Tribal Nation leadership to honor these agreements. And it will take decisive action by this Administration to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States. To do otherwise is dishonorable to the Tribal Nations whom were the first conservationists for the vast resources which make up our great country.

The following recommendations are put forward by the Tribal Budget Formulation Workgroup as the national Tribal request for FY 2022. As proposed, these necessary investments in the IHS delivery system will provide the resources needed to achieve improved health outcomes for our people. Throughout the document you will see the Tribal priorities for program increases and details on the importance of each program area at the IHS.

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Fully Fund IHS at \$48 Billion	
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Increase the President’s FY 2021 Budget Request for the Indian Health Service by a Minimum of 40% over FY 2021 Workgroup Recommendations (\$12.759 billion in FY 2022)	
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Support the Preservation of Medicaid, the Indian Health Care Improvement Act and Other Indian-Specific Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)	
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**INDIAN HEALTH SERVICE**

# FY 2022 Summary of the National Tribal Budget Recommendation

**+30% LEVEL**

<b>Planning Base (FY 2021 National Tribal Budget Recommendation)</b>		<b>\$9,144,169</b>
<b>Current Services - All 12 Areas recommended full funding</b>		<b>\$377,084</b>
Staffing Costs for Newly-Constructed Facilities Health Care Facilities		75,000
Contract Support Costs Need (estimate)		100,000
Health Care Facilities Construction Projects Priority List (estimate)		100,000
105(l) Lease Cost Agreements <sup>2</sup>		199,500
<b>Total Binding Obligations</b>		<b>474,500</b>
<b>Current Services &amp; Binding Obligations Total:</b>		<b>\$851,584</b>
<b>RANK</b>	<b>PROGRAM EXPANSION</b>	<b>INCREASE AMOUNT</b>
1	Hospitals and Health Clinics	569,624
2	Purchased/Referred Care (formerly CHS)	460,385
3	Mental Health	308,816
4	Alcohol and Substance Abuse	255,047
5	Dental Services	207,244
6	Maintenance & Improvement	152,807
7	Health Care Facilities Constr./Other Authorities	152,399
8	Sanitation Facilities Construction	114,493
9	Indian Health Care Improvement Fund	104,161
10	Electronic Health Record Systems (New)	95,265
11	Urban Indian Health	90,941
12	Community Health Representatives <sup>3</sup>	107,299
13	Public Health Nursing	57,266
14	Equipment	44,336
15	Health Education	32,901
16	Facilities & Environmental Health Support	6,498
17	Indian Health Professions	3,398
18	Direct Operations	352
19	Self-Governance	13
20	Tribal Management Grants	3
21	Alaska Immunization	2
<b>Total (Program Expansion)</b>		<b>\$2,763,251</b>
<b>Total (Planning base + Program Expansion)</b>		<b>\$11,907,420</b>
Percent over Planning base		30%
<b>Total ( Base + Current Services + Program Expansion)</b>		<b>\$12,759,004</b>
Percent Over Planning Base		40%

<sup>2</sup> Total \$105(l) funding is estimated to be \$337.5M, with a FY2021 Tribal Budget Base is \$138M, resulting in a net change of \$199.5M as an estimate. This is lower than discussed the day off, which used the FY2019 IHS Enacted level as the base.

<sup>3</sup> 2/ Includes \$20M added, over the average Area allocation, as approved by the Workgroup. Per the Workgroup decision, this increase does not impact the overall priority for CHRs.

# FY 2022 National Tribal Budget Recommendation

	FY 2020 Enacted	FY 2021 National Tribal Budget Recomm.	Current Services — Estimates*					Current Services Subtotal
			Federal Pay CO, CS	Tribal Pay	Inflation		Population Growth	
					Non Medical	Medical		
<b>SERVICES</b>								
Hospitals and Health Clinics	2,324,606	3,193,844	23,357	34,218	2,165	61,349	42,539	163,628
Electronic Health Record System (New)	8,000	0	0	0	0	0	0	
Dental Services	210,590	427,467	2,369	3,236	86	5,470	3,823	14,984
Mental Health	108,933	398,446	913	1,695	168	2,954	1,977	7,707
Alcohol & Substance Abuse	245,603	503,928	884	6,192	734	7,315	4,429	19,554
Purchased/Referred Care	964,819	1,507,362	0	0	326	37,182	17,427	54,935
Indian Health Care Improvement Fund	72,280	168,507	84	0	0	2,731	1,301	4,116
<b>Total, Clinical Services</b>	<b>3,934,831</b>	<b>6,199,552</b>	<b>27,607</b>	<b>45,341</b>	<b>3,479</b>	<b>117,001</b>	<b>71,496</b>	<b>264,924</b>
Public Health Nursing	91,984	140,620	799	1,361	33	2,620	1,658	6,471
Health Education	20,568	78,539	0	0	0	0	0	0
Comm. Health Reps	62,888	136,579	17	0	0	926	432	1,375
Immunization AK	2,127	2,331	0	0	0	85	39	124
<b>Total, Preventive Health</b>	<b>177,567</b>	<b>358,069</b>	<b>816</b>	<b>1,361</b>	<b>33</b>	<b>3,631</b>	<b>2,129</b>	<b>7,970</b>
Urban Health	57,684	105,905	67	1,099	216	1,442	878	3,702
Indian Health Professions	65,314	77,459	70	0	922	0	785	1,777
Tribal Management	2,465	2,691	0	0	0	0	0	0
Direct Operations	71,538	74,514	1,973	371	173	167	1,334	4,018
Self-Governance	5,806	6,118	105	0	33	0	87	225
<b>Total, Other Services</b>	<b>202,807</b>	<b>266,687</b>	<b>2,215</b>	<b>1,470</b>	<b>1,344</b>	<b>1,609</b>	<b>3,084</b>	<b>9,722</b>
<b>Total, Services</b>	<b>4,315,205</b>	<b>6,824,308</b>	<b>30,638</b>	<b>48,172</b>	<b>4,856</b>	<b>122,241</b>	<b>76,709</b>	<b>282,616</b>
<b>FACILITIES</b>								
Maintenance & Improvement	168,952	316,559	0	0	0	6,574	3,034	9,608
Sanitation Facilities Constr.	193,577	288,104	497	0	0	7,139	3,479	11,115
Health Care Fac. Constr.	259,290	467,646	0	0	0	6,467	2,985	9,452
Facil. & Envir. Hlth Supp.	261,983	271,888	4,694	2,874	122	5,355	4,525	17,570
Equipment	28,087	53,437	0	0	0	935	432	1,367
<b>Total, Facilities</b>	<b>911,889</b>	<b>1,397,634</b>	<b>5,191</b>	<b>2,874</b>	<b>122</b>	<b>26,470</b>	<b>14,455</b>	<b>49,112</b>
<b>TOTAL, Services &amp; Facilities</b>	<b>5,227,094</b>	<b>8,221,942</b>	<b>35,829</b>	<b>51,046</b>	<b>4,978</b>	<b>148,711</b>	<b>91,164</b>	<b>331,728</b>
CONTRACT SUPPORT COSTS CSC	855,000	922,227	0	8,671	874	22,003	13,808	45,356
<b>Total, Contract Support Costs</b>	<b>855,000</b>	<b>922,227</b>	<b>0</b>	<b>8,671</b>	<b>874</b>	<b>22,003</b>	<b>13,808</b>	<b>45,356</b>
<b>TOTAL, IHS</b>	<b>6,082,094</b>	<b>9,144,169</b>	<b>35,829</b>	<b>59,717</b>	<b>5,852</b>	<b>170,714</b>	<b>104,972</b>	<b>37,7084</b>

\$ Change over FY 2021 National Tribal Budget Recommendation

% Change over FY 2021 National Tribal Budget Recommendation

\* Current Services and Binding Obligations are estimates and/or reasonable projections of potential costs.

**MARCH 15, 2020**  
(Dollars in Thousands)



	Binding Obligations — Estimates*					Current Services & Binding Oblig. Total	Program Increases	FY 2022 National Recomm. TOTAL	Comparison	
	Staffing for New Facilities	Contract Support Costs	Healthcare Facilities Priority List	105(l) Lease Cost Agreements	Binding Obligations Subtotal				change over FY 2021	
									\$	%
	75,000	0	0	199,500	274,500	438,128	569,624	<b>4,201,596</b>	1,007,752	47%
							95,265	<b>95,265</b>	95,265	
	0	0	0	0	0	14,984	207,244	<b>649,695</b>	222,228	109%
	0	0	0	0	0	7,707	308,816	<b>714,969</b>	316,523	301%
	0	0	0	0	0	19,554	255,047	<b>778,529</b>	274,601	112%
	0	0	0	0	0	54,935	460,385	<b>2,022,682</b>	515,320	53%
	0	0	0	0	0	4,116	104,161	<b>276,784</b>	108,277	150%
	75,000	0	0	199,500	274,500	539,424	2,000,543	<b>8,739,519</b>	2,539,967	68%
	0	0	0	0	0	6,471	57,266	<b>204,357</b>	63,737	71%
	0	0	0	0	0	0	32,901	<b>111,440</b>	32,901	160%
	0	0	0	0	0	1,375	107,299	<b>245,253</b>	108,674	173%
	0	0	0	0	0	124	2	<b>2,457</b>	126	6%
	0	0	0	0	0	7,970	197,468	<b>563,507</b>	205,438	118%
	0	0	0	0	0	3,702	90,941	<b>200,548</b>	94,643	184%
	0	0	0	0	0	1,777	3,398	<b>82,634</b>	5,175	9%
	0	0	0	0	0	0	3	<b>2,694</b>	3	0%
	0	0	0	0	0	4,018	352	<b>78,884</b>	4,370	6%
	0	0	0	0	0	225	13	<b>6,356</b>	238	4%
	0	0	0	0	0	9,722	94,707	<b>371,116</b>	104,429	55%
	<b>75,000</b>	<b>0</b>	<b>0</b>	<b>199,500</b>	<b>274,500</b>	<b>557,116</b>	<b>2,292,718</b>	<b>9,674,142</b>	<b>2,849,834</b>	<b>69%</b>
	0	0	0	0	0	9,608	152,807	<b>478,974</b>	162,415	97%
	0	0	0	0	0	11,115	114,493	<b>413,712</b>	125,608	65%
	0	0	100,000	0	100,000	109,452	152,399	<b>729,497</b>	261,851	108%
	0	0	0	0	0	17,570	6,498	<b>295,956</b>	24,068	10%
	0	0	0	0	0	1,367	44,336	<b>99,140</b>	45,703	193%
	<b>0</b>	<b>0</b>	<b>100,000</b>	<b>0</b>	<b>100,000</b>	<b>149,112</b>	<b>470,533</b>	<b>2,017,279</b>	<b>619,645</b>	<b>71%</b>
	<b>75,000</b>	<b>0</b>	<b>100,000</b>	<b>199,500</b>	<b>374,500</b>	<b>706,228</b>	<b>2,763,251</b>	<b>11,691,421</b>	<b>3,469,479</b>	<b>70%</b>
		100,000	0	0	100,000	145,356	0	1,067,583	145,356	18%
	<b>0</b>	<b>100,000</b>	<b>0</b>	<b>0</b>	<b>100,000</b>	<b>145,356</b>	<b>0</b>	<b>1,067,583</b>	<b>145,356</b>	<b>18%</b>
	<b>75,000</b>	<b>100,000</b>	<b>100,000</b>	<b>199,500</b>	<b>474,500</b>	<b>851,584</b>	<b>2,763,251</b>	<b>12,759,004</b>	<b>3,614,835</b>	<b>62%</b>
			\$377,084			\$851,584	\$2,763,251	\$3,614,835		
			4.1%				48%	39.5%		

# Introduction

## Reclaiming Tribal Health: A National Budget Plan to Rise Above Failed Policies and Fulfill Trust Obligations to Tribal Nations

Tribal Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 13-14, 2020 to develop the national Indian Health Service budget recommendations for the FY 2022 budget year. The budget priorities are highlighted below:

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  - » +\$377 million for full funding of current services
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  - » +\$2.7 billion for program increases for the most critical health issues (~30% above FY 2021 Workgroup Recommendation). Top priorities for program expansion include:
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- Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
  - » Health IT for full implementation of interoperable EHR systems & tele-health capacity at ~\$3 Billion estimate based on 25% of VA cost estimates for FY 2022. (Note: this estimate will be adjusted once the HHS/IHS HIT Modernization decisions are finalized);

<sup>4</sup> Includes placeholder estimates for Contract Support Costs (CSC), 105(l) lease agreements, Health Care Facilities Construction Projects Priority List, and staffing for new facilities and new Tribes

- » Support the efforts outlined in the HHS/IHS Modernization Project’s Roadmap Report. The President’s Budget request for FY 2022 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment.
- » Health Facilities Construction Funding & Equipment (~\$15 Billion)
- Mandate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions
- Mandate Advance Appropriations for the Indian Health Service
- Authorize federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level
- Authorize mandatory appropriations for Contract Support Costs (CSC) and 105(l) lease agreements
- Request \$337 million in FY 2022 for section 105(l) line item to ensure that growing 105(l) lease costs are fully paid without impacting increases to other critical IHS line items. Oppose IHS action to unilaterally restrict ISDEAA authorities in the absence of Tribal consultation.
- Permanently reauthorize the Special Diabetes Program for Indians and increase funding to \$200 million per year, with built-in automatic annual inflationary increases.

Tribal Leaders have put forward a national budget request each year which proposes to phase in funding increases and bring the federal government closer to fulfilling the treaty and trust obligations for health services. These requests have been largely ignored and funding continues to fall short of what is needed to sustain a viable health system in Indian country. Tribal leaders request that their be a meaningful investment in health infrastructure and services which would eliminate untenable third world conditions. Tribal nations must be able to build a health system which is designed to raise the health status of all AI/ANs and to respond to public health emergencies. Tribal leaders strongly believe that it is time that this great country acknowledge this failure and take action immediately. The United States has the authority and resources

to fulfil the treaty and trust obligations to the indigenous Tribal nations of these great United States. What we need is political will & commitment to close the deal.

This duty to fulfil his Trust obligation is no less true today. Senate Interior, Environment, and Related Agencies Subcommittee Ranking Member Tom Udall stated on February 11, 2020, “In any legislation or work with Tribes I undertake, I’m guided by three core principles: respecting Tribal sovereignty, promoting Tribal self-determination, and ensuring meaningful government-to-government consultation takes place.”

Unfortunately, as stated in the Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans which was released in December 2018 by the U.S. Commission on Civil Rights, “Due at least in part to the failure of the federal government to adequately address the wellbeing of Native Americans over the last two centuries, Native Americans continue to rank near the bottom of all Americans in health, education, and employment outcomes.”

Specific to health, Tribal Nation communities continue to suffer the highest rates of health disparities of any other citizen group. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population. In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

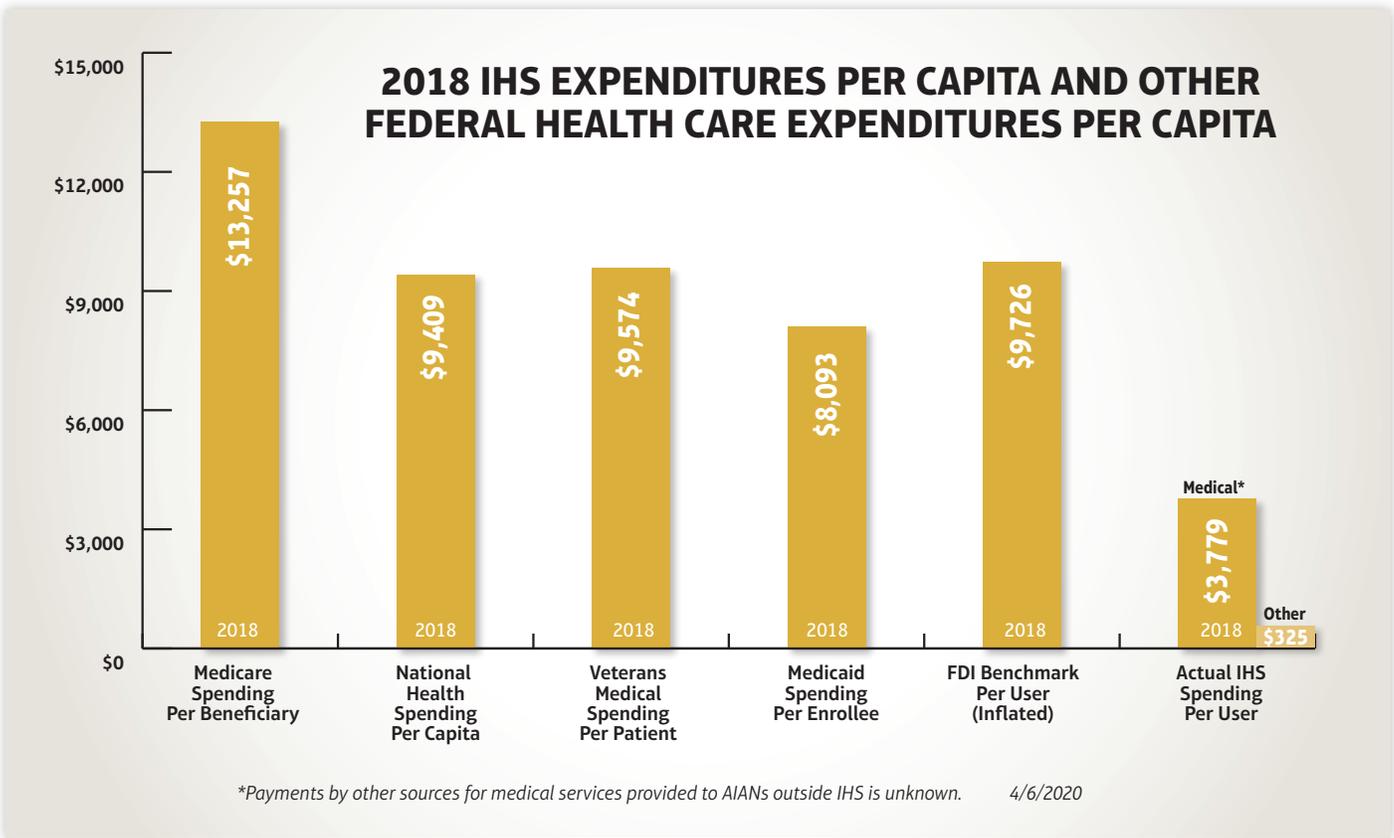
These unacceptable health conditions, can be directly linked to the persistent chronic underfunding of the IHS, and the other social and economic circumstances which

exist in many Tribal reservations and villages. The discretionary nature of the federal budget that systemically fails to fulfill trust and treaty obligation is a legal, ethical, and moral violation of the greatest order. Unfulfilled Trust and Treaty obligations results in American Indian and Alaskan Native people living sicker and dying younger than other Americans. Bipartisan collaboration between Congress and the Administration, has allowed the Indian Health Service budget to minimally binding obligations such as for CSCs and current services, with some small targeted funding for certain programs.

The Administration, with the support of Congress, must devise a plan to appropriate funds which go beyond just sustaining maintenance-level services which have been essential to cover expenses related to population growth and legal obligations for full funding of CSCs Leaders of our Tribal Nations strongly urge that this Administration address the historic agreements which were essential to the power and growth of these United States by putting

forth a real budget which will finally eradicate the atrocious health disparities which has overwhelmed Indian Country during these occupation decades. It will take a committed partnership between the United States and Tribal Nation leadership to honor these agreements. And it will take decisive action by this Administration to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States. To do otherwise is dishonorable to the Tribal Nations whom were the first conservationists for the vast resources which make up our great country.

The following recommendations are put forward by the Tribal Budget Formulation Workgroup as the national Tribal request for FY 2022. As proposed, these necessary investments in the IHS delivery system will provide the resources needed to achieve improved health outcomes for our people. Throughout the document you will see the Tribal priorities for program increases and details on the importance of each program area at the IHS.

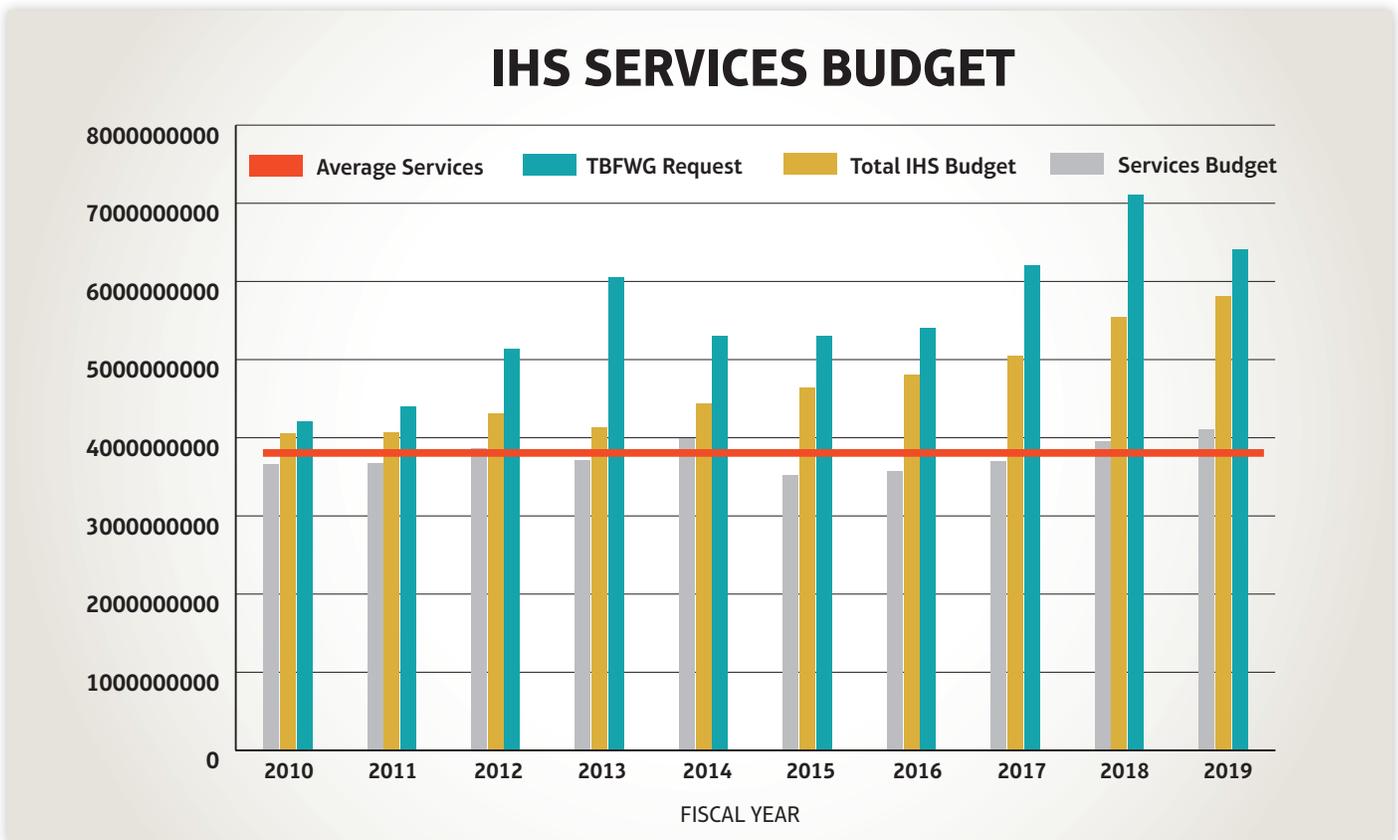


**RECLAIMING TRIBAL HEALTH: WHY HAVEN'T PRIOR YEAR INCREMENTAL INCREASES ACHIEVED MEANINGFUL RESULTS?**

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Incremental increases are essential to cover expenses related to population growth and the rightful full funding of Contract Support Costs (CSC). However, even with an overall increase of 50% from FY 2010 to FY 2020, this falls far short of even addressing medical inflation. The roughly 2-3% annual increase to the IHS budget does not even keep pace with year to year increases in medical inflation, which are projected to be 6.5% in 2020. Moreover, with the exception of FY 2006, in every other year the IHS budget has not passed on time, leading to a partial or full-year Continuing Resolution (CR). Because of the inherent budget constraints under a CR, which also don't account for medical inflation, the IHS budget is effectively decreasing over time in terms of its purchasing power and competitiveness with the mainstream health-care system.

Leaders of our Tribal Nations insist that a true and meaningful investment be made to finally eradicate the atrocious health disparities which has overwhelmed Indian Country for years. It will take a true commitment between the United States and Tribal Nation Leadership to put a strategy and budget in place. AI/AN Tribes have put our best strategy and budget together in this FY 2022 Budget Request; it is time for these United States to put forward their best strategy and budget to fulfil Trust responsibilities. Decisive action by this Administration must occur to prioritize department resources to bring the health of AI/AN citizens closer to parity with the rest of the citizens of the United States. We must rise above just settling for maintenance funding to sustain what has proven to be an unacceptable level of health care in Tribal reservations and villages.

The chart below services depicts how funding for services has remained flat over time even as the overall IHS budget has seen increases in actual dollars to address other obligations.



## IMPLEMENTING A NATIONAL PLAN TO RISE ABOVE FAILED POLICIES

This year, the workgroup recommends a 40% increase for IHS over the FY 2021 Workgroup Recommendation which will raise the bar to address crisis level quality and safety issues inherent in I/T/U health facilities. We cannot begin to address substandard health outcomes in Tribal communities by only providing maintenance-level funding for current services. The major administrative challenges which plague the IHS, will not be resolved until we face the fact that we cannot continue to financially starve the core system. To fund services at only maintenance levels while demanding different results is disingenuous.

Significant consideration must also be placed on the known social determinants of health which impact the ability to impact results. Economic conditions play a huge factor when looking to address health concerns, especially in under-developed, high cost rural communities. In 2018, 23.7% of AI/ANs were estimated to be living in poverty, compared to the national average of 11.0%. Just under one-fifth of AI/ANs lacked health coverage in the same year, while nationally only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is difficult to obtain due to under-counting of AI/ANs in the U.S. Census, rates of overcrowded housing clearly indicate a significant shortage of available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally. On some reservations, unemployment is as high as 80 or 90%. 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. When the IHS is underfunded, it affects the ability to recruit, retain and train staff, and facilities deteriorate resulting in safety being compromised. This leads to a vicious cycle of forced closure by CMS of services or facilities, further exacerbating the economic opportunities for Tribal Nations.

These facts, combined with down-spiraling health disparities experienced by AI/ANs, demonstrate the human consequences of underfunding IHS. Deferral of care due to funding and workforce shortages has pushed more and more Tribal members into health conditions wherein prescription opioids are used to treat chronic pain otherwise

be treated earlier successfully with non-opioid therapies, if they were available. Failure to address basic health needs through routine visits and preventative care also has led to preventable diseases becoming fatal when the diagnoses are too late to seek treatment. The underfunding of IHS is not just a fiscal challenge – time and time again, it means the difference between life or disability and even death for many AI/ANs.



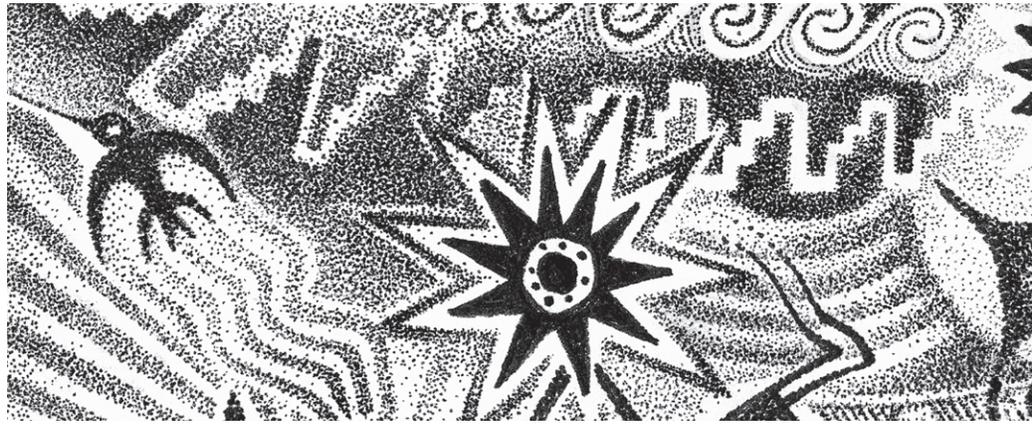
*“YOU WERE HERE LONG BEFORE ANY OF US WERE HERE.”*

*President Donald Trump*

## TAKING ACTIONABLE STEPS TO FULFILL TRUST OBLIGATIONS TO TRIBAL NATIONS

The 35-day government shutdown at the end of 2018 and start of 2019, destabilized Native health care delivery and health care provider access; as well as Tribal Governments, families, children and individuals. Many programs were forced to ration care, forced providers to go without pay and some facilities closed their doors altogether. With the further likelihood of shutdowns and delayed federal appropriations, we firmly believe that advanced appropriations for IHS will allow for greater planning, more efficient spending, and higher quality care and government services for AI/ANs. Advance appropriations would help honor the federal Trust Responsibility and help ensure that the federal government meets its obligations to the Tribes in the event that Congress cannot enact the federal appropriations by the start of the fiscal year.

Advance appropriations would also help promote government efficiency. In September 2018, the Government Accountability Office (GAO) (GAO-18-652) found that IHS and Tribes are given significant administrative



burdens due to the fact that the IHS has to modify hundreds of contracts each time there is a CR. In addition, the GAO found “uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs.” Advance appropriations would create parity between IHS and other federal health providers and create better program stability. We urge the Administration to fully support IHS advance appropriations in the FY 2022 budget request as that will significantly aid advocacy efforts in Congress.

It is also important to ensure that the government meets its Trust obligations through the Medicaid program as authorized through the Indian Health Care Improvement Act. The ability to access Medicaid reimbursements help our severely underfunded health systems receive third party revenue meant to backfill a portion of the federal government’s trust responsibility. In FY 2019, 3rd party reimbursement equaled over \$1 billion for IHS and an even higher percentage of Tribal programs. In fact, for some Tribal health programs, 3rd party reimbursement

can equal as much as 50-60% of all health funding. In times of federal shutdown, the Indian health system relies more heavily on this alternate source of funding to operate. It is critical that AI/ANs continue to have access to Medicaid which it is now reliant on as an important source of revenue to sustain operations of the Indian health system.

In short, the Trust Responsibility to all AI/ANs must be honored and legal obligations to provide safe and quality healthcare must be fulfilled. This is true whether services are provided directly through the IHS agency, under Tribal Self Determination compacts and contracts, or within Urban Indian programs. Senate Interior, Environment, and Related Agencies Subcommittee Ranking Member Tom Udall stated on February 11, 2020, “In any legislation or work with Tribes I undertake, I’m guided by three core principles: respecting Tribal sovereignty, promoting Tribal self-determination, and ensuring meaningful government-to-government consultation takes place.”

# 1st Recommendation

Fully Fund IHS at \$48 Billion



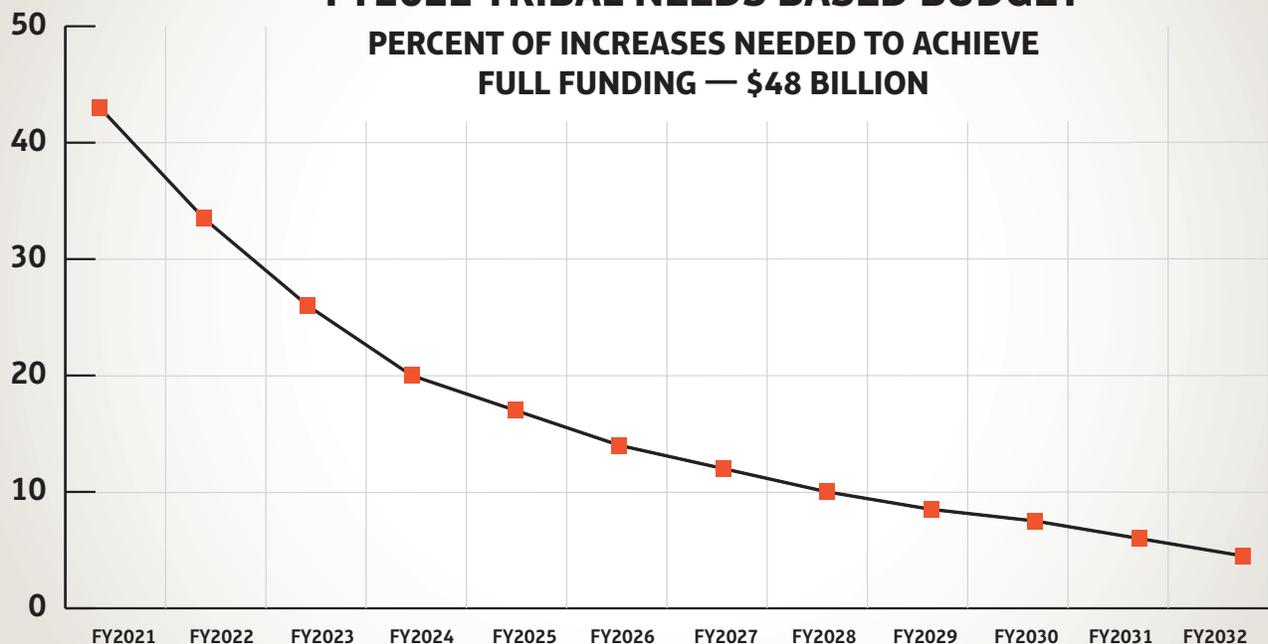
Every year, the IHS budget increases by roughly 2-3%, with the majority of increased funding going towards binding obligations, current services, and the rightful full funding of Contract Support Costs (CSC). In recent years, and since court decisions mandated continued payment irrespective of funding availability, and as more and more Tribal Nations elect to enter into such agreements, costs for 105(l) lease agreements continue to increase. In FY 2019 alone, IHS reported a \$72 million shortfall in funding availability for current 105(l) lease agreements. In fact, roughly 37% of the increase to the annual discretionary IHS budget from FY 2019 to FY 2020 went to 105(l) lease agreements alone. It is essential that Congress continue funding 105(l) leases and CSCs, as these are contractual obligations to sovereign Tribal governments. But without meaningful increases to medical services, facilities, sanitation, and other needs, the Indian health system will fail to effectively reduce AI/AN health disparities.

Since 2003, sovereign Tribal leaders have been working collaboratively to develop national Tribal priorities for healthcare to arrive at a fully-funded IHS budget. Every year since, Tribal leaders, health policy experts, and advocates convene to revise the estimates to adjust for medical and non-medical inflation, but also to comply

with new costly federal mandates, full funding of all provisions in the Indian Health Care Improvement Act (IHCIA), modernization of the IHS electronic health record (EHR) system, and other emergent needs. In 2018, the Workgroup first recommended transitioning to a new methodology for calculating a full needs-based IHS budget. Starting with the FY 2021 recommendations, the Workgroup replaced the Federal Employee Health Plans (FEHP) per user cost benchmark with a benchmark based on national health expenditures (NHE). The NHE classification presents a more accurate and complete picture of need, and allows for better comparison among categories over time.

Yet every year, per capita funding gaps between IHS and national health expenditures continue to grow, and the annual increases to the IHS budget fail to adequately account for facilities upgrades, including newly authorized facilities under IHCIA. Existing space in IHS facilities is only at 52% of need based on the size of the IHS population. While the average age of hospitals nationwide is 10 years, it is nearly four times older in Indian Country, at 37.5 years. In FY 2021, the Workgroup estimated that full funding for IHS would need to equal \$37.6 billion. However, upon more critical assessment, the Workgroup

### FY2022 TRIBAL NEEDS BASED BUDGET PERCENT OF INCREASES NEEDED TO ACHIEVE FULL FUNDING — \$48 BILLION



## FY 2022 AI/AN NEEDS BASED FUNDING PROPOSED TOTAL FUNDING ESTIMATE

### GROSS COST ESTIMATES

Source of Funding is not estimated

Need Based on FY 2018 Existing Users at I/T Sites	Need based on FY 2018 Expanded for Eligible AIAN at I/T/U Sites*
1,725,999	3,040,558

CURRENT SERVICES	\$ Per Capita	Billions	Billions
<b>Medical Services</b>	<b>\$9,726</b>	<b>\$16.79</b>	<b>\$29.57</b>
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; Services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits.	Based on 2018 FDI benchmark; which is based on the National Health Expenditure (NHE) model.	\$ Per Capita FY 2018* Existing Users	\$ Per Capita FY 2018* All Eligible AI/AN Served at ITU sites
<b>Current Facilities Services</b>		<b>\$10.28</b>	<b>\$10.28</b>
Existing space in IHS facilities (14 million ft <sup>2</sup> ) is substantially less than required (~27 million ft <sup>2</sup> ) needed. The shortage is a consequence of AI/AN demographic trends, especially: population growth; modern facility codes/standards; and obsolete older space. IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of \$10.3 billion to upgrade and modernize. 25 U.S.C. 1631 et seq., requires the HHS Secretary to submit to Congress a report every five years that describes the IHS health care facilities needs (including inpatient health care facilities; outpatient health care facilities; specialized health care facilities such as for long-term care, alcohol and drug abuse treatment, wellness centers, and staff quarters; and the renovation and expansion needs).			
<b>Health Information Technology Improvements</b>		<b>\$0.00</b>	<b>\$0.00</b>
Department of Health and Human Services (HHS) is working with Indian Health Service (IHS) to evaluate the Resource and Patient Management System (RPMS). RPMS is used to manage clinical, financial and administrative information in all IHS, and some Tribal and Urban healthcare facilities. Tribes are closely monitoring a forthcoming HHS/IHS report on IHS health IT infrastructure to ensure that funding estimates align with Tribal priorities for a modern and interoperable health IT system.			
<b>IHCIA Scholarship/Workforce Development</b>		<b>\$1.00 (initial)</b>	<b>\$1.00 (initial)</b>
The IHCIA authorizes the IHS scholarship, loan repayment, and health professions training programs to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). IHS, Tribal and urban Indian facilities experience chronic and pervasive health provider shortages that contribute to lower quality and less accessible care for AI/ANs. As Tribes work to calculate an estimate of full-funding for health workforce in Indian Country, an initial placeholder estimate of \$1 billion is included.			
<b>Total Annualized Services</b>	<b>\$9,726</b>	<b>\$28.07</b>	<b>\$40.85</b>
FACILITIES		Billions	Billions
<b>New IHCIA Authorized Facilities</b>		<b>\$4.26</b>	<b>\$4.26</b>
The IHS has begun assessing facility needs to provide newly authorized service types in the IHCIA. These service categories have not been historically provided through the IHS health care network. These specific service types require corresponding unique facility types. The IHS's facility planning and design methodology does not include criteria for such services yet; however, developing and adopting planning criteria are currently underway.			
<b>Sanitation Facilities Construction</b>		<b>\$2.90</b>	<b>\$2.90</b>
The SFC Program provides American Indian and Alaska Native homes and communities with essential water supply, sewage disposal, and solid waste disposal facilities. IHS environmental engineers plan, design, and manage most SFC projects; many of those engineers are assigned to one of the twelve IHS Area Offices. The SFC program is an integral part of the IHS disease prevention effort that impact 405,000 AI/AN homes.			
<b>TOTAL</b>			
Total Annualized Services + One-time Upfront Facilities Upgrades		<b>\$35.23</b>	<b>\$48.01</b>

Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the number of AIAN eligible — which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

\*Crudely Estimated — AI/ANs residing in service areas, including urban areas, discounted for AIANs already partially served by I/T sites.



has revised and increased this estimate to \$48 billion. The new figure for full funding more comprehensively accounts for current facilities services, sanitation facilities construction, and new facilities authorized under IHCIA.

In addition, it includes a placeholder estimate of \$1 billion for IHCIA Scholarship/Workforce Development. It is clear that Indian Country is in significant need of funding to address health workforce shortages. According to a 2018 GAO report, shortages for providers including physicians, nurses, nurse practitioners, pharmacists, and other types were 25% across eight out of twelve IHS Areas, reaching as high as 31% in certain areas. An initial \$1 billion investment is needed to fill these critical gaps in health workforce in Indian Country.

Furthermore, Department of Health and Human Services (HHS) is working with Indian Health Service (IHS) to evaluate the Resource and Patient Management System (RPMS). RPMS is used to manage clinical, financial and administrative information in all IHS, and some Tribal

and Urban healthcare facilities. Tribes are closely monitoring a forthcoming HHS/IHS report on IHS health IT infrastructure to ensure that funding estimates align with Tribal priorities for a modern and interoperable health IT system.

The failure to produce necessary funding each year have caused per capita health funding gaps to grow, and the health disparities between AI/ANs and other populations to widen. The cost and amount of time required to close these funding and health disparity gaps has predictably also grown. The full-funding estimate has been updated every year, using the most current available population and per capita health care cost information. The full funding estimate has been updated every year, using the most current available population and per capita health care cost information. The *IHS need-based funding aggregate cost estimate for FY 2022* is now \$48 billion, based on the FY 2018 estimate of [3.04 million eligible] AI/ANs eligible to be served by I/T/U health programs.

# 2nd Recommendation

**Increase the President's FY 2021 Budget Request for the Indian Health Service by a Minimum of 40% over FY 2021 Workgroup Recommendations (\$12.759 billion in FY 2022)**



# Current Services and Binding Agreements

Tribal leaders are adamant that the FY 2022 budget request, as a starting point, provides an increase of \$851.5 million over the FY 2021 Workgroup recommendation to cover Current Services and all other binding obligated requirements. Tribes have long insisted the annual request must transparently disclose all known expected cost obligations in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. Deliberately understating the amount necessary to meet the entire fiscal obligation for binding agreements beyond Current Services creates a false expectation that a slight funding increase is available to expand needed program services. In fact, in past years, a 2-3% funding increase has not been sufficient to maintain the status quo, effectively resulting in an actual decrease from the prior year. These real cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population growth, planned increases in staffing for new and replacement facilities, contract support costs, healthcare facilities construction priorities, Section 105(l) lease costs, and all expected off-the-top mandatory assessments. The workgroup strongly recommends that full funding for Current Services and other “binding” fiscal requirements at the true projected costs of \$9.144 billion be requested as reflected in this section.

## **CURRENT SERVICES (FIXED COSTS) +\$377 MILLION**

The Workgroup recommends an increase of \$377 million over the FY 2021 Workgroup Recommendation for direct and Tribally provided health care services to cover increased costs associated with population growth, pay cost increases for workers, medical and non-medical inflation, and ensure continued levels of health care services. Typically, the proposed funding by the Administration falls short of actual need. The Workgroup recommends an increase of \$88.9 million for population growth. Population growth estimates are determined by a 1.8% increase.

The FY 2022 Tribal Budget Request for Current Services also includes an increase of \$35.8 million for Federal Pay Costs and \$59.7 million for Tribal Pay Costs. Tribal and federal facilities cannot continue to offer salaries below the competitive market. Current IHS pay rates are so far below what other providers offer, (including the Veterans’ Administration) that physician vacancy rates at IHS continue to linger at 34%; dentist vacancy rates are at 26% and physician assistant vacancy rates are at 30%. No health system can run a quality program lacking one-third of the necessary staff. Further, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal pay freeze that may be imposed in FY 2022. We cannot allow

pay scales for our health professionals to be so standard they are forced to look elsewhere to seek a fair wage.

The Current Services request also includes \$5.85 million for Non-Medical Inflation and \$170.7 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services as the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), the index for all items less food and energy increased 2.1 percent over the past 12 months. The medical inflation in 2020 is predicted to be 6.5 percent. The Workgroup asserts that the rates of inflation applied to Hospitals and Clinics, Dental Health, Mental Health, and purchased/referred care (PRC) in developing the IHS budget should correspond to the appropriate components in the CPI to reflect the true level of funding needed to maintain current services.

While the budget has received upward adjustments since 2008, these increases have done little to address the huge disparities in funding for Tribal health care compared to similar expenditures for the rest of the U. S. population. With the total funding need now estimated at \$48 billion, the Indian Health system remains severely underfunded at \$6.04 billion. When compounded with rising medical inflation and population growth, Indian Health budgets are, in real dollars, trending backwards.

## **BINDING AGREEMENTS (FIXED COSTS) +\$474 MILLION**

### **HEALTH CARE FACILITIES CONSTRUCTION (PLANNED) +\$100 MILLION**

In FY 2022, \$100 million is the minimum requested amount to fund priority health facility construction projects, which are next in line on the approved IHS health care facilities five-year plan. With an average investment in health facilities infrastructure that is far below need, the reality is that it will be decades before the IHS catches up on its backlog of planned health facility construction projects. The IHS Facilities Appropriations Advisory Board's 2017 report on the funding gap for projects on the construction queue, supports the conclusion that the HCFC budget line has been historically underfunded. The current HCFC priority list has eight remaining projects which total \$2.4 billion.

A program increase of \$100 million affords the advancement or possible completion of only two projects on the list that are already started. As the FY 2022 appropriation makes its way through Congress, Tribes remain hopeful that these necessary investments in health facilities infrastructure will be supported by the Administration and Congress. This \$100 million for the FY 2021 budget supports the projects in the FY 2019-2020 requests. Along with funds for staffing and quarters, an increase of \$100 million would at least move projects more towards completion and provide the needed level of quality of care these Tribal communities so desperately need. The tremendous backlog of current construction projects and the overall need in all IHS regions is a major concern of the Tribal Leaders nationwide.

### **SECTION 105(L) LEASES**

At the February 2020 Workgroup convening, Tribal leaders voted unanimously to move funding for 105(l) leases to mandatory appropriations. While mandatory appropriations remains the long-term goal, Tribal Nations and organizations across the United States also support achieving a separate, indefinite appropriation to meet Section 105(l) lease costs, a binding obligation that has impacted other lines of the Indian Health Service (IHS) budget. While the Workgroup is requesting \$337 million for Section 105(l) leases in FY 2022, it is critical that other IHS lines be insulated from any shortfalls, and that these funds be considered separate and outside of increases to the agency.

The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324(l) authorizes IHS to enter into a lease for a facility upon the request of a Tribal Nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have grown exponentially in the past 3 years, with many Tribal Nations increasingly turning to 105(l) leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

As held by the U.S. District Court for the District of Columbia under *Maniilaq Association v. Burwell* in 2016, Section 105(l) leases must be paid in full by IHS. However, in response to growing lease proposals and after failing to adequately project costs in both FY 2018 and FY 2019, IHS ignored Tribal recommendations by unilaterally reprogramming critical funding twice from other line items to fund these obligations. This included \$25 million in FY 2018 from inflationary increases, as well as \$72 million in FY 2019 from inflationary increases and staffing packages due to delays in construction. For FY 2020, Congress provided \$125 million for 105(l) lease funding, an \$89 million increase from the FY 2019 enacted level. While this increase helped to prevent another large reprogram within the IHS budget, it impacted overall funding for IHS by consuming approximately 50% of the agency's total appropriations increase in FY 2020.

The FY 2021 President's Budget Request includes a separate, indefinite appropriation for 105(l) leases which enjoys strong support from Indian Country. However, IHS's estimate of \$101 million for FY 2021 was well below the Workgroup's FY 2021 recommendation of \$138 million. In addition, while the overall proposed budget for IHS was \$6.02 billion — a roughly \$190 million increase from 2019 enacted amount — a majority of the proposed increase was consumed by 105(l) lease obligations.

The Administration's FY 2021 Budget Request unilaterally proposes to limit the existing authority that Tribal Nations with 105(l) facilities currently exercise under ISDEAA. These proposals include:

- 40,000 square feet size requirement for section 105(l) facilities which would impose a Congressional approval requirement for 105(l) leases supporting medical facilities that exceed the 40,000 square feet rule;
- Restriction on funds used for lease compensation for any fiscal year or calendar year in which the lease

proposal is received less than 120 days before the end of the year; and

- Restrictions on 105(l) lease funding for facilities that serve non-IHS beneficiaries in addition to IHS beneficiaries.

No Tribal consultation was conducted regarding these proposals, even though most hospitals, including hospitals serving Tribal communities, are larger than 40,000 square feet and provide a multitude of services, including those to surrounding communities. It is wholly inappropriate that the Administration would recommend limiting existing authorities of Tribal Nations under ISDEAA, particularly without first engaging in ongoing and frequent consultation with Tribal Nations regarding proposals that would greatly impact Tribal health programs and patients.

**Recommendation:** The Workgroup strongly supports moving 105(l) leases to mandatory appropriations. While this remains the long-term goal, the Workgroup also strongly supports a separate indefinite appropriation for Section 105(l) leases. However, the Workgroup stands opposed to IHS acting unilaterally to restrict ISDEAA authorities in the absence of Tribal consultation. The Workgroup requests \$337 million in FY 2022 for section 105(l) leases to ensure that growing 105(l) lease costs are fully paid without impacting increases to other critical IHS line items.

#### **TOTAL FY 2022 REQUEST FOR FIXED COSTS:**

##### **Current Services \$377,084,000**

- Federal Pay Costs \$35,829,000
- Tribal Pay Costs \$59,717,000
- Inflation (non-medical) \$5,852,000
- Inflation (medical) \$170,714,000
- Population Growth \$104,972

##### **Binding Agreements \$474,500,000**

- Staffing for New & Replacement Facilities \$75,000,000
- Health Care Facilities Priority List \$100,000,000\*
- Contract Support Costs \$100,000,000\*
- 105(l) lease agreements \$337,500,000\*\*

*\*these placeholders are estimates only and are subject to adjustment based on actual requirements*

*\*\*While the summary document only outlines \$199.5 million for 105(l) lease costs, total funding requested for 105(l) leases for FY 22 is \$337.5 million; the \$199.5 million is the difference between the FY 22 request of \$337.5 million and the FY 2021 Tribal request of \$138 million*

#### **CONTRACT SUPPORT COSTS (ESTIMATE) +\$100 MILLION**

The Workgroup recommends an increase of \$100 million over the FY 2020 enacted budget to address legally obligated Contract Support Cost (CSC) funding for new and expanded programs. This is in addition to the \$45.35 million required to fund current service estimates that include federal and tribal pay costs, inflation, and population growth. The Workgroup recognizes that this amount is subject to change based on the actual CSC obligations and reconciliation requirements of the IHS-CSC Manual. Approximately, 60% of the IHS budget is operated by Tribes under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). The Act allows Tribes to assume the administration of programs, services, functions, and activities previously carried out by the federal government. The IHS transfers operational costs for administering health programs to Tribes through the “Secretarial amount,” which is the amount IHS would otherwise have spent to administer the health programs. In addition, Tribes are authorized to receive an amount for CSCs that meet the statutory definition and criteria. The additional \$145.35 million over the FY 2020 enacted budget of \$855 million, is requested to fund administrative costs associated with ISDEAA contracts and compacts entered into with the federal government. The ISDEAA, in addition to recent court decisions, require that 100% of these costs be paid, and are a legal and binding requirement for the IHS to comply.

## Program Expansion Increases – Services Budget

The National Tribal Budget Formulation Workgroup recommends the FY 2022 Program Increases outlined in this section that represent a critically needed infusion of resources, totaling \$2.763 billion (+40%) above the FY 2021 Workgroup Recommendation. These national priorities identified and agreed to by Tribal leaders is the result of a year-long Tribal consultation process that includes discussion by individual Tribes and urban Indian health programs, meetings held by each IHS Area Office and a final national session in which Tribal Leaders representing each region of the country came together to develop the national priorities for the Indian health care system. These recommendations build upon prior progress that has been gained through efforts by IHS, Tribes and Urban Indian programs to improve the delivery and quality of health care and reduce the high level of health care disparities that are magnified among the AI/AN population.

### HOSPITAL & CLINICS: +\$569.6 MILLION

For FY 2022, the Workgroup recommends an increase of \$569.6 million above the FY 2021 recommendation for a total funding request of \$4.201 billion for the Hospitals and Clinics (H&C) line item. Sufficient funding for H&C remains the top priority for FY 2022, as it provides the base funding for 605 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the core funding that provides direct medical care services to American Indian and Alaska Natives (AI/AN). Increasing H&C funding is critical as it supports medical care services provided at IHS and Tribally-operated facilities, including emergency care, inpatient and outpatient care, and specialized care, including for diabetes prevention, maternal and child health, youth services, communicable and infectious disease treatment, and women's and men's health. Importantly, H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs.

The demands on direct care services are a continuously 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. In addition, rarely do the 2-3% increases to the annual appropriated IHS budget adequately account for rising medical inflation year to year. This effectively means that, over time, IHS and Tribal health systems are losing funding over time. Medical inflation particularly impacts the H&C line item as IHS and Tribal sites fail to keep up with rising medical costs. Underfunding of H&C translates to rationed care that is less accessible and of lower quality, further limiting efforts towards making meaningful improvements to AI/AN health disparities.

The demands on direct care services are a continuous challenge in our facilities. Adding chronic challenges 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 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 members experience, an increase of \$569 million is not exorbitant, but realistic in terms of fulfilling unmet needs across Indian country.

Tribes are committed to working with IHS and HHS to make meaningful impacts in terms of improved health outcomes. AI/AN communities experience significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse than other populations. Preventative and primary care programs reduce costly medical expenditures for specialty care and treatment.

A critical component to achieve the full potential of Hospital and Clinics is fully funding the Indian Health Care Improvement Act (IHCIA). The provisions in this law represent a promise made by the federal government to significantly improve the health of our people, yet this law remains unfunded. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHCIA authorities. Tribes also request that funding these new authorities should be in addition to the base level Hospital and Clinics (H&C) funding.

## **HEALTH INFORMATION TECHNOLOGY SERVICES ESTIMATE OF \$3 BILLION, INCLUDING +\$95.3 MILLION FOR FY 2022**

(IHS) provides the technology infrastructure for a nation-wide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than 100 applications. A properly resourced IHS HIT program directly supports better ways to: 1) care for patients; 2) pay providers; 3) coordinate referral services; 4) recover costs; and 5) support clinical decision-making and reporting, resulting in better care, efficient spending, and healthier communities.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. TBFWG also has recommended a meaningful investment into the IHS HIT system to address the impact of the Veterans Health Administration (VHA) recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. In preparation for future modernization, the Department of Health and Human Services (HHS) and IHS evaluated the current electronic health record system, the Resource and Patient Management System (RPMS) and, based on the evaluation, developed the *Roadmap* Report to guide modernization efforts over the next five years. The Roadmap Report lays out a number of opportunities for FY 2020-2022, including establishment of a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection and procurement, implementation planning, and testing.

TBFWG acknowledges and fully supports the efforts outlined in the *Roadmap* Report and appreciates the President's FY 2021 request of \$117 million to build on the FY 2019 successes. Therefore, TBFWG maintains its recommendation for a separate HIT budget line item investment to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients.

The Workgroup requests a program increase of, at a minimum, \$95.3 million for EHR systems for FY 2022 as part of the request to fully fund HIT under the HIT Modernization Project. The Workgroup recommends full

funding for HIT based on the outcomes of the HHS/IHS HIT Modernization and puts a placeholder estimate of \$3 billion based on current data. However, the Workgroup expects this number to be adjusted to reflect a more accurate cost once the final HHS/IHS recommendations for HIT are finalized.

An adequately-resourced IHS (HIT) program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY22 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment.

## **DENTAL SERVICES +\$207.2 MILLION**

One of the long-standing unresolved health issues in American Indian and Alaska Native (AI/AN) communities is the lack of Dental Care and Dental Providers available to serve our Tribal community members. Overall, AI/ANs have significantly higher rates of dental caries and periodontal disease in all age groups. Untreated tooth decay causes pain & infections that may lead to problems, such as eating, speaking, and in children growing and learning.

IHS and Tribal dental programs have long been challenged to meet the very high level of need for health care services in general, including oral healthcare. Based on facts gathered from the Department of Health and Human Services the need for restorative services has far exceeded the capacity of the dental programs with more than 1 out of 3 AI/AN children (37%) between 1-5 years of age having untreated decay. On average, AI/AN 2-5 year old children had 4 teeth with dental caries, compared to the US all races rate of only 1.1

Many communities do not have on-site services to provide dental services with advanced caries. The lack of services available affect both adults and children alike. Adult dental treatment typically ends in extractions. Services for children require transports to larger communities for specialty care, where many children require restorations and extractions under general anesthesia. Precise data are not available, but with about 25% of children requiring general anesthesia, this rate is at least 50 times (i.e., 5000%) higher than the US all races rate. Officials estimate that 25% of AI/AN children in some communities require full mouth restoration under general anesthesia, a rate 50 to 100 times that of the general population. Some experts

## COMMUNITY HEALTH AIDE PROGRAM (CHAP) EXPANSION

The Community Health Aide Program (CHAP) was established in Alaska over 50 years ago. Community Health Aides are the only medical providers in smaller rural communities in Alaska and receive their training at certified CHAP training Centers in Alaska. Community Health Aides are trained to systematically assess all patients for their presenting conditions, using the Community Health Aide Manual (CHAM) and are able to treat certain conditions under standing orders from a referral physician, and / or after consultation with an assigned provider.

In Alaska, the Tribal health organizations receive limited resources from IHS for CHAP and many tribal health organizations are using non-IHS resources to staff their training centers and to update the CHAM. Further, a CHAPs medical scope of practice is clearly defined and is very different from

the role of Community Health Representative (CHR).

The Indian Health Care Improvement Act (IHCIA) at Section 111 provides the authorization to establish a CHAP throughout the Lower 48. Tribes in Alaska and across other the Areas have made it clear that standing up a Community Health Aide Program will require additional financial resources. Tribes have also instructed that CHAP nationalization should occur without negative impacts to the already insufficient resources awarded to Alaska. For the first time, the FY 2020 budget included \$5 million for nationalization of CHAP. In the proposed 2021 President's budget the CHAP, CHR, and Health Education line-items were combined into one 'Community Health' line-item and the total proposed amount was reduced by 50%. Not only is consolidation of the line-items detrimental to the CHR program, but it does not provide any meaningful funding

towards the expansion of the Community Health Aide Program throughout the Lower 48.

The CHAP – Tribal Advisory Group (CHAP-TAG) was established by IHS as an unfunded mandate and was tasked to determine how to establish a Community Health Aide Program in other regions, outside of Alaska. Under IHS guidance, the focus of the CHAP-TAG has been on creating a policy to establish a National Federal Certification Board; a draft policy was sent to IHS legal counsel for their review. IHS should task the CHAP-TAG to provide further guidance regarding the development of CHAP Training Centers and CHAP programs for areas outside of Alaska and determine the funding needs to expand CHAP throughout the Nation. IHS must take advantage of the 50 plus years of experience with CHAP in Alaska.

have stated that it could be the largest health disparity in the country.

Factors such as poverty, geography, lack of oral health, education, language or cultural barriers, fear of dental care and the belief that people who are not in pain do not need dental care significantly impact these rates. AI/AN experience extreme disparities in oral health. AI/AN preschool children have the highest rate of tooth decay than any population group in the country. For example, on the Pine Ridge Reservation the W.K. Kellogg Foundation found 40% of children and 60% of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. One potential reason is that the dental hygienist-to-population ratio within the Indian Health Service is 1:9,300 while the general population is at 1:2,000.

## MENTAL HEALTH +\$308.8 MILLION

Mental health is a significant priority for FY 2022. Tribal leaders recommend a \$308.8 million increase above the FY 2021 Workgroup recommendation for total funding of \$714.9 million. Funding increases would be used to implement Section 127 of the Indian Health Care Improvement Act (IHCIA) allowing for the increase of the number of mental health providers and funding training/education; Section 702 to expand behavioral health care for prevention and treatment; Section 704 to provide more comprehensive care through detox, psychiatric hospitalization and community-based education and rehabilitation programs; Section 705 to expand the use and dissemination of a Mental Health Technician Program to serve patients; as well as, Section 715 to expand Behavioral Health research grants to allow

tribes to find more asset-based, innovative and effective approaches to address issues like Indian youth suicide. The additional increase would also fund the new provisions in the IHCA (Sections. 707, 708, 710, and 712) such as: Comprehensive Behavioral Health and Treatment Programs, Fetal Alcohol Spectrum Disorders Programs, Long-Term Treatment Programs for Women and Youth. Current State Reimbursement Rates are inadequate for small programs to be self-sustaining. Additional funds would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs.

This increase would mean an more than 600% increase in funding for mental health services in Indian Country above the FY 2020 enacted level. 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. Inadequate funding resources limit Tribes implementing cultural and asset-based approaches to address these issues. Thusly, Tribes seek additional resources to enhance current services and to fund the implementation of the above-listed provisions highlighting the following two as examples:

- Behavioral Health Prevention and Treatment Services: Establishes the authorities for comprehensive services and emphasizes collaboration among alcohol and substance abuse, social service and mental health programs.
- Mental Health Technician Program: Authorizes comprehensive training of community mental health paraprofessionals, including Behavioral Health Aides under CHAP, to provide community based mental health care that includes identification, prevention, education and referral for treatment services and the use and promotion of traditional health care practices.

The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among American Indians and Alaska Natives is well documented. 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, studies are suggesting that AI/ANs are not receiving the

services they need to help reduce the disparate statistics.<sup>5</sup> Healthcare has an increasing focus on prevention and wellness, and more must be done to address mental health, which impacts co-morbid conditions and outcomes related to chronic illness. Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical *and* mental health. It is important to note that the recent increases in behavioral health funding has only been allocated through limited time-sensitive competitive grants. The grant-funded nature is an inefficient funding mechanism that does not support long-term program sustainability and has created haves and have-nots in Indian Country which serves a barrier to address behavioral health crisis and interventions and does not support an integrated continuum of care. Mental Health resources must be recurring and allocated equitably across the I/T/U system via a non-grant and non-competitive distribution.

Coordinated telehealth psychiatric services for complex cases with multiple medications is crucial to patient care. Funds are needed to support infrastructure development 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, asset-based approaches, 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, as well as address adverse childhood events and historical traumas to break the cycles and conditions that contribute to perpetuating or exasperating poor mental health outcomes.

With regard to addressing mental health crises, 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, assess and refer to the appropriate level of care. Many communities and areas lack a sufficient number of hospital beds for

5 Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry*, 162, 1723-1732. Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with first nations women in group counseling. *Canadian Journal of Counseling*

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. It is the costliest method of care and, unfortunately, leads to patients not receiving the appropriate level of care and emergency rooms routinely being on divert for regular medical emergencies due to beds being occupied with mental health patients who are waiting for appropriate beds to open up.

Lack of behavioral 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 reviewing data from 2003-2014 approximately 70% of AI/AN descendants resided in non-metropolitan areas, including rural areas. The residential status can affect the circumstances surrounding suicide. 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 and arguments preceding AI/AN suicides. Also, the need for postvention, such as establishing survivor support groups, are key to interrupting or reducing the potential of suicide contagion.<sup>6</sup> An increase in funding can support increased use of tele-behavioral health services and support training of local mental health paraprofessionals which would allow a greater percentage of the AI/AN population to be screened, seen by behavioral health specialists and most importantly, treated.

Tribes have expressed the need to increase funding for mental health programs specifically for long-term treatment, housing, and after-care facilities/staffing. Strengthening funding for Section 702 of the IHCA includes support in meeting these needs. For example, displaced or homeless veterans returning home from active duty service, individuals returning home after a long period of incarceration, and/or returning home after substance use treatment will benefit from a transitional living environment that assists them while they readjust to their environment and surroundings. The TBFWG has made behavioral health services a major budget priority for many years and continues this emphasis in FY 2022 as investment in behavioral health services has shown positive return. For example, treating depression and anxiety

has shown between 3.3 to 5.7:1 return on investment in reduced/avoided medical costs, improved productivity, and improved health status.<sup>7</sup> This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral health issues.

## **ALCOHOL & SUBSTANCE ABUSE**

### **+\$255.04 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 including, but importantly not limited to, opioid addiction.<sup>7</sup> Tribal leaders agree that this topic remains a high priority for FY 2022. Roughly \$532 million above the FY 2020 enacted amount, for a total funding level of \$778.5 million. The purpose of the Indian Health Service Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral and physical 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.

The 2018 National Survey on Drug Use and Health (NSDUH) found that 10% of Native Americans have a substance use disorder; 4% an illicit drug use disorder and 7.1% an alcohol use disorder. Nearly 25% of Native Americans reported binge drinking in the last month. The same survey also showed that nearly 1 in 5 Native American young adults (age 18-25) have a substance use disorder, 11% with illicit drugs and 10% with alcohol.<sup>8</sup>

In 2015 AI/ANs had the highest drug overdose death rates (metropolitan: 22.1 and non-metropolitan: 19.8 per 100,000) and the largest percentage change increase in the number of deaths over time than any other group.<sup>9</sup> Concerning youth and the critical need for prevention and early intervention, reservation-based American Indian

<sup>7</sup> It is important to note many tribes have found the opioid grants to be very restrictive and too specific to combat the overall epidemic of alcohol and other substance addictions. Funds need to be dispersed using a non-grant, non-competitive methodology and must allow greater flexibility in order to combat substance use disorders equitably and holistically.

<sup>8</sup> Substance Abuse and Mental Health Services Administration (2019). 2018 National Survey on Drug Use and Mental Health

<sup>9</sup> Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12. DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1>

<sup>6</sup> Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides Among American Indian/Alaska Natives - National Violent Death Reporting System, 18 States, 2003-2014. *MMWR. Morbidity and mortality weekly report*, 67(8), 237-242. doi:10.15585/mmwr.mm6708a1

students are at high risk for substance use compared with US youths in general. According to Swain et.al. rates of alcohol and marijuana abuse among Native American Youth on reservations are 3.4 times higher than national U.S. students.<sup>10</sup>

In 2016-2017, AI/AN students in 8th, 10th and 12th grade reported substantially higher lifetime and last-30-day substance use rates compared with the Monitoring the Future students, with greatest disparity at eighth grade: last-30-day substance use relative risks for grade 8 were 2.1 (95% CI, 1.4-3.0) for alcohol, 4.2 (95% CI, 3.1-5.8) for marijuana, and 2.4 (95% CI, 1.7-3.3) for other illicit drugs.<sup>11</sup> And while accurate national data is challenging a linkage study by the Northwest Tribal Epidemiology Center found that during 1999-2001, AI/AN and whites in Washington had similar age-adjusted total drug, opioid-involved, and heroin-involved overdose mortality rates. And while overdose death rates increased significantly for both groups in subsequent years, the increase was much sharper among AI/AN than among whites. During 2013-2015, 184 drug overdose deaths occurred among AI/AN in Washington, including 126 (68.5%) that involved opioids. The rates were higher for total drug (2.7 times), opioid-involved (2.7), and heroin-involved overdose mortality (4.1) among AI/AN than among whites.<sup>12</sup> In Alaska, Meth overdose mortality more than doubled between 2015-2017. The 2017 Alaska Youth Risk Behavior Survey showed that 7% of the youth had used prescription pain medication without prescription from a physician in the last 30 days; nearly 14% of students reported binge drinking in the last 30 days and 1.8% reported using heroin. SAMHSA data from 2014 also indicate that Native American adolescents have the highest rate of lifetime tobacco product use, marijuana use, use of pain relievers and non-medical use of prescription type psychotherapeutics.<sup>13</sup> The Billings Area reports that Montana has seen statewide Meth offenses up 313% from 2012-2016 and that meth trafficking offenses comprise approximately 95% of Federal drug prosecutions.<sup>14</sup>

10 Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open*. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

11 Substance Abuse and Mental Health Services Administration (2019). 2018 National Survey on Drug Use and Mental Health

12 Joshi S, Weiser T, Warren-Mears V. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives — Washington, 1999–2015. *MMWR Morb Mortal Wkly Rep* 2018;67:1384–1387. DOI: <http://dx.doi.org/10.15585/mmwr.mm6750a2>

13 Substance Abuse and Mental Health Administration (2014). SAMHSA American Indian/ Alaska Native Data

14 Data provided by the United States Department of Justice, United States Attorney, Kurt G. Alme.

The Great Plains Area also reports having the one of the highest alcohol-related death rate in the country. Highlighting the need to allow comprehensive approaches and flexibility in SUD funding to address issues like opioid addiction and suicide prevention holistically and comprehensively removing artificial silos and employing inefficient funding mechanisms such as granting to address alcohol and substance abuse.

According to SAMHSA data from 2018, nearly 13% of AI/AN population need substance use treatment, but only 3.5% actually receives any treatment. Current I/T/U alcohol and substance abuse treatment approaches 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, 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. 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. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming. New approaches are also needed to reduce alcohol and substance abuse related health disparities in motor vehicle death rates, suicide rates, rates of new HIV diagnoses, binge drinking and tobacco use. In Alaska, for example, 1 in 3 motor vehicle and boating fatalities in 2012-2016 was alcohol related.

Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability and the challenges with the grant-funded model, several culturally responsive in-patient treatment centers have had to close their doors leaving major gaps in service availability and more specifically availability of detox beds with the rising number of opioid and/or other addictions. Methamphetamine, opioid and heroin use is high in many IHS regions, with limited treatment facilities available.

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, those funds continue to be allocated through competitive grants, despite Tribal objections. For over a decade, Tribes have noted that IHS reliance on grant programs is counter to the federal Trust Responsibility and undermine self-determination tenets. 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, due to grant restrictions. Furthermore, because grant funding is never guaranteed, vulnerable communities, with the greatest needs but least capacity, often slip through the cracks. The needed increase must be applied to IHS funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and 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.

One Tribal leader said it most plainly and simply, “Left untreated, alcoholism is a terminal disease.” In fact, if left untreated, as indicated earlier, addiction places considerable burden on the health system in unintentional injuries, chronic liver disease, cirrhosis, and facilitates the transmission of communicable diseases such as HIV and Hepatitis C, both having catastrophic effects on our health system. Effects from historical trauma, adverse childhood events, poverty and other social determinants of health, 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.

In addition to funding needed to support detox and rehabilitation services, Tribes have also reported a critical need for aftercare services and transitional housing. 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 with which individuals first experiment; 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. Alaska Native people experienced the highest rate of death contributed to smoking during 2012-2016; the highest prevalence was among Native men age >65, who were twice as likely to die from smoking related causes as females of the same age group.

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 for prevention and education regarding all drugs is evident in recent verbal reports from Tribal leaders in Alaska that drug dealers had thrown little bags with crystal methamphetamine in with the regular candy that gets distributed among children and youth at the end of potlach gatherings.

Domestic violence rates are alarming, with 39% of AI/AN women experiencing intimate partner violence — the highest rate in the U.S. 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 and asset-based prevention and treatment.

### **PURCHASED/REFERRED CARE +\$460.385 MILLION**

For FY 2022, the Workgroup recommends an increase of \$460.385 million for a total funding level of \$2.02 billion for the Purchased and Referred Care Services (PRC) line item. PRC is vital to ensuring adequate care is provided to American Indian and Alaska Natives and continues to remain a top funding priority.

IHS and Tribal operated facilities serve primarily rural populations and provide limited primary care and community health services. PRC was established to allow for IHS and Tribal operated facilities to secure essential health care services from private sector providers when such services, especially emergent and specialty care services, are not available within the Indian Healthcare Delivery System. Much of the secondary care, and nearly all of the tertiary care needed, must be purchased from non-IHS facilities. PRC funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition and pharmacy services.

Historically, inadequate funding for the Indian Healthcare Delivery System and PRC forces IHS and Tribal Nations to ration health care based on an antiquated ranked medical priority system because the federal government has not met its trust and treaty obligations. Often PRC funding doesn't extend beyond Priority I status, which thereby creates significant challenges in the health status of individual AI/ANs and communities.

Investments in PRC would be used to improve both access to care and the quality of care. Increasing access to outside health care services and working with off-site providers to improve the quality of care provided under PRC will help to reduce health disparities and the number of deaths due to heart disease, cancer, diabetes, unintentional injuries, chronic liver disease, chronic lower respiratory disease, stroke, suicide, influenza/pneumonia and nephritis.

### **INDIAN HEALTH CARE IMPROVEMENT FUND +\$104.1 MILLION**

In FY 2022, the Workgroup recommends an increase of \$104.16 million for the Indian Health Care Improvement Fund (IHCIF), for total funding of \$276.7 million. The Indian health system faces significant funding disparities when compared to other Federal health care programs., Because of its limited funding, IHS currently spends only \$3,779 per user nationwide compared to the average national healthcare spending of \$9,409 per user. More funding disparity exists within IHS among Areas and Tribes within each Area.

The IHCA established the Indian Health Care Improvement Fund (IHCIF) to eliminate the deficiencies and inequities in health status and health resources of Indian Tribes. The legislation requires a report to Congress documenting the level of funding needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal organization.

Despite significant AI/AN health disparities, a rising user population, and legislative authority to fund the IHCIF to address resource deficiencies and inequities, Congress has only provided \$259 million for distribution to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF via the Level of Need (LNF) formula since adopted in 2001. While Tribes are appreciative of the 2020 allocation of \$72.28 million, the IHCIF was not allotted additional funding in FY2019 or FY2020. Given that user population is increasing year over year and health disparities continue to grow, steady consistent funding is necessary to achieve the goals of the IHCIF. Unfortunately, gains in parity also have been negated by rescissions and sequestration.

During the past two years, the joint IHCIF Tribal/Federal Workgroup met to review and update the existing IHCIF data and develop recommendations for IHS to consider and make a final determination on the allocation methodology. The final report was due to the IHS Director in July 2019, but to date no report has been released. The NTBFWG suggests the workgroup complete the report soon and forward to the IHS Director so a final determination can be made.

The NTBFWG specifically requests the following:

- The IHCIF Tribal/Federal Workgroup should finalize the IHCIF report;

- Through Tribal consultation, the IHS Director adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future; and
- The IHS should update the data in the IHCIF allocation methodology and release to all Tribes annually; and
- Increases and equitable distribution of the IHCIF will ensure greater access to high quality, culturally appropriate care and services across the I/T/U system.

### **PUBLIC HEALTH NURSING +\$57.266 MILLION**

Public Health Nursing (PHN) is a community health-nursing program that focuses on promoting health and quality of life and preventing disease and disability. The PHN program provides quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families and community groups. Home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. However, PHN also offers traditional food programs that focus on food choices that are not only culturally appropriate but consider health challenges for AI/ANs, health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, and education programs. The request includes inflation plus \$57.2 million in expanded services for total funding recommendation of \$204.3 million.

### **HEALTH EDUCATION: + \$32.9 MILLION**

Tribal Leaders seek a \$32.9 million increase to the Health Education line item. Health Educators have a different role than CHRs as they are lead many of the community wide health education initiatives. These may entail advancing information across Tribal systems that involve the Tribal governments and various departments, the local public schools, Tribal schools and boarding schools and coordination with state and other federal agencies and institutions. Health Educators, for example, are able to develop health curricula and materials that help our communities become more familiar with complicated health risks in order to prevent and better manage them. They have been especially successful in developing school

health curricula, workforce policy and educational materials for patients as emerging health risks effect the populations. Tribal leaders request no less than a \$32.9 million increase to this line item in FY 2022 for total funding at \$111.4 million.

### **Impact of Community Health/CHAP Consolidation**

In the FY 2021 Budget Request, Tribal Leaders learned that the Administration seeks once again to alter IHS Preventative Health Services. A new line item titled, “Community Health” was proposed to be created and would merge the Community Health Aide Program (CHAP), Community Health Representatives (CHR) and Health Education under this line item. It’s stated that IHS obtained Tribal input on this proposal, but for many Tribal Leaders they have not been apprised of consultation and are concerned that a total of \$44 million is sought to operate all three programs would not be adequate. At the FY 2020 enacted level, when combined these three line items total over \$88 million. To consolidate these critical line items by cutting their funding in half is very concerning.

### **COMMUNITY HEALTH REPRESENTATIVES: + \$107.3 MILLION**

Tribal Leaders on the National Tribal Budget Formulation Workgroup recommend that the FY 2022 budget provide a **\$107.3 million** increase to the CHR line item to a total funding level of \$245.2 million. CHRs are front line community health workers that are highly valued and a trusted source of preventative health information provided to Tribal members for the last 50 years in home and community settings. They relay information not only in our Native languages, but also in a manner that is culturally appropriate with a focus on the many facets of wellness which encourages Tribal members to obtain the necessary clinical services to address health issues they may be experiencing. CHRs are also considered a valued member of the medical team whose role it is to follow-up on patients that have been discharged from IHS or other health care facilities.

CHRs are part of the direct provision of health services and are authorized in federal law in the Indian Health Care Improvement Act (25 U.S.C. § 1616). Without the services provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients will not receive their necessary follow-up services and many will have difficulty accessing the health care system.

In FY 2018, IHS reported that more than half of the visits performed by CHRs were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members.

CHR's integrate basic medical knowledge about health promotion and disease prevention with local community knowledge to provide high-quality follow-up, which improves the quality of service delivery through culturally competent care. CHR's also assist in implementing initiatives which support patient safety and community-based care. CHR's provide services like in-home patient assessments of medical conditions, glucose testing and blood pressure tests to determine if the patient should seek further care, and may also provide transportation to medical appointments. The Navajo Nation is an example of where CHR's are not only addressing chronic diseases, but advance knowledge to patients on a broad range of health risks. These include oral health care, preventing tuberculosis and influenza and addressing a sexually transmitted disease outbreak. CHR's at the White Mountain Apache Tribe have engaged in Rocky Mountain Spotted Fever (RMSF) public health prevention measures, including animal control. The Yavapai Apache Nation has trained CHR's how to administer Narcan to prevent death due to an opioid overdose. Without an adequate increase to maintain these efforts, Tribes who rely on CHR programs to coordinate and conduct preventative education efforts will have difficulty maintaining their current system of support to high risk clients who need screening, education and monitoring visits as well as lose their local knowledge that helps keep communities safe.

### **ALASKA IMMUNIZATION – +\$2,000**

In FY 2022 the Workgroup recommends an increase of \$2 thousand above a \$124,000 increase for medical inflation and population growth for the Alaska Immunization program over the FY 2021 Workgroup recommendation and totals for current services and binding obligations for a total of \$2.457 million. The Hepatitis B Program: Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor hepatitis B infection, as well as hepatitis A in FY 2016, immunizations maintained high vaccine coverage rates;

hepatitis A vaccination coverage was 89% and hepatitis B vaccination coverage was 94%.

*Immunization (Hib) Program:* Immunization is a fundamental health prevention activity for Alaska Native people. In 1990, elevated rates of Haemophilus Influenzae B (Hib) among Alaska Native children prompted an immediate call to action for increased vaccination coverage, especially in Alaska Native communities with limited access to care. High vaccination coverage rates have resulted in a 99% reduction in Hib meningitis and vaccination coverage rates amongst Alaska Native children continue to be the highest in Alaska. The ANTHC Immunization Program maximizes the prevention of vaccine-preventable disease by providing directed resources, staff training, and coordination to Tribes in Alaska. Support services also include site visits and consultation for the varying electronic health records (EHR) systems within each Tribal health organization to facilitate immediate access to complete vaccine records. Dedicated immunization funding has ensured continued access to vaccines in Alaska Native communities and high vaccine coverage for Alaska Native children and adults.

### **URBAN INDIAN HEALTH +\$90.941 MILLION**

Urban Indian organizations (UIOs) were established in 1976 by tribes that advocated for trust and treaty health rights for AI/ANs who live off reservations and are therefore considered to be “urban Indians”. There are currently 41 IHS UIOs, which operate 74 facilities in 22 states. UIOs provide a wide range of culturally competent health care and social services to urban AI/AN communities including primary care, oral care, HIV treatment, substance use disorder treatment, behavioral health, and other preventive services. The TBFWG recommends a \$90,941,000 increase above the FY 2021 planning base, which would change the urban Indian health line item to \$200.5 million overall. UIOs receive direct funding from primarily the one line item – urban Indian health – and do not receive direct funds from other distinct IHS line items, including the Hospital and Health Clinics, Mental Health, Alcohol & Substance Abuse, Indian Health Care Improvement Fund, Health Education, Indian Health Professions, or any of the line items under the IHS Facilities account. Due to historically low funding levels for urban Indian health, UIOs are chronically underfunded. This increase would therefore make a huge difference to UIOs in providing care to urban Indians.

Compounding on the low funding levels, portions of UIO funds have been reprogrammed from urban Indian health. The federal government should ensure that UIOs are held harmless from unrelated budget shortfalls or funding diversions. For instance, although UIOs do not benefit from, or have access to, § 105(l) lease cost agreement funding, more than \$1.5 million was reprogrammed from urban Indian health over the last two FYs. In addition, the chronic underfunding of UIOs as they work to provide for a growing population of urban AI/ANs makes it essential to ensure their continued eligibility for grant or funding initiative opportunities, including behavioral health initiatives and SDPI. Finally, when the federal government fails to fund or operate at full capacity, such as periods of a government shutdown, IHS is unable to provide the majority of funds to UIOs resulting in a loss of critical funding and operational shortfalls. This was evident during the 2018-2019 federal government shutdown, which had the following impacts on UIOs: facility closures, staff layoffs, reduced hours, canceled programs/services, and more – ultimately impacting the abilities of UIOs to provide services to their AI/AN patients.

It is also imperative to highlight that UIOs have been deemed ineligible for other cost saving measures available to the other components of the IHS I/T/U system, including, among others:

- Federal reimbursement to states at the 100% Federal Medical Assistance Percentage (FMAP) for services provided at UIOs:

In recognition that the Responsibility for AI/AN health care belongs to the federal government and not the States, the federal government pays 100% of the costs incurred by the states to reimburse IHS for the Medicaid services the agency provides to AI/ ANs. This rate is known as the Federal Medical Assistance Percentage (FMAP). The FMAP rate is 100% for services provided at IHS and tribal providers, but not UIOs.

- Reimbursement from the Department of Veterans Affairs (VA) for services provided to dually eligible AI/ AN veterans:

In 2010, IHS and the VA signed a memorandum of understanding (MoU) to promote inter-agency collaboration which “recognize (d) the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such

efforts requires local adaptation to meet the needs of individual Tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs.” However, the MoU has been implemented for IHS and Tribal providers, but not UIOs.

- Malpractice insurance through the Federal Tort Claims Act:

The Federal Tort Claims Act (FTCA) allows federally-supported health care centers to secure medical malpractice liability protection with the federal government acting as their primary insurer at no cost. IHS and Tribal providers are covered under the FTCA, as well as Community Health Centers, but UIOs are not. Consequently, UIOs must divert precious dollars from health care to pay for expensive malpractice insurance, which can cost hundreds of thousands of dollars per annum.

Below are the identified hot topics and priorities for Urban Indian Health.

1. Increased funding for urban Indian line item: Although more than 70% of AI/ANs reside in urban or suburban areas (according to the most recent census), less than 1% of IHS’ budget is spent on urban Indian health care. In fact, most recent funding increases for urban Indian health fail to even keep up with health care inflation. UIOs are also unable to access PRC funding or numerous other categories of funding in IHS’ budget (including line items under the Facilities account) and have been overlooked for newly available grant funding. Funding for urban Indian health must be significantly increased if the federal government is, to finally, and faithfully, fulfill its trust responsibility. However, it is also imperative that such an increase not be paid for by diminishing funding for already hard-pressed IHS and Tribal providers.
2. Dissemination of Urban Indian Health Funding to UIOs: Critical funding for UIOs has recently been reprogrammed to fulfill unrelated budgetary shortfalls under programs for which UIOs are ineligible. In FY 2018 and FY 2019, IHS reprogrammed more than \$1.5 million from the already budget-constrained UIOs in order to satisfy the cost of 105(l) leases.
3. Retain Eligibility for IHS UIOs to Participate in Grant Programs: Because UIOs suffer from significant

underfunding, they often must seek additional funding opportunities in order to provide more services and serve more patients, including grants. If grant-making is eliminated for IHS and Tribal facilities in lieu of direct funding, UIOs should separately retain eligibility for grants under these programs – or would lose critical funding. This includes behavioral health funding for IHS’s current initiatives and SDPI. 24 UIOs are current recipients of IHS’s behavioral health initiatives and 30 UIOs currently receive SDPI funds. The preservation of grant funds for UIOs should not impact the ability of grants distribution to transfer to direct funding for IHS and Tribal facilities.

4. Eligibility for IHS UIOs to Participate in New Programs: Similarly, UIOs should be eligible for new IHS programs. This includes the nationalization of a Community Health Aide Program (CHAP). Many UIOs would benefit from a national CHAP, as well as Dental Health Aide Therapists, and Behavioral Health Aide Therapists. It is thus imperative that UIOs are included in the nationalization of CHAP so that the entire I/T/U system can offer patients increased access to quality care. In addition, UIOs should be included in the novel opioid funding opportunity as appropriated by Congress in FY 2019 as a Special Behavioral Health Program for Indians.
5. Implementation of Unfunded IHCIA Provisions for Urban Indian Health: Finally, there are numerous provisions of the IHCIA designed to benefit UIOs that have not been funded by Congress. Critical programs for UIOs can be found throughout Title V of IHCIA and include, for example funds for Facilities Renovation (Sec. 509).

The budget priorities for UIOs include:

- Dental services;
- Diabetes prevention and treatment;
- Behavioral health;
- Health Information Technology;
- Facilities renovation; and
- Care for AI/AN veterans.

The Indian Health Professions Program has seen much success throughout the years including, but not limited to, the following:

- Enabling AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian Self Determination in the delivery of health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

### INDIAN HEALTH PROFESSIONS +\$3.4 MILLION

In FY 2022, the National Tribal Budget Formulation Workgroup recommends increasing the Indian Health Professions line by \$3.4 million to a total funding amount of \$82.63 million. IHS and Tribes continue to struggle to recruit and retain qualified medical professionals to work in facilities serving Indian Country. In 2018, the Government Accountability Office (GAO) published a report, “*INDIAN HEALTH SERVICE: Agency Faces Ongoing Challenges Filling Provider Vacancies (GAO-18-580)*,” estimating the vacancy rates at federal IHS sites, as follows: Physicians - 34%; pharmacists - 16%; nurses - 24%; dentists - 26%; physician’s - 32% and advanced practice nurses - 35%. The 2017 IHS data examined in the report indicated that large percentages of vacancies for providers was especially crucial in eight IHS Areas.

The IHS system competes with the private sector, as well as the Veterans Administration in recruiting and maintaining health providers. However, there are a few tools available to the IHS and Tribes that provide unique advantages in recruitment, principal among them – the IHS Scholarship and the IHS Loan Repayment Program (LRP). We need comprehensive efforts to encourage AI/

ANs to enter into health careers including resources to increase access to federal and state scholarships and loan repayment programs. While a major focus is to create a pipeline of AI/AN students entering health care careers, there are many factors, including long-term support and educational infrastructure that have to be addressed. The GAO report noted that a total of \$48.3 million was the need to fund all of the professional loan applicants in FY 2016, but IHS was only able to fund 437 out of 939 applicants. IHS also reported that only 456 of the new scholarship applicants of 1,250 new online scholarship applications could be funded. In total, that year \$3.3 million was the amount needed to fund all of the qualified applicants.

Due to unmet health care needs, outpatient IHS and Tribal facilities and UIOs that receive funds through Title V of the IHCA are automatically designated as Federally Qualified Health Centers (FQHCs) and therefore, Health Professional Shortage Areas (HPSAs). In addition, Tribes are automatically designated as population HPSAs. Automatic HPSA designations do not expire, but Health Resources Services Administration (HRSA), asks that designations be updated to ensure that the score is accurate. The benefits of the score includes improving access to primary care, dental and mental health providers through the loan repayment for National Health Service Corp (NHSC) providers. HRSA announced to Tribal Leaders in 2019, that it is going to modernize the HPSA designation process as well as update the Auto-HPSAs in 2020. In advance of the changes HRSA recommended that facilities update their information and include the data requested (demographic data, access to fluoridated water and rates of alcohol and substance abuse).

Another concern is that some states do not allow Tribal health centers to be eligible sites for the State Loan Repayment Program (SLRP). States receive these funds from HRSA's Bureau of Health Workforce (BHW). In order to be eligible, the service site must implement a sliding fee scale. Tribal health centers do not have policies to implement a sliding fee scale therefore disqualifying the provider from utilizing the SLRP at a tribal facility.

In addition to the requested increase of \$3.4 million in FY 2022 to increase funding for scholarships and expand loan forgiveness options, Tribes also recommend that the inclusion of health managers and administrators in the professions eligible to apply for these funds. In American Indian health care systems, these are vital positions. Consideration must also be given to the expansion of

Alaska's Community Health Aide Program (CHAP) in the lower 48 and the inclusion of CHAP providers in the LRP or Health Professions Scholarship Program. It is requested that IHS expedite and elevate this as a priority by fiscal year 2022. Other measures must be addressed to increase recruitment and retention of professionals and institute comprehensive efforts to encourage American Indian/Alaska Natives to enter into health careers. For example, Tribes supported amending Internal Revenue Service (IRS) statutes to fully exclude IHS scholarships and loans from an individual's taxable income. Updating clinical and administrative Grade Salary (GS) levels to enhance IHS salaries making them competitive with the Veterans Administration is also sought. Lastly in light of HRSA's proposal to modernize Auto-HPSA designations, a deeper dive into the impact of the policy change is needed. It is further requested that consultation take place on this matter at the 2020 Regional Department of Health and Human Services Tribal Consultation sessions.

### **TRIBAL MANAGEMENT GRANTS +\$3,000**

The Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103(b) (2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. Under the authority of the ISDEAA, the program was established to assist all federally recognized Indian Tribes and Tribally-sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity. The request for Tribal Management Grants is \$2.694 million. The purpose of the TMG Program is to assist federally-recognized Tribes and Tribally-sanctioned Tribal organizations in assuming all or part of existing IHS programs, services, functions, and activities (PSFAs) through a Title I contract and to assist established Title I contractors and Title V compactors to further develop and improve their management capability.

Although the IHS agency has made this discretionary competitive grant program a lesser priority than direct health services, there has actually been an increase in the interest by Tribes and Tribal organizations to explore their inherent right to assume management of their own health delivery systems. Tribes have objected to attempts by the Administration to zero out the TMG funding. TMGs are available to Tribes and Tribal organizations to

allow for the completion of feasibility studies, planning and evaluation studies, and health management structure framework development. The intent of the TMG program provides Tribes/Tribal Organizations the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination. These grants are necessary to assist Tribes and Tribal organizations with:

- Planning – funds up to \$50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.
- Evaluation – funds up to \$50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist T/TO improvements to its health care delivery system.
- Feasibility – funds up to \$70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.
- Health Management Structure (HMS) grants are funded up to \$300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, management systems, health accreditation, as well as correction of audit material weaknesses.

### **DIRECT OPERATIONS +\$352,000**

The overall funding request for Direct Operations for FY 2022 is \$78.88 million. The Direct Operations budget supports the (IHS) provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives (AI/AN). The IHS is the only HHS agency whose primary function is direct delivery of health care. Funds are used to promote the efficient and effective administration and oversight of national functions such as: human resources (HR), financial management, acquisitions, internal control and risk management, health care and facilities planning, health information technology, Contract Disputes Act claims analysis, and other administrative support and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

The IHS Headquarters provides overall program direction, authorities, and oversight for the 12 IHS Areas and 170 Service Units: it formulates policy and distributes resources; also provides technical expertise to all components of the Indian health care system, including IHS direct service, Tribally operated programs, and urban Indian organizations (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters works in partnership with the Department of Health and Human Services (HHS) and sister agencies to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters also works with HHS to formulate the annual budget and necessary legislative proposals, and respond to congressional inquiries.

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services management and delivery.

Program increases for Direct Operations will allow the continued implementation of all quality and patient safety and will enable the agency to be responsive to deficiencies cited in the previous GAO High Risk Report. A funding increase will enable operational support necessary for carrying out the functions of the new Office of Quality (OQ). The OQ provides for quality systems integration and address quality assurance, patient safety, business intelligence, risk management, and quality improvement. Funds will also be used to strengthen the agency's capacity for oversight in key areas such as workforce management and development, finance, acquisitions, and other evolving areas identified by agency leadership. This will increase the efficiency and effectiveness of Headquarters programs focused on policy management and compliance, competency training, evaluation, data analysis and reporting, and accountability. The non-inherent federal function portion of Direct Operations funds are available for Tribal Shares distribution if a Tribe or Tribal Health Organization exercises its right to assume management of federal functions under ISDEAA Title I or Title V.

## SELF-GOVERNANCE +\$13,000

To support and expand Self-Governance training and technical support in FY 2022 through the Office of Tribal Self-Governance (OTSG), the Workgroup is requesting a program increase of \$13,000, on top of an additional \$225,000 for adjustments to federal pay, non-medical inflation, population growth, for an overall budget request of \$6.356 million. OTSG is responsible for a wide range of agency functions that are critical to honoring the IHS's relationship with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups, under authorization of Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137. Title V authorizes Tribes and Tribal Consortia to enter into Self-Governance compacts, self-determination contracts and related funding agreements to assume federal programs, functions, services, or activities (PFSA), and associated Tribal Shares, placing the accountability of PFSA service provision with Tribal nations. This request supports expansion of the implementation of the IHS Tribal Self-Governance program, funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and funds Tribal shares needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program.

Today, Indian Tribes and Tribal organizations administer over one-half of IHS resources through ISDEAA self-determination contracts and Self-Governance compacts. There is a growing interest by Tribes to explore Self-Governance as an option to exercising its self-determination rights. The Self-Governance budget supports activities, including but not limited to: government-to-government negotiations of Self-Governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALNs); technical assistance on Tribal Consultation activities; analysis of Indian Health Care Improvement Act (IHCIA) authorities; Self-Governance planning and negotiation of Cooperative Agreements; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee which advises the IHS Director on Self-Governance policy decisions.

## SELF-GOVERNANCE PLANNING AND NEGOTIATION COOPERATIVE AGREEMENTS

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements. These agreements assist Tribes in planning and negotiation activities; technical assistance, analysis and systems review are all part of those negotiation activities. IHS ALN's, Tribal technical advisors and financial expertise are required to successfully advance Tribes wanting to assume administration of their health systems. The budget supporting Planning and Negotiation Cooperative Agreements assist Tribes to secure expertise, and IHS to ensure staff are available to respond to technical assistance requests. There are two types of cooperative agreements to assist Tribes in attaining Self-Governance:

- The *Planning Cooperative Agreement* provides resources to Tribes entering into Title V compacts and to existing Self-Governance Tribes interested in assuming new or expanded PSFAs. Costs supported by the planning cooperative agreements includes legal and budgetary research, internal Tribal government planning, and organization preparation relating to the administration of health care programs. The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes or modifications are necessary to successfully support those PSFAs.
- The *Negotiation Cooperative Agreement* provides resources to Tribes to help defray the costs related to preparing for and conducting Self-Governance program negotiations. The design of the negotiation process: 1) enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs, 2) observes the government-to-government relationship between the United States and each Tribe, and 3) involves the active participation of both Tribal and IHS representatives, including the OTSG. These cooperative agreements provide funds to support Tribal and federal negotiation teams, who work together in good faith to enhance each Self-Governance agreements.

## Facilities

The Indian Health Service system is comprised of 46 hospitals (24 IHS operated, 22 Tribal) and 556 health centers, health stations, village clinics, and school health centers (85 IHS operated, 471 Tribal). At these facilities there were an estimated 40,494 inpatient admissions and 13.752 million outpatient visits in 2018.<sup>15</sup>

	HOSPITALS	HEALTH CENTERS	ALASKA VILLAGE CLINICS	HEALTH STATIONS	SCHOOL HEALTH CENTERS
IHS	24	50	N/A	24	11
Tribal	22	285	127	54	5

<sup>15</sup> Source: Indian Health Service. Fiscal Year 2021 Congressional Justification. See page CJ-279.

On average, IHS hospitals are 40 years of age, which is almost four times more than other U.S. hospitals with an average age of 10.6 years.<sup>16</sup> A 40 year old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized – about 52% – for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic, and outdated design which makes it difficult for the agency to deliver modern services.<sup>17</sup>

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.

<sup>16</sup> Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals (2015 ed., pp. 176-179): <https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/>

<sup>17</sup> *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. Indian Health Service. July 6, 2016. Accessed at [https://www.ihs.gov/newsroom/includes/themes/newihstheme/display\\_objects/documents/RepCong\\_2016/IHSRTC\\_on\\_FacilitiesNeedsAssessmentReport.pdf](https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf) on November 7, 2016. p. 12

At current rates of funding, if a new facility was built today, it would not be replaced for 400 years! 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 non-compliance, 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 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).<sup>18</sup> "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

<sup>18</sup> Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011.

totaling approximately \$166 million.”<sup>19</sup> In fact, more than 1/3 of all IHS hospitals deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.<sup>20</sup>

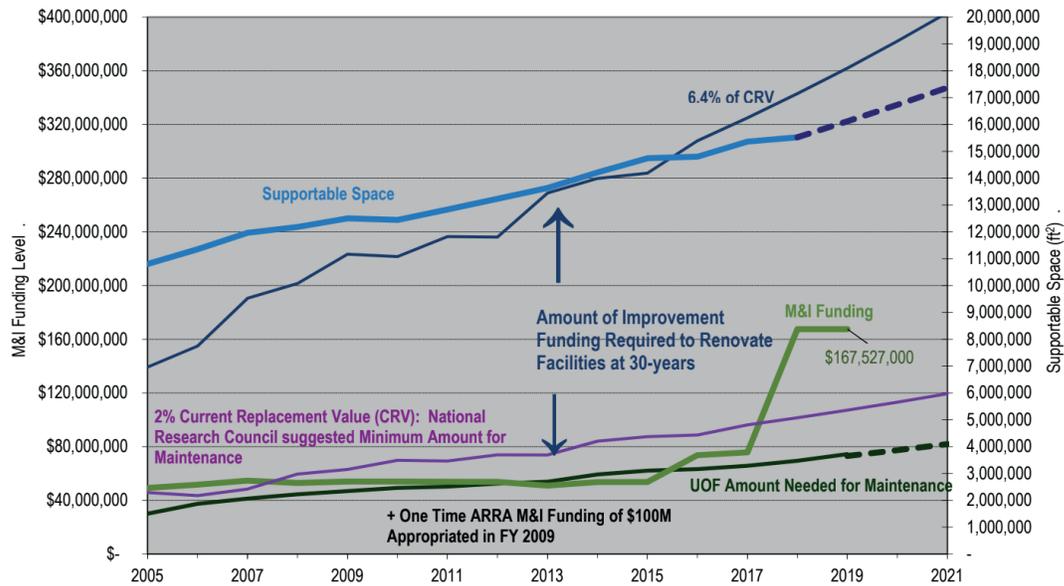
For many AI/AN communities, these failing facilities are the only option that patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere. As several Tribal leaders have testified, all our patients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

**MAINTENANCE & IMPROVEMENT  
+\$152.8 MILLION**

The recommended program increase for Maintenance and Improvement (M&I) is \$152.8 million above the FY 2021 Workgroup Recommendation, including an additional \$9.6 million to account for medical inflation and population growth, for total funding \$478.9 million. M&I funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. Investing in current facilities infrastructure is a critical need within the Indian Health Delivery system. Allowing the continued deterioration of critical health facilities goes against the mission of the Indian Health Service and Tribes to provide quality healthcare to all Tribal citizens. The Indian Health Service Facilities Appropriations Advisory Board (FAAB) provided the following data on the M&I program in the Facilities Appropriations Information Report dated March 7, 2019:

<sup>19</sup> Ibid, p. 14.  
<sup>20</sup> Ibid, 15.

Maintenance and Improvement Appropriations



Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The M&I program funding is distributed through a formula allocation methodology.

The FY-2019 Maintenance and Improvement (M&I) funding is \$167.5 million which is a 121% increase from 2017. From 2007 to 2015, M&I appropriations remained flat at about \$53 million annually. Consequently the annual M&I funding was less than the amount needed for Preventive, Routine and Non-routine Maintenance from 2011-2015. By 2015, M&I funding was only about 80% of the amount required to properly maintain the existing facilities. The backlog of deferred maintenance is about \$650 million, which if unaddressed could cost significantly more if systems fail.<sup>44</sup> Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards. The table below show the activities that use M&I funding along with an estimate of need predicated upon facilities being renovated at 30-years of life and replaced at 60-years of age.

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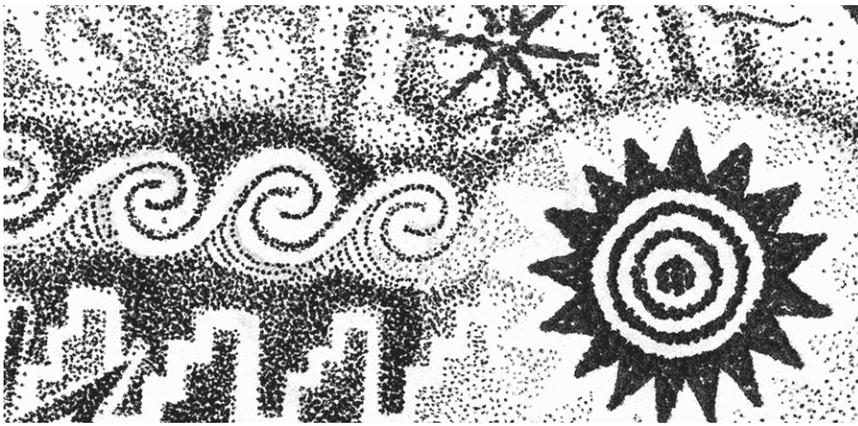
Maintenance and Improvement (M&I)	M&I Annual Need*
Actual M&I Appropriation ~2.8% of "Current Replacement Value" (CRV) or ~\$167 million annually M&I Funding is intended to cover:	~6.4% of CRV = UPF+1/5 BEMAR +Improvements = \$355 million annually
<b>Improvements:</b> Renovations; Alterations; upgrades/replacement of primary mechanical, electrical, or other building systems; and site improvements. Improvements increase the facility's useful life and are capitalized in accordance with the accounting principles.	Assumes Major Renovation at 30 years or ~3.0% of CRV ~\$180 million
<b>Deferred Maintenance:</b> Maintenance not performed as scheduled and delayed to a future period. The Backlog of Essential Maintenance Alteration and Repair (BEMAR) deficiencies deferred because of a lack of staffing or funds to implement corrective measures.	Assumes 5-year BEMAR Cycle 1/5 BEMAR of ~2.2% of CRV ~\$130 million
<b>Non-Routine Maintenance:</b> Unscheduled emergency work to restore services or remove problems that could interrupt services. <b>Routine Maintenance:</b> Curative work to restore or repair systems that fail due to action of the elements, fire, storm or other disasters, or use near to or beyond the expected useful life. <b>Preventive Maintenance (PM):</b> Scheduled work to preserve/restore facility (inspect, lubricate, replace components, paint, etc.).	University of Oklahoma Formula (UOF) = ~1.3% of CRV ~\$75 million
M&I Funding is also used for: <ul style="list-style-type: none"> <li>• Maintaining compliance with accreditation standards of the Joint Commission or other accreditation bodies;</li> <li>• Ensuring that health care facilities meet building codes and standards;</li> <li>• Environmental compliance including audits, remediation, and improving energy and water efficiency;</li> <li>• Demolition of vacant, excess, or obsolete federally-owned buildings; and</li> <li>• Executive Orders and public laws, e.g., energy conservation, seismic, environmental, accessibility, and security.</li> </ul>	
* Based on Major Facility Renovation at 30 years, a 60-year facility replacement cycle and 5-year BEMAR Cycle.	

The average age of IHS healthcare facilities is ~40 years with only limited recapitalization in the plant. The average age, including recapitalization and reinvestment, of U.S. private sector hospitals is approximately 10 years. Maintenance costs increase as facilities and systems age. Available funding levels are impacted by:

- Age and condition of equipment may necessitate more repairs and/or replacement;
- Lessened availability of service/repair parts for aging equipment and limited vendor pool in remote locations;
- Increases in supportable space. Between 2011 and 2015, supportable space increased 3.5 percent per year;
- Increased costs due to remote locations;
- Costs associated with correcting accreditation-related deficiencies;
- Increasing regulatory and/or executive order requirements; and

- Environmental conditions impacting equipment efficiency and life

The FY 2022 Tribal M&I budget request will bring Tribes closer to addressing critical backlog, and will support maintenance and improvement objectives including routine maintenance as well as ensuring compliance with accreditation standards of The Joint Commission (TJC) or other applicable accreditation bodies. Investments that improve the patient outcomes, increase access, and reduce operating costs are proven to be cost-effective.



### **SANITATION FACILITIES CONSTRUCTION +\$114.5 MILLION**

Tribal Leaders continue to prioritize environmental health concerns and request a \$114.5 million program increase for the IHS Sanitation Facilities Construction (SFC) line item in FY 2022, including an additional \$11 million to account for federal pay, medical inflation, and population growth, to a total funding amount of \$413.7 million. As with other infrastructure issues in Tribal communities, the need to complete sanitation projects is great. The IHS Facilities Appropriations Report (March 7, 2019) which provided to the Tribal Facilities Appropriations Advisory Board, identifies that the nationwide sanitation deficiency in 2019, now totals approximately \$2.7 billion and severely affects Alaska Area, Navajo Area, Great Plains Area and the California Area. In fact, all IHS Areas reported high numbers of homes that require sanitation improvements. With sufficient resources for the SFC line item aids the prevention of communicable and environmentally related diseases such as pneumonia, influenza, and respiratory syncytial virus by providing for these basic necessities:

- Water, Wastewater and Solid Waste Facilities for existing AI/AN homes and/or communities
- Water, Wastewater and Solid Waste Facilities for newly identified AI/AN Tribal housing projects
- Special or Emergency Projects.

Projects are cooperatively developed with and transferred to Tribes, which in turn assume responsibility for the operation of safe water, wastewater, and solid waste systems, and related support facilities. Tribes have to seek funding through other sources, such as the U.S. Department of Agriculture's Water and Environmental Programs (WEP) to fund technical, managerial and financial capacity for water, wastewater and solid waste management. In addition, funding for tribally led water/waste water operator certification and training is

principally funded by the HHS-ACF-OCS Community Services Block Grant Rural Community Development (RCD) program through the U.S. Department of Health and Human Services. Without the combined resources of IHS and these agencies, access to safe drinking water and vital public health services, in many Tribal communities would not be met. The TBFWG is concerned that the President's FY 2021 budget has zeroed-out the RCD program. The human health and economic well-being of low-income rural Tribal communities throughout the nation are directly dependent on the services funded by the RCD program. At minimum, the RCD program must be restored to \$11.0 million.

### **EQUIPMENT: +\$44.4 MILLION**

Another top priority of the Tribal Leaders is a program increase of \$44 million for the IHS Equipment line item to a total funding amount of \$99.1 million. This number represents the necessary funding to address critical medical equipment needs at health facilities managed by the IHS and Tribes, including enhancements at small ambulatory facilities that will be preparing to open in FY 2022. Funding the Equipment line item is essential to maintain quality medical care by insuring the routine replacement and repair of medical equipment at the 1,500 federally and tribally operated health care facilities currently managing approximately 90,000 biomedical devices. These consist of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately \$500 million. Like any medical system in this country, resources are required to repair or replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment. This will enhance speed and accuracy of diagnosis and treatment and reduce referrals to the private sector. Because the average useful life of medical equipment is approximately 6 to 8 years,

IHS would require approximately \$80 million annually. In the United States, a facility's annual medical equipment maintenance costs should be between 5% and 10% of medical equipment inventory value, which would equate to \$25 to \$50 million annually for the IHS. This fund also supports transfer of excess Department of Defense medical equipment (TRANSAM) to IHS/Tribal programs, replaces ambulances, and provides equipment funding for Tribal facilities constructed with non-IHS funding. Despite the link to quality care, the FY 2022 IHS Budget Request seeks to cut the Equipment line item by \$4.19 million, reducing it to \$23.8 million.

### **FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT: +\$6.49 MILLION**

The TBFWG requests a program increase of just under \$6.5 million for the Facilities and Environmental Health Support (FEHS) budget line item to a total funding level of \$295.9 million for FY 2022. The FEHS provides essential staff that supports IHS Headquarters, Area Offices, and Service Unit activities, and also provides advisement to Tribes. These essential activities include:

- Operating and managing facility and staff quarters' construction
- Technical advisement on environmental health services, injury prevention and environmental health/sanitation facilities construction
- Conducting the responsibilities of the Office of Environmental Health & Engineering (OEHE), which encompasses IHS headquarters and engineering services staff and the management of facilities appropriation services and activities.

The role of IHS Environmental Health program is to deliver a comprehensive, national and community- evidence-based program, which has 5 focus areas: Children's environment, Safe drinking water, Vector-borne and communicable disease, Food safety, and Healthy homes. They work hard to identify environmental health hazards and risk factors in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, Tribal staff and work with tribal councils to provide advisement on the applicable governance strategies that keep people safe.

### **HEALTHCARE FACILITIES CONSTRUCTION +\$152.39 MILLION**

The National Budget Formulation Workgroup recommends a program increase of \$152.399 million over the FY 2021 Workgroup Recommendation, including an additional \$109.4 million for medical inflation, population growth, and binding obligations related to the Health Care Facilities Construction (HCFC) Priorities List for a total funding level of \$729.4 million for FY 2022. Currently, IHS uses its HCFC appropriations to fund projects off the "grandfathered" HCFC priority list until it is fully funded. As noted in the section of this report titled, "Binding Obligations," in 1989, Congress directed IHS to develop the current HCFC priority system. Originally there were 27 projects on the priority list. There are 12 remaining projects on the list which are currently estimated to cost \$2 billion. Once those projects are funded, IHS is required to implement a new priority system which is outlined in the Indian Health Care Improvement Act of 2010. It requires each IHS Area to generate an updated priority list every three years for a combined submission of top Area priorities to the U.S. Congress. Priority lists may now include, in addition to inpatient and outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and other health related renovation and expansion projects. Not later than one year after the establishment of the new priority system, criteria for ranking or prioritizing facilities other than hospitals or clinics will be submitted to Congress for consideration. The law also allows the development of innovative approaches to address the unmet need for health facility construction and authorizes that a portion of construction funding may be used as an *Area Distribution Fund* to each IHS Area.

It is envisioned by the National Budget Formulation Workgroup that the recommended program increase may support other projects, such as Small Ambulatory Health Clinics and Health Stations, the Joint Venture Construction Program and innovative approaches that are developed in consultation with Tribes and in accordance with the policy to confer with urban Indian organizations. Many of the existing facilities are obsolete with an average age of 47 years and have long surpassed their useful lives. These facilities are grossly undersized for the identified user populations, which has created crowded conditions for staff, patients, and visitors. In many cases, existing services have been relocated outside the main



health facility; often times to modular units, in order to provide additional space for primary health care services. These conditions create difficulties for staff and patients, increases wait times, and inefficiencies within the health care system become problematic.

As the existing health care facilities age, associated building equipment and components are also deteriorating to a point of failure and the decreasing availability of replacement parts on aged equipment disrupt health care service delivery. For example, water supply systems which provide potable water to older health facilities frequently experience failures, requiring the systems to be shut down for extended periods of time. This often results in patient care to be discontinued until appropriate repairs can be made. The rural and often isolated conditions associated with many health facilities complicate and extend the time required to make needed repairs. Constant system failures deplete maintenance and improvement funds and sometimes require the use of third party collections or other funding sources that would otherwise be used for direct patient care. In terms of medical and laboratory equipment, the IHS makes every attempt to keep pace with changing and updated technologies; however, due to limited equipment funds, IHS health facilities will typically use equipment well beyond their expected useful life. The construction of new health care facilities alleviates many of the problems associated with the failing infrastructure.

#### **FACILITIES APPROPRIATIONS ADVISORY BOARD (FAAB) ADVISEMENT**

Tribal leaders participate on the IHS Facilities Appropriations Advisory Board (FAAB) to study the policies, procedures, and funding recommendations related

to facilities issues. This assures that the methodologies utilized to determine the requested funds are accurate for needed infrastructure improvement in Indian country. The FAAB transmitted advisement to the National Budget Formulation Workgroup on March 14-15, 2019 and included a Facilities Appropriations Information Package so that Tribal Leaders representing all 12 IHS Areas would have up to date information on all of the programs funded through IHS Facilities Appropriations - Maintenance and Improvement, Sanitation Facilities Construction, Health Care Facilities Construction, Facilities and Environmental Health Support and Equipment.

In summary the FAAB specified the following in terms of Health Care Facilities Construction (HCFC):

- The current rate of HCFC appropriations (~\$240 million/year), a new facility in 2019 would not be replaced for 250 years.<sup>21</sup>
- To replace IHS facilities every 60 years (twice a 30 year design life), would need HCFC appropriations of ~\$700 million/annually.<sup>22</sup>
- IHS would need HCFC appropriations of ~\$750 million/annually to match the U.S. expenditures in health-care facility construction.<sup>23</sup>

<sup>21</sup> IHS. Facilities Appropriations Information Report (Package). March 7, 2019. p. 3.

<sup>22</sup> Ibid

<sup>23</sup> Ibid



- Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable. As noted in the 2016 Facility Needs Assessment Report.<sup>24</sup>

### **FACILITIES & ENVIRONMENT SUPPORT +\$6.49 MILLION**

The TBFWG requests an additional \$6.49 million for the Facilities and Environmental Health Support (FEHS) budget line item for a total of \$295.9 million. The FEHS provides resources to staff and support its headquarters, regional, area, district, and service unit activities. These activities include Facilities Support, Environmental Support and Office of Environmental Health & Engineering (OEHE) Support. Facilities support include operations and management staff for facilities and staff quarter and construction management support. Environmental Health Support provides staff and operating costs for environmental health service, injury prevention, institutional environmental health and sanitation facilities construction staffing. OEHE support includes IHS headquarters staff, engineering services staff and direct support and management of overall facilities appropriation services and activities.

The IHS delivers a comprehensive, national and community-based and evidence-based Environmental Health program which has 5 focus areas: Children’s environment,

Safe drinking water, Vector-borne and communicable disease, Food safety, and Healthy homes. They work hard to identify environmental health hazards and risk factors in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, Tribal, and community members.

<sup>24</sup> DHHS, IHS. The 2016 Indian Health Service and Tribal health Care Facilities’ Needs Assessment Report to Congress. June 2016. Accessed on October 6, 2016 at [https://www.ihs.gov/newsroom/includes/themes/newihstheme/display\\_objects/documents/RepCong\\_2016/IHSRTC\\_on\\_FacilitiesNeedsAssessmentReport.pfd](https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pfd)

# 3rd Recommendation

## Support the Preservation of Medicaid, the Indian Health Care Improvement Act and Other Indian-Specific Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)

More than 40 years ago, Congress 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.”

The Indian Health Care Improvement Act’s (IHICIA’s) enactment and permanent authorization in 2010 protects the future of Indian health and also secures a solid foundation for Tribes, Tribal organizations and Urban Indian Organizations (UIOs) to see that authorized programs and services become realized. Indian Country continues to advocate Congress for accompanying appropriations while engaging with IHS to ensure that the agency’s budget reflects Tribal priorities. In renewing the IHICIA, 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.”

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 2021 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 Tribes 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 the IHS and Tribal Health programs.

Also, important existing Tribal protections in the Medicaid program must be preserved. These include:

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Purchase and Referred (PRC) is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under PRC.
- If an AI/AN elects to enroll in a Managed Care Organization (MCO), they are allowed to designate an Indian health care provider as their primary care provider if in-network.
- A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as “resources” for purposes of determining Medicaid eligibility for AI/ANs.
- Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery.
- An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider.

## **INDIAN HEALTHCARE IMPROVEMENT ACT IMPLEMENTATION AND PRESERVATION**

The IHCIA provides a wealth of resources and opportunities for Tribal health care institutions, families, providers and patients. Tribes worked collaboratively with Congress to develop legislation that included impactful and bipartisan reforms. Provisions included in the IHCIA are the result of years of negotiations, meetings and strategy sessions. The permanent reauthorization of the IHCIA safeguards the resources of the Indian health care system and has re-ignited hope the of quality health care delivery.

Despite efforts to augment funding through third party revenue, the IHS remains a vastly underfunded foundation of the I/T/U health system - representing yet another broken promise to Indian Country. Mainstream America increases its healthcare focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and more recently, modernizing its Health Information Technology infrastructure. Supporting these improvements for Tribes in the IHCIA and other Indian-specific provisions is critical.

Tribes have worked tirelessly for over a decade to renew IHCIA and it remains critical for Congress and the Administration to ensure that the full intentions of the law are realized. To provide context for how much of the law has not been implemented, the following represents several categories of programs that have not been implemented and funded, though authorized by IHCIA:

### **1. HEALTH AND MANPOWER –**

*Includes:* Continue to support Community Health Representatives despite the President’s recommendation to transition to Community Health Aide Program (support both programs); demonstration programs for chronic health professions shortages

### **2. HEALTH SERVICES –**

*Includes:* authorization of dialysis programs; authorization hospice care, long term care, and home / community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment an office of men’s health.

### **3. HEALTH FACILITIES –**

*Includes:* demonstration program with at least 3 mobile health station projects; demonstration projects to test new models/ means of health care delivery

### **4. ACCESS TO HEALTH SERVICES –**

*Includes:* Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs

### **5. URBAN INDIANS –**

*Includes:* funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health

### **6. BEHAVIORAL HEALTH –**

Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants to for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides

### **7. MISCELLANEOUS –**

*Includes:* Provision that North and South Dakota shall be designed as a contract health service delivery area

Clearly, a plan must be put in place to ensure that the intended outcomes of this law are actually realized. It is critical that additional funds are allocated so the full implementation of these programs can continue without compromising other critically needed services. We urge the Administration to add appropriations to the FY 2022 request so that the dream of the IHCIA can finally become a reality.

Furthermore, any rulings by the courts on the unconstitutionality of the ACA must sever the Indian Health Care Improvement Act and certain Indian-Specific provisions in the ACA that are of critical importance to the delivery of health services to Indian country, from the larger ACA. These Indian health provisions have a separate purpose and genesis from the larger ACA and should remain in effect.

# 4th Recommendation

## Fund Critical Infrastructure Improvements Which Impact Patient Care

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IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record and more than 100 applications. A properly resourced IHS HIT program directly supports better ways to: 1) care for patients; 2) pay providers; 3) coordinate referral services; 4) recover costs; and 5) support clinical decision-making and reporting, resulting in better care, efficient spending, and healthier communities.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. Thankfully, the FY 2020 enacted budget included \$8 million for a new electronic health record (EHR) line item in the IHS Services Account. TBFWG also has recommended a meaningful investment into the IHS HIT system to address the impact of the Veterans Health Administration (VHA) recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. In preparation for future modernization, the Department of Health and Human Services (HHS) and IHS evaluated the current electronic health record system, the Resource and Patient Management System (RPMS) and, based on the evaluation, developed the *Roadmap* Report

to guide modernization efforts over the next five years. The *Roadmap* Report lays out a number of opportunities for FYs 20-22, including establishment of a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection and procurement, implementation planning, and testing.

TBFWG acknowledges and fully supports the efforts outlined in the *Roadmap* Report and appreciates the President's FY 2021 request of \$117 million to build on the FY 2019 successes. However, Tribes are very concerned that a more accelerated funding strategy is critical to appropriately and realistically advance the \$3 billion investment which will be needed to allow IHS to either update the current EHR & RPMS suite or initiate an alternatives analysis similar to the VHA. Therefore, TBFWG maintains its recommendation for a separate HIT budget line item investment to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients.

An adequately-resourced IHS Health Information Technology (HIT) program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY22 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment.

# 5th Recommendation

## Advocate that Tribes and Tribal Programs be Permanently Exempt from Sequestration

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In FY 2013, Indian health programs were subject to a 5.1 % automatic, across the board cut. This means a staggering \$220 million left the IHS, which is already severely underfunded. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS direct service programs were left with an impossible choice – either deny services or subsidize the federal trust responsibility. In fact, many did close their doors for several days per month and forced others to deliver only PRC for Priority I. The Indian Health Service is one of only four federally funded services providing direct patient care; however, it was the only one of the four not exempted from sequestration. This oversight, which created an unsafe hardship

for Indian patients seeking care, must be permanently corrected.

While the Bipartisan Budget Act of 2019 (P.L. 116-37) ended discretionary sequestration through FY 2021, it did not include a permanent exemption for IHS. In short, Indian health simply cannot take any more sequestration cuts.

The Workgroup strongly encourages the Administration to work with Congress to ensure that Tribes do not find themselves in this situation again, and that the FY 2022 budget reflect that by including a request to permanently exempt the IHS from sequestration.

# 6th Recommendation

## Support Advance Appropriations for the Indian Health Service

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Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies Appropriations bill, which contains the funding for the Indian Health Service, has been enacted by the beginning of the fiscal year. The belated enactment of a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011). These delays make it very difficult for Tribal health providers and IHS to adequately address the health needs of American Indians and Alaska Natives. According to the Government Accountability office (GAO): “uncertainty resulting from recurring [continuing resolutions] and from government shutdowns has led to adverse financial effects on tribes and their health care programs” (GAO-18-652). The GAO shows that because of that uncertainty in funding, IHS and Tribal providers have significant challenges recruiting and retaining health providers and Tribes are given significant administrative burdens due to the fact that the IHS has to modify hundreds of contracts each time there is a continuing resolution.

The 35-day partial government shutdown at the start of 2019 had a devastating impact the Indian health system. Tribes throughout the country reported rationed care, reduced services, and some facilities closed altogether. This reckless shutdown destabilized Native health delivery and health care provider access; as well as Tribal Governments, families, children and individuals. With the further likelihood of shutdowns and delayed federal appropriations, Tribes firmly believe that advance appropriations for IHS will allow for greater planning, more efficient spending, and higher quality care for American Indian and AI/AN patients.

An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. 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. Advance appropriations for IHS would support the ongoing treatment of patients without the worry of 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.

Advance appropriations would allow Indian health providers to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when Congressional decisions funnel down to the local level.

As in past years, the TBFWG continues to request that the Administration support Advance Appropriations for IHS in its FY 2022 Budget Request.

# 7th Recommendation

**Allow federally-operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds flexibly across accounts at the local level**

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Our seventh request supports flexibility for federally-operated health facilities and IHS headquarters to have the authority to adjust programmatic funds across accounts. This will maximize efficiency and effective use of federal dollars at the local level. Local control means that resources will be addressed by need, instead of priorities that might not be relevant to immediate health issues. Current appropriations law often creates a barrier for the IHS to fully utilize authorized annual funding. For Fiscal Years 2019 and 2020, the IHS was granted two-year authority to obligate/re-obligate funding, which has

provided some needed flexibility to fully and efficiently utilize its appropriation. However, additional flexibility is still needed to allow IHS ability to reprogram funding if savings are achieved in one fund. For example, programs such as Purchased/Referred Care are severely lacking funds to meet critical health needs, and services are often denied due to lack of funding. Such programs can benefit from reallocation of savings to provide additional health services. It is requested that IHS be granted greater budget flexibility to reprogram funding to meet health service delivery priorities, in consultation with Tribes.

# 8th Recommendation

## Support funding of Tribes outside of a grant-based system

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The health needs of Indian people are chronic and multi-faceted; such needs deserve to be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes may receive awards and benefit from somewhat consistent increases, while other Tribes do not. This creates two categories of Tribes – those that have obtained technical experience and financial resources to secure competitive awards, and those that do not. There are many Tribes without the capacity to secure competitive grant funding who and do not benefit from increases to appropriations as a result. There are too many restriction and requirements to federal grants in terms of reporting, limitations on use of funds, and timelines detract from patient care. Burdensome federal requirements also creates additional administrative burden for receiving Tribes. Ironically, Contract Support Costs (CSC), the administrative funds obligated in addition to direct base funding, are not provided to manage grant awards. Only indirect costs are allowed with grant funds and must be subtracted from the total grant award, causing far less funding for the actual provision of health services. Grant programs counteract the relationship between Tribal Nations and Tribes and does not uphold the federal trust responsibility.

### *IHS should never use a grant program to fund ongoing critical Indian Health needs*

About \$60 Million of the Behavioral Health budget (Mental Health and Alcohol & Substance Abuse

Programs) has been dedicated to special “set-aside” grant programs and initiatives rather than increases to existing Behavioral Health programs. The two main grant programs created targeted prevention of domestic violence and methamphetamine/suicide, and not all I/T/Us received grant awards. While worthy causes, the IHS needs to prioritize flexible, recurring base funds because grants bind funds to specific “hot topic” diseases or issues. This does not bode well for the many chronic diseases from which AI/ANs disproportionately suffer. For example, a large focus on the methamphetamine epidemic a decade ago may have distracted from the epidemic in pain medicine abuse, thus contributing to the opioid crisis across Indian Country today. Even though one IHS Area or community may struggle most with opioid addiction, others continue to fight alcohol and methamphetamine addictions; yet, under the grant making process, tribes cannot redesign the available programs and services to meet community needs.

Funding for ongoing health services in FY 2022 should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. Across Indian Country, the high incidence of chronic health conditions like heart disease, suicide, cancer, substance abuse, diabetes, and cirrhosis is well documented. Grants used to address any Indian health issue limits funding for and restricts access to culturally appropriate care.

# 9th Recommendation

## **Permanently Reauthorize the Special Diabetes Program for Indians and increase funding to \$200 million per year, plus annual inflationary increases, and the option for Tribes to receive funds through 638 contracts and compacts**

The Workgroup recommends that the Administration propose permanent enactment of the Special Diabetes Program for Indians (SDPI). In recent years, the highly successful program has only been renewed in short 1-2 year increments (and in 2017-18 just a few months!). In fact, since September 30, 2019, SDPI has gone through four short-term extensions of several weeks to several months. This has created significant disruption for the program, and led to programs losing providers, curtailing services, delaying launches of new initiatives, and also delaying purchases of necessary medical equipment. This creates instability in the program, to the detriment of staff recruitment and retention, long-term planning, and overall effectiveness. The current authorization expires on November 30, 2020. In addition, SDPI has not received an increase in funding since FY 2004 which means the program has effectively lost over a third of its buying power over the last 15 years due to medical inflation and the significantly increased costs of diabetes care. Any renewal or permanent enactment should ensure that inflation is built into final funding levels.

Few programs are as successful as SDPI at addressing chronic illness and risk factors related to diabetes, obesity, and physical activity. SDPI has proven itself effective, especially in declining incidence of diabetes-related kidney

disease. A 2019 report from the Assistance Secretary for Preparedness and Response (ASPR) found that SDPI saves up to \$52 million per year in Medicare expenditures. The incidence of end-stage renal disease (ESRD) due to diabetes in American Indians and Alaska Natives has fallen by 54% - a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost \$90,000 per patient, per year, so this reduction in new cases of ESRD translates into significant cost savings for Medicare, the Indian Health Service, and third party payers. We believe that permanent enactment of SDPI is a common-sense approach.

SDPI has had positive clinical and community outcomes, including: the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2010 and has held steady at this improved average for 7 years; the average LDL (“bad” cholesterol) declined from 118 mg/dL in 1998 to 95 mg/dL in 2010; and more than 80% of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities and serves for AI/AN children and youth.

Permanent reauthorization of SDPI is a common-sense approach that will support a highly successful program.

# Conclusion

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The social determinants of health and poor health status of health and poor health status for AI/ANs could be dramatically improved with adequate investment into the health, public health and health delivery systems in Indian Country. Tribes are grateful for the recent incremental increases to the IHS Appropriation over the last several years. We have increasing concerns however that the failure to fulfill the full Trust and Treaty obligations cannot be met with significant investment in infrastructure including equipment, buildings and technology. Additionally, that funding for program costs are needed, including staffing capacity, in order have a real impact on improving health outcomes. Increases in the IHS annual appropriated budget since FY 2008 have not been sufficient enough to even cover costs associated with medical and non-medical inflation. Increases have barely kept pace with population growth and the rightful full funding of Contract Support Costs. Funding must be identified to actually realize marked improvements in health outcomes and to build public health infrastructure for all AI/ANs.

This budget proposes a 40% increase in the total IHS budget for FY 2022. Fiscal trends confirm that this level of investment is critical if we are to restore the health of our people and wellness of our reservations and villages. Our history includes countless federal policies which have sought to destroy Native communities. The devastating health effects of these policies are seen today in both large and small ways. The 35-day government shutdown is only the most recent example. This reckless political decision

– over completely unrelated political partisan squabbles – destabilized Native communities and health systems. Yet again, the First Peoples of this pro-claimed great nation became casualties of a destructive federal decision.

The TBFWG implores the Administration to work with Congress in FY 2022 to enact a serious investment in Indian health that will honor and fulfill the promises made to our ancestors. One important first action is to support the enactment of Advance Appropriations for IHS. This will reaffirm that the government is committed to eliminating disruption to the IHS health delivery system, no matter what delays in the discretionary appropriations budget might occur. Advance appropriations is a common sense solution that will not place undue burden on the federal budget, but create greater sustainability for Tribal communities.

As important, and as noted multiple times in this document, the Administration must put in place a strategy to support stable and full funding for the IHS through any and all available means. Medicaid and other payer resources, for example, were used by many IHS and Tribally operated health systems to cover essential costs during the recent government shutdown. It is critical that the Administration honor the trust responsibility through permitting IHS and Tribal facilities to access to the Medicaid program; allowing states to tailor their benefit plans and requirements to fit unique Indian needs will ensure that Medicaid works in Indian Country. Work



requirements, block grants and other barriers to AI/AN enrollment do not reduce federal costs; they only revert the burden of these incurred expenses on the already under-funded IHS budget. Similarly, competitive grant programs are inefficient and lead to less available funding for programming by imposing administrative burdens over and above program costs. In many cases, grants do not reach the communities that need them the most and only advantage areas where administrative resources are available to research and apply for them.

The Indian Health Service budget represents a sacred promise made between these United States and our ancestors to fulfill the trust and treaty obligation to provide healthcare services to all American Indians and Alaska Natives. Time and again, Congress and the courts have affirmed this federal trust responsibility. This Administration must take actionable steps to fulfill this promise by putting forward a true and impactful budget proposal. Our proud Nations continue to suffer from preventable or treatable diseases and our citizens die younger than other Americans. This hidden truth must be addressed quickly and in a meaningful way. Failure to apportion an adequate level of funding for health services and programs within the Indian Health Service, as well as continued failure to investment in Tribal Public Health systems and basic health system infrastructure, are the primary reason for these unconscionable and avoidable health disparities. This document reflects the AI/AN Tribal budget priorities for this Administration to

consider as it formulates the FY 2022 budget request. We believe that it provides a clear roadmap to make meaningful progress toward satisfying fulfillment of the agreement made by the United States, as our federal trustee, to provide quality health care to the 574 federally recognized Tribes in America.

The National Tribal Budget Formulation Workgroup, representing 574 sovereign Tribes, strongly believe that it will take a concerted bipartisan effort to put forward a national budget plan to rise above the failed policies which have held our nation captive to third world health conditions. Our antiquated system is a barrier to our ability to reclaim Tribal Health and eliminate decades of preventable health deficiencies. The Tribal Budget Formulation Workgroup members are ready to work collaboratively with the strength of our government-to-government relationships, to achieve real progress to finally eliminate unacceptable health disparities suffered by Tribal citizens. It is imperative that a budget which proposes full funding of a minimum \$48 billion be made a priority under this Administration. Doing so will result in a strong and sustainable Indian health system which can effectively respond to public health threats and finally create wellness in all American Indian and Alaska Native nations. Doing so will raise this great nation above past failed Indian policies and for the first time fulfill Treaty and Trust obligations to Tribal Nations. We stand ready to help make this dream a reality.

# Acknowledgements

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**Special thanks to all IHS Staff,  
especially the IHS Budget  
Formulation staff, for assistance  
in preparation of this document.**

# Area Reports

Hot Issues by IHS Service Area



# ALASKA

## BUDGET INCREASES

### 1. ALL BUDGET LINES CURRENT SERVICES (PAY ACT COST, INFLATION, POPULATION GROWTH) AND BINDING OBLIGATIONS

The United States has a federal trust responsibility and legal obligation to provide services and resources in order to deliver health care to Alaska Native and American Indian (AN/AI) people. This legal and moral duty includes the responsibility to maintain the current levels of health care that were previously funded in past years' budgets and binding obligations like new facility staffing, contract support costs, and facility costs (105(l) leases and village-based clinics) to support the delivery of health care. Unfortunately, the severe and chronic underfunding of the Indian Health Service (IHS) has failed to adequately meet the needs of fulfilling the federal trust responsibility and has resulted in significant loss of purchasing power. This has resulted in a deteriorating infrastructure and underfunding of critical programs and services. As such Alaskan Tribal Leaders and Representatives assert that the IHS Current Services and Binding Obligations must be preserved with increases to ensure no loss of services, the maintaining of current programs, and to preserve and improve the current state health infrastructure.

#### 105(l) Lease Cost Agreements

The Maniilaq case<sup>25</sup>, establishes that section 105(l) of the Indian Self-Determination and Education Assistance Act (ISDEAA) requires IHS to enter into a lease for a facility owned or leased by the tribe or tribal organization. IHS must compensate the tribe or tribal organization fully for its reasonable facility expenses. In order to properly respond to this legal and binding obligation, Alaska tribes recommend that a separate, indefinite discretionary appropriation for 105(l) leases be established, similar to that for contract support costs (CSC). This would ensure full funding of lease costs while protecting funding for other vital program increases in the IHS appropriation. An indefinite appropriation would also save IHS and Congress from the impossible task of identifying specific amounts needed in any given year to fully fund 105(l) leases. Section 105(l) lease costs have much in common with CSCs: the mandatory funding in statute, the difficulty in projecting the funding needs, and their central role in health program administration. We recommend that IHS request to Congress the use of language already used for CSC appropriations, "such sums as may be

necessary", to ensure that IHS can meet these binding obligations fully.

*Village Built Clinics:* The Alaska Area further recommends that Village Based Clinics (VBCs) be fully funded and separated from 105(l) lease funding. The Maniilaq case reasoning does not apply to VBCs, and the Alaska Area wants to ensure that the language in the current appropriations under Hospitals & Health Clinics stays in the appropriation for VBCs and only the 105(l) portion gets moved.

Note: To reflect this recommendation, Alaska inserted a new set of rows in our FY 2021 electronic workbook (starting on row 47, below Contract Support Costs) titled 105(l) Lease Cost Agreements. This illustrates that the treatment of 105(l) funding is consistent in manner in which CSC funding is requested and funded by Congress; and does not complete with program increases.

### 2. PARITY IN PROGRAMS

#### a. IHS Advance Appropriations

Most important, until an advanced appropriation bill is passed by Congress, the Alaska Area recommends that IHS continue to annually request from the Office of Management and Budget (OMB) an "exception apportionment" for full year funding for self-governance tribal programs in the (very likely) event of a continuing resolution.

The FY 2019 government shutdown, which affected the IHS, as well as historical reoccurring continuing resolutions significantly hamper IHS and tribal operations. The challenges associated with budgeting, compact negotiations, operations, recruitment, retention, provision of services, and particularly have adversely impacted facility maintenance and construction efforts. Providing sufficient, timely and predictable funding is needed to ensure the federal government meets its obligation to provide uninterrupted, safe health care for AN/AI Indian people.

Since FY 1998, appropriated funds for medical services and facilities through IHS have not been provided before the commencement of the new fiscal year except for only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, was enacted by the beginning of the fiscal year.

25 Maniilaq Ass'n v. Burwell, 170 F. Supp. 3d 243 (D.D.C. 2016).

In FY 2010, the Veterans Administration (VA) medical care programs achieved advance appropriations due to the impact on patient care when funds are not made available in a timely manner. The fact that Congress has implemented advance appropriations for the VA medical programs provides a compelling argument for tribes and tribal organizations to be given equivalent status with regard to IHS funding. Both systems provide direct medical care and both are the result of federal policies. Just as the veterans' groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of the VA to properly plan and manage its resources, so do tribes and tribal organizations who share similar concerns about the IHS health system.

We urge the IHS to work with the Administration and Congress to take the necessary steps for IHS funding to begin an advanced appropriation cycle so that tribal health care providers, as well as the IHS, can know what their next year's funding will be in advance and thereby better plan their budgets and administer their programs.

**b. Health IT:**

Across the Alaska Tribal Health System (ATHS), the use of Information Technology in maintenance of patient and provider records, as well as the actual delivery of health care services, is essential. Because of unique geographic challenges and the ATHS referral system, adequately functioning Health IT services are even more important. Providing adequate financial resources to carry out these functions is critical to the ATHS and will support IHS in moving away from the antiquated RPMS system to 21st century solutions including commercial off the shelf options. IHS needs to provide an accurate estimate of cost for the Administration and Congress to consider. Tribes are striving for parity between other federal agencies and departments, particularly the Department of Veterans Affairs in its endeavors to implement a new EHR system.

IHS added a new sub-line item for Electronic Health Record System. The Alaska Tribal Health System has dedicated millions of dollars of its own resources to support conversion from the RPMS system to commercial off the shelf systems. Any funds appropriated to a new sub-line item must also be available to Tribes and Tribal Health Organizations who have already converted off the RPMS system. This a parity adjustment and should not come from the proposed program increases detailed in item 3. Hospitals & Clinics through item 6. Sanitation Facilities Construction below.

**c. Hepatitis C Treatment**

The Veterans Affairs received additional resources for Hepatitis C and consequently implemented a program supported by funding and resources, resulting in VA clinicians being able to provide treatment for all their patients with HCV, whereas IHS clinicians cannot. AN/AI people deserve the same quality of care and the same level of resources as the VA, particularly since the IHS serves the population with the highest HCV-related mortality and highest incidence of acute HCV in the country.

IHS needs to work with the Administration and Congress to advocate for funds to build parity with the VA in addressing HCV and to ensure new HCV medications are available in the IHS' National Core Formulary. IHS needs to advocate for the elimination of HCV in the AN/AI population and support efforts to enhance prevention, screening, and treatment of HCV in all AN/AI communities.

**d. Best Treatment**

In FY 2019, Tribes and Tribal health organization in Alaska were initially excited when they were notified of "an opportunity to receive free HCV treatment for patients", that at closer look turned out to be an obsolete medication that was no longer best practice and would not have worked for over 99% of HCV patients in Alaska.

Treatment opportunities made available to IHS and Tribal programs should be on par with national best practices and on step with treatment modalities made available to the VA.

**PROGRAM AND SERVICES  
INCREASES: +\$ \$2.743251 B**

**3. HOSPITALS & HEALTH CLINICS +\$1.508788B**

**a. 105(l) Lease Cost Agreements**

Alaska Tribes have removed this item from the Hospitals and Health Clinics sub-line item as described under the Current Services and Binding Obligations section.

**b. Telehealth**

Telehealth remains a critical component in the delivery of care throughout the State of Alaska and is intricately paired with the CHAP program. The ATHS is a true system of care that provides services to over 177,000 AN/AIs and is comprised of:

- 180 small community primary care centers
- 25 sub-regional mid-level care centers
- 4 multi-physician health centers
- 6 regional hospitals
- Alaska Native Medical Center tertiary care

Telehealth increases local capacity to provide care and medical oversight. It reduces both the cost and stress of travel in medically underserved areas in a state that has one of the lowest rates of medical specialists in the United States, spans over 660,000 square miles, and where 80% of the communities are not on the road system. At times, weather prohibits flights in and out of rural communities. Being able to use telehealth and connect to physicians and specialists at larger clinics and hospitals has saved lives.

**c. Joint Venture Construction Program and Small Ambulatory Grants Program**

The IHS Joint Venture Construction Program (JVCP), a partnered effort between Tribes and IHS, and the Small Ambulatory Grant Program (SAP) have been cost-effective mechanisms to address the health care facilities shortage, separate from the IHS Facilities Construction Priority System. These programs have increased access to care in communities with dire health care needs. Alaska Tribes advocate for IHS to again announce new cycles for JVCP applications and SAP grants in FY 2022.

Alaska Tribes recommend allowing construction projects already started, that are being developed in accordance with IHS design /construction criteria. Similarly, the Alaska Area supports tribal efforts to expand existing facilities to meet the needs of their communities, and such proposals should not be penalized. This is especially relevant in Alaska where the construction season is extremely short, materials are extremely expensive, and must be shipped via barge, which might only arrive 1 or 2 times per year. For these reasons, Alaska Tribes must plan years in advance.

The Alaska Area urges the inclusion of dedicated behavioral health facilities in the JVCP solicitations, given the high priority of substance abuse issues and the need for residential treatment centers.

**d. CHAP training**

The shortage of available Community Health Aides and Practitioners (CHAPs) available to villages and other rural areas presents a significant risk to the health of Alaska Native people and the strength of the

ATHS. The CHAPs are the “backbone” of the Tribal health system, in many cases, the CHAPs are the only providers of care in their respective communities. When this care is not available, beneficiaries needing even the most routine care are forced to travel, at great personal and system expense, to regional hubs. Often times, the shortage of primary care results in symptoms going unaddressed and even minor maladies escalate to medical situations requiring far costlier treatments and procedures. Adequately funding CHAP training is an essential step in ensuring that communities have local healthcare providers and ensure the rest of the ATHS functions correctly.

The CHAP program has proven effective and efficient and as the program is considered for expansion to the Lower 48, Alaska Tribes and Tribal Health Organizations offer their support and expertise. As the CHAP program is supported by Congress and is being implemented nationally, additional funds are necessary for training and expansion. Building training capacity will be essential if the CHAP program is expanded nationally. IHS should plan accordingly and request the true need and ensure, as instructed by language in the FY 2020 Conference Report, that Alaska programs are not adversely impacted if new training centers are established.

**a. Staff Housing**

Recruitment of health professionals is greatly impeded by the lack of housing. In primary care, for example, housing availability was ranked fourth out of ten important issues in primary care physician retention.<sup>26</sup> In many Alaskan communities, there is no availability of staff housing. IHS needs to work with the Administration and Congress on addressing the shortage of staff housing and appropriating much needed funds separate from the IHS Health Care Facilities Construction Priority System. The current system is not addressing the need and funding for staff housing must be identified separate from the facilities priority system. Funding to maintain and replace the few existing houses has not been made available for the past 20-plus years. In addition, not all clinics offer permanent housing for providers or even temporary housing for visiting specialists or locum staff. Staff working in rural clinics often are required to sleep on cots, or on the floor, in sleeping bags or in some areas (if available) are placed in costly lodging options. This disrupts their ability to be well-rested and alert

<sup>26</sup> [https://academy.3rnet.org/uploads/2/6/8/3/26836754/3rnet\\_academy\\_session\\_7.pdf](https://academy.3rnet.org/uploads/2/6/8/3/26836754/3rnet_academy_session_7.pdf)



when providing routine and 24/7 on-call emergency patient care.

#### **4. DENTAL SERVICES +\$685.813 M**

Oral health is a leading health indicator going beyond the mouth, gums and teeth. Poor oral health is correlated with several chronic diseases including diabetes, heart disease, stroke, and is even associated with premature births and low birth weight. Frontier and rural communities in Alaska had limited options and infrastructure to provide dental services. This challenge has forced innovation, like the implementation of the Dental Health Aide Therapists program, an evidence-based model, that was initiated in the United States in Alaska. Supporting Dental Services and oral health is essential in protecting health.

#### **5. MAINTENANCE & IMPROVEMENT +\$274.325 M**

The facilities priority system backlog means that many tribes and tribal health programs must rely on aging facilities and clinics that are in dire need of improvement. With the average age of many Tribal facilities well beyond their anticipated and projected lifespan, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is compromised. In order to provide the level of care necessary to ensure a minimum standard of patient care, more resources need to be provided at the facility and clinic level.

#### **6. SANITATION FACILITIES CONSTRUCTION +\$274.325 M**

The provision of Indian sanitation facilities is a very important component of the overall effort required to achieve a reduction in waterborne disease outbreaks, a goal highlighted in Healthy People 2020 “Topics & Objectives” for Environmental Health. Safe drinking water supplies and adequate waste disposal facilities

are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people. The increases received in FY 2018 were a sorely needed infusion to address the gross disparity suffered by Alaska Natives and American Indians in having access to safe water and sanitation services.

Alaska has clinics (where temperatures can drop to -30 degrees or colder) that have instructions posted in out-houses on how to capture a urine sample. It is unfathomable in this day and age and with the vast wealth of this nation that we have communities suffering these developing world conditions. Furthermore, for the existing water and wastewater systems all over the state of Alaska and across the nation, many are failing or out of regulatory compliance. New methods and technology are being developed to address this problem, however, many tribal communities in the United States do not have a taxable land base to provide for such needed infrastructure necessary to promote public health, leading to increased risk of skin and respiratory infection and costly community outbreaks of communicable disease.

The IHS Sanitation Facilities Construction Program, an integral component of the IHS disease prevention activity, has carried out authorities since 1960 using funds appropriated for Sanitation Facilities Construction to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally related diseases have been dramatically reduced, by about 80 percent since 1973. IHS physicians and health professionals’ credit many of these health status improvements to IHS’ provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. There is still a considerable way to go to move the honey bucket into the museums, the flat funding in FY 2019 slows progress to realizing this objective.

# ALBUQUERQUE

The Albuquerque Area Service Units and Tribes highly recommend that current services and binding obligations be fully funded for the Indian Health Service. The lack of chronic underfunding by Congress has a direct negative impact on the health and welfare of Native Americans.

Increased funding will enable the IHS to meet their shared mission of raising the health status of Native Americans/ Alaska Natives. Additional funding would increase our capacity to enhance our patient-centered care model and patient/family/tribal engagement and partnership effort.

There continues to be a great need for comprehensive, culturally appropriate personal and public health services that are available and accessible to American Indians and Alaskan Native (AI/AN) people (IHS Strategic Goal #1).

## TOP RANKED BUDGET INCREASES:

### HOSPITAL & CLINICS

At the Taos Picuris Health Center, H & C is needed for support of current services and continued access to quality Health Care and to support Patient Center Medial Home (PCMH). The Health Center supports increased funding in Hospitals and Clinics to enhance equipment necessary for the community and the Emergency Response team to respond efficiently and appropriately.

The Jicarilla Apache Nation recommends that funding be provided to support the provision of MRI services in support of patients transported to and seen at the Jicarilla Service Unit Urgent Care. Offering this service to ambulatory patients will also provide them these services locally rather than travelling out of town. In addition, the community has a need to purchase defibrillators, AEDs and bleed kits to be located at various locations in the community. Having this equipment available at high patient traffic areas such as the administrative building will support training efforts being offered by the Jicarilla EMS staff. The onsite equipment will also assist with responding quickly to patients who require immediate access to this equipment. Currently, the Jicarilla EMS is called to respond to these scenarios and the risk of a delay to these emergency situations may occur depending on the location of the EMS unit within the community.

*I H S Strategic Plan: Goal 1. Reform, strengthen, and modernize the Nation's Healthcare System. 1.2 Expand*

*safe, high-quality healthcare options, and encourage innovation and competition. Goal 2. Objective 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

The Southern Colorado Ute Service Unit recommends an increase to Hospitals and Health Clinics (H&HC) to the IHS Budget in FY22. Because H&C is the least restrictive budgetary line item, an increase would result in the most good and assist in meeting the Mission of the Agency, along with the Goals and Priorities of the IHS Strategic Plan.

The Southern Ute and Ute Mountain Ute Tribes remain concerned about access to primary health care and specialty care for tribal members and all AI/AN. Funding for H&C across the Indian Health Service does not meet current need and IHS and tribal health care facilities require large supplementations from tribal funds and third party collections each year to operate. With proper funding the ability to provide in-house, direct care to patients for medical specialists, diabetes care, and cancer screening, diagnosis, and care increases resulting in improvements to the Government Performance and Results Act (GPRA) measures. In addition, many AI/AN must travel great distances to receive specialty health care. The burden on the individual is great and continuity of care suffers. With increased funding in H&HC, the direct access to specialty services and high quality health care increases, relieving the burden to patients and the tribe. Moreover, with an increase in funding to H&HC, the ability of the IHS to recruit highly qualified staff (people) also rises resulting in an innovative Indian Health System that promotes excellence and quality (IHS Strategic Goal #2). (see also, IHCIA Chapter 18, Subchapter I-II).

Ysleta del Sur Pueblo recommends an increase to support current services and expand new services. Ysleta Del Sur Pueblo envisions future direct healthcare delivery as a "one stop shop" providing needed primary care and supporting ancillary services within the Pueblo to resident tribal members, descendants and family members. The projected mission population for 2025 is 2,677 users, a number based on anticipated aggressive tribal membership growth as driven by both internal and external factors. Projection of population assumes growth rates (30.6% incremental, or 3.4% annually) applied to 2012 resident tribal members. Additional priorities include dental services to meet the current demand of dental health screening, early intervention, treatment and prevention as well as funding the increased population and medical inflation needs. The importance of the promotion of healthy lifestyles is a high health priority.

The Albuquerque Service Unit tribes believe that, the Hospitals and Clinics (H&C) Line item has been underfunded for many years. Funding support the operations of IHS is needed to support current services, and for the expansion of services, purchase of necessary supplies and equipment and hire additional staff. IHS and tribally operated (638) facilities located on the reservations are often the only place that Native American patients can obtain healthcare. In the urban setting, such as the Albuquerque Metropolitan Area, the Urban Indian population heavily relies of facilities such as the Albuquerque Indian Health Center and First Nations Community Healthsource to obtain direct healthcare services. By the year 2050, it is anticipated that the Native American population will reach approximately 8 million, thereby requiring us to increase access to care by hiring additional and expanding services to help meet the need.

Increased H&C funding is also greatly needed in order for IHS to become more competitive with the salaries for physicians in regard to recruitment and retention. Recruiting, and more importantly, retaining a core of primary care providers is essential to successfully achieving improved clinical outcomes, maintaining a Patient Centered Medical Home status and continuity of care. Due to changes in healthcare delivery and payment systems, as we move away from a fee-for-service and more towards a pay for performance and wellness system, prevention is key. Additional H&C dollars will be needed to focus on wellness and prevention, which has proven to more cost effective than reactive spending to treat the illness, chronic disease or injury.

Jointly the Zuni Pueblo, Ramah Navajo Tribe and Zuni-Ramah Service Unit, recommends continued increase to the Hospital & Clinic (H&C) line item budget for the FY-2022. The H&C line item consistently falls short in keeping up with inflation costs in providing critical and basic healthcare to the Native American/Alaska Native population. Insufficient H&C funding impacts on all services areas such as inpatient, outpatient, emergency room, and medical support services, i.e., laboratory, pharmacy, nutrition, diagnostic imagining, medical records, physical therapy, diabetes, maternal and child health, youth services, women's and elder's health. In addition, disease surveillance and communicable diseases including but not limited to HIV/AIDS, tuberculosis and hepatitis. Insufficient funding only hinders the Indian Health Service from meeting its primary mission in elevating the health status of Native Americans/Alaska Native populations. The Hospital & Clinics funding levels have never been increased to a level to cover 100% of operational costs to provide basic direct patient healthcare services.

It continues to be well-known that the inmates of federal prisoners receive more health care services than Native Americans/Alaska Native due higher funding per capita.

Continued uncertainty of the Affordable Health Care Act (AHCA) is still a serious concern for the Zuni Pueblo and Ramah Navajo Tribe. Changes such as a repeal of the law or limitations in healthcare coverages will have an adverse effect to the revenue generation operations of the Zuni Hospital and the Pine Hill Health Center, as well as, to the patient population. Funding levels received by Indian Health Service are insufficient to cover cost for all basic healthcare services and facility operational cost for any IHS or Tribal facility. Accreditation of hospitals and clinics are also affected due to inadequate funding levels. The Zuni-Ramah Service Unit not only provides services to its patient population of 11,000+, but an additional 3,000+ Native Americans/Alaska Natives who chose the Zuni Hospital or the Pine Hill Health Center as their primary healthcare provider.

An increase in H&C will ensure that continuum of basic services are available to eligible Native Americans/Alaska Natives, support IHS and Tribal facilities to continue their work and efforts in elevating the health status of the population served and meet the National GPRA performance target goals.

The Santa Fe Service Unit Health Board recommends that one fifth of all budget increases be directed towards Hospitals and Health Clinics, a share that is the same as last year's recommendations. These funds are used primarily to support staffing and services within the service unit. Although the SFSU is fortunate to be fully staffed or nearly fully staffed in most critical clinical departments, the HB recognizes it is critical to offer regionally competitive salaries and state-of-the-art services to ensure high quality care within all of the service unit's facilities.

#### **MENTAL HEALTH**

At the Taos Picuris Health Center, thru our Tribal Court system, we are seeing an increase of tribal members in court due to mental health issues.

The Jicarilla Service Unit supports an increase in funding in both Mental Health and Alcohol and Substance Abuse line items in support of new initiatives in which the Jicarilla I H S and Jicarilla Apache Community programs are partnering. The Jicarilla Apache Nation programs are requesting funding be applied to development and enhancing the existing Mental Health Services and the

Alcohol and Substance Abuse services in the community. Partnerships are being formed with the Administration at the Dulce Independent Schools to train and develop a behavioral support system within the school system to address student behavioral issues that impede coursework and teaching. In addition, the Jicarilla Behavioral Health Department continues to integrate services with the staff at the Jicarilla Service Unit and efforts are made to provide training to the community to create cultural based healing events that focuses on key values such as belonging, mastery, interdependence and generosity.

*I H S Strategic Plan: Goal 2, Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

The Southern Colorado Ute Service Unit recommends an increase to the Mental Health Programs line item. The Service Unit recognizes a huge need within Indian Health for Mental Health Care and its link to the Opioid Epidemic and Alcohol and Substance Abuse. American Indians/Alaskan Natives have serious mental health disorders, including anxiety, depression, suicide and substance abuse compared to other ethnic groups stemming from Historical Trauma. A very small proportion of the budget has been devoted to addressing this need and many health care facilities do not provide mental health services according to the American Foundation of Suicide Prevention. The seemingly insurmountable need for mental health professionals to address the many scars due to historic trauma is apparent in light of increased suicides and attempted suicides as well as increased substance abuse. Within the service unit, the scarce mental health services available are pulled in many directions, such as to the Bureau of Indian Affairs Detention Center in the community of Towaoc, CO, to community initiatives and addressing the increased needs of Tribal Adults and Children in local schools. In addition, the recent closure of the Alcohol and Substance Abuse Recovery Center in Ignacio, CO (Peaceful Spirits) left a huge void in the area with the nearest available residential treatment facility many hours away. (IHCIA Chapter 18, Subchapter III, 1638c and IHS Strategic Plan, Objective 1.3: Increase access to quality health care services).

At Ysleta Del Sur Pueblo, additional funding of \$164,595 is necessary to address the growing mental health concerns and issues for treating and expanding services. New funds would allow an increase in professional workforce to address a growing population, increase behavioral health training, and community education programs.

At the Albuquerque Service Unit, Mental Health issues continue to plague many Native American communities. There are several mental health related disparities that still exist. Recruiting and retaining professional and culturally sensitive healthcare professionals remains challenging. There is a great need for counseling/therapy services. It has been estimated that depression is quite prevalent in the outpatient primary care setting, with estimates of 9% to 16% of general medical outpatients. An estimated 60% of mental healthcare delivery occurs in the primary care setting. Healthcare has an increasing focus on prevention and wellness, and more must be done to address mental health, which impacts co-morbid conditions and outcomes related to chronic illness. Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical *and* mental health.

At the Mescalero Service Unit, the Line Item concerning the Mental Health Program has continuously been underfunded. History of prior years' shows the program has incurred deficits and/or services have not been provided due to inadequate funding. Coordinated telehealth psychiatric services for complex cases with multiple medications is crucial to patient care, and an increase in funding will provide increased personnel to carry this caseload. Next, transportation is a huge problem for our patients and hinders continuity of care, as missed appointments are missed opportunities for needed treatment. Mental Health services are crucial for adolescents and adults that have severe mentally ill-complicated drug profiles. Acute hospitalization for suicidal ideations and long-term residential treatment is lacking and greatly needed. Coordination with other agencies and community outreach suffers under the current short staff situations as the program operates in crisis mode. Funding increase will improve the capacity for the behavioral health department to increase staffing which will allow our staff to reach a large number of community members. There are very limited space available for mental health treatment resulting in transferring our patients 100 miles away for treatment.

The Ramah Navajos and the Pueblo of Zuni priorities as any other American Indian/Alaska Natives is the reduction of the health disparities of chronic diseases in our Tribal Nations. Ramah Navajos believes the root causes of these health disparities are due to traumas – historical and inter-generational, that continues to this day with all of the social illnesses causing adverse childhood experience (ACE) cycle.

*“Trauma has been garnering more and more attention over the past few years; with the rampant climb of Post-Traumatic Stress Disorder and the understanding of what can cause it. Intergenerational trauma among American Indians is an area of study that has just started to generate attention from communities inside Indian country, academicians and the medical profession.” (Intergenerational Trauma: Understanding Natives’ Inherited Pain. Mary Annette Pember)*

“According to researchers, high rates of addiction, suicide, mental illness, sexual violence and other ills among Native peoples might be, at least in part, influenced by historical trauma. The 1998 ACES study conducted by the Centers for Disease Control (CDC) and Kaiser Permanente showed that such adverse experiences contribute to mental and physical illness. AI/AN have been traumatized by historical genocide and colonial oppression. Mainstream media is full of stories about the dramatic improvements allowing science to see more clearly how trauma affects our bodies, minds and even our genes.” (ibid)

#### PTSD in AI/AN Population

- AI/AN communities in general have higher risk of experiencing trauma than any other ethnic group
  - Twice as likely as general population to develop PTSD
  - Higher levels of PTSD reflect higher exposure to trauma
  - Related problems: body pain, lung disorders, general health problems, substance abuse, pathological gambling
  - Most frequently implicated trauma is military combat
  - 2nd most common is interpersonal violence
- (IHS Trauma Informed Care & Historical Trauma Informed Care Webinar Series: Part I in 3 Part Series for Healthcare Providers)

To reduce our health disparities in our AI/ANs, ACE must be prevented, trauma must be prevented through PHN/CHR/CHAP intervention programs such as home visitation for our elders, children, and venerable adults using a trauma informed care delivery of healthcare. Our mental and medical health workers need training on delivering trauma informed care to effectively reduce the health disparities in AI/AN populations.

The Ramah Navajo and Pueblo of Zuni supports the increase funding for Mental Health and Alcohol and Substance Abuse Prevention Programs to help reduce the health disparities in our AI/AN communities.

At the Santa Fe Service Unit, for most of the past decade, our HB has asserted that within our local tribal

communities the greatest unmet need is for the treatment of conditions related to mental health disorders, alcohol, and substance abuse. As a proportion of total budget increases, this is not changed from last year’s recommendations. However, the HB recommends that these conditions be considered as one priority rather than as two separate health priorities as would be implied by the separate line items. The rationale for this consolidation comes from a recognition that untreated mental health issues can lead to an increase in risk for alcohol and substance abuse, and that those with alcohol and substance abuse disorders oftentimes have co-existing mental health diagnoses. By addressing these simultaneously in this budget proposal, the HB hopes to highlight their significance.

The Pueblo of Laguna states that increased funding will allow for the expansion of mental health services in I.H.S. and Tribal facilities to address a myriad of mental health issues impacting Native Americans.

Addressing mental health issues in the communities through direct services, from qualified, licensed, Therapists, Counselors, traditional Healers and lay providers is critical. Depression, suicide ideation, co-occurring disorders and other more serious mental health issues are ongoing in the community. There is a dire shortage of mental health providers and alternate models of care are necessary. Increasing integration of mental health services into primary care is critical to promote health and wellness from disease. A major concern is the access and cost to inpatient mental health facilities. Laguna Behavioral Health recorded over 1,600 patient therapy encounters in 2018 and over 2,203 as of November 2019 for therapy and counseling services. These services were provided through the tribal programs’ trained staff, contracted providers and through intern program participants.

The community of To’Hajiilee has experienced an abnormal increase in the rate of youth and adult suicidal ideation and completions in the last three years. Moreover, but only anecdotally, the number of deaths due to long-term alcohol abuse has been suspected because there is a lack of data in the actual causes of death. Nonetheless, there is an increase in the number of patients, physician and court referrals, for mental health, alcohol and substance abuse services in the past year. We have integrated primary care and behavioral health providers into the clinic setting in order to quickly identify and address mental health/substance abuse issues. However, we remain short staffed for mental health therapists because of insufficient funds. As such, we are recommending funding for mental health/substance abuse services as our number one priority.

**PURCHASED/REFERRED CARE (PRC)  
(FORMERLY CONTRACT HEALTH SERVICES)**

At the Taos Picuris Health Center, the facility has been able to move into Priority 4 at this time primarily due to Medicaid Expansion in the State of New Mexico. There is concern about Medicaid Expansion in the State of New Mexico continuing under the current administration. We are recommending this increase be used to try to maintain current priority level.

The Southern Colorado Ute Service Unit recommends an increase to the Purchased/Referred Care (PRC) line item (IHCIA Chapter 18, Subchapter III, 1638c). The Service Unit recognizes the need for increased access to specialty services both within the clinic (direct care/contracted specialists) and referral services for secondary and tertiary care for all American Indians and Alaskan Natives (AI/AN). The Southern Ute Indian Tribe (SUIT) greatly augments its PRC activity with tribal funds. Specialty services at both clinics consist of Nephrology, Rheumatology, Psychiatry, Optometry and Podiatry, but do not meet the current demands and needs of the patients. Additional specialty services such as Orthopedics, Chiropractor, Acupuncture and alternative pain management, Traditional Medicine and Dialysis are greatly needed and could be procured with additional PRC funding. Some Areas within the IHS have benefited from Medicaid Expansion and have been able to cover more PRC Medical Priorities, many AI/AN within the IHS system do not enjoy these benefits. In addition, recent changes to the Affordable Care Act are negatively affecting access to specialty services especially in rural areas. In order to align with the IHS Priority: Partnership and Resources, and Goal #1, Objective 1.2 and 1.3 the IHS needs to recruit/retain specialists and enhancing relationships with outside partners to improve upon the care of AI/AN patients.

YDSP ranks PRC as a priority, due to the increased cost of specialty services that must be contracted due to the limited scope of services provided at the health clinic. The increase will address the specialty services required to meet the population growth and patients referred from the health center.

At the Albuquerque Service Unit, the Purchased & Referred Care Line Item has been underfunded for many years. Patient access to services beyond what can be provided as direct care at an IHS facility is critical to ensuring that medical conditions that range from chronic and ongoing care, cancer treatment, in-home care and catastrophic medical conditions are treated. Ongoing specialty care for chronic medical conditions can become very

costly. Additionally, only 1 or 2 CHEF cases or patients with a diagnosis such as cancer requiring very expensive medications, treatments, prolonged hospitalization can quickly utilize much of the budget.

The Zuni Pueblo and the Ramah Navajo Tribe recommends an increase to the FY-2022 IHS Line Item Budget for PRC. This will assure that eligible Native American/Alaska Natives (NA/ANs) have access to medically necessary and specialty services not available at IHS and Tribal facilities in light of the ongoing uncertainty of the Affordable Care Act (ACA) at the National level. Any negative rulings about the Affordable Care Act will definitely have an adverse impact the Zuni-Ramah Service Unit's PRC 11,000+ patient population. The Affordable Care Act continues to have a positive impact for Medicaid eligible who are now able to receive more healthcare services than before allowing the service unit's Purchased Referred Care to cover the needs of those not eligible for Medicaid and those not eligible for Medicare, VA, or simply cannot afford to be eligible or afford to purchase a healthcare plan due to economics. Similar to other tribes, The Zuni-Ramah Service Unit's patient population is considered high risk due to life-threatening complications of chronic conditions such as: diabetes, kidney disease, substance abuse, mental health issues, trauma, and others. The service unit's PRC recurring base budget of \$4,511,459.00 in FY 2019 was still insufficient to cover all costs for services provided (shortfall of \$400,000). Continued increase of PRC budget will ensure that Native Americans/Alaska Natives will receive medically necessary care to prevent loss of life and limb, receive timely diagnostic services to prevent further complications of diseases/injuries, and maintain quality of life as well as assist facilities to meet GPRA targeted goals and support the overall mission of Indian Health Service in elevating the health status of Native Americans/Alaska Natives.

The Santa Fe Service Unit Health Board recommends that 15% of all funding increases go to Purchased/Referred Care. Although this is a substantial proportion of the proposed increases, it continues a trend of incremental decreases over the past several years. Specifically, it is an absolute proportionate decrease of 5% compared to last year's recommendations and 10% lower than the year before. Beneficiaries in the SFSU who are PRC eligible have benefitted significantly since the full implementation of the Affordable Care Act just over five years ago, albeit indirectly. Specifically, PRC is the payer of last resort, and with expanded Medicaid under the Affordable Care Act, a marked increase in PRC-eligible patients are also Medicaid eligible. This has led to sizeable PRC surpluses

in the SFSU, allowing virtually all PRC referrals to be approved. Despite this, the HB recognizes that changes to Medicaid eligibility can occur in the future, and they endorse continuing to increase PRC funding at a national level to ensure expanded access to non-IHS specialty services that are crucial to fulfilling the agency's mission.

The Pueblo of Laguna states that funding increases in this line item are critical to ensure tribal member and other Native Americans have access to provision of care outside the I.H.S. via referrals, in private and Tribally-operated facilities through the acquisition of health care and medical services that are otherwise not available. PRC allows for the purchases of medical care and urgent health care services from private, local, and community health care providers that include hospital care, physician services, outpatient services, laboratory, dental, radiology, pharmacy, and transportation services. Increase in funding for PRC will allow for a wider scope of emerging industry standards of direct care to be provided to treat medical conditions and illnesses of Native American patients. The payment rate methodology will be applicable to the Tribal run health systems and increase flexibility for payments for specialized service.

The community of To'Hajiilee states that due to the uncertainty of the longevity of the ACA and Medicaid expansion in New Mexico, we must anticipate a rise in PRC expenditures should the health insurance availability to our beneficiaries change. Any loss in health insurance will be a devastating blow to the patient and family but also to Tribal and IHS organizations that rely heavily on third party reimbursements to supplement the deficiencies in Congressional funding.

## **ALCOHOL AND SUBSTANCE ABUSE**

At the Taos Picuris Health Center, it is recognized that there is a high prevalence of alcohol & substance abuse, depression, suicide, and violence occurring in our communities. This increase would support the National Opioid issue with a federal/tribal collaborative effort. Dr. Reese is taking the initiative to reach out to communities to form partnerships on this multi-faceted issue.

Increase funding in both Mental Health and Alcohol and Substance Abuse line items in support of new initiatives in which the Jicarilla I H S and Jicarilla Apache Community programs are partnering. The Jicarilla Apache Nation programs are requesting funding be applied to development and enhancing the existing Mental Health Services and the Alcohol and Substance Abuse services

in the community. Partnerships are being formed with the Administration at the Dulce Independent Schools to train and develop a behavioral support system within the school system to address student behavioral issues that impede coursework and teaching. In addition, the Jicarilla Behavioral Health Department continues to integrate services with the staff at the Jicarilla Service Unit and efforts are made to provide training to the community to create cultural based healing events that focuses on key values such as belonging, mastery, interdependence and generosity.

*I H S Strategic Plan: Goal 2, Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

YDSP recognizes the high prevalence of Alcohol & Substance Abuse and recommends a budget increase to expand current services and fund New Programs related to Behavioral Health under the IHCA. YDSP recognizes the high prevalence of Alcohol & Substance Abuse, Depression, Suicidality, and Violence occurring among the community. New funding would expand the scope of treatment, such as establishing group homes or inpatient treatment facilities and hiring more clinicians and case managers to address the alcohol & substance abuse problems.

At the Albuquerque Service Unit, the Alcohol and Substance Abuse Line Item has also been underfunded for many years. Funding is needed to support the operation of IHS and is needed to support current services and the expansion of additional prevention, outreach and education services. There is currently an IHS initiative to reduce the abuse and misuse of opiates in Indian Country. This "legal" form of substance abuse is becoming widely recognized as a form of substance abuse that negatively impacts our patient population. There are also ongoing challenges to with alcohol abuse and other illicit drugs and more alcohol and substance abuse services are needed.

At the Mescalero Service Unit, inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources. Alcohol and substance abuse cause an increase in the number of injury related patient visits to our hospital as well as to the private sector and emergency department. An increase in funding is required to allow opportunities for our members to participate in an in-patient treatment program with stays that last from 60 to 90 days. Although the Mescalero Tribe has a 90-day inpatient program through a 638 contract, the complexity of substance abuse disorders to include alcohol,

methamphetamines and opioid abuse are most often so severe that the patient demand requires more intense treatment services than what the program can provide.

Many facilities do not have immediate access to culturally relevant treatment programs so individuals are required to seek off reservation services to facilities located in areas that range from 100 to 200 miles away. Funds will also provide detoxification services for those individuals that require that level of care prior to admission to a long-term treatment facility.

The Zuni Ramah Service Unit believes that inadequate funding for alcohol and substance abuse services has a ripple effect on other funding sources. Alcohol and substance abuse cause an increase in the number of injury related patient visits to our hospital as well as to the private sector emergency department. This puts an increased burden on Purchase Referred Care Services. We need an increase in funding to make available opportunities for members to participate in in-patient treatment programs with stays that last from 60 to 90 days. Many facilities do not have immediate access to culturally relevant treatment programs so individuals are transported to facilities located in areas in that range from 500 to 700 hundred roundtrip miles away. Funds will also be used to provide detoxification services for those individuals that require that level of care prior to being admitted to the long term treatment facility.

Our recommended increase is to address the high patient percentage of alcohol related and substance abuse related encounters. The I.H.S providers treat patients for these types of diseases on a daily basis. Finally, many EMS programs spend many hours dealing with the accident related, domestic violence incidences and trauma related incidences that occur due to these diseases. Not only will this increase access to care, but this initiative will provide better customer services based on the community needs and make I.H.S a good investment in efforts to partner with the tribally operated Alcohol and Substance Abuse Program.

The funding to Alcohol and Substance abuse treatment services should include direct service treatment, individual therapy services, group therapy services and medication management options such as naltrexone and suboxone therapy. Cirrhosis rates, and accidental death rates that are alcohol related remain high. Arrest rates are also high and the number one arrest category for the Pueblo of Zuni remains public intoxication/disorderly conduct. Staffing needs remain high and collaboration is imperative to address these issues. Medication management options

such as Naltrexone and Suboxone must be considered as a treatment option. There are currently very limited funds available for in-patient treatment.

In previous years, there have been insufficient increases to the Alcohol and Substance Abuse Program. The positions specific to address substance abuse have remained vacant, limited or nil at many facilities. Our communities suffer tremendously with alcohol related illnesses such as depressions, post-traumatic stress disorder, grief, alcoholism, bi-polar disorder, suicide, etc. With the on-going absence of credentialed and licensed staff (i.e. psychologists, psychiatrists, clinical staff, social workers, etc.) it is very difficult to determine a patient's level of care. In the absence of such services, patients are placed on waiting lists and eventually become frustrated from waiting for an appointment and not having their medical needs met. This leads to clients abusing alcohol or other substances to temporarily manage their own health needs. In addition, patients with severe alcoholism are left untreated and become a danger to themselves or the community at large.

At the Santa Fe Service Unit, for most of the past decade, our HB has asserted that within our local tribal communities the greatest unmet need is for the treatment of conditions related to mental health disorders, alcohol, and substance abuse. As a proportion of total budget increases, this is not changed from last year's recommendations. However, the HB recommends that these conditions be considered as one priority rather than as two separate health priorities as would be implied by the separate line items. The rationale for this consolidation comes from a recognition that untreated mental health issues can lead to an increase in risk for alcohol and substance abuse, and that those with alcohol and substance abuse disorders oftentimes have co-existing mental health diagnoses. By addressing these simultaneously in this budget proposal, the HB hopes to highlight their significance.

The community of To'Hajiilee has experienced an abnormal increase in the rate of youth and adult suicidal ideation and completions in the last three years. Moreover, but only anecdotally, the number of deaths due to long-term alcohol abuse has been suspected because there is a lack of data in the actual causes of death. Nonetheless, there is an increase in the number of patients, physician and court referrals, for mental health, alcohol and substance abuse services in the past year. We have integrated primary care and behavioral health providers into the clinic setting in order to quickly identify and address mental health/substance abuse issues. However, we remain short staffed for mental health therapists because of insufficient funds. As such, we are recommending funding for

mental health/substance abuse services as our number one priority.

## **DENTAL**

At the Taos Picuris Health Center, we feel the Dental program is under staffed. The focus is of our dental program is almost exclusively on preventive care and acute dental issues. Dental Health is tied to overall health and early warning signs of other diseases can be caught.

The Southern Colorado Ute Service Unit recommends an increase to Dental Services. The Service Unit recognizes a need for dental professionals to provide high quality dental care particularly aimed at preventative services and dental hygiene to preserve teeth versus extractions. Increased access to specialty services within the clinic such as dental hygienists, endodontics and orthodontics is needed and will assist in meeting dental GPRA measures. (see IHCIA, Chapter 18, Subchapter 2, 1621 and IHS Strategic Plan, Objective 1.3: Increase access to quality health care services).

Ysleta del Sur Pueblo recommends an increase to support current services and expand new services. Ysleta Del Sur Pueblo envisions future direct healthcare delivery as a “one stop shop” providing needed primary care and supporting ancillary services within the Pueblo to resident tribal members, descendants and family members. The projected mission population for 2025 is 2,677 users, a number based on anticipated aggressive tribal membership growth as driven by both internal and external factors. Projection of population assumes growth rates (30.6% incremental, or 3.4% annually) applied to 2012 resident tribal members. Additional priorities include dental services to meet the current demand of dental health screening, early intervention, treatment and prevention as well as funding the increased population and medical inflation needs. The importance of the promotion of healthy lifestyles is a high health priority.

At the Albuquerque Service Unit, there is a critical need for adult dental services across the Albuquerque Service Unit, particularly for the Urban Indian, uninsured population. Dental exams are a standard of care for all adult, but particularly for pregnant women, diabetics and those with HIV. Many Urban Indian patients have to make a long drive to find a dental clinic located on the surrounding reservations, but very often cannot make the long drive to the outlying dental clinics and cannot get dental services, other than being seen for a dental emergency.

At the Mescalero Service Unit, while sufficient tools and technology exist to prevent and control oral disease, American Indians/Alaska Native (AI/AN) children continue to experience tooth decay at higher rates than the general population. According to the National Institute of Dental Research, dental caries is the most common disease in childhood, and at the same time, the most preventable. The first oral health survey of a national, community based sample of AI/AN preschool children confirms that in the United States, AI/AN children served by IHS/Tribal programs are one of the racial/ethnic groups at highest risk of ECC. At the Mescalero Service Unit, the department is staffed with one Dentist and one Dental Assistant and cannot meet the demand for dental care of the patients. The increase in funding would improve access to care and services with a focus on dental care and prevention. Community outreach education is crucial to dental care. Parents and the community must become involved in addressing the high-risk behaviors of diet including high levels of sugar to prevent problems in the first place. More preventative care, sealants, and early intervention visits that are non-threatening will combat the dental issues that the facility sees daily. Additional dentists, hygienists and space is needed to improve overall patient care. Funding for materials for patient education on preventive measures is a high need.

The Zuni Ramah Service Unit believes that oral health is often neglected in the care of American Indians and Alaskan Native population. Although there has been improvement, AI/ANs still have poor dental health outcomes. Missing teeth, periodontitis, pain and dental caries contribute to the low SES of AI/AN.

Poor dental health is not an isolated condition. It affects other medical conditions. Patients with diabetes and poor dental health have trouble maintaining a proper diet and correct glycemic control. Poor dental health can affect self-esteem of individuals.

Additional capacity to increase access, new programs at schools, integration of new technologies, and onsite abilities for surgery through increased funding to increase staffing levels of dentists, hygienists and dental assistants will open up needed appointment times for patients allowing patients to have biannual cleanings and same day appointments; and resources to support dental supplies and equipment. School based screening and education activities can become sustainable with consistent and adequate staff resulting in increased access to dental services at both the clinic and community levels. New technologies are available that can provide same day crowns, bridges and veneers onsite allowing patients to return to work

with fewer lost days. The capacity for surgeries allows for implants, when coupled with dentures, patients experience better outcomes.

Supporting legislation is found in 25 USC §1602, which directs programs to raise the health status of Indians to levels set in the Healthy People 2020 Initiative. The Healthy People 2020 goal is the prevention and control of oral and craniofacial diseases, conditions, and injuries and improve access to related services. Making a comparison to the 2020 goals and objectives is difficult since IHS published data is not formatted or collected according to Healthy People 2020.

HEALTHY PEOPLE 2020 COMPARED TO IHS				
MEASURE	AGE	IHS	2020	2020 OBJECTIVE
Dental Caries	3-5	76%	30%	OH-1.1
Dental Caries	35-49	64%	25%	OH-3.1
Dental Caries	65-74	45%	15.4%	OH-3.2
Dental Caries	75+	48%	34.1%	OH-3.3
Missing Teeth	45-64	83%	68.8%	OH-4.1
Periodontitis	55+	49%	40.8%	OH-5
Dental Access	All	29.2%	49%	OH-7

Chart 1. Select Healthy People 2020 objectives compared to IHS data from GPRA and Data Briefs.

Two years ago, the Santa Fe Health Board recommended that 20% of all budget increases should be directed towards expanded dental services. In the past two to three years, the SFSU has successfully entered into agreements with regional private sector oral surgeons, endodontists, periodontists, and other dental specialists to provide higher level care that is primarily paid for out of PRC funds. Last year, the HB recommended continued support of dental programs within the SFSU, but recommended budget increases that were proportionately half of the previous year’s recommendations. This priority and its associated recommended proportionate increase remains unchanged this year.

At the Pueblo of Laguna, increased funding is needed to address the ongoing prevalence of substance abuse, including marijuana, Meth, Alcohol, prescription pain medications and an increase in Heroin on tribal reservations. Especially on reservations that border rural and metropolitan cities. Continued efforts to address the issues of alcohol abuse with a focus on American Indian youth and young adult populations is critical. Alcohol abuse and

poly- substance use disorder and in relation to co-occurring disorders has increased in community, as evidenced by the increasing number of referrals, arrests and police engaged responses in the community. The impacts of alcohol and substance abuse on families is tracked in social problems such as child abuse and neglect referrals, domestic violence and DWI incidents. The tribal system has minimal funding to fully address substance abuse issues, through increased, well trained, licensed staff and emerging industry Providers. The current Behavioral Health program works to incorporate preventative practices into their scope and implement MRT, Peer support, and Wellness Court as alternatives to address substance abuse problems. The Pueblo Behavioral Health Program works to develop their programs to cover the entire spectrum of alcohol and substance use disorders, from awareness and identification to recovery to prevention. A major focus of this funding must be on substance use interventions and awareness that were not typically on reservations; some issues like the influx of electronic cigarettes and their use by youth and adults.

The community of To’Hajiilee is asking for additional dental funds based on community needs. There are several community members that are diabetic and who suffer from periodontal disease which leads to loss of teeth and thus a need for partials and dentures. A significant number of children in the community are in need of fillings, braces and 78% have dental caries. We also see a significant number of patients from outlying communities and urban Indians from the Albuquerque Area. Our current dental budget is \$242,000 which is insufficient considering the current dental health needs of the community as well as other Native American beneficiaries in surrounding communities.

**COMMUNITY HEALTH REPRESENTATIVE**

At the Taos Picuris Health Center, we recommend an additional increase for the CHR program. This is a vital program for our communities and for IHS. This program supports culturally appropriate health services and preventive care. Very often, the CHR is a first responder for many different types of issues identified in the home. They are in a position to provide vital information to tribal programs as well as the IHS health care team.

The Southern Colorado Ute Service Unit recommends an increase to Community Health Representatives (CHR). The Service Unit acknowledges a staffing shortage coupled with an increase demand of the services provided by the CHR program, particularly due to the increase of

the scope of work as it pertains to elderly care. The CHR department provides assistance to patients and the community in promoting healthy lifestyles and disease prevention as well as transportation services to and from clinic and referral appointments. As mentioned, the demand for services have increased and are integrally tied to access to care and in increasing Public Health in our communities and meeting GPRA measures within our clinics and hospitals. In addition, it is anticipated with better funding this demand will continue to increase. (see IHCA, Chapter 18, Subchapter I, 1616 and IHS Strategic Plan, Objective 1.3, Strategies, Health Care Service Access Expansion).

YDSP requests additional funding for the CHR program to continue meeting the expanded support efforts for health education activities and community education. The program continues to support the diabetes prevention program that is not part of the SDPI.

The Santa Fe Service Unit Health Board and their SFSU Governing Body colleagues unanimously endorse adding Community Health Representatives (CHR) to the list of our top five priorities for budget increases. Although located entirely within tribal communities, CHRs are a vital link between our agency's clinical services and our beneficiaries. A non-exhaustive list of regular CHR duties include non-emergency medical transport, assisting in chronic medication management, regular visits to homebound patients, community-based health and wellness education, and liaison work between patients and medical professionals. Despite the exceptional value they add to our agency, their funding has been vulnerable in recent years, as evidenced by the following trends:

- National tribal CHR budget recommendations: \$92.2 million (FY 2019) ⇒ \$83.2 million (FY 2020) ⇒ \$136.6 million (FY 2021)
- President's initial proposed CHR budget: \$58.9 million (FY 2018) ⇒ \$0 (FY 2019) ⇒ \$24 million (FY 2020)
- Enacted CHR budget: \$60.3 million (FY 2017) ⇒ \$62.9 million (FY 2018) ⇒ \$62.9 (FY 2019)

In summary, over the past three years, national tribal budget recommendations have trended towards incremental increases in the CHR line item, whereas the President's initial proposed budgets have reflected a dramatic decrease in funding (actually, complete defunding in FY 2019). Ultimately, the actual CHR budget has remained fairly constant, but the SFSU HB maintains that it is critical to include this as a top priority for future budget increases in order to secure stable future program resources.

At the Pueblo of Laguna, CHR programs are community-based health care providers that provide a unique, culturally sensitive scope of services to community and tribal members. CHRs are the critical first line of coordination care between many patients in rural reservations and clinical providers at I.H.S. and clinicians. In the Pueblo, the CHR program has over 3,733 documented patient care contracts ranging from health education, case management, patient care and transportation. Increased funding will allow for CHRs to continue to expand their roles in critical areas such as point of care testing, home visitation, transportation, care coordination and advocacy. An area of concern that arose in 2019 is the potential threat to not fund the CHR program while advocating for the CHAPS model as a more viable alternative for all tribal communities. Both the CHR and CHAP program should be presented as options for Tribal governments to contract based on the needs of the community. Both programs provide critical clinical care linkages and direct clinic care linkages necessary for addressing health problems in the community. Future funding for the CHR program will be strengthened when Department of Labor and Medicaid recognize and authorize reimbursement for direct services by CHRs

#### **HEALTH CARE FACILITY CONSTRUCTION**

The Jicarilla Apache Nation is requesting an increase in funding in Health Care Facility Construction to support community programs including funding to build four major building sites. The first is a Nursing Home which is needed as all elders who must seek Nursing home services are admitted to locations that range from 45 miles to 160 miles from Dulce. This is causing a hardship to families who want to visit and check on the well-being of the family member. The second building is a Safe house for behavioral health victims of domestic violence. The closest safe house available is located in Shiprock, NM which is more than 100 miles away. The third building is a Public Safety building located on the southern end of the reservation. The unit would include enough bays for two ambulances and a heliport. The fourth building would be set up as a halfway house or transitional home. The patients who complete treatment programs are in need of a location to stay and to receive counselling support until they can be transitioned back into the community. This effort will support the initiatives that are being created to address alcohol and substance abuse.

*I H S Strategic Plan: Goal 1. Reform, strengthen, and modernize the Nation's Healthcare System. 1.2 Expand*

*safe, high-quality healthcare options, and encourage innovation and competition.*

### **SANITATION FACILITIES CONSTRUCTION**

The Southern Colorado Ute Service Unit recommends an increase for Sanitation Facilities Construction (IHCIA Chapter 18, Subchapter III, 1632). The Service Unit identified an inconsistency of modern sanitation facilities and services between most of the citizens of the United States and American Indians/Alaskan Natives. Sanitation, good hygiene and safe water are fundamental to health. There should be every effort made to ensure proper sanitation facilities are available to each AI/AN community. In particular, in the Ute Mountain Ute Tribal communities in Towaoc, CO and White Mesa, UT, many elders' homes need better infrastructure; connected to sewer and water utilities. With an increase in funding particularly to Sanitation Facilities Construction, this gap can be bridged; allowing increased public health. (see also, IHS Strategic Plan, Objective 1.3, Strategies, Health Care Service Access Expansion, 14. Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services...)

The Mescalero Apache Tribal community lacks adequate water & sewer services to serve about 35% of the tribal members that require the service for new homes with a waiting list of approximately 22 homes pending water and sewer services and an anticipated 15-20 homes projected per year. Given the number, it will take years to provide services much less to services currently waiting on assistance. The tribe needs additional resources to meet the current needs. Overall, water and sewer are inadequate with constant breaking/leaking of lines that undermine the ability to get ahead of the issues at hand. The solution is to address the overall sanitation through a competent and maintained infrastructure that will deliver adequate and safe services to the community and to the Mescalero Service unit.

### **ELECTRONIC HEALTH RECORD**

At the Taos Picuris Health Center, funding is needed to support the next generation software that IHS will select since the VA moving onto a commercial package.

The Mescalero Service Unit Electronic Health Record is our lifeline in providing patient care. Electronically our EHR systems allows hospital staff to provide and monitor

all our patient needs. With EHR our patients are able to access their medical records using the Personal Health Record "PHR" program. An increase in funding will provide better health care by improving all aspect of patient care, including safety, and improved efficiency. By the service unit staying abreast with current technology, we will continuously be up to date in this competitive arena.

The Pueblo of Laguna states that the electronic health record is key to the current I.H.S., Tribal and private/public health care systems for storing patient health information and sharing critical information with key providers linked to the patients care. Critically important is the linkage and access to E.H.R. for PRC referred and Tribal health care providers that are authorized to provide care. Funding for E.H.R. must be focused on enhancing the current system and expansion to allow non-I.H.S. tribal health programs to access the E.H.R. system to share critical patient information that will lead to better medical treatments and care plans for clients. Some funding should be dedicated to expanding to allow Tribal access to E.H.R. through industry standard mechanisms that ultimately protect patient privacy and provide maximum security in E.H.R. All 638 Contractors, especially those using 638 share to implement the PFSA's, must have access to RPMS to document Currently, the Pueblo of Laguna tribal health programs have no direct access into E.H.R. which creates barriers for Tribal providers who are part of the patient's health care team.

### **PUBLIC HEALTH NURSING**

At the Taos Picuris Health Center the PHN is a vital member of the team in our PCMH model.

The Jicarilla Service Unit supports increased funding in Public Health Nursing to provide adequate staffing to address patient concerns so that local community programs will not be required to backfill these services. The Jicarilla Service Unit has been unable to meet the needs of the patient care in the community recently due to increases in workload and availability of limited staff. When the PHNs are not available, the Jicarilla EMS and Jicarilla CHRs are asked to step in and fill this void periodically. This has caused more workload to the two programs in which it has been difficult to sustain.

*I H S Strategic Plan: Goal 2, Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.*

At the Pueblo of Laguna, the introduction and maintenance of a solid public health program in the tribal community is key to the prevention of the spread of communicable diseases and the management of chronic diseases requiring medication management and education. The PHN program has a significant role in working with tribally funded prevention and early intervention programs such as CHR, SDPI, Head Start and Community Paramedics to implement screenings, training, and support for direct medical needs. Increasing the funding for PHN will aid in the development of quality care teams in the community, which will bridge services and communications between clinical providers and the community. The PHN scope allows for nursing level services to be provided in home and in the community based on physician/provider orders. PHNs are able to support patient's post-hospitalization and post-partum delivery to prevent costly re-hospitalization of patients and ensure quality, culturally competent medically directed services in the community. The Pueblo of Laguna has one PHN who provided 910 documented direct patient services encounters ranging from Home visiting to direct patient care in community. Critical aspects of the PHN program involve the PHNs ability to engage a public health response for disease threats and out breaks such as Pertussis and to consult with Medical Doctors and Medical Providers on specific medical orders for patients and families. Public Health Nurses working in collaboration with CHRs and other field base providers can create a circle of health security for patients and strengthen care coordination and case management, which leads to positive patient health outcomes

**H&C - INDIAN HEALTH CARE IMPROVEMENT FUND**

At the Mescalero Service Unit, the Hospital and Clinics Program has been underfunded for many years. In prior years, the program has been incurring deficits and/or services have not been provided due to inadequate funding. The increase will maintain or supplement services that have been achieved to date. Due to the remoteness of the facility an increase in urgent care hours is needed as the nearest Emergency Room is 25 miles away. During the winter months the travel for community members becomes a hardship. An extension of Urgent Care hours can be sustained with recurring funds

The CBNHC 638'd clinic operations July 1, 2016. CBNHC increased the encounter rate by 65% in 2019. Anytime a patient is seen by clinic staff on a face-to-face basis it is considered an encounter. This is a different calculation in how billable visits are calculated. Since we

fully contracted IHS services in July 1, 2016, there is a 3.4 fold increase realized - 7,377 in 2017 to 24,772 encounters in 2019. With increased funding in IHCIF, CBNHC could certainly be able to hire additional clinic and behavioral staff to meet the increased demand from not only the To'Hajiilee community but other surrounding communities, including urban Indians residing in Albuquerque, NM. CBNHC does not receive additional funding for serving these additional populations which is basis of our request to fund IHCIF.

**MAINTENANCE & IMPROVEMENT**

At the Taos Picuris Health Center, we recommend an additional increase for M&I to maintain aging facilities.

**HEALTH ED**

YDSP requests additional funding to continue to develop and support programs that promote healthy lifestyles and reduce risk of chronic disease across the lifespan, such as promote prevention and treatment of Diabetes, health screenings, early intervention, treatment and prevention classes, prenatal classes, and nutrition classes that promote traditional farm to table food.

**EQUIPMENT**

The Pueblo of Laguna believes that increased funding for equipment will allow for the support, maintenance and replacement of biomedical equipment at IHS and Tribal health care facilities. Well maintained, high quality and state of the art equipment is critical to the provision of high-quality care to Native American patients. Many I.H.S. facilities and tribal health facilities are able to depreciate and replace equipment within reasonable use limits, and often are required to recycle used equipment from other facilities. Of major concern is the accuracy of equipment used for diagnostics and imaging that is used to identify major health problems and issues.

Tribal clinics can benefit from increased funding in equipment to ensure they have the state-of-the-art equipment in place for diagnosis, screening and analysis to ensure high quality care is provided.

## INDIAN HEALTH PROFESSIONS

At the Taos Picuris Health Center, funding is needed to support tribal members getting education to support their communities. We need the best people we can get in Indian Country and the loan repayment program is an excellent recruitment tool.

## URBAN

The FY2022 Albuquerque Urban Indian Health Programs include the Denver Indian Health and Family Services, Inc. and Albuquerque's First Nations Community HealthSource. Our urban programs budget proposal focuses on funding activities that will continue to build capacity and technology infrastructure to provide the best possible support for the delivery of clinical care services at all levels through enhanced systems, evaluation, technical assistance, training, and policy and health care services.

- Pay, Inflation, Population Growth: This funding item is critical for addressing the demand/need for health services by the urban Indian communities. An estimated 83,000 urban Indians reside in Denver and 55,000 reside in Albuquerque. More than 150 tribes are represented in each of these areas. Our urban populations are relatively young and tend to move back and forth between their homelands and the urban areas. With the Affordable Care Act, our programs have enrolled thousands of urban Indians in Medicaid however, we also continue to serve a large uninsured urban Indian population. As the urban Indian population grows, the demand and need for accessible and quality health services will grow. Urban programs must be funded to meet this need.

*Effects of previous years funding:* In Fiscal year 2019, both programs were able to allocate funds into recruitment and retention.

- Improved Information Systems and Reporting: This funding item is important to address the increasing electronic trends and requirements in the health care environment and the need for urban programs to be equipped to meet these changes. Examples of the integration of health IT with health care currently include a variety of electronic methods such as the management and documentation of patient health information and the formulation of clinical decision support through electronic health record systems, linkages to needed medications through e-prescribing, improved access to health services through telehealth, quality care

standards through meaningful use, and chronic disease monitoring through disease registries. These examples underscore the increasing health information technology trends and the need for urban programs to ensure their readiness and compliance to meet these changes. Adherence to these changes will also ensure urban Indian program support of IHS's reporting system requirements and overall mission.

*Effects of previous years funding:* In Fiscal year 2019, funds were used for continued support of our electronic health record.

- Improving the Quality of Health Programs: This funding item is important for urban programs to effectively address the health care needs of the urban Indian communities. Quality encompasses a range of areas including access, clinical effectiveness, and integration of services, cultural competence, and coordination and continuity of services. Given the disproportionately high rates of chronic diseases and health disparities experienced by the urban Indian populations, quality health programs are vital for improving their wellness and health outcomes. Hence, the budget increases will not only assist programs in achieving quality health services but will support IHS' commitment of providing quality health services.

*Effects of previous years funding:* Continued commitment of providing culturally responsive services.

- Expanding Technical Assistance Training, and Policy: Budget increases in this area are being requested to help urban programs develop and deliver cost effective and quality models of care that address the holistic (including cultural) needs of its patients and communities and to develop and implement policies that promote wellness and positive health outcomes. Trainings through webinars, workshops, conferences, metric toolbox kits, etc. will assist urban programs in enhancing the capacity of their staff and formulating and implementing effective policies. This increase will also support IHS' overall mission to provide quality care and will allow for an effective use of resources and staffing.
- Prioritizing Health Care Services: Budget increases in this area are being requested to assist urban programs in prioritizing health care services by conducting assessments such as community needs assessments, health care assessments, surveys, town halls, self-assessments, etc. to assist them in prioritizing health care services that best meet the needs of their communities. Budget increases in this area will also enable urban programs to

provide community-wide health education and disease prevention activities that address the prioritized health care services.

#### **THE LINKAGE TO IHCIA PROVISIONS,**

##### **WHERE APPLICABLE**

Urban programs will continue to support the provisions to expand health coverage, improve the quality of health-care for all American Indians/Alaska Natives and engage in disease prevention and health promotion activities.

#### **LINKAGE TO GPRA PERFORMANCE**

##### **TARGETS AND OUTCOMES?**

The recommended budget increases were based on a review of multi-year GPRA and national urban Indian health programs' data trends in comparison to IHS benchmarks which are used to assess need, performance and quality. The areas being recommended for budget increases address the provision of quality of health services (e.g., using standard performance metrics such as GPRA), infrastructure (including technology) needs related to quality such as data reporting and tracking, trainings to increase capacity through education on best practices for providing effective and culturally appropriate services, and anticipated increases in population growth of urban Indians over the next ten years. Funding recommendations also address the prioritization of health care services (e.g., diabetes, cardiovascular disease, oral health, etc.) which is critical for addressing the significant health disparities experienced by the urban Indian communities and, most importantly, for ultimately improving their health outcomes. Additional funding to meet performance targets and outcomes will allow programs to achieve these goals.

#### **LINK REQUESTS TO INDIAN HEALTH**

##### **SERVICE STRATEGIC PLAN:**

Our programs will use the budget recommendations to be in full alignment of the 2019-2023 IHS Strategic Plan. Funding will be prioritized to ensure that comprehensive, culturally appropriate services are accessible to our American Indian/Alaska Native families. Areas of improvement will promote excellence and quality through a strategic quality improvement plan, strengthen program management and operations within our programs, and improving communication by continuing to enhance our IT infrastructure.

## BEMIDJI

Purchased/Referred Care, Hospitals & Clinics, Alcohol & Substance Abuse, Urban, Mental Health, Traditional Healers, Long Term Care, Public Health Nursing and Dental. +30% over the FY 2021 National Tribal Budget Recommendation

### **BUDGET NARRATIVE / JUSTIFICATION**

Each Area will submit a Narrative document that describes and supports the agreed upon budget recommendation as follows:

1. How the recommended budget increases should be allocated, i.e., why each increase is important and how it will affect certain programs or initiatives.
2. The linkage to IHCIA provisions, where applicable.
3. How will each of these increases improve a facet of the HHS Secretary's priorities; people, partnership, and patients?
4. Linkage to GPRA performance targets and outcomes.

### **BUDGET INCREASES**

#### **1. PURCHASED/REFERRED CARE (PRC) +\$612MM**

The Bemidji Area recommends 22.31% or \$612M, of increased funding available be applied to the Purchased/Referred Care (PRC) budget line item. The Bemidji Area Tribal programs are heavily dependent on PRC. Historically, the Bemidji Area Tribal programs were primarily PRC programs as part of the Great Plains Area when Bemidji was a Program Office. Approximately 2/3 of the Area Tribes are considered small Tribes and, therefore, do not typically have the capacity to provide comprehensive health services through conventional methods of a clinic and are heavily dependent upon PRC to provide services to their communities. Combining this reality with rural locations increases the demand on PRC for patient transportation costs. Overtime, all Area Tribal programs have invested their own resources to build primary and direct care arrangements for their respective communities to meet the need. While primary and direct care programs exist, access to more advanced care is still needed and PRC funding increases will assist with this need along with augmenting direct care services.

#### **2. H&C +\$464.2M**

The Bemidji Area recommends 16.9%, or \$464M, of the increased funding available to the Hospitals & Clinics

(H&C) budget line item. Increases in the H&C line not only allows Areas and Tribal programs to apply the funding in a targeted, applicable, independent, and program specific manner but also utilizes their individual clinic functions to support the direct care needs unique to each tribal community.

The funding requested in the H&C line will also contribute providing current unfunded programs and services as authorized by the Indian Health Care Improvement Act (IHCIA). The IHCIA further establishes the Indian Health Care Improvement fund (IHCIF). The IHCIF is to help eradicate deficiencies in health resources which addresses American Indian and Alaskan Natives (AI/AN) health disparities. The limited resources now being received is not enough to even cover the basic primary and urgent care needs of AI/AN. The health care disparities of AI/AN with cancer, diabetes, heart disease, suicide, injury and substance abuse is well documented. To achieve notable and meaningful health outcomes it has to be understood the need for increased funding. The increased H&C funding could provide the much needed boost for resources to AI/AN health programs, giving healthcare programs flexibility in finding effective treatments unique to their health delivery systems in reducing the health disparities of their community members.

The Bemidji Area continues to list as one of their “hot topic” issues the need for a regional treatment center, specifically targeting psychiatry adolescent care and opioid addiction recovery. An increase of H&C funds could be used to address this enormous need. Currently, inadequate funding prohibits the advancement of a center as authorized by the IHCIA, Section 708. The center would increase adolescent care and family involvement services to address the increased disparities with opioids and drug addiction habits. A regional center would help alleviate the travel burden for patients and family members who now need to travel extensive distances to seek these services. The need for families to participate in the patient’s recovery is crucial for a successful outcome.

### **3. ALCOHOL & SUBSTANCE ABUSE (ASA) +380M**

The Bemidji Area recommends 13.9%, or \$380M, of the funding available be applied to the Alcohol & Substance Abuse budget line item to address the drug abuse issues of the Area. The impact of alcohol and substance abuse within the Area is having a dramatic negative effect on lives, families and communities of the native people. There is a huge demand for increased funding to combat this adverse societal condition. Several Tribes within the Bemidji Area have declared a “state of

emergency” with the growing epidemic of increased abuse of alcohol and drugs, particularly opioids. This is a multi-faceted problem, which requires involvement of multiple agencies from Tribal Leaders, law enforcement, education and health care professionals, to States, Federal Agencies and the community to solve. There is also a need for alternative resources such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to abused medications along with a regional treatment center. The recent opioid crisis has led to large federal funding levels to combat this emergency, however, Bemidji Area Tribes have found the opioid grants to be very restrictive and too specific to combat the overall epidemic of alcohol and other substance addictions. There needs to be greater flexibility with the opioid grants to combat this issue as a whole.

There is a compelling case in the Bemidji Area for increased funding of IHCIA, Section 708, authorizing adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care. Currently, there is inadequate funding available which attributed to the increased disparities with opioids and drug addicted habits.

There is also insufficient funding for after-treatment care to break the rehab treatment – prior situation cycle. Funding Sections 708 would be beneficial in advancing support in achieving greater success rates and breaking the addiction cycle.

### **4. URBAN HEALTH+316.6M**

The Bemidji Area recommends 11.5%, or 316.6M, of the funding available be applied to the Urban Health budget line item to provide critical funding for health care to the large AI/AN populations in the urban settings of large cities. This increase in funding to Urban Health would align with authorized new programs and services of the IHCIA Title I – Subtitle E: Health Service for Urban Indians, Sec. 164 – Expand Program Authority for Sec. Urban Indian Organizations [25 U.S.C. § 1660e].

Along with congressional appropriations Urban Health programs are highly reliant on grants to maintain operations. Many times grants are restrictive, specific in scope, changing requisite, reduced or eliminated. This changeable condition makes it difficult to plan and maintain a balanced level of facility operations. Increases of recurring budget appropriations would enable urban programs to maintain a more uniform level of services for their patients.



## 5. MENTAL HEALTH +295.5M

The Bemidji Area recommends 10.8%, or \$295.5M of funding available be applied to the Mental Health (MH) budget line item to address the root causes of community members' mental health issues. As the Bemidji Area has found, the inability to address the root cause has manifested into an increasing problem of prescription and synthetic drug abuse/misuse as well as experimentation and addiction to illicit drugs. This funding recommendation supports Section 127 of the IHCIA for increasing the number of mental health providers and funding training/education as well as Sections 704 and 705, which advance the behavioral health programs and programming to address community issues.

Bemidji Area Tribes expressed Mental Health program increased funding needs specifically to be for long-term treatment and after-care facilities/staffing to combat mental health diseases. Strengthening funding for Section 702 of the IHCIA would include support in meeting these needs.

There was also discussion on increases of funding for mental health education resources for prevention and dealing with the onset of mental health issues within the communities.

## 6. TRADITIONAL HEALERS/MEDICINE +211M

The Bemidji Area recommends 7.7%, or \$211M of funding available be applied to the H&C budget line item to address the need for traditional healers in the AI/AN health care facilities. Funding of traditional healers and medicine aligns with Section 143 of the IHCIA – Indian Health Care Deliver Demonstration Projects amending Section 307. This section authorizes the use of alternate or innovative methods to test alternative health care models. The implications of the vast health care disparities of AI/AN requires improvement of the cultural competence

among health care and social services personnel which is provided by the IHCIA.

According to World Health Organization, use of traditional Healers is common throughout the world in both developed and developing countries. Integration of traditional Native American healing practices into mainstream treatment interventions is often recommended when working with Native patients. Funding remains a barrier in providing indigenous traditional healers which are urgently needed to address the health disparities in Native populations. Funding would enhance the eliciting the native healer perspectives on preventing and treating the many diseases plaguing the AI/AN population.

## 7. LONG TERM CARE +190M

The Bemidji Area recommends 6.9%, or \$190M, of the funding available be applied to the H&C budget line item to address Long Term Care needs. American Indians and Alaskan Natives (AIAN) prefer to be in their own homes and communities throughout their lives. In the past, elders stayed at home with their families in multi-generational homes, but that is not always possible as their care needs exceed what their family and other supports can provide. Thusly, AIAN elders are finding themselves in nursing and assisted living homes in urban area, far from their families and communities. The Long Term Care funding aligns with the Indian Health Care Improvement Act (IHCA) authorities currently unfunded. The unfunded IHCA disciplines Bemidji Area would like IHCA – Section 124, specifically, supports long term care (LTC). This funding is needed to keep elders in their communities close to their related cultural background. The funding will assist the tribal communities in time-honored responsibilities of taking care of their elders. Increases in Home Health Care will also extend the time a patient is able to remain in their home.

## 8. PUBLIC HEALTH NURSING +147.6M

The Bemidji Area recommends 5.38% or \$147.6M, of increased funding available to the Public Health Nursing (PHN) budget line item. The increased funding for PHN will greatly benefit healthcare outcomes by increased staff and resources for improved disease prevention and early detection of health disorders. The instances of early detection of disease and prevention will have greater enhanced outcomes and decrease demands for other patient care budget line funding.

## 9. DENTAL +126.7M

The Bemidji Area recommends 4.6%, or \$126.7M, of the funding available be applied to the Dental budget line item to address the Area and Tribal program needs. Dental services are a growing need in the Area and a recent analysis of the funding received showed that the current level of funding equates to only \$20 per individual in the Bemidji Area. In the Bemidji Area specifically, Tribal programs are establishing and expanding dental program operations but the limited funding leave the programs with the difficulty of balancing and supplementing these changes with other funding, thereby, eroding the program's purchase power. The changes to the programs are needed as Area Tribes recognize that the oral health is a component of holistic care. Oftentimes, oral health suffers/diminishes as collateral damage when the need for medical care is greater from a fiscal perspective but studies have shown that dental problems are exacerbated when coupled with chronic disease. Needed funding will improve access to dental/oral health care services and treatment. Additional funding will educate youth, families and communities on good oral health methodologies, thereby, increasing self-awareness, image and esteem.

### IN BEMIDJI AREA:

1. Purchased/Referred Care (PRC) +\$612M
2. Hospital and Health Clinics +\$464.2M
3. Alcohol and Substance Abuse (ASA) +\$380M
4. Urban Health +\$316.6M
5. Mental Health +\$295.5M
6. Traditional Healers +\$211M
7. Long Term Care (LTC) +\$190M
8. Public Health Nursing (PHN) +\$147.6M
9. Dental +\$126.7M

# BILLINGS

## MENTAL HEALTH

Mental Health is the #1 priority for the Billings Area for the FY2022 Budget Formulation. In 2019, the tragedy of suicide continued with suicide clusters on several reservations. The Billings Area Office (BAO) of the Indian Health Service (IHS) and Tribal Behavioral Health Departments are striving to increase behavioral health services. The BAO has devoted personnel and resources to assist behavioral health delivery in all of the service units. The Community Health Aide Program (CHAP), passed through the Montana Legislature in the Spring of 2019, has great potential for increasing behavioral health clinical and community-based services. The IHS and Tribes in Montana and Wyoming are working to implement this program as soon as possible. Community Health Aides will work in the areas of Behavioral Health, Dental, and Medical.

The Tribes of Montana and Wyoming see as a strong correlation between substance abuse and trauma issues stemming from mental health disorders. Data available indicates Mental Health is severe in Native Country. For every life lost to suicide, 135 lives are exposed (Julie Cerel, 2019). Native Americans are four times more likely to commit suicide compared to the national average. American Indians communities did not fare as well as other communities for several socio-economic indicators, including lower high school graduation rates, higher unemployment, and lower household income (Montana Department of Public Health and Human Services, 2017). The report indicates in Montana:

- 66% of American Indian students graduate high school in 4 years;
- nearly 2 in 5 children live in poverty;
- 84% American Indian adults reported one or more adverse childhood experience;
- Suicide rate for American Indians is estimated at 29%;
- 15% of American Indian people report frequent mental distress;
- Nearly 1 in 5 American Indian high school students reported attempting suicide and 15% of American Indian adults report frequent mental distress.

In 2018, on the Chippewa Cree Tribe of Rocky Boy conducted a Community Health

Assessment (CHA) Report with the Center for Health Equity, Education, and Research (Center for Health

Equity, Education, & Research, 2019). In 2018, the CHA reports:

- 216 patients have been diagnosed with Anxiety Disorder, 141 Depression and 70 Post Traumatic Stress Disorder (PTSD);
- 15% of people that took the CHA survey had been told that their child should receive mental health services;
- 27% of students in Box Elder High School reported attempting suicide within past
- 12 months and 38% reported attempting suicide in Box Elder Middle school;
- 37% of students in Rocky Boy High School reported attempting suicide within past 12 months and 34% reported attempting suicide in Rocky Boy Middle school;
- 32% of people that took the CHA survey reported that a friend/relative tried to commit suicide;
- 1 in 5 experienced symptoms of depression, 32% had friend or relative who attempted suicide;
- 39% experienced 4 or more traumatic events during their childhood; and
- 68% of participants had experienced trauma as an adult and 44% reported having unresolved grief.

Furthermore, the entire State of Montana is designated as a High Professional Shortage Area (HPSAs) for Mental Health Care (Montana Department of Public Health and Human Services, Primary Care Office, 2018, p. 13). Tribal Leaders for the Billings Area have expressed concern about the lack of mental health services and a need for more mental health clinicians and professionals. It is imperative that behavioral health and primary care services are coordinated between both the IHS and Tribes to overcome challenges with recruitment and retention of mental health clinicians and other providers such as social workers. Increased Mental Health dollars will assist with the Billings Areas ability to hire and retain quality professionals and provide improved mental health services to our patients. An increase in mental health funding will also provide for increased staffing of qualified people into the mental health workforce.

In FY 2019, the Billings Area has met the Government Performances and Results Act of 1993 (GPRA) measures for Depression Screening or Mood Disorder, 12-17 years old and 18 years and older, at 44.47% and 48.02% consecutively. Mental Health Services is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1621h. The Mental Health supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of American Indian/Alaska Native (AI/AN) communities.

## ALCOHOL AND SUBSTANCE ABUSE

Alcohol and Substance Abuse (ASAP) issues continue to plague our communities as a severe health care crisis and epidemic. Without the proper treatment and recovery support Substance Use Disorders (SUDs) negatively affect the health & well-being of individuals, their families and communities throughout their lifespan and have a high societal toll on public and private systems. Our healthcare providers are working towards building an integrated behavioral health approach, embedding mental health and SUD efforts as mental health trauma can be seen as a catalyst for our people choosing alcohol and substance abuse as a means of coping.

Studies conclude that Alcohol is still the most abused drug among AI/AN communities followed by the use of methamphetamine (meth). In the state of Montana, we are seeing increases in meth offenses, driving under the influence (DUI) of meth cases and meth trafficking offenses. Methamphetamine use is overwhelming our foster care system, the need for inpatient treatment and long-term outpatient & recovery services is definitely needed, burdening primary health and mental health care, increase addictions within families as it normalizes in a homes and communities, significantly increasing violent crime and property crime and overcrowding our jails. Data provided by the United States Department of Justice, United States Attorney, Kurt G. Alme indicates:

- Statewide meth offenses up 313% from 2012-2016;
- Meth DUI cases up from 73 to 301 from 2011-2016;
- US Attorney's Office prosecutions of meth trafficking offenses up by 1/3 from 2017-2018, and are about 95% of Federal drug prosecutions;
- Children in foster care statewide increased 66% (2377 to 3951) from 2014 to 2018;
- Yellowstone County's child abuse/neglect cases increased 177% from 2014 to 2017 to 574 cases;
- In almost 65% of those cases, at least one primary caregiver abused meth.
- Average age of child removed was 6 years old; and
- 42% of Yellowstone County children removed in 2018 were Native American.

In June 2019, Montana released the statewide Community-Level Needs Assessment reports and determined that Montana is primarily a rural state with a total population of just over 1 million (Montana Department of Public Health and Human Services, 2019). One in seven Montanans live in Yellowstone County, which is located in the state's south central region (population 156,332). Billings, the state's largest urban center

(population 109,550), is also located here. The Northern Cheyenne and Crow Nation reservations border Yellowstone County. Yellowstone County is a regional hub for healthcare services, with individuals from across Montana and Northern Wyoming traveling to Billings to access medical care, including SUD treatment. The AI/AN population has grown by 20% in the City of Billings from 2010-2017. Substance misuse and abuse are common in the Yellowstone County/Billings community with more than 4,000 individual's aged 12 years or older dependent on or abusing illicit drugs. Youth with trauma histories and access to illicit substances in their home and social networks, are initiating substance use early in adolescence and are at increased risk for developing SUDs. Methamphetamine users report that the drug is easy to obtain in Yellowstone County and that the potency and availability of the drug is driving addiction. Women using methamphetamine, particularly those of child-bearing age, are over-represented in the drug treatment courts, Montana Department of Corrections treatment facilities, and in probation and parole.

Substance misuse and abuse exacts a substantial toll on individuals and families in Indian Country, as well as the health, human service and justice systems that serve these communities. Methamphetamine use, and its associated criminal and social impacts, have increased rapidly in recent years, demanding a community level response to stem the tide of this growing epidemic. Drug overdose is the 10th leading cause of death in Yellowstone County and the two hospital systems in the area recorded more than 15,000 visits for SUDs in 2018.

Nationally for AI/AN's overdose deaths are 2 times greater than the national average and there is a 519% increase in overdose deaths from 1999-2015. Within our AI/AN communities on the reservations in Billings Area, ASAP health services consist of outpatient levels of care that include intensive outpatient, aftercare, relapse prevention and referrals to inpatient treatment. The Blackfeet Tribe operates the Crystal Creek Treatment Lodge Center which is the only program of the (8) AI/AN treatment service providers in Montana offering Primary Residential Inpatient treatment with a total of 16 beds. The severity of our addicted population who need inpatient treatment have limited funding and resources to send all the people needing this level of care on all our reservations.

Data from the Rocky Boy Health Care (RBHC) Community Health Assessment (CHA) reports from participants surveyed that (Center for Health Equity, Education, & Research, 2019):

- 23% those prenatal screening reported on using opioids and 96% agreed that Drug use is a big problem;
- 29% of RBHC patients, age 9 to 75 years old, were screened for problem with alcohol use and in FY 2018, 34% were screened for same problem;
- Among youth (born 1994-2017) who received substance use evaluations at White Sky Hope Center (WSHC):
  - » 46.4% reported alcohol use o 28.6% reported marijuana use o 8.9% reported opiate use.
  - » 1.8% reported amphetamine use; and
  - » 59.7% out of 504 WSHC client's intakes reported alcohol as their number 1 choice of substance abuse.

Nationally for AI/AN's overdose deaths are 2 times greater than the national average and there is a 519% increase in overdose deaths from 1999-2015. For these reasons, the Billings Area Tribal Leaders request additional funds and resources to continue to build capacity and provide quality treatment services.

In the Billings Area, met 2 of 3 GPRA ASAP screening measures have been met: Tobacco-35.63% and Alcohol-44.95%. The third screening measure, Brief Intervention and Referral to Treatment (SBIRT) decreased to 5.21% in comparison to 28.33% for FY 2018. ASAP is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1621h. ASAP supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

## HOSPITAL & CLINICS

In the Billings Area, Hospitals and Health Clinics (H&C) funds essential, personal health services for AI/AN. The quality and safety of care at federally operated facilities is a top priority. The Billings Area understands it is important to continue to advocate for additional hospitals and clinics funding for our health facilities and its staff. The IHS and Tribes primarily serve small, rural populations with primary medical care and community-health services. Further, current levels of H&C funds for IHS, Urban and Tribal programs are persistently underfunded. Tribal Program areas are also limited in the services they can provide every year; this is mostly due to stagnant budgets that do not increase with inflation and cost of living in rural areas. Third party reimbursement is highly needed to assist in fulfilling fiscal shortfalls and providing services that are not funded through the IHS or other Federal

funding, including programs such as suicide prevention and oral health intervention.

Specialty services that were provided by our service units such as nephrology, pediatrics, obstetrics and gynecology and urology are no longer available at current funding levels. As a result, patients are forced to drive hundreds of miles in order to receive specialty care. With communities that have high unemployment rates, this makes accessing health care services particularly difficult. Third party billing offered a pathway to providing these services, however, with the current cuts to Montana's Medicaid Expansion, these programs may be in jeopardy of continuing or not able to be fully realized at all.

The successful recruitment and retention of employees is a high priority for the IHS. The Billings Area requests additional funds for the recruitment and retention of medical personnel for IHS facilities. An increase in medical providers would help decrease patient visits in our Urgent Care and reduce long waiting time for medical appointments. The IHS is modernizing its credentialing and privileging processes to facilitate the hiring of qualified practitioners. The credentialing process evaluates the qualifications and practice history of a provider such as training, residency, and licensing.

Tribes in the Billings Area request additional funds to support and expand the Community Health Aide Program (CHAP) to improve local health outcomes related to health care access and delivery. The Montana Medicaid Program Section 53-6-101 was amended to reflect the Federal statues related to CHAP. CHAP provides a network of health aides trained to support other health professionals while providing direct health care, health promotion, and disease prevention services. The additional funds request will assist in the development of a training network with Tribal colleges and universities, CHAP certification Boards, increased partnership and collaboration with State and Federal partners, and for CHAP expansion in the Tribal communities of Montana and Wyoming.

The Billings Area H&C request includes funds to provide health care services for the Little Shell Tribe of Chippewa Indians federally recognized on December 20, 2019.

After Federal recognition, new Tribes are eligible for funds and services within the IHS. Additional funding is requested so that the concomitant increase in healthcare service demand does not impact or diminish the funding available for care of existing direct service Tribes.

The IHS Health Information Technology (HIT) Program uses a secure, certified Electronic Health Record (EHR) system in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. Within the IHS HIT program, the IHS EHR is used to provide critical support for the Indian Health Service/Tribal/Urban (I/T/U) health care system. Collecting, analyzing, and interpreting health information is done through a network of tribally operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology supports personal health services (including the EHR and telemedicine) and public health initiatives (such as Baby Friendly Hospitals and Improving Patient Care) that are primarily funded through the H&C budget. The IHS HIT Program continues to face increased demand for systems improvements and enhancements, rising costs, and increased IT security requirements driven in part by medical advances, and ever-growing and more complex requirements for health information technology capabilities. These requirements come from government and industry initiatives, program needs of health programs, and operational requests of I/T/U health care facilities. Virtually any new program initiative has information technology requirements for functionality, modality, data collection, and reporting which then must be added to a clinician's work flow and managed within the HIT portfolio.

H&C is linked to all GPRA measures, see Appendix A. H&C is linked to the Indian Health Care Improvement Act, U.S. Code, Title 25, Chapter 18. The H&C supports the IHS Strategic Plan FY 2019-2023.

### **PURCHASED/REFERRED CARE (PRC)**

The Purchased/Referred Care (PRC) Program is integral to providing comprehensive health care services to eligible AI/AN. PRC will always remain a top health care priority because of the constant and underfunded need for: standard, specialized, and emergency care/procedures not provided by our local clinics or if a clinic is unavailable. The need for preventative medical service and program operation must maintain priority to better manage patient health care for our AI/AN population. Proper funding for the PRC program is essential to assure our patients receive health care services not available at our IHS Unit and/or if a clinic is unavailable for prevention of minor or chronic illnesses from progressing into major complications. Research has shown that prevention helps to reduce overall costs for medical care for both the facilities and

the patient. A budget increase in PRC is essential to allow for AI/AN patients to be treated in a timely manner for their current medical conditions and improving their overall health with a lower cost to the healthcare system.

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). CHEF is established to support and supplement PRC programs that experience extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses. The CHEF is used to reimburse PRC Programs for high cost cases (e.g., burn victims, motor vehicle crashes, high-risk obstetrics, cardiology, etc.)

PRC is linked to several authorized programs in the Indian Health Care Improvement Act, 25 U.S.C. § 1621r, 1621s, 1621u, 1621y, 1642, and 1646. The PRC supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

## **DENTAL SERVICES**

Dental is a top ten priority for the Billings Area because of ongoing access to Dental Care. We continue to recognize the various health care disparities associated with poor dental health. Despite the recent additional Purchase/ Referred Care funding into the dental programs in the Billings Area, it will take time for Service Units to reach a preventive state to address the poor dental care for adults, children, and the elderly. Dental and Oral Health is underfunded each year as community user populations increase from the Urban tribal population needs for Direct Care Services. Most, if not all Billings Area Service Units do not meet the Dental Access Government Performance and Results Act of 1993 (GPRA) measure due to insufficient number of dental providers, dental assistant and other support staff. Dental services are limited to the number and type of dental providers at each service unit. Emergency care dental cases take priority over preventative care and education when compared to the private sector dental model. Preventative and restorative services can be a struggle due to funding shortages for staffing and/or updated dental equipment needs at each service unit in the Billings Area. Preventive care and education begins with the newborn age. Pediatric Dentists have little time to educate. Studies show that good preventative dental care in children has a lasting effect on good oral health and decreasing other medical health disparities as adults. Budget increases will improve and help expand dental programs to become more preventative by early

interventions in the schools and community outreach efforts. Additional funding will increase recruiting efforts, staff stability and retention, preventative education programs and services, which ultimately can improve future dental and medical health of all AI/AN patients we serve.

In FY 2019, the Billings Area has met the GPRA measures for Dental: General Access, Sealants, and Topical Fluoride at 32.41%, 24%, and 44.35% consecutively. Dental Health is linked to the Indian Health Care Improvement Act, U.S. Code, Title 25, Chapter 18. The Dental Health supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

## **PUBLIC HEALTH NURSING (PHN)**

The Public Health Nursing program is a community health nursing program that focuses on the goals of promoting health and quality of life and preventing disease and disability. The PHN provides quality, culturally sensitive health promotion and disease prevention nursing care services to AI/AN communities. PHN's improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they transition from hospital to home in an effort to decrease hospital readmissions. The PHN provide communicable disease assessment, outreach, investigation, and surveillance to manage and prevent the spread of communicable diseases. PHN's contribute to the several of the IHS prevention efforts by providing communicable immunization clinics, public health education and engaging their AI/AN people in healthy lifestyles. PHN's conduct home visiting services for: maternal and pediatric populations, elder care services including safety and health maintenance care, chronic disease care management and communicable disease investigation and treatment. The PHN program supports the IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly designation and accomplishing the following activities: providing patient education, assessment, and referral services for prenatal, postpartum and newborn clients during home visits.

PHN accomplishments are documented in several Billings Area for which GPRA screening measures have been met: Tobacco-35.63%; Domestic Violence-45.86%, Depression-12-17 years old 44.47%, Depression Screening-18+ years 48.02%, Alcohol44.95%, and Adult Influenza-25.73%. PHN is linked to several authorized programs on the Indian Health Care Improvement Act,

25 U.S.C. § 1621b, 1621c, 1621h, 1621n and 1665i. The PHN supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

### **COMMUNITY HEALTH REPRESENTATIVES**

Community Health Representatives (CHR) is a vital program in the Billings Area. The CHR program is 100% tribally operated. CHRs are frontline public health workers who are trusted members of the community and serve as a link between the IHS, including associated health programs, and AI/AN patients and communities. The aim of the CHR program is to help AI/AN patients and communities achieve an optimal state of wellbeing by providing health promotion and disease prevention, wellness and injury prevention and education, language translation and interpretation, transportation to medical appointments and delivery of medical supplies and equipment within the tribal community. Without the CHR program, many patients within the Billings Area would not have access to health care. The CHR provides access to health care on the reservation for the elderly, handicapped and disadvantaged populations. The CHR program needs sustained and increased funding to provide quality health services. CHR's services for mental health, opioids, and chronic illnesses have continued to increase.

CHR is authorized by the Indian Health Care Improvement Act, 25 U.S.C. § 1616. CHR supports the IHS Strategic Plan FY 2019-2023, Goal 2 Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities.

### **URBAN INDIAN HEALTH**

The urban health centers in Billings Area receive approximately \$3,735,021 annually. In 2017, the U.S. Census Bureau reports approximately 25,127 AI/AN living in the catchment areas of the five urban centers which is 30% of the total population of AI/AN in the Billings Area. The funding levels throughout the IHS for the urban centers is inadequate and does not meet the healthcare service needs of the urban population. Our urban centers see a user population similar to that of a direct service or tribal health facility each year while operating on a \$607,000 yearly average budget. The Billings Area Tribes and Urban Indian Health Organizations are advocating for 5% increase for FY 2022 which is \$136,405,000 increase to the FY 2021 recommendation. In FY 2019,

the Ambulatory Patient Care (APC) workload increased by 2,200 visits from FY 2018.

The Billings Area GPRA measures includes Urban sites, see Appendix A. Urban Indian Health is authorized in the Indian Health Care Improvement Act, 25 U.S.C. § 1651.

Urban Indian Health supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

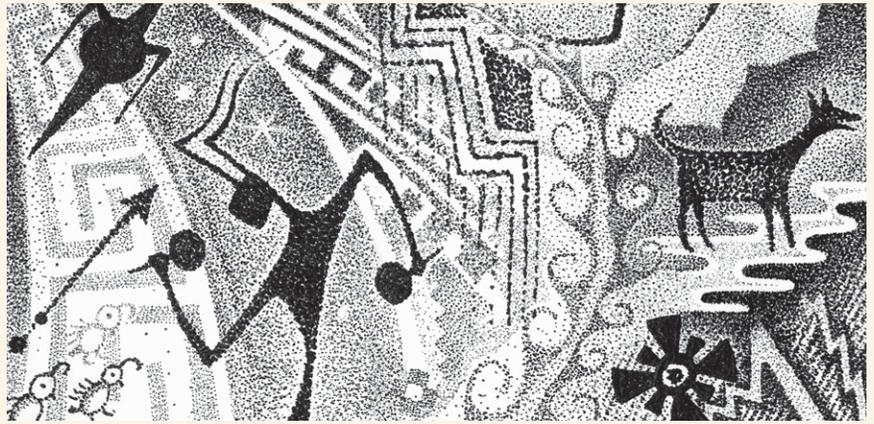
### **INDIAN HEALTH CARE IMPROVEMENT FUND (IHCIF)**

The IHCIF is a priority for the Billings Area to expand needed services and to allow for increased access. The need for expanded services is apparent, and any additional funding helps increase access and services. IHCIF funds will be utilized to ensure comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people through recruitment and retention. Also, funds are used to build staff capacity which strengthens, and sustains collaborative relationships, increases access to quality health care services, and increases health care service access expansion. The IHCIF promotes excellence and quality through innovation of the entire IHS, Tribal and Urban (I/T/U) into an optimally performing organization, creates quality improvement capability at all levels within the organization, and helps provide better care to the community. Improving access and services helps strengthen programs and management of the I/T/U.

The health resources available to an Tribes or Tribal Organizations includes health resources provided by the IHS as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

The IHCIF is authorized on the Indian Health Care Improvement Act, 25 U.S.C. § 1621.

The IHCIF supports the IHS Strategic Plan FY 2019-2023, Goal 1 and Objective 1.3: Increase access to quality health care services.



## HEALTH EDUCATION

The need for ongoing community health education is imperative to the wellbeing of AI/AN in the Billings Area. The Tribal Health education is the backbone of preventive health care. The program focuses on the importance of educating patients to make positive choices in their lifestyles and how they utilize health services. Numerous studies have shown correlations between low health literacy and poor health outcomes. The Tribal Health programs in the Billings Area currently offer Diabetes, Nutrition, Special Supplement Nutrition Program for Women, Infants, and Children (WIC), Diabetes prevention and a formal Health Education program. Due to restrictive funding annually, community outreach to improve health literacy is not at the desired level. School based health education can also get a message out to our youth to reinforce health education at the earliest levels. Informing younger generations about the consequences of unhealthy lifestyles will greatly affect their overall lifestyles. Increased funding could offer more opportunity to provide additional community outreach activities in order to improve health education within the Billings Area, ultimately improving health disparities that may exist.

Health Education is linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. § 1621b, 1621c, 1621h, 1621n and 1665i. Health Education supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objective 1.3: Increase access to quality health care services and Goal 2 Objective 2.2: Provide care to better meet the health care needs of AI/AN communities.

## REFERENCES

Center for Health Equity, Education, & Research. (2019). Rocky Boy Chippewa Cree Tribe Community Health Assessment 2019. Boston, MA.

Julie Cerel, P. (2019). *How Many People Are Exposed to Suicide? Not Six*. The American Association of Suicidology.

Montana Department of Public Health and Human Services (DPHHS). (2019). *Substance Abuse Connect: Prevention, Treatment, Enforcement Substance Use in Yellowstone County: A Community-Level Needs Assessment*.

Montana Department of Public Health and Human Services. (2017). *A Report on the Health of Montanans*.

Montana Department of Public Health and Human Services, Primary Care Office. (2018). *Health Professional Shortage Area Data*.

# CALIFORNIA

The California Area is submitting a Budget Recommendation at the +30% level over the FY 2021 Recommendation. The California Area Office and California Area Tribal Leaders support funding the California Area's Top 13 Budget Funding Priorities: Purchased/ Referred Care, Behavioral Health , Obesity/ Diabetes , Dental , Methamphetamines/Suicide/ Domestic Violence, Small Ambulatory , Health Information Technology, Maintenance and Improvement, Pharmacy, Community Health Representative, Urban, Joint Venture, and Sanitation Facilities Construction.

The California Area Office and California Area Tribal Leaders also support and recommend 105(l) leases be a separate appropriation and an additional budget line item going forward, similar to Contract Support Costs.

## BUDGET INCREASES

### 1. PURCHASED/REFERRED CARE +466M

The California Area recommends that IHS continue increasing funds for Purchased/Referred Care (PRC) and Catastrophic Health Emergency Fund (CHEF) to address the current reported unmet needs represented by the large number of deferrals and denials. There are no Indian Health Service or Tribal hospitals in the California Area, therefore tribal healthcare organizations rely heavily upon PRC funding. The vast majority of Area health programs provide primary care; as a result, the majority of PRC funds are used for specialty referrals, pharmacy services, laboratory testing, and diagnostic studies. PRC funds are rarely adequate to cover Levels of Care beyond Priority II. Few health programs are able to cover inpatient services. This is reflected in the low number of California Area CHEF Cases. The CAO continues to encourage and assist programs to report PRC deferrals and denials. The need in California is actually greater than the data suggests. In 2017, only 25 of the 38 health programs reported deferred and denied data.

### 2. BEHAVIORAL HEALTH +438M

The lack of behavioral resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. In the California Area, the lack of funding is reflected in the 2017 Government Performance and Results Act (GPRA) Data. Over 2,500 youth and almost 10,000 AI/AN

patients were not screened for depression at tribal programs in the California Area. Of patients that were diagnosed with depression, only 30% received a prescription for antidepressants with enough medication (with refills) to last 12 weeks, and only 10% received enough medication (with refills) to last 6 months. Additionally, over 4,000 women were not screened for domestic violence and over 13,000 patients were not screened for alcohol use. 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.

### 3. OBESITY/DIABETES +411M

The leading cause of death for American Indians/Alaskan Natives (AI/ANs) is heart disease caused by obesity, diabetes, depression and poverty. The national rate of diabetes for AI/ANs is 15.2%. Tribal and urban Indian healthcare programs use these funds to offer education, self-management support through professional and community led education, direct clinical and specialty care for AI/AN patients battling diabetes and obesity. Behavioral health issues are also addressed which contribute to the obesity and diabetes rates of AI/ANs.

### 4. DENTAL +301M

Dental decay rates of AI/AN children and adolescents are twice the national average and contribute to serious diseases. California Tribal Leaders recommend increases for better equipment and wellness programs, especially since lack of dental care creates or exacerbates other health problems, particularly in the diabetic. California Tribal Leaders also recommend funding Dental Therapy and Dental Therapists. This classification would allow Native healthcare programs to serve more clients.

### 5. METHAMPHETAMINES/SUICIDE/ DOMESTIC VIOLENCE +246M

Rates of methamphetamine addiction and related crimes, suicide and acts of domestic violence are disproportionately higher among American Indians and Alaskan Natives. According to the CDC, suicide is second leading cause of death among AI/AN youth between the ages of 10 and 34 and 8th leading cause of death among AI/AN of all ages. An estimated 45% of AI/AN women and 1 in 7 men experience intimate partner violence, yet according to our 2017 Government Performance and Results Act (GPRA) data, over 4,000 women at California tribal health programs were not screened for domestic violence. In 2017, 5 California health programs received

IHS Domestic Violence Prevention Initiative funding and 14 received IHS Methamphetamine/Suicide Prevention Initiative funding which highlights the need for these programs in California. Increasing funding in these areas will allow tribal programs to connect more individuals to help through higher rates of screening, outreach and referral processes strengthening and additional trained staffing.

#### **6. SMALL AMBULATORY +192M**

The California Area strongly supports funding for new health care facilities under Sec. 141 of the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) as well as Section 306, P.L. 94-437, of the IHCIA which authorizes the IHS to award grants to Tribes and/or Tribal organizations for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. California Tribal Leaders report that increased funding resources for Tribal healthcare ambulatory health care facilities would help meet modern health care delivery program needs for those facilities with insufficient capacity to deliver such services through the construction, operation and maintenance of facilities that meet building code requirements and health care accreditation standards. The FY 2017 Budget Request included \$10 million for the Small Ambulatory Grants (SAP) program of which \$5 million was approved. The FY 2018 Budget included an additional \$10 million for a total of \$15 million. California Tribal Leaders recommend increased funding for the SAP program.

#### **7. HEALTH INFORMATION TECHNOLOGY +164M**

The California Area supports a large investment in health information technology; Tribal and Urban Indian health programs require a strong medical records system that is both interoperable and offers modern features, including a public health component. The Resource Patient Management System (RPMS) and medical records interface Electronic Health Record (EHR) comprise a powerful database technology in need of modernization or replacement with a commercial product. The cost of this effort would overwhelm the current IHS budget – a financial commitment similar, but appropriately scaled to the Veterans Administration electronic medical records replacement effort is required.

#### **8. MAINTENANCE AND IMPROVEMENT +164M**

Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/

compacts. The M&I program funding is distributed through a formula allocation methodology. Annual M&I funding is usually less than the amount needed for Preventive, Routine and Non-Routine Maintenance. The backlog of deferred maintenance is about \$570 million, which if unaddressed could cost significantly more if systems fail. Maintenance costs increase as facilities and systems age. Available funding levels are impacted because:

1. Age and condition of equipment may necessitate more repairs and/or replacement;
2. Lessened availability of service/repair parts for aging equipment and limited vendor pool in remote locations;
3. Supportable space has increased 3.5 percent per year;
4. Increased costs due to remote locations;
5. Costs associated with correcting accreditation-related deficiencies;
6. Increasing regulatory and/or executive order requirements; and Environmental conditions impacting equipment efficiency and life.
7. An increase in M&I funding would ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

#### **8. PHARMACY +137M**

The net prices for drugs are increasing four-times faster than the rate of inflation (approximately 133% from 2007 to 2018). Specialty drugs (e.g. Rheumatoid Arthritis, HIV, and Hepatitis C) have the highest inflation rate followed by brand name drugs. Tribal and Urban healthcare programs can access Federal discounted drug programs such 340B and Veterans Affairs Pharmaceutical Prime Vendor Program (VA PPVP) as a means of affording medications. There are twelve (12) Tribal pharmacies in the California Area that utilize 340B and three (3) Tribal pharmacies that utilize the VA PPVP and 340B. Tribal pharmacies are able to generate revenue for their respective clinics utilizing 340B, however with Governor Newsome's Executive Order (EO N-01-19), their ability to generate revenue utilizing 340B will be non-existent. Though Tribal and Urban healthcare programs can still access VA PPVP, the VA contract does not allow for resale of medications which would prevent Tribal pharmacies from generating revenue through these means. Despite the ability to purchase medications at discounted costs, Tribal and Urban healthcare centers may still face difficult decisions on how to cover remaining drug costs as their revenue margins decrease substantially.



## 9. COMMUNITY HEALTH REPRESENTATIVE +98M

Across IHS, CHR Programs provide essential services for an under resourced, heavily chronic disease- burdened segment of the overall population. Just over \$2 million, of the reported \$60 million for IHS CHR budget, is available for CA Area CHR programs. Per data obtained through the IHS CHR Data Mart, California Area tribal and Urban Indian RPMS-using CHR programs in FY 2017 provided over 57,703 services with 76,413 client contacts. Over the course of this time period, the top CA Area Urban CHR program areas of activity (by visit) were socio economic-assistance (845) and diabetes (331); the top 5 categories of CA Area tribal program CHR activity were those associated with the following categories: Diabetes, Hypertension, Injury control, Administration and management, and Cardiovascular disease. Per a report generated through the IHS CHR Data Mart, between FY 2017 and FY 2019, the overall CA Area CHR services declined by 74,216 and the client contacts declined by 112, 030. During this same time period, the number of CA Area CHR reporting sites declined from upwards of 16 to 2, with no CA Urban reports available through the CHR Data Mart for FY 2019. CHRs provide essential services in terms of patient education, health promotion /disease prevention and transportation for members of their communities. It is highly likely that the CHR services in the California Area have not declined to the extent indicated, however that there is not a proper accounting of services since many of the CA Area sites have moved to Non-RPMS systems. IHS does not currently have a method for capturing CHR activity (Services and contacts) from Non-RPMS users, those without access to CHR Reporting Package. Such system challenges are barriers to capturing CHR data from Non-RPMS users and influence attempts to understand the actual impact of CHR work. CHRs often work hand-in-hand with healthcare professionals to extend services into the community setting, providing invaluable services that bridge coverage gaps by connecting patients with much

needed healthcare and socio-economic services in communities where aging population, high chronic disease burden, and limited resources (funding and staff shortages) may lead to ultimately unacceptably poor health and quality of life outcomes for AI/ANs.

## 10. URBAN +54M

Nearly seven out of every ten American Indians/Alaska Natives (AI/AN) live on or near cities, and that number is growing. California has more AI/AN than any other state, and just 10% have access to IHS clinical services. Recent studies document poor health status and inadequate healthcare available and accessible to the urban AI/AN population living off of their reservations/rancherias. In California, as in other states, urban Indians who must move to reservations for health care might have to wait months to reestablish residency, and then might spend even more time on a waiting list before getting treatment. Many become sicker and some even die before reaching the top of the list. Even among the urban Indian health organizations, not all are able to provide the full spectrum of health services needed by urban Indians. Urban programs offer behavioral health services and wellness assessments, dental, outreach referral services as well as comprehensive ambulatory healthcare services. None are connected to a hospital and few are connected to specialty care services. There are ten urban Indian healthcare programs in California.

## 11. JOINT VENTURE +38M

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from their own funds, through financing, grants, contributions, or a combination thereof, for the construction of their health facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to

equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS agrees to request a funding increase from Congress for additional staffing and operations consistent with a fully executed beneficial occupancy of the health care facility.

**12. SANITATION FACILITIES CONSTRUCTION +27M**

The California Area recommends that IHS continue increasing funds for the Sanitation Facilities Construction (SFC) Program to support a wide range of community-based public health activities focused on improved water supply and sanitation facilities, increasing tribal capacity to operate and maintain O&M) the facilities, in addition to supporting tribes during emergency responses. According to the SFC STARS database, the California Area has an unmet need of over \$63 million for 1,221 homes with water-related and 1,649 with sewer-related Deficiency Level 3 and higher needs. The SFC Program provides on-site trainings and has developed innovative approaches such as Tribes-Helping-Tribes to increase tribal O&M capacity. The California Area tribes have and will likely continue to experience impacts from drought, wildfires, winter storms and most recently utility power shutoffs. The SFC Program partners with federal and state agencies and technical assistance providers to coordinate resources and provide technical and financial assistance to tribes during the emergency responses.

# GREAT PLAINS

Tribal leaders representing the 17 Tribes 1 Service Unit, and 1 Urban Clinic of the Great Plains Area met on November 6, 2019, to develop the Indian Health Service Great Plains Area FY 2022 Tribal Budget Recommendations.

These federally recognized Tribes have approximately 199,504 enrolled federally recognized Tribal members (Bureau of Indian Affairs, 2010) and cover a four state region that includes 18 federally recognized Tribes and Tribal service areas in North Dakota, South Dakota, Nebraska, and Iowa. This large landmass measures approximately 5,966,279 acres, including trust lands, spread across the counties to include in the severely economically distressed service areas.

American Indians served in the Great Plains Area suffer from the worst health disparities in the nation. Death rates from preventable causes, including type 2 diabetes, alcoholism, unintentional injuries, suicide, etc., are several-fold greater than the rest of the national IHS population and the general US population. At the same time, the health system designed to serve this population is severely underfunded, and the services provided to address the disparities are not adequate to meet the needs of the Indian population in the Great Plains Area. Direct services funding has not increased in over two funding years. As medical and health care costs increase, the funding is not increasing to meet our needs.

It is the position of the Great Plains Tribes that even if the estimated 30% recommendation is funded, it is inadequate to meet the needs of a growing Tribal community and uphold the trust responsibility outlined in the Indian Healthcare Improvement Act (IHCIA), to provide the “highest possible health status to Indians and to provided existing Indian health services with all resources necessary to effect that policy”.

The Great Plains Area Health and Budget priorities by Tribal consensus are as follows: FY 2022 IHS Great Plains Area National Budget Recommendations at 30% program increase (Dollars in thousands).

- 1. Mental Health ..... \$548,650
- 2. Alcohol & Substance Abuse..... \$548,650
- 3. Hospitals & Clinics ..... \$548,650
- 4. Community Health Representatives ..... \$274,325
- 5. Urban Health..... \$274,325
- 6. Dental Services..... \$192,028

- 7. Public Health Nursing..... \$137,163
- 8. Health Education..... \$137,163
- 9. Health Care Facility Construction ..... \$ 75,439

**1. MENTAL HEALTH**

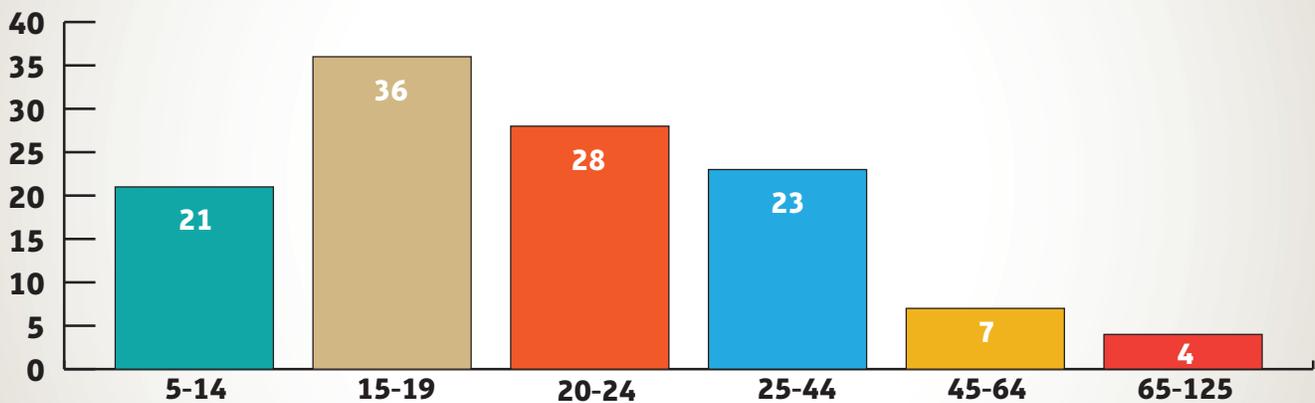
Significantly high rates of suicide among American Indians and Alaska Natives continue. The Great Plains Area suicide rate is among the highest of any of the 12 IHS areas. Behavioral Health referrals are often outsourced to professionals who are great distances away from the Tribal communities, resulting in missed appointments and poor follow-up care.

The remote locations of most Indian reservations and Tribal lands is a barrier to receiving services. Most housing on reservation is inadequate to meet the needs of growing Tribal populations, including Tribal members,

and clinical staff are unable to secure adequate housing. This further discourages qualified licensed/credentialed providers to seek employment in Tribal areas. Retaining professionals on reservations also makes it difficult to provide adequate services to receive care, if they choose to seek care at all.

It is becoming apparent that historical and intergenerational trauma are realistic causes of American Indian youth feeling hopeless, helpless, and lost. Despite the grants available by various states and federal agencies to address suicide on reservations, there is still a high volume of youth suicides in the Great Plains Area. Established intervention and prevention programs have begun to address suicide among the youth, but an unprecedented amount of suicides and suicide attempts continues to exist.

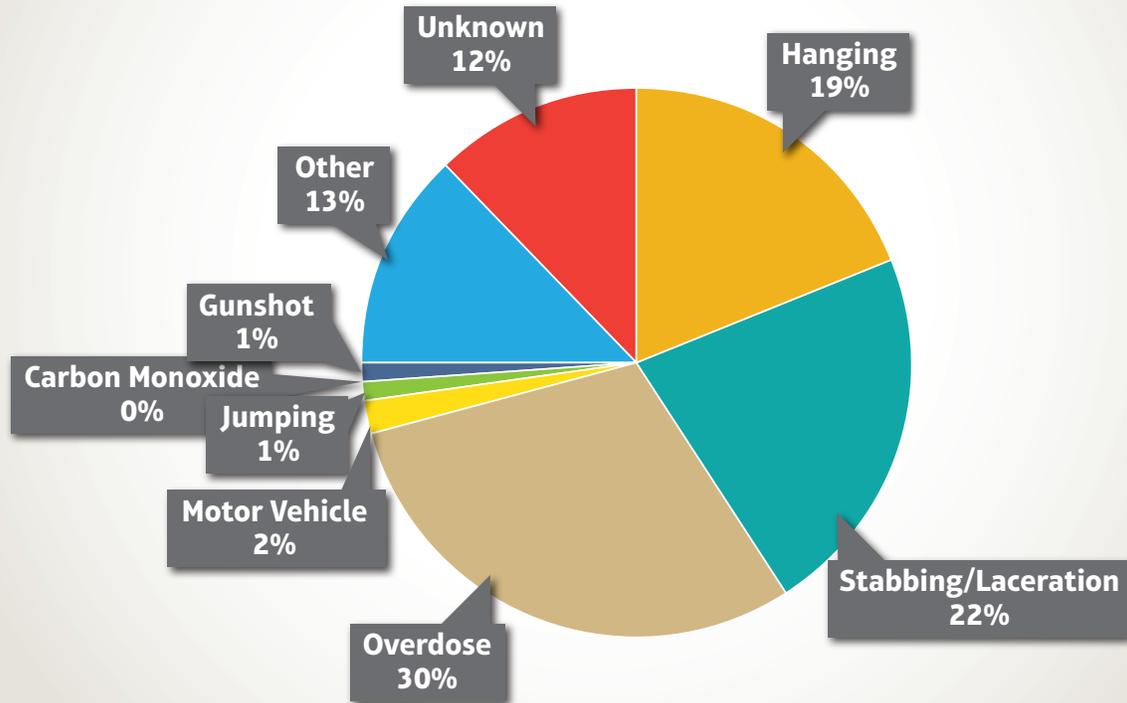
**GREAT PLAINS AREA SUICIDAL BEHAVIORS**



## GREAT PLAINS AREA SUICIDAL BEHAVIOR METHODS

(Ideations/Attempts)

RPMS Aggregate Suicide Data Report | Act occurred: Jan 1 - Dec 31, 2019



### 2. ALCOHOL & SUBSTANCE ABUSE

Great Plains Area has the one of the highest alcohol related deaths and the second highest rate of suicides in the country. Most of the Alcohol and Substance Abuse programs in the Great Plains Area are contractual. The need for additional funding to assist Tribes in developing primary care facilities, after-care, and behavioral health models is greatly needed in order to fully utilize opportunities for third party funding (Medicare, Medicaid, Private Insurance, and Veteran's benefits) through the Affordable Care Act.

Alcohol abuse in Indian Country contributes to the high rate of violence and crimes on the reservations as well as alcohol related motor vehicle accidents. Motor vehicle accidents and liver disease are among the top alcohol induced deaths among AI/ANs. There is an overwhelming

need for medically monitored detox center(s) in the Great Plains Area.

Drug abuse in Indian country contributes to the increased numbers of domestic violence, assaults/battery, burglary, child abuse/neglect, and weapons violations. The Great Plains Area has seen a drastic increase in the use of methamphetamines and prescription drugs that include non-medical use of pain relievers, sedatives, stimulants, and tranquilizers.

Overall, Great Plains Area AI/ANs were 3.5 times more likely to die of chronic liver disease and cirrhosis when compared to all AI/ANs in the United States. South Dakota reservation counties had the highest rate ratio of the four state regions, being over 4 times more likely to die from alcohol and substance abuse.

### **3. HOSPITALS & CLINICS (H&C)**

The Great Plains region relies heavily on Direct Care Services. More than half of the Great Plains Area budget is allocated to Hospitals & Clinics. Great Plains Area identifies this as a priority because it provides the base funding for the hospitals, clinics, and health programs that operate on the Area reservations which are predominately rural.

Increasing H&C funding is necessary to support the following: primary medical care services, inpatient care, routine ambulatory care, and medical support services—such as laboratory, pharmacy, medical records, information technology, and other ancillary services. In addition, H&C funds provide the greatest flexibility to support community health initiatives, targeting the health conditions disproportionately affecting American Indians/Alaska Natives in areas of diabetic, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis.

The incidence of leading infectious disease (ID) in the Great Plains is significantly higher among AI/ANs than among the white population, especially in the Dakotas, where American Indians experienced substantially higher burden of Syphilis, and other recent outbreaks. The all-cause of mortality rate between 1990 and 2013 among AI/AN in the Great Plains was double that of the white population.

### **4. COMMUNITY HEALTH REPRESENTATIVES**

Within the reservation boundaries, many Tribal members need assistance to navigate the IHS healthcare system and overcome the many barriers to accessing health care in a rural community. Community Health Workers (CHW) are trusted members of the community and help individuals' access health care services. Services typically provided by CHWs include health promotion and health education, arranging for transportation, disease-specific education, specific direct services care, assisting individuals to navigate the health care system, and connecting individuals to other community service supports.

CHWs integrate basic medical knowledge about health promotion and disease prevention with local community knowledge. They often play a key role in follow-up care and patient education in Native languages and assist health educators with preventive initiatives. CHWs are an integral part of the Indian community and an integral member of the health care team.

### **5. URBAN HEALTH**

The Great Plains Area has 2 urban clinics in South Dakota; located in Sioux Falls, South Dakota and Omaha, Nebraska. The clinics provide health care services to the urban Indians who do not have access to the resources offered through IHS or Tribally operated health care facilities because they do not live on or near a reservation. The base funding for Urban Health in the Great Plains Area provides improving Urban Indian access to health care centers to improve health outcomes, implementing and utilizing advanced health information technology, expanding access to quality, culturally competent care for Urban Indians through collaboration with other federal agencies.

In order to continue providing integrated care or even maintain current services, a significant increase to the Urban Health funding will allow program stability and an opportunity to look at program growth.

### **6. DENTAL SERVICES**

Great Plains Indian Health Service currently has 21 dental programs with six program locations within hospitals. There are federally- and Tribally-run facilities. Basic services include preventive, emergency, restorative, oral surgery, and pediatric dentistry is emphasized, although, a limited amount of endodontics, periodontics, and prosthetics is available. Oral health in the Great Plains Area is complicated by the multiple comorbidities and a high rate of early childhood caries.

American Indian children are disproportionately affected by oral disease compared with the general population. Overall, American Indian children have significantly higher rates of dental caries and periodontal disease in all age groups.

According to the Federal Office of Minority Children (OMH), American Indian children aged 2 to 4 years have five times the rate of dental decay compared to all children, and 6- to 8-year old American Indian and Alaska Native children have nearly twice the rate of dental caries experience. Untreated rates for decay in these age groups are two to three times higher than in the same age groups within the general population. American Indian adults have two and half times higher rate of periodontal disease than the national population.

Factors such as poverty, geography, underserved areas, lack of oral health education, language and cultural barriers, fear of dental care, and a belief that people who

are not in pain do not need dental care, significantly impact these rates. In fact, within the Great Plains Area, American Indian preschool children have the highest rate of tooth decay than any population in the country. On the Oglala Sioux Indian reservation, the W.K. Kellogg Foundation found 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. The Great Plains Area has long been challenged to meet the very high level need for health care services, including oral healthcare for younger children. The need for restorative services has far exceeded the capacity of the dental programs.

Many communities do not have on-site services for children with advanced caries, and thus there is a constant stream of transports of children to larger communities for specialty care, where many children require restorations and extractions under general anesthesia. Precise data are not available, but with about 25% of children requiring general anesthesia, this rate is at least 50 times (i.e., 5000%) higher than the US, other races rate.

## **7. PUBLIC HEALTH NURSING**

The Great Plains Area Public Health Nursing (PHN) is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability. The PHN program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary, and tertiary prevention services to individuals, families, and community.

The benefit of having funding for PHN, in 2016, the Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community. The intervention was to improve health outcomes of high risk patients through a community case management model that utilized the PHN as a case manager.

The PHN program continues to review the delivery of service for safe and quality standards of various accrediting bodies. This activity includes coordinating with the Joint Commission to define the PHN services as an integrated IHS service for review and continued efforts to host webinars to share practices on safe and quality care.

## **8. HEALTH EDUCATION**

Health education focuses on keeping people and their communities healthy. Defined by the World Health

Organization: “Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing the knowledge or influencing their attitudes”.

In the Great Plains Area collaboration with Tribes to increase Colorectal Cancer screening rates was implemented. The Turtle Mountain Band of Chippewa Indians Health Education and the Turtle Mountain Service Unit-Quentin Burdick Health Care facility PHN program are both recipients of the North Dakota Colorectal Cancer Screening Award. Collaborative efforts have led to a 10 percent increase in colorectal screening and an 80 percent Tribal member screening rate.

In an area where mortality among American Indians is most often due to heart disease and cancers, through accidents, diabetes, and chronic liver disease, Health Education has become an integral piece of health care for Tribal members of the Great Plains area. Health Education teaches, inspires, and supports families to adopt healthier lifestyles.

## **9. HEALTH CARE FACILITIES CONSTRUCTION**

According to the Health Facilities Construction Fact Sheet located on the IHS website, “The average age of IHS health care facilities is greater than 37 years. Because of the increasing user population and insufficient space, many facilities are severely overcrowded. This impedes American Indian/Alaska Natives access to health care and precludes an increase in the number of health care providers. When a facility is replaced, the new facility is typically three to four times larger. Expansion provides access to health care for the 10-year projected user population and space for additional staff and some new services.”

The Great Plains Area is in desperate need of resources that will address the ongoing facility deficiencies. As facilities age, reliability and effectiveness become questionable in the rural locations of the Great Plains Area Tribes.

Great Plains Area needs for Health Care Construction HFDS Report shows a total of 1,482,427 SF of supported space Great Plans Area Master Plan indicates 2,800,000 SF is needed

Master Plan Need – 2,800,000 SF  
HFDS Maximum Supportable Space – 1,484,700 SF  
Current Space Needed – 1,315,300 SF

# NASHVILLE

The Nashville Area offers the following budget recommendations for FY 2022: Fund the Indian Health Service at **\$11.9 Billion, +30% over the FY 2021 proposed budget levels, a recommended increase of \$2.7 Billion.**

- At +30%, fund Program Expansion beyond Current Services and Binding Obligations at \$11.9 billion for the following Clinical Services programs:
  - » Hospitals and Clinics \$569.8 million
  - » Purchase Referred Care \$561 million
  - » Alcohol/Substance Abuse \$463.8 million
  - » Mental Health \$446.1 million
  - » Dental Health \$375.4 million
  - » Electronic Health Record System (New) \$373.7 million

## TOP 6 BUDGET INCREASES

### 1. HOSPITALS & CLINICS +\$569.8 M

Funding for Hospitals & Clinics (H&C) remains a top tribal budget priority, as more than half of the IHS H&C budget is transferred under P.L. 93-638 contracts or compacts to the Tribes, who are responsible for approximately 58% of the IHS outpatient workload and 50% of the inpatient workload. H&C funding supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy and other services. H&C funds also supports community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, elder health and disease surveillance.

### 2. PURCHASED/REFERRED CARE (PRC) +\$561 M

PRC funding is one of the key budget priorities for the Nashville Area. IHS and the Tribes serve primarily small, rural populations and provide mainly primary care and community health services. Much of the secondary care, and nearly all of the tertiary care needed, must be purchased from non-IHS facilities. PRC funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition

and pharmacy services. These funds are critical to securing the care needed to treat injuries, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs.

As with H&C funding, these investments in PRC would be used to improve both access to care and the quality of care. Increasing access to outside health care services and working with off-site providers to improve the quality of care provided under PRC will help to reduce health disparities and the number of deaths due to heart disease, cancer, diabetes, unintentional injuries, chronic liver disease, chronic lower respiratory disease, stroke, suicide, influenza/pneumonia and nephritis.

### 3. ALCOHOL/SUBSTANCE ABUSE PROGRAM (ASAP) +\$463.8 M

Alcohol has wide-ranging adverse consequences. Identifying the factors that contribute to alcohol-related problems and understanding the fundamental biological, environmental, and developmental factors is key to developing preventive and treatment approaches in a culturally appropriate and community driven context. This is critically important because although Native Americans are less likely to drink than white Americans, those who do drink are more likely to binge drink, have a higher rate of past-year alcohol use disorder compared with other racial and ethnic groups, and are twice as likely to die from alcohol-related causes than the general American public (NIAAA). Increasing ASAP funding to tailor resources for preventing, treating, and facilitating recovery from alcohol problems across the lifespan, including at the embryonic and fetal stages to eliminate fetal alcohol spectrum disorders. The resources must be available for tribal nations to adequately address detoxification, inpatient rehabilitation in a culturally appropriate environment, and support for residential treatment as well as sober housing. The increased funding for ASAP is also needed to allow for integrated approaches to address co-occurring substance use and mental health disorders and to reduce health disparities through a comprehensive public health approach.

### 4. MENTAL HEALTH +\$446.1 M

Mental Health, is a top tribal health priority. The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among American Indians and Alaska Natives is well documented. A mental illness regularly disrupts a person's thinking, feeling, mood, ability to relate to others and function, but with early intervention and proper support and treatment,

outcomes can be improved. Lack of access to timely, high-quality treatment is the greatest barrier to healthy Native American individuals and communities. Hundreds of IHS, Tribal, and Urban Indian Mental Health programs across the nation offer access to community-based integrated primary care and preventive mental health services that are culturally appropriate and integrated with primary care with options for specialty tele-behavioral services. However, the majority of programs are small and staffed with one provider. To ensure that everyone who seeks treatment is able to receive it, additional resources are required.

### **5. DENTAL HEALTH +\$375.4 M**

AI/ANs suffer disproportionately from dental diseases: 3-5 year-old AI/AN children have approximately four times as much tooth decay as the general U.S. population (43% vs. 11%), causing significant consequences such as delayed speech development, poor self-esteem, and high costs to repair; 6-9 year-old AI/AN children suffer almost twice as much decay as the general U.S. population (83% vs. 45%), resulting in increased missed school days, poorer school performance, and pain; and 13-15 year-old AI/AN children have five times the tooth decay prevalence as the general U.S. population (53% vs. 11%). Even in adults, the prevalence of disease is much higher: in adults over the age of 35, AI/ANs have more than five times the prevalence of periodontal disease as the general U.S. population (16.2% vs. 2.9%).

As a result of these disparities in oral disease, the IHS has created national initiatives. The IHS Early Childhood Caries (ECC) Collaborative is focused on preventing tooth decay (ECC) in American Indian/Alaska Native (AI/AN) children under the age of 71 months. The ECC Collaborative began in 2010 with the goal of reducing ECC in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, Head Start teachers, and more. By the end of the first five years of this initiative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9% and significantly increased prevention and early intervention efforts (sealants increased by 65.0%, the number of children receiving fluoride varnish increased by 68.2%, and the number of therapeutic fillings increased by 161.0%), resulting in a net decrease of ECC prevalence from 54.9% in 2010 to 52.6% in 2014. To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451

children in 2010 and 11,873 in 2014 - the largest oral health surveillance sample size ever of this age group in the AI/AN population.

Increased funding for dental health will enable the IHS to support – through the continuation of existing initiatives – increasing the workforce, improving efficiency of programs, and prioritizing oral health in an effort to reduce the aforementioned disparities in oral health in the AI/AN population.

### **6. ELECTRONIC HEALTH RECORD SYSTEM (NEW) +\$326.8 M**

RPMS has been utilized by IHS for 34 years and through partnership and cost sharing with the U.S. Department of Veteran's Affairs (VA) IHS has been able to develop and design specific applications to meet the unique needs of the Indian healthcare delivery system. On June 5 2017, when the VA announced its plans to modernize their EHR and move from the current Veterans Information System and Technical Architecture (VistA) to a commercial off the shelf (COTS) system. This announcement forced IHS to evaluate the future of RPMS EHR to determine if the agency can maintain costs without the support of the VA or if the IHS too should consider a new option.

Over the years, IHS has been able to limit the costs associated with upgrades to the RPMS EHR by building upon the upgrades and advancements that the VA had made to VistA, which is similar in infrastructure to the RPMS. It has been cost-effective to maintain RPMS with the VA's partnership, especially when faced with limited increases to the health information technology budget line in IHS's annual appropriation.

Due to the growing needs of health information technology within the Indian healthcare system, IHS has faced a need for increases in operational and maintenance costs, however funding has remained stagnant. Before moving forward, IHS should strongly consider the costs of implementing a new EHR system that would replace RPMS. The Indian health care system suffers from chronic underfunding and shortages in resources. Nashville Area Tribal Nations have deep concerns on not only the costs to IHS associated with transitioning to a new EHR system but the subsequent costs for maintenance system updates as well. Since 2015, funding for the IHS Health Information Technology (HIT) Program that administers RPMS has remained stagnant at \$182,149,000. We have concerns that if a new system is implemented, IHS and Tribally operated facilities may not have enough funding for these updates and the burden of the costs may cause

shifting of funding from other vital IHS services. Given the current underfunding of the IHS system, any changes to the Indian health system requiring additional resources without increased funding would be inconsistent with the federal government's trust responsibility to provide for the health of Indian people.

## REMAINING TOP 10 BUDGET PRIORITIES:

### 7. MAINTENANCE AND IMPROVEMENT (M&I)

M&I funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. M&I is also used for maintaining compliance with accreditation standards of the Joint Commission or other accreditation bodies.

There has been an increase in M&I funding for the past two fiscal years, but this has only begun to address the long running deficit causing a large Backlog of Essential Maintenance and Repair. In addition, due to low Health Care Facilities Construction funding, existing infrastructure continues to age. The average age of IHS healthcare facilities is ~40 years. Additional improvement funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

Additional M&I funding would allow IHS to increase the quality of care provided to Native Americans and Alaska Natives.

### 8. SANITATION FACILITIES CONSTRUCTION (SFC)

Funds appropriated for water supply and waste disposal facilities are under the Sanitation Facilities Construction (SFC) line item. Projects are cooperatively developed with and transferred to Tribes which in turn assume responsibility for the operation of safe water, wastewater, solid waste systems, and related support facilities.

The SFC program receives funds for three types of projects:

- a. Water, wastewater, and solid waste facilities for *Existing* American Indian and Alaskan Native (AI/AN) Homes and/or Communities:
  - i. The sanitation project need for *Existing* AI/AN Homes and/or Communities at the end of year 2019 was \$2.6 billion nationally and \$29.1 million for the Nashville Area.
  - ii. There were over 110,000 AI/AN homes nationally and 2,425 homes within the Nashville Area at the end of year 2019 that needed some form of sanitation facility improvement.
- c. Water, wastewater, and solid waste facilities for New AI/AN Homes and/or New Communities; and
- d. Special or emergency projects.

Infant mortality rates, gastroenteritis mortality rates and other environmentally-related diseases in AI/AN populations have been reduced by about 80 percent since 1973. The availability of sanitation facilities, environmental health efforts and improved housing have been major factors in reducing these mortality rates in AI/AN populations. In addition, research by the Centers for Disease Control and Prevention found that rural populations without in-home water service had significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus. This study shows that the SFC Program is a key factor in the health status of AI/AN people. With increased funding, additional progress can be made in preventing illness related to deficient sanitary facilities.

### 9. HEALTH EDUCATION

Health educators are a necessary part of a culturally appropriate approach to addressing health concerns by teaching people about behaviors that promote wellness in American Indian and Alaska Native communities. The goal of the Health Education program is to help Indian people live well and stay well. Cross-cutting prevention approaches, aimed at education-driven voluntary behavior change activities offer the best hope of improving disease-related AI/AN mortality and morbidity. The Health Education program supports the provision of community, school and worksite health promotion, patient and professional education, and the development of educational materials for staff, patients, families and communities.

### 10. HEALTH EDUCATION

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Education program supports the provision of community, school and worksite health promotion, patient and professional education, and the development of educational materials for staff, patients, families and communities.

## **11. URBAN INDIAN HEALTH**

The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. The Urban Indian Health Program line item is distributed through contracts and grants to the individual Urban Indian Health programs. The distribution is based upon the historical base funding of these programs. The funding level is estimated at 22% of the projected need for primary care services. Eighteen (18) additional cities have been identified as having an urban population large enough to support an Urban Indian Health Program. 2010 Census data shows that 71% of all American Indians and Alaska Natives live in urban centers. The President's FY 2017 budget marked the third straight year that funding for urban Indian health fell below 1% of total Indian Health Service funding.

It is important to bear in mind that urban Indian health programs are funded from a single IHS line item, and do not have access to funding appropriated to other areas of the IHS budget. Thus, any increase the Administration has proposed for the broader Indian Health Service budget will not benefit urban Indian health programs or the Native communities they serve. It is critical that Congress direct resources to the urban Indian health line item to provide health care services to urban Indian patients.

## **HEALTH CARE FACILITIES CONSTRUCTION**

The Health Care Facilities Construction (HCFC) Appropriations are the primary source for new or replacement healthcare facilities. The number, location, layout, design, capacity and other physical features of healthcare facilities are essential for: Eliminating health disparities, Increasing access, Improving patient outcomes, Reducing O&M costs, Improving staff and operational efficiency, Increasing patient, visitor, and staff safety, Improving staff satisfaction, morale, recruitment and retention, Reducing medical errors and facility-acquired infection rates.

The absence of an adequate facility frequently results in either treatment not being sought, or sought later prompted by worsening symptoms, and/or the referral of patients to outside communities. Referrals significantly

increase the cost of patient care and causes travel hardships for many patients and their families.

At the current rate of HCFC appropriations (~\$240 million/year), a new facility in 2019 would not be replaced for 400 to 450 years. To replace IHS facilities every 60 years (twice a 30 year design life), would need HCFC appropriations of ~\$700 million/annually. Without a sufficient, consistent, and re-occurring HCFC appropriation, the entire IHS system is unsustainable.

Health Care Facilities Construction funding is needed in the Nashville Area. \$100 million has been requested under Obligated Agreements for previously approved health facility construction projects in accordance with the IHS Planned Construction Budget, referred to as the 5-Year Plan.

While the Nashville Area has supported increased funding for Health Care Facilities Construction in the past, the Area has not historically benefited from this program. The development of a revised Health Care Facilities Construction Priority System and the language in the permanently reauthorized Indian Health Care Improvement Act's new funding mechanisms for health care facilities construction provides some hope that future funding becomes available to replace outdated Nashville Area health care facilities. IHS has yet to approve the revised priority system for implementation or to create an Area Distribution Fund to address Nashville Area facility construction needs. The Nashville Area Tribal Nations request that IHS develop and implement an Area Distribution Fund for the Facilities line item, so that other Area facilities get smaller projects completed while IHS continues to work on the "grandfathered" priority list.

## **FACILITIES AND ENVIRONMENTAL HEALTH**

The Facilities Support, Sanitation Facilities Construction and Environmental Health Services programs are funded out of the Facilities and Environmental Health Account. Facilities and Environmental Health support funds are used for the planning, construction and maintenance of hospitals and clinics to provide the highest quality of care in a safe clean environment; to assure new facilities meet or exceed health care accreditation standards; to identify hazards and risks to Area Tribal members through the development and implementation of comprehensive environmental health programs; to assess environmental conditions; and to provide technical assistance as needed. In recent years the Nashville Area has grown to include six new Tribes and four additional Service Units



so additional funding is required to provide needed services. Along with the additional Tribes and Service Units, many of our Tribes are expanding services and building additional facilities such as Elder housing and Domestic Violence Shelters so additional staff is needed to assess new facilities on at least an annual basis.

In the last two years, there has been a significant increase in M&I funding without a corresponding increase in Facilities and Environmental Health Support funds for staffing. The additional funds are used for planning and monitoring health care facility maintenance programs to guarantee public safety, maintain high health care accreditation standards, and maintain a healthy environment for staff and patients.

Since many of our facilities are older, some need extensive renovations which adds work to both Facilities and Environmental Health staff in terms of plan review, construction review, and technical assistance.

The Division of Sanitation Facilities Construction (SFC) designs, and supervises the construction of water, wastewater, and solid waste facilities. Engineers also inspect water, wastewater, and solid waste facilities with Division of Environmental Health Services staff in an effort to provide clean, safe water for Area Tribes. In recent years the SFC project budget has doubled without a corresponding increase in staffing dollars, which increases work for SFC certainly, but also increases the need for additional Facilities and Environmental Health staff in regards to increased inspections and technical assistance.

## **STANDING AREA PRIORITY RECOMMENDATIONS**

### **ADVANCE APPROPRIATIONS**

Since Fiscal Year 1998, appropriated funds for the Indian Health Service have been released after the beginning of the new fiscal year. Most often caused by a Congressional

failure to enact prompt appropriations legislation, late funding has severely hindered Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts. Congress has recognized the difficulties inherent in the provision of direct health care that relies on the appropriations process and traditional funding cycle and has appropriated beginning with FY 2010, advance appropriations for the VA medical care accounts. As the only other federally funded provider of direct health care, IHS should be afforded the same budgetary certainty and protections extended to the VA.

### **FUNDING OBLIGATION FOR 105(L) LEASES**

ISDEAA authorizes the IHS to enter into a lease with Tribal Nations for a facility used to administer and deliver PFSAs. Historically, the appropriations for facilities has been underfunded, so these lease agreements allow Tribal Nations to collect additional funds to maintain their facilities and frees up other resources that could be utilized to deliver health care services. To the disadvantage of the IHS, IHS doesn't receive separate appropriation for 105(l) lease agreement, though, if entered into, IHS has a binding obligation to pay these agreements, in accordance with regulatory criteria.

As more Tribal Nations enter into 105(l) agreements, the burden of payment could increase exponentially over time and be detrimental to the IHS Budget. Nashville Area Tribal Nations believe that funding for 105(l) lease agreements should be funded similar to Contract Support Costs, as a separate appropriation account with an indefinite amount- "such sums as may be necessary." Funding similarly to CSC would alleviate the burden that IHS and Tribal Nations experienced in FY 2017 and 2018, where IHS had to make a decision to pay for the lease agreements with program funding from unallocated inflation increases, which ultimately denied Tribal Nations in need of program increase to keep pace with the costs of living and health care.

### **SPECIAL INITIATIVE FUNDING FOR NEW TRIBES**

The six newly recognized Tribal Nations in Virginia, Chickahominy Indian Tribe, Chickahominy Indian Tribe – Eastern Division, Monacan Nation, Nansemond Indian Tribe, Rappahannock Tribe, and the Upper Mattaponi Tribe, were recognized on January 29, 2018, as well as Pamunkey’s recognition in 2016. These tribal nations are now eligible for services provided by the Indian Health Service. While the FY 2020 budget request included funding for programs and services, it did not include special initiative funding leaving these tribes without funding for special initiatives for grant programs, such as Special Diabetes Program for Indians and all of the IHS behavioral health initiatives.

### **HEPATITIS C**

Hepatitis C (HCV) infection is the most common blood-borne disease in the United States, disproportionately impacting racial and ethnic minorities, including American Indians and Alaska Natives (AI/AN). In 2015, AI/AN experienced a rate of acute HCV higher than that of other minority populations, with AI/AN women more than 50% likely to die from viral hepatitis compared to their non-Hispanic white counterparts. As a result, the Indian Health Service has increased its focus on HCV Elimination, with the goals of increased HCV screening, prevention of new viral hepatitis infections, and the reduction of viral hepatitis fatalities.

With an increase in initiatives to address opioid abuse in Indian Country, attention to viral hepatitis exposure is critical. Indeed, the highest risk of HCV infection occurs among injection drug users and persons with sexually transmitted infections. Additionally, the co-infection with HIV in those with HCV is estimated between 50% and 90%, with higher HCV viral load, more rapid progression to HCV-related liver disease, and increased risk for cirrhosis and liver cancer. Approximately 1 in 4 people living with HIV are co-infected with HCV.

Intensified education around Hepatitis C is critical to ensuring tribal and urban Indian communities have the necessary knowledge to protect themselves from infection and/or to access effective antiretroviral therapies. Such efforts would likewise assist in the prevention of HIV and STIs given the parallel risk of exposure. Knowing that risk amplifies where injection drug use is present, it is vital to include this information in any efforts to prevent and treat opioid abuse. A strong health promotion/disease prevention approach could have significant impacts on the health Indian Country.

## **NAVAJO**

### **MAINTENANCE & IMPROVEMENT (M&I)**

The Navajo Nation recommends a 46 percent funding increase to the Maintenance & Improvement (M&I) budget line item appropriation for the Indian Health Service. The Indian Health Service (IHS), Division of Facilities Operation at Headquarters and the Facilities Management/Health Facilities divisions at the Area Level include the activities that support the operation of health care facilities to accomplish its ultimate goal: the delivery of health care. The Division is involved in the maintenance, repair, and improvement of:

- Physical Plant (buildings);
- Utility Systems (exterior and interior);
- Clinical Equipment (medical and often non-medical);
- Grounds, Roads, and Parking Lots;
- Building Service Equipment Systems that provide the physical environment for patient care.

Organizing these engineering related services include assessing the structure, utilities, and equipment, designing modifications, preparing engineering drawings and specifications for repairs and improvements, and troubleshooting major components or system failures. The Division is also responsible for the realty, clinical engineering, and facilities environmental programs.

The IHS maintains government owned/leased buildings whether operated by the IHS or Tribal health programs pursuant to contract or compact arrangements executed under the provisions of the Indian Self Determination and Education Assistance Act (P.L. 93-638).

IHS also provides funding to Tribally owned/leased buildings containing health programs pursuant to contract or compact arrangements executed under the provision of the Indian Self Determination and Education Act (P.L. 93-638).

The M&I program objectives include:

- Providing routine maintenance for facilities
- Achieving compliance with buildings and grounds accreditation standards of The Joint Commission (TJC) or other applicable accreditation bodies
- Providing improved facilities for patient care
- Ensuring that health care facilities meet building codes and standards ensuring compliance with Executive Orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

Continued funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

The M&I appropriation has historically been underfunded. The amount of funding historically provided was adequate to fund at the level of sustainment. Sustainment is activities conducted to keep the buildings in their current condition. This is only to keep the building in their current condition with no replacement or upgrades of building infrastructure. Since FY 2017, the IHS has M&I funding beyond the amount required for sustainment. In addition in FY 2018, FY 2019, the IHS received a total of \$173.9 million to address the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The Navajo Area requests these levels be maintained, as it is needed to continue to address the BEMAR. This is an IHS required report on the current backlog, which now totals approximately \$767 million.

The proposed increase would incrementally improve the IHS capability to meet sustainment and repair/replace/improve existing infrastructure and building equipment for each health facility.

This increase will help IHS and Tribal facilities to maintain, improve the condition index, and meet accreditation requirements of these facilities.

**MAINTENANCE & IMPROVEMENT INDIAN HEALTH CARE IMPROVEMENT ACT (IHICIA) PROVISIONS:**

The FY 2022 budget request is aligned with the provisions of the IHICIA 25 U.S.C. §1631, 1632, 1634, and 1638(a) includes language for M&I funds.

M&I funds are to be used by and available to the Indian Health Service and Tribe or Tribal Organization to maintain the operation of hospital and health facilities to keep them in operational and in compliance with accreditation standards.

**GOVERNMENT PERFORMANCE AND RESULTS**

**ACT OF 1993 (GPRA) PERFORMANCE**

**TARGETS AND OUTCOMES:**

The increase of M&I dollars will allow the IHS to keep all existing health care facility operational.

Given there are few opportunities for the replacement facilities, maintaining current facilities is imperative. This will allow the IHS to continue to provide health care and meet the GPRA performance targets and outcomes.

**HEALTH FACILITIES CONSTRUCTION**

The FY 2022 budget request for an additional \$470 million is to support Health Facilities Construction. Nationally, the Indian Health Service (IHS) has 9 new Inpatient and Outpatient and Small Ambulatory facilities, Staff Quarters Program, and Joint Venture Construction Program planned for construction, with only two facilities currently funded for construction.

The Navajo Nation requests the U.S. Congress to continue to support health care facility construction projects including infrastructure development and the design of Navajo’s next major project, the Gallup Indian Medical Center in Gallup, New Mexico.

Further, Congress is urged to consider appropriation of funding in the estimated amount of \$552 million for the Navajo health facilities that remain on the IHS Construction Priority List. The planning and construction of projects on the List will elevate the quality of care and increase access to care. Congress is also asked to acknowledge other facility needs and to be cognizant of future Navajo health care facilities, which require expansion, renovation and/or replacement.

The most current IHS Annual Facilities Planning document (Five -Year Plan) lists 9 national projects, including four Navajo health facility projects. The final Program Justification Documents (PJD) and Interim PJDs for the four Navajo projects were approved by the IHS and are listed as follows with estimated funding needs:

PROJECT	ESTIMATED COSTS	ADDED COSTS
Dilkon Health Center	\$ 214,800,000	
Pueblo Pintado Health Center	\$ 97,400,000	
Bodaway-Gap Health Center	\$ 124,600,000	
Gallup Indian Medical Center	\$ 552,000,000	\$1 million

*\*These figures could change based on approved final Project Justification Documents & current construction costs*

The Navajo Area Indian Health Service (NAIHS) currently has four health facilities (1 inpatient hospital and 3 outpatient clinics) on the national IHS Health Facility Construction Priority List, with a total combined cost estimate of \$876.8 million. The existing facilities are obsolete with an average age of 49 years and have long surpassed their useful lives. The facilities are grossly undersized for the identified user populations, which has created crowded conditions among staff, patients, and visitors. In many cases, existing services are relocated outside the

main health facility. Often, modular office units provide additional space for medical primary health care and specialty services. Such displacement of medical services creates difficulties for staff and patients and increases wait times, resulting in numerous inefficiencies within the health care system which delays care.

As the existing health facilities age, associated building equipment and infrastructure also deteriorate to a point of failure. The decreased availability of replacement parts for aged equipment and infrastructure ultimately disrupt the already limited medical services. For example, piping systems that provide potable water for health services, frequently experience failures, requiring the systems to be shut down for extended periods of time. This often results in discontinuation of patient care until the appropriate repairs are made. The rural and isolated conditions associated with the NAIHS health facilities complicates the repair of failed systems and extends the time required to make needed repairs. The constant system failures deplete designated maintenance and improvement funds and requires the use of third party collections or other funding sources that would otherwise be used for direct patient care. In terms of medical and laboratory equipment, the NAIHS makes every attempt to keep pace with changed and modernized technologies; however, due to limited equipment funds, the NAIHS health facilities will typically use equipment well beyond their expected useful life. The construction of new health facilities alleviates many of the problems associated with failing building systems and equipment, while simultaneously modernizing medical, laboratory and information equipment technologies.

**HEALTH FACILITIES CONSTRUCTION IHICA PROVISION:**

The FY 2022 budget request is aligned with the provisions of the Indian Health Care Improvement Act (IHICA) (25 U.S.C., SUBCHAPTER III--HEALTH FACILITIES) to improve quality and access to care by making available modern health facility square footage, facility infrastructure, and modern medical and information technologies. In line with the IHICA is the IHS Health Care Priority System that identifies Health Facilities Construction projects for priority inpatient, outpatient, staff quarters development, Joint Venture, and Youth Regional Treatment Centers. Increased funding eliminates deficiencies in health status and health resources, eliminates backlogs in the provision of health care services, and meets the health care needs of the Navajo people in an efficient and equitable manner.

**GPRA PERFORMANCE TARGETS AND OUTCOMES:**

Increased funding for health facilities construction and renovation eliminates incidences of and types of

complications resulting from diabetes and other chronic diseases; and capitalizes on community health promotion and disease prevention programs.

A dedicated health facility is an organized array of medical services located in an area, and this existing structure with core services and staffing resources permit the identification and implementation of health care measures for monitoring health outcomes, hence monitoring of population health. Where health facilities exist, there is a determined implementation of the mandated GPRA performance targets and better outcomes.

The health facilities in Navajo meet regulatory requirements for safe and quality care as they are the Joint Commission (JC) accredited or Centers for Medicare and Medicaid Services (CMS) certified.

**WATER & SANITATION**

The Navajo Nation has more than 3,400 homes which lack funding for adequate water and sewer facilities. The total Navajo Nation water and sewer economically feasible unmet need is more than \$132 million. It has been proven that as the number of homes using available clean, safe water has climbed; the incidence of death due to intestinal disease in childhood has fallen. Decreased disease rates reduce medical costs. Therefore, increased funding, to address this severe Navajo Nation backlog, is requested. The additional resources will help to reduce the backlog of sanitation facilities needed to serve existing homes and will also address the need for sanitation facilities for eligible new homes being constructed annually.

The provision of sanitation facilities is an extension of primary health care delivery. The availability of essential sanitation facilities can be a major factor in breaking the chain of waterborne communicable disease episodes but by no means is their value limited to disease intervention. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts. Efforts by other public health workers are much more effective when safe water and adequate wastewater disposal systems are in place.

Patients admitted to the hospital have longer lengths of stay due to lack of sanitation facilities at home. An example of this is an elderly patient with a broken hip that should be discharged home but has no indoor water and sewer facilities and typically, uses an outhouse located a long distance from the home. Many of these patients

end up being admitted to nursing homes where exposure to nosocomial infections may worsen the chance of good outcome and return home.

The provision of sanitation facilities also has other far-reaching, positive effects. The availability of such facilities is of fundamental importance to social and economic development. In turn, such development leads to an improved quality of life and an improved sense of well-being.

A recent cost benefit analysis indicated that for every dollar IHS spends on sanitation facilities to serve eligible existing homes; at least a twentyfold return in health benefits is achieved. The IHS Sanitation Facilities Construction Program has been the primary provider of these services since 1960.

#### **WATER & SANITATION IHCA PROVISION:**

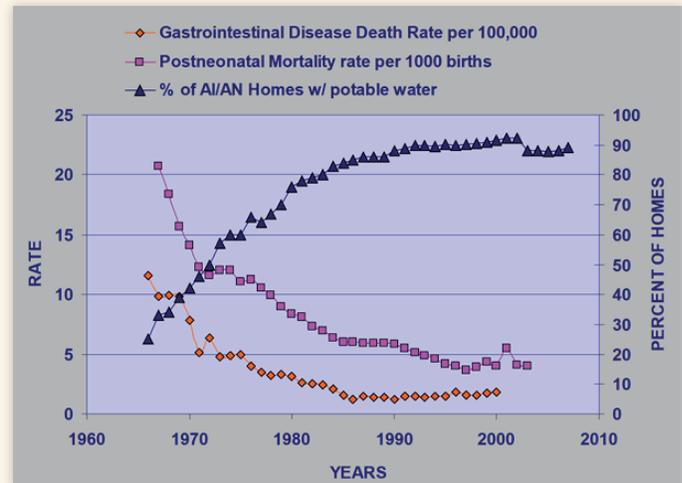
Provision of safe water and sanitary waste disposal facilities is referenced in 25 U.S.C. § 1632.

#### **GPRA PERFORMANCE TARGETS AND OUTCOMES:**

The GPRA measure for providing new or improved water, wastewater, and solid waste facilities to existing homes and new and like new homes is 17,500. Increased funding will increase the number of homes served.

Increased water and sewer (P.L. 86-121) funding will allow IHS to provide facilities to more homes, thus improving the quality and access to health care as described below.

Families with satisfactory environmental conditions in their homes, which include safe water and sewerage systems, require appreciably fewer medical services and place fewer demands on the Indian Health Service (IHS) and Tribal primary health care delivery system. The Indian Sanitation Facilities Act, P.L. 86-121, authorizes the IHS to provide essential sanitation facilities, such as safe drinking water and adequate sewerage systems, to Indian homes and communities. The SFC Program is a preventative health program that yields positive benefits. A recent cost benefit analysis indicated that for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a twentyfold return in health benefits is achieved. The IHS Sanitation Facilities Construction Program has been the primary provider of these services since 1960.



While 1% of the U.S. general population lacks access to safe water, 9% of Indian homes lack access to safe water.

There is a large national backlog of needed sanitation facilities construction projects in Indian Country. With inflation, new environmental requirements, and population growth, the current sanitation appropriations are not reducing the backlog. In addition to providing safe sanitation facilities to existing homes, the IHS also provides sanitation facilities to new homes.

#### **MENTAL HEALTH**

The Navajo Area recommends funding increase to the Mental Health budget category. Existing challenges continue because, in part, mental health treatment services are limited. Overcoming and resolving shortages of licensed qualified mental health providers is a significant obstacle due to lack of available housing and offering of competitive salaries. Recruiting and hiring providers requires the Navajo Nation and the NAIHS to invest a considerable amount of time and resources to educate providers that may not have any background or experience in working with or treating American Indians or in native communities where reliance upon spiritual, cultural and traditional beliefs to treat mental illness exist. These traditions are unique to Indian Tribes and not consistently incorporated into modern medical treatment methods when addressing mental health illness. The lack of inpatient mental health services continues to be detrimental to the treatment of mental health patients. In many patients, the severity of the mental illness would benefit from inpatient therapy but instead they receive only infrequent outpatient therapy or none at all. Despite attempts to effectively manage mental health illness, Navajo families and communities continue to experience behavioral

health crises involving depression, violence, alcohol and substance abuse or neglect. Behavioral health issues also influence the physical health of individuals.

**MENTAL HEALTH IHCIA PROVISIONS:**

25 U.S.C. § 1621(b) - Mental Health Prevention and Treatment Services.

**GPRA PERFORMANCE TARGETS AND OUTCOMES:**

There are two GPRA measures relevant to the mental health line item, including depression screening or mood disorder, for ages 12-17 years, and depression screening or mood disorder, among individuals age 18 and over:

- In Fiscal Year 2019, Navajo Area exceeded the depression screening measure target for ages 12-17 which was 27.60% by performing at 41.85%. Overall, the national performance was 37.25%.
- The target for the depression screening measure for ages 18 and over was 42.2%. Navajo Area performance, 48.76%, for this measure exceeded the target. National performance was 42.56%.

**PREVENTATIVE HEALTH**

**(COMMUNITY HEALTH REPRESENTATIVES, PUBLIC HEALTH NURSING AND HEALTH EDUCATION)**

The Navajo Area recommends an 18 percent increase to the Community Health Representatives (CHR), Public Health Nursing (PHN), and Health Education Program (HE) budget line items. The current levels of funding are inadequate to fully provide quality health care and health education services to the Navajo Nation. The increased funding supports expansion of services and training for the CHR, PHN and Health Education staff as paraprofessionals to provide instruction and practical experience in prevention activities and health services.

The 10 leading causes of death on the Navajo Nation are unintentional injuries, heart disease, cancer, diabetes, mellitus, chronic liver disease and cirrhosis, cerebrovascular disease, influenza and pneumonia, intentional self-harm (suicide), dementia, and alcohol dependence.<sup>27</sup> In comparison to the US population, the leading cause of death is heart disease, cancer, unintentional injuries.<sup>28</sup> The health disparity must be reversed through enhancement of primary prevention and care to our Navajo people.

27 Navajo Nation Epidemiology Center, 2019. Unpublished report. 2017 Leading Causes of Death for Navajos.

28 Murphy SL, Xu JQ, Kochanek KD, Arias, E. Mortality in the United States, 2017. NCHS Data Brief, no 328. Hyattsville, MD: National Center for Health Statistics. 2018.

PHNs, CHRs, and Health Educators are trained to provide communities with culturally-appropriate education and awareness relating to preventive health, emergency response, and communicable diseases.

Health educators are extremely valuable in Navajo communities by raising awareness of lifestyle choices and decisions. Health services provided by health educators help prevent countless sick days for workers and students, guide individuals to practice sanitary and hygiene habits that prevent crippling and deadly diseases from being transmitted and spread. Furthermore, health educators are a vital source to interpret health education messages from English to Navajo. Proper interpretation results in breaking the chain of infection, prevention of new and emerging diseases for community members residing across approximately 27,000 square miles.

CHR are integral in the Navajo health care system to link the patient to health services to reduce readmissions and emergency department admissions through home visits to patients with chronic health conditions such as asthma, diabetes mellitus and hypertension. The current levels of funding do not meet the staffing needs of the program. The program requires nine CHRs to fulfill one CHR per community. As syphilis outbreaks are seen in the US, the program is the leader in providing tuberculosis and sexually transmitted disease prevention and surveillance. The inadequate number of personnel contributes to quality of care and preventative education of chronic diseases that are preventable.

PHNs are vital in population health using nursing, social, and public health sciences as defined by the American Public Health Association. The public health nursing practice is uniquely tied to improving the health of communities through vaccinations, screenings, assessment and education on prenatal/postpartum and chronic disease, and lastly communicable disease investigation and education.

Enhanced federal investments and adherence to the federal trust responsibility is essential to delivery of high quality care, care coordination, and effective prevention of chronic diseases to the Navajo people. The Navajo population is projected to increase in the coming years requiring expansion of services. According to the 5-Year American Community Survey, the Navajo population on the Navajo Nation has increased by 3% and the United States has increased by 6.6% between 2010 and 2015.<sup>29</sup> To ensure that our Navajo Nation is prepared to meet the

29 Navajo Nation Epidemiology Center, 2019. Five Year American Community Survey.



unique health care needs of this growing population, the Navajo Nation requests continued investment in CHRs, PHNs, and health educators. As health professionals, they are fundamental in primary, secondary and tertiary prevention, as well as, bridging primary care with community health outreach and education. In closing, CHRs, PHNs, and health educators serve as public health professionals who are trusted in the community, schools, and the workforce.

**PREVENTATIVE HEALTH IHCIA PROVISIONS:**

The justification for the proposed budget increase outlined in this request is aligned with the authority of IHCIA, Title 25, Section 1621 b, health promotion/disease prevention services; 1621q. Prevention, control, and elimination of communicable and infectious diseases.

**GPRA PERFORMANCE TARGETS AND OUTCOMES:**

This proposed budget increase request is in alignment with the following GPRA clinical performance measures:

- Immunizations
  - » Influenza Vaccination 6mo-17yrs
  - » Influenza Vaccination 18+
  - » Adult Immunizations
  - » Childhood IZ
- Childhood Weight Control

**HOSPITAL AND CLINICS (H&HC)**

The Navajo Area continues to recommend a funding increase to the Hospitals and Health Clinics (H&HC) budget category as it funds essential, personal health services through medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. The federally-operated healthcare facilities in the five Service Units serve 67.8 percent of the Area User Population while the Tribally-operated healthcare facilities serve 32

percent of the Area User Population. Similar to most IHS regions, personal health care services are integrated with community health services. Most of these particular types of programs are provided directly by the Navajo Nation government, which includes public/community health programs targeting health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and hepatitis.

Resources under the H&HC budget category are distributed to all healthcare delivery stakeholders in the Navajo Area, including Indian self-determination contracts and Tribal self-governance compacts. Increased H&HC appropriations supports all stakeholders in the Navajo Area, which also support Health Information Technology systems and infrastructure, Navajo Epidemiology Center, and other community health initiatives of the Navajo Nation government.

**HOSPITAL AND HEALTH CLINICS IHCIA PROVISIONS:**  
*25 U.S.C. § 1601*

**GPRA PERFORMANCE TARGETS AND OUTCOMES:**

Navajo Area met the five GPRA diabetes care measures in FY 2019:

- Controlled blood pressure: Target: 52.30%; Navajo Area performance: 56.3%; National performance: 57.19%;
- Nephropathy assessment: Target: 34.00%; Navajo Area performance: 47.73%; National performance: 43.97%;
- Poor glycemic control: Target: Baseline; Navajo Area performance: 23.05%; National performance: 17.4%;
- Retinopathy exams: Target: 49.70%; Navajo Area performance: 54.82%; National performance: 49.67%;
- Statin therapy: Target: 37.5%; Navajo Area performance: 51.86%; National performance: 47.39%.

Navajo Area also met the Cardiovascular Statin Therapy measure in FY 2019.

- CVD statin therapy: Target: 26.6%; Navajo Area performance: 38.04%; National performance: 32.2%;

Navajo Area met all four **Immunization** measures in FY 2019.

- Adult Immunizations – all age-appropriate immunizations: Target: 54.90%; Navajo Area performance: 64.76%; National performance: 53.26%;
- Childhood immunizations: Target: 45.60%; Navajo Area performance: 56.95%; National performance: 41.44%;
- Influenza vaccinations for ages 18 and over: Target: 18.8%; Navajo Area performance: 29.08%; National performance: 23.63%;
- Influenza vaccines for ages 6 month to 17 years: Target: 20.60%; Navajo Area performance: 37.11%; National performance: 25.68%.

Navajo Area met the GPRA **HIV Screening** measure.

- HIV Screen: Target: 17.3%; Navajo Area performance: 40.73%; National performance: 30.85%.

## INFORMATION TECHNOLOGY

At the Navajo Area Budget Formulation meeting in November 2019, participants identified that Information Technology as one of the top five priorities for Federal, Tribal, and Urban programs across Navajo Area. In 2018, the Chief Information Officer at Navajo Area Office compiled data collected by federal, Tribal, and urban programs for a 5-year plan of Information Technology purchases and needs. The data is still applicable for the current year.

The data was presented at 2020 Budget Formulation to inform participants the need for Information Technology to be included in the top five priorities for Navajo Area. In addition, Navajo Area health care facilities identified bandwidth infrastructure challenges and upgraded equipment to allow health care facilities to provide services to provide quality health care.

SUMMARY OF SPENDING	FY2019 PLANNED TOTAL COSTS	FY2020 PLANNED TOTAL COSTS	FY2021 PLANNED TOTAL COST	FY2022 PLANNED TOTAL COST	FY2023 PLANNED TOTAL COST
FTE & Contract Costs Total	\$9,402,585.00	\$9,547,057.00	\$8,416,966.00	\$8,574,017.00	\$8,717,498.00
Hardware Replacement Total	\$12,935,005.00	\$12,734,158.00	\$7,647,922.00	\$8,389,974.00	\$8,850,814.00
Software Total	\$3,413,894.11	\$1,948,354.04	\$2,036,666.04	\$2,107,772.04	\$2,211,416.04
Planned Project Total	\$10,114,496.00	\$6,962,381.00	\$3,965,059.00	\$5,106,822.00	\$5,062,980.00
Planned Cloud Projects Total	\$210,000.00	\$0.00	\$8,500.00	\$0.00	\$470,000.00
<b>Total Area IT Spending</b>	<b>\$36,075,980.11</b>	<b>\$31,191,950.04</b>	<b>\$22,075,113.04</b>	<b>\$24,178,585.04</b>	<b>\$25,312,708.04</b>

### INFORMATION TECHNOLOGY PROVISION:

HHS and IHS Health Information Technology Modernization Research Project completed an assessment for federal, Tribal, and urban programs in 2018. The project provides valuable insight on ways for IHS to streamline its health IT infrastructure, applications, and capabilities. The IHS currently uses the Resource and Patient Management System, or RPMS, to manage clinical, financial, and administrative information in the Indian health system. RPMS was developed in close partnership with the Veterans Health Administration and has been somewhat dependent on the development of the VA health IT system, known as VistA. By adapting VistA, IHS reduced expenditures on developing and maintaining the system. They will assist IHS by informing

recommendations for a modern health IT system that will address clinical, process and technical gaps for improving health care outcomes within the Indian health system. Moreover, they will facilitate a successful transition from dependence on the VistA system. This process involves several stages collecting valuable stakeholder input, including the voice of Tribal members and leaders. The process will help inform planning and decision-making at IHS, including development projects and acquisitions. The project included:

- Project planning and strategy;
- Convening an expert advisory panel on IHS health information technology;

- Assessment of current health information technology in a sample of IHS, Tribal and urban sites;
- Developing a health IT community of practice;
- Health information technology analysis and recommendations; and
- Health information technology initiatives roadmap and strategy.

This project is in line with our mission at the Office of Information Technology to provide a highly reliable and efficient health information system to support the delivery of health care to the American Indian and Alaska Native people. It is also in alignment with the White House initiative to modernize federal IT. IHS recently participated in a panel discussion on IT modernization in government with IT leaders from other federal government agencies. We discussed federal government priorities in modernizing our IT systems.

**GPRA PERFORMANCE TARGETS AND OUTCOMES:**

Placing Information Technology in the top five priorities for 2022 and in future Budget Formulation recommendations will allow IHS to be prepared for data analysis and recommendations provided by the HHS and IHS Health Information Technology Modernization Research Project. The data analysis and recommendation will allow for IHS to plan future expansions, future upgrades, and /or future modernization of the electronic health record, and equally important, to assist the Agency will achieving all GPRA performance targets and outcomes.

## OKLAHOMA CITY

The Oklahoma City Area Indian Health Service (OCAIHS) serves the states of Oklahoma, Kansas, a portion of Texas, and Richardson County, Nebraska. Forty-three Tribals are represented within the Area with 38 in Oklahoma, 4 in Kansas, and one in Texas. In FY 2019, the Oklahoma City Area (OCA) user population was 388,486 – the largest user population in IHS representing 23.4% of the total. The OCA is the lowest funded IHS Area per capita. The I/T/U health systems within the Area manage 8 hospitals, 59 health centers (which includes 3 urban health clinics), 1 school health center, and 1 regional youth alcohol and substance abuse treatment center. The large number of Tribal health care facilities and programs is a strong reflection of the partnership and cooperation within the OCA to fulfill the existing health care needs of our community.

According to the 2018 American Community Survey 5-year report, there are 927,946 American Indians and Alaska Natives (AI/ANs) alone or in combination with one or more other races in the OCA. This represents the potential users for our Area’s I/T/U health system that reside within the service area.

The goal is to improve the overall health status of our patients. One challenge is overcoming health disparities such as a higher mortality rate in proportion to the general population. According to the Oklahoma State Department of Health-Vital Statistics, the top five causes of death for the AI/ANs in Oklahoma with a comparison to All Races combined is shown below. The age-adjusted rate of Deaths due to Accidents (unintentional injuries) and Diabetes is higher for AI/ANs.

**TOP 5 RANKED CAUSES OF DEATH-ICD10  
(STATE OF OKLAHOMA)**

AMERICAN INDIAN/ALASKA NATIVES	ALL RACES COMBINED
1 Diseases of heart	1 Diseases of heart
2 Malignant neoplasms	2 Malignant neoplasms
3 Accidents (unintentional injuries)	3 Chronic lower respiratory diseases
4 Chronic lower respiratory diseases	4 Accidents (unintentional injuries)
5 Diabetes mellitus	5 Cerebrovascular disease

Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics 2015-2017, on Oklahoma Statistics on Health Available for Everyone (OK2SHARE).

**BUDGET RECOMMENDATIONS**

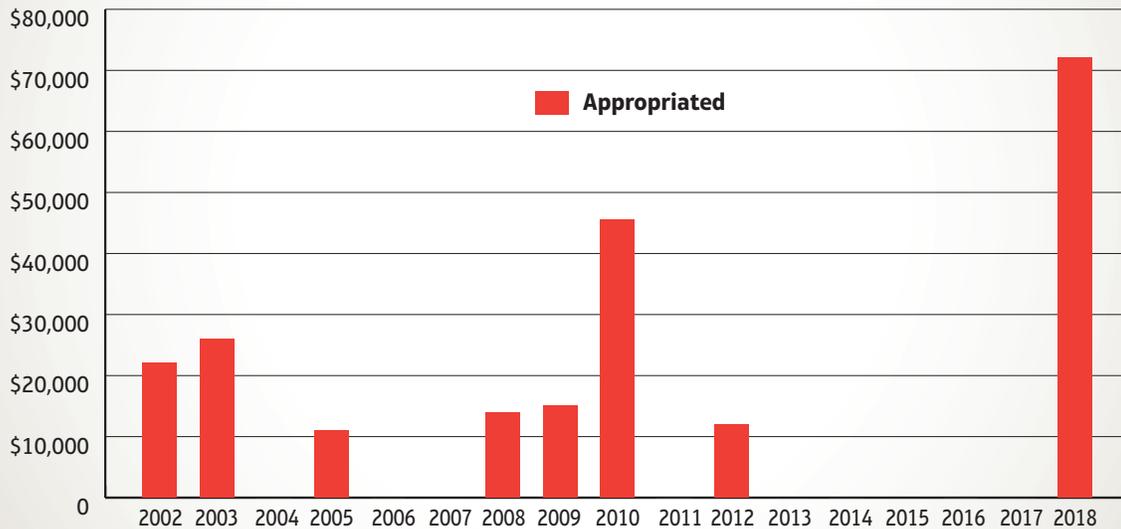
**1. INDIAN HEALTH CARE IMPROVEMENT FUND (HOSPITALS AND HEALTH SERVICES)**

The Indian health system faces significant funding disparities when compared to other Federal health care programs. This disparity continued to grow in 2017, with all IHS per capita spending at just \$4,078, while the national average per capita spending was \$9,726. The historic allocations of resources appropriated to the IHS have created significant inconsistencies throughout the system. Over the years, allocation methodologies have created a disparity of available resources by line items when reflected in a per capita amount. While youth trauma, suicide, and substance abuse treatment is a priority, so are elders with heart disease and dementia, children who need vaccinations or suffer a routine infection, as well as adults with type 2 diabetes or bipolar disorder. In short, quality health services remain a priority for all our citizens. The OCA has historically had the lowest funding per capita

amongst the Areas in overall IHS funding, in FY 2019 the OCA per capita amount is \$2,075.

The Indian Health Care Improvement Act (IHCIA) established the Indian Health Care Improvement Fund (IHCIF) to eliminate the deficiencies and inequities in health status and health resources in Indian Country. Despite significant AI/AN health disparities and a legislative mechanism to address resource deficiencies and inequities, only \$258.8 million has been distributed to IHS Service Units, Indian Tribals, or Tribal organizations through the IHCIF via the Level of Need (LNF) formula since adopted in 2001. While Tribals are appreciative of the 2018 allocation of \$72.28 million, the IHCIF was not allotted additional funding in FY2019. Given that user population is increasing year over year and health disparities continue to grow, steady and consistent funding is necessary to achieve the goals of the ICHIF. Unfortunately, gains in parity also have been negated by rescissions and sequestration. The most underfunded units require immediate attention.

**INDIAN HEALTH CARE IMPROVEMENT FUND — LEVEL OF NEED FUNDED**  
**FY 2000-2018 TOTAL APPROPRIATIONS = \$258,893**  
 (Dollars in Thousands)



In FY 2022, the OCA requests an increase for the IHCIF. During the past two years, the joint Tribal/Federal Workgroup developed recommendations for IHS to consider and make a final determination on the allocation methodology. The final report was due to the IHS Director in July 2019, but to date no report has been

released. The OCA strongly suggests the workgroup complete the report soon and forward it to the IHS Director so a final determination can be made. OCA specifically requests the following:

- Complete the final report with recommendations on the new allocation methodology for the IHCIF;
- Through Tribal consultation, the IHS Director adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future; and
- Communicate with all Tribals the new allocation methodology for the IHCIF; and
- Update the data in the IHCIF allocation methodology be released to all Tribals annually; and
- Identify and train new permanent statistical/technical staff as point of contact for future IHCIF need calculations; and
- Reduce per capita disparities for the most underfunded as the top priority to promote greater equity in health care funding.

Such an increase and equitable distribution of the IHCIF will ensure greater access to high quality, culturally appropriate care and services across the I/T/U system for the ever-increasing user population.

## **2. MAINTENANCE AND IMPROVEMENT**

Maintenance and improvement (M&I) funds are the primary source for maintenance, repair, and improvements for IHS and Tribal health care facilities. Funding infrastructure maintenance is central to the delivery of and access to quality health care service. Recent Congressional increases to M&I provided for some major repair projects. However, the M&I budget is funded at just over half of need to effectively maintain the physical condition of IHS-owned and Tribally-owned healthcare facilities – which further distresses the backlog in essential maintenance and repairs, totaling nearly \$650 million.

The average age of IHS health care facilities is ~40 years, with only limited recapitalization in the plant due to a growing Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). Comparatively, the average age, including recapitalization and reinvestment, of U.S. private sector hospitals is approximately 10 years. Failure to fully fund BEMAR exacerbates the overall quality of and access to care across the entire IHS Health System. New facility construction is similarly underfunded and physical plants are not being replaced. Therefore, sustainable funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

Given the underfunded situation, IHS and Tribals have been forced into either a deferred maintenance scenario (which is the practice of postponing maintenance activities

in order to postpone costs), meet budget funding levels, or realign available budget monies. The failure to complete needed repairs will lead to asset deterioration resulting in higher costs, asset failure, and health and safety implications. Geaslin's Inverse-Square Rule for Deferred Maintenance says that maintenance deferred until failure will cost 15 fold the repair value or the original value squared. The OCAIHS is concerned that unless a substantial infusion of M&I funds are provided in the FY 2022 budget cycle, that we will not be able to perform many required maintenance and improvement projects and this will cause irreparable harm to many IHS and Tribal facilities. The OCAIHS recommends a significant increase to maintain existing IHS and Tribal facilities and to address the backlog of nearly \$650 million of essential maintenance and repairs.

## **3. PURCHASED AND REFERRED CARE (PRC)**

Purchased Referred Care is health care purchased by an Indian health care provider from non-Indian health care providers and facilities when direct health care services are not available.

The OCA IHS ranks last of the twelve IHS Areas in funding available for PRC services based on active patients. The level of funding in OCA was \$311.20 per person for FY 2019. As a result, the IHS is not able to purchase needed care from specialists and must prioritize its expenditures for only the most serious and life threatening care. Historical data indicates a majority of the current base PRC funding is used for Priority I (life and limb threatening) services, which impacts the ability of IHS to meet its Mission of raising the health status of the AI/AN people to the highest possible level.

The sheer volume of OCA PRC denials/deferrals illustrates the need for additional funding. In FY 2019, the numbers of PRC denied cases were 20,118 and deferred cases totaled 27,512 for those facilities reporting. Of the deferred cases, over 90% were for acute and chronic care. In FY 2019, OCA Catastrophic Health Emergency Fund (CHEF) reimbursed cases was \$10 million, more than double the requests/payments for FY 2018. The lack of state level Medicaid expansion in OCA has resulted in no relief of the financial pressure to provide even basic life-and-limb services. Furthermore, in the five years (2014-2018), the OCA averaged over 18% of funded CHEF cases nationally but was funded at only at 11% on average when compared to all other IHS Areas combined.

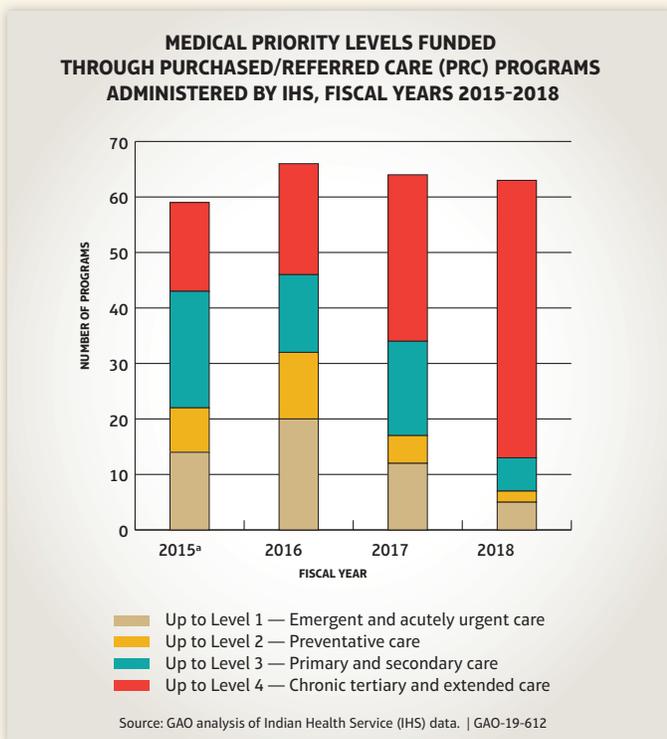
Again, the OCA does not have adequate funding for specialists, such as cardiologists, oncologists and orthopedic

surgeons, readily available. OCA does not have tertiary hospitals and must utilize PRC to provide that aspect of specialty care. The cost of providing such services is disproportionately burdensome on all PRC resources. The existence of IHS/Tribal hospitals in OCA does not mean there are specialty services available, which must be purchased, nor timely access to direct services, due to waiting times for appointments.

The lack of appropriations leaves many without access to primary health care services and even more to specialty and referred care. Other barriers also exist, such as, distance from an Indian Health care facility, overburdened health care facilities due to lack of resources, and services not provided due to lack of resources.

Due to the lack of PRC resources available per patient, IHS-eligible individuals are routinely denied access to needed care until the situation is grave enough to threaten life or limb. Routinely denied and deferred services consist of orthopedic diagnostics and treatment, which often prevents AI/ANs from being in the workplace. Other services, such as sophisticated diagnostic procedures, are also often denied or deferred due to medical priority.

*The OCA recommends continuing increased funds for PRC by making it a high national priority. The OCA also recommends that distribution continue to be primarily based upon the patient population to be served with PRC.*



Finally, the OCA PRC programs have continued to be negatively impacted by the lack of Medicaid expansion. Other IHS Areas have experienced an expansion in their ability to provide a broader range of PRC, meeting more levels of medical priority. In its 2019 report, numbered GAO-19-612, the Government Accountability Office found that from 2013 through 2018, most IHS-administered PRC programs moved from covering only the most acute and emergent cases (referred to as Priority 1) to funding nearly all types of care covered by the PRC program.

Although the positive impact of Medicaid expansion has been profound on a national level, the IHS has noted that *Oklahoma City Area remains one of the few IHS Areas that only fund Priority Level 1 services for PRC, which is borne out by the numbers of denied and deferred cases described above, as well as the increase in CHEF requests from OCA.* Without Medicaid expansion, the OCA patients are often solely dependent upon PRC and the significant funding limitations of this program, and the disparity in PRC resources continues to grow.

Prioritization of PRC directly contributes to access to care described in Goal 1 of the IHS Strategic Plan, which states:

*Access:* Many facilities operated by the IHS and Tribes are located in rural or remote settings and may be unable to provide comprehensive health care services and/or acute and specialty care services. To help meet the health care needs, the PRC program purchases services from private health care providers for eligible patients. Although PRC funding may meet the full patient need in some IHS areas, funding may not be sufficient to meet the need in others.<sup>30</sup>

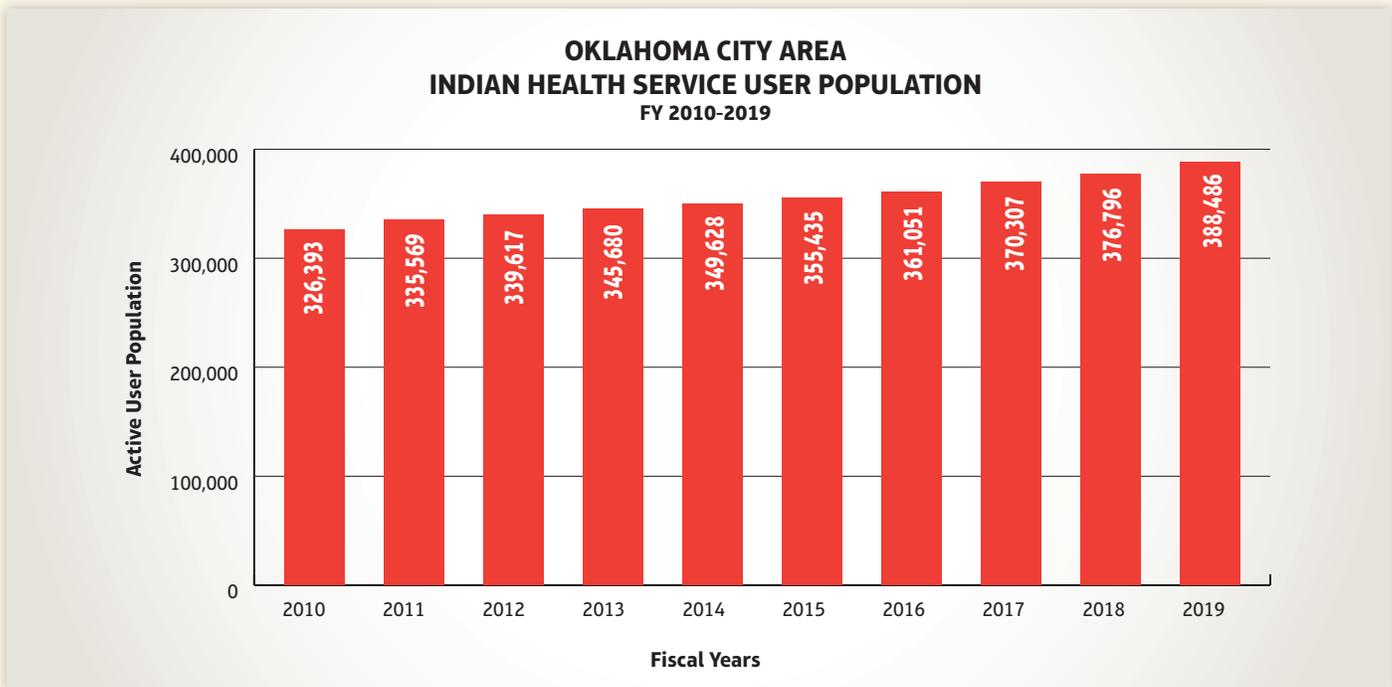
#### 4. HOSPITALS AND HEALTH CLINICS, INCLUDING \$5 MILLION FOR HEALTH IT

Hospitals and Health Clinics (H&HC) in the OCA funds essential personal health services for a user population of 388,486 AI/ANs including medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, and health information management. The IHS system of care is unique in that personal health care services are integrated with community health services. In addition, the program includes public and community health initiatives targeting

<sup>30</sup> Department of Health and Human Services, Indian Health Service. (2019) Indian Health Service Strategic Plan. Retrieved from [https://www.ihs.gov/sites/strategicplan/themes/responsive2017/display\\_objects/documents/IHS\\_Strategic\\_Plan\\_FY%202019-2023.pdf](https://www.ihs.gov/sites/strategicplan/themes/responsive2017/display_objects/documents/IHS_Strategic_Plan_FY%202019-2023.pdf)

health conditions disproportionately affecting AI/ANs such as diabetes, maternal and child health disparities, and communicable diseases including influenza, HIV/AIDS, and hepatitis. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions.

The increase is critically needed to help fund increasing staffing costs, primarily in rural America. The IHS has seen a drastic surge in population over the last 10 years without a sufficient increase in funding to support the added population. The OCA continued to see a 19% increase in User Population from 2010-2019, as reflected in the table.



This population growth is important to note because during fiscal years 2018 and 2019, increases normally set-aside for inflation were reprogrammed from unallocated, but appropriated inflation increases, to specific non-inflation line items, such as 105(l) leases. The diversion of such appropriated amounts negatively affected our Hospitals & Health Clinics (H&HC) budget, which is already severely underfunded and serves a growing population. It is important to note that all Tribals benefit from inflationary increases whereas only a few benefit from 105(l) lease awards; reprogramming such funding is always divisive and creates “winners” and “losers.” Because of this, the OCA continues to support a separate, indefinite appropriation for 105(l) lease funding.

increase of almost 10% in pharmaceutical expenditures. OCA must continue to provide life-saving medications used to treat heart failure and diabetes, even though drug costs continue to rise. H&HC funding must increase to meet this critical need.

Finally, screening and early detection efforts, which are known to be life-saving through preventative and managed care, have not historically been funded. Within the OCA, there is an increased need to focus on early detection of cancer, diabetes, and heart disease as well as communicable diseases like HIV and Hepatitis C, so that intervention at an early stage can prevent other chronic conditions from co-occurring or in some cases, cure the disease altogether.

Another issue of concern within the OCA is the ever-rising costs of pharmaceuticals, which have led to decreasing formularies. Over the last three years, the IHS has seen an



### **HEALTH INFORMATION TECHNOLOGY - \$5 MILLION**

In Fiscal Year 2019, the Department of Health and Human Services (HHS) and IHS evaluated the current Health Information Technology (HIT) infrastructure, electronic health record system and, based on the evaluation, developed the Roadmap Report. The Roadmap lays out a number of opportunities for FY 20-22, including establishment of a Project Management Office and governance structure, acquisition planning, HIT selection and procurement, implementation planning, and testing.

To achieve the plan as described in the Roadmap Report, HHS must request and receive dedicated appropriations to secure current RPMS functionality and address the identified critical infrastructure gaps through acquisition and planning. Information technology that supports both personal health services (including the Electronic Health Record and telemedicine) and public health initiatives has historically primarily been funded through the H&HC budget.

Due to the complexity of HIT and the need to transition and improve legacy systems, OCA continues to recommend that a new separate line item is essential. According to the Roadmap Report, IHS should be preparing for training and transition in Fiscal Year 2022. Though exact costs estimates have not been identified at the time of this drafting, the OCA recommends that request made through the Project Management Office or the HIT Modernization Advisory Committee be included in the FY2022 Presidential Budget.

### **5. URBAN FACILITIES**

Although approximately 78% of AI/ANs reside in urban areas, the IHS funding allocation for Urban Indian health reflects less than 1% of the total annual IHS budget. In addition, Urban Indian Health Programs (UIHP) do not receive funding from other line items which the other facets of the IHS system receive, like the facilities budget. Moreover, in recent years, IHS has added 6 new programs

to the Title V budget line item; yet there has not been a commensurate increase in the sole line item funding these programs – the Urban Indian budget. UIHPs are also ineligible for other payment options that reduce costs for the other facets of the IHS system – including Federal Tort Claims Act coverage, which results in UIHPs having to use a portion of their limited funding for costly malpractice insurance. Similarly, services provided at UIHPs are not reimbursed at the 100% Federal Medical Assistance Percentage rate that similar services are at IHS and Tribally operated facilities.

There are a total of 41 UIHPs spanning across 22 states, including 3 UIHPs in the Oklahoma City Area: Hunter Health in Wichita, KS; Kansas City Indian Center in Kansas City, MO; and Urban Inter-Tribal Center of Texas in Dallas, TX. These facilities are Urban Indian Organizations operating pursuant to a grant or contract under Title V of the Indian Health Care Improvement Act and embody the third prong of the Indian health care delivery – IHS/Tribal/UIHP – system. Because UIHPs receive substantially less funding from the IHS budget, they are often faced with the harsh reality of obtaining supplemental sources of funding to provide more services to more AI/ANs living in urban areas.

It is recommended we prioritize urban Indian health funding in addition to Tribal health priorities to advocate that Congress increase the budget to appropriate funding levels for both.

**FY 2022 IHS BUDGET PHOENIX AREA TRIBAL RECOMMENDATIONS  
+\$2.7 BILLION OVER THE FY 2021 NATIONAL TRIBAL BUDGET RECOMMENDATION**

(Dollars in Thousands)

ACTIVITY	FY 2019 IHS ANNUALIZED CONTINUING RESOLUTION	FY 2020 IHS PRESIDENT'S BUDGET REQUEST	FY 2021 NAT. TRIBAL RECOMM. FOR CURRENT SERVICES/ PROGRAM INCREASES (TOTALS)	FY 2022 PHOENIX AREA NATIONAL BUDGET RECOMMENDATION (TOTALS)	PERCENTAGE CHANGE
Clinical Services	3,616,147	3,996,964	6,199,552	1,703,762	27.48%
Preventive Health	170,968	118,258	358,069	177,115	49.46%
Other Services	179,287	171,320	266,687	82,946	31.1%
Facilities	868,704	803,026	1,397,634	779,428	55.77%
Contract Support Costs	717,970	855,000	922,227	(TBD – Per required appropriation)	
<b>TOTAL</b>	<b>5,553,076</b>	<b>5,944,567</b>	<b>8,221,943</b>	<b>11,887,420</b>	<b>+30%</b>

**FISCAL YEAR 2022 IHS BUDGET NARRATIVE**

Tribes in the Phoenix Area recommend a total Indian Health Service (IHS) budget of **\$11.8 billion** for Fiscal Year (FY) 2022. This represents a program increase of **30% above** the FY 2021 National Tribal Budget Recommendation of \$8.2 billion, which served as the planning base for the FY 2022 budget formulation process. Program increases in the top 7 budget line item priorities in the Services and the top 3 line items in Facilities were agreed upon at the meeting. They are:

**IHS SERVICES - TOP 7**

1. Community Health Representatives **+\$110.7 million** (81% increase)
2. Alcohol & Substance Abuse **+\$352.8 million** (70% increase)
3. Mental Health **+\$251.2 million** (63% increase)
4. Dental Services **+\$202 million** (47% increase)
5. Indian Health Professions **+\$35.6 million** (45.9% increase)
6. Health Education **+\$35.2 million** (44.8% increase)
7. Urban Health **+\$46.3 million** (43.7% increase)

**IHS FACILITIES - TOP 3**

1. Equipment **+\$158.9 million** (297% increase)
2. Health Care Facility Construction **+\$353 million** (75.4% increase)
3. Sanitation **+\$127.4 million** (44.2% increase)

Several of the priorities connect to provisions of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. Chapter 18) as well as to the specific line items. Tribes have specified these line items because in their view

they are inadequately funded. Neither the enacted FY 2019 Annualized Continuing Resolution (CR) nor the FY2020 Budget Request met the need.

**CURRENT SERVICES/BINDING OBLIGATIONS**

Tribal Leaders noted the importance of funding current services and the Federal government's binding obligations (fixed costs) in the FY 2022 IHS Budget Request. The leadership concurs with the FY 2021 National Tribal Budget Recommendation and understands it will be updated at the National Tribal Budget Formulation Work Group meeting scheduled on February 13-14, 2020 in Crystal City, VA. The Tribal estimate for Current Services and Binding Obligations in FY 2021 totaled **\$670 million over** the FY 2019 enacted amount to cover Current Services. All other binding obligations are as follows:

**Total FY 2021 Request for Fixed Costs: Current Services & Binding Obligations:**

**CURRENT SERVICES:**

Federal Pay Costs.....	\$ 19,398,000
Tribal Pay Costs.....	\$ 29,097,000
Inflation (non-medical).....	\$ 32,207,000
Inflation (medical).....	\$ 87,374,000
Population Growth .....	\$ 88,928,000
Current Services Sub Total .....	\$257,004,000

**BINDING OBLIGATIONS**

Staffing: New & Replacement Facilities .....	\$ 75,000,000
Facilities Construction (Priority List) .....	\$100,000,000
105(l) leases (New).....	\$138,000,000
Newly Recognized Tribe Funding .....	\$ 11,500,000
Contract Support Costs .....	<u>\$100,000,000</u>
Binding Agreements Sub Total.....	\$424,500,000
<b>TOTAL: \$670 million</b>	

Binding Obligations are amounts that IHS funds due to statutory requirements and includes pending construction projects and New Staffing. The National Budget Formulation Workgroup has provided placeholder amounts of \$100 million for construction and \$75 million for staffing at facilities that may be scheduled to open in any given year.

Tribes and urban Indian program representatives at the Phoenix Area meeting developed a 30% national budget request reflective of their agreed upon priorities. The issues and concerns surrounding the top 7 Services priorities and the top 3 Facilities priorities are described below.

**INDIAN HEALTH SERVICES**

**1. COMMUNITY HEALTH REPRESENTATIVES (CHR) +\$110,784,000 (81% INCREASE)**

Tribal Leaders in the Phoenix Area noted that the CHR line item has hovered at \$58 million since 2014. In recognition of the important work CHRs do and the need to elevate and enhance their efforts, a **\$110.7 million** increase is requested. The distribution within that line item would address the following:

- +\$100.7 million overall increase to the line item to almost double the current FY 2020 level of funding at \$62.8 million
- +\$10 million to address Rocky Mountain Spotted Fever (RMSF), mosquito and other vector borne diseases and challenges through environmental public health related activities and community education.
- +\$783,000 to address other regional and local priorities.

Tribal leaders recognize the role of CHRs as members of the local IHS or Tribal health care delivery team providing information on health risks, policies, procedures and a range of preventative services to Tribal members. In Tribal communities, Public Health Nurses (PHNs) are working with CHRs to assist them under their required scope of work. CHRs must comply with standards of practice and fulfill training requirements. They are

highly regarded in Tribal communities, but Tribes have struggled due to insufficient appropriations to make available suitable salaries as well as hire more CHR’s to help with the workload. A program increase is sought to provide direct relief to these tribally operated programs.

The IHCIA provision that is associated with this priority is:

Community Health Representative Program (25 U.S.C. § 1616)

**2. ALCOHOL & SUBSTANCE ABUSE +\$352,836,000 (70% INCREASE)**

Alcohol and substance abuse health risks continue to be a major concern and correlates to the top leading cause of death in the Phoenix Area, which is, unintentional injury, primarily motor vehicle fatalities, poisonings and falls and the fourth leading cause of death which is chronic liver disease and cirrhosis. A **\$352 million** increase is needed to institute the Comprehensive Behavioral Health Prevention and Treatment Program which is in accordance with the Indian Health Care Improvement Act (25 U.S.C. §1665c). According to the law, “the Secretary, acting through the Service shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include, if feasible and appropriate, systems of care.” The increase will fund prevention, acute detoxification, residential and outpatient treatment, community-based rehabilitation and aftercare, community education, staff training and specialized residential treatment programs for high-risk populations. It is also imperative that coordination of care addresses any co-occurring mental health disorders. This is more fully discussed under the Behavioral Health Hot Issue briefing paper that accompanies this report.

Tribes in the Phoenix Area continue to advocate for the resources needed to implement numerous behavioral health programs authorized by the IHCIA provisions identified below. These should remain at the forefront of agency planning.

The IHCIA provisions associated with this priority are:

- Comprehensive behavioral health prevention and treatment program (25 U.S.C. §1665c.)
- Indian women treatment programs (25 U.S.C. § 1665f.)
- Indian youth program (25 U.S.C. § 1665g.)

### 3. MENTAL HEALTH +\$251,244,000 (63% INCREASE)

Tribal Leaders in the Phoenix Area seek an overall increase of \$251.2 million dollars for the Mental Health line item to increase the ability of mental health programs to continue their important work that includes outpatient counseling, psychiatric evaluations, crises response, case management and care coordination. The appropriations requested in FY 2020, a \$9.1 million increase, is inadequate to provide the necessary level of screenings and services which assist patients that contemplate or attempt suicide, engage in self-harm, that experience depression, violence and other emotional trauma. The increase is also needed so that IHS and Tribes may fully institute behavioral health integration within primary care. Additional concerns are noted below:

- The need for qualified mental health providers; in particular, Tribes voiced the difficulty in recruiting and retaining fulltime professionals to work and adapt to Tribal settings. Tribal Leaders are aware of the need to *grow our own* Indian health professionals to fill this need.
- Youth and adults in Tribal communities that experience severe depression, suicidal thoughts, anxiety and other forms of mental illness must be focused on. Prevention and treatment efforts, including Traditional Healing and Faith-Based counseling, as requested, would yield positive results.
- There is a need to access higher levels of psychiatric care for AI/AN patients within the HIS or by connecting patients to state services. However, legal processes in state or Tribal Courts and the referral processes are further complicated by State requirements if an individual is Medicaid eligible. Comprehensive case management that results in the coordination of care is necessary for each patient's stabilization and the key to their recovery.

There are numerous provisions in the Indian Health Care Improvement Act (IHCIA) that pertain to mental health. Tribes in the Phoenix Area seek the new resources to enhance current services and to fund implementation of the following two provisions pertaining to mental health care and co-occurring disorders. These are:

- Behavioral Health Prevention and Treatment Services (25 U.S.C. §1665, 25 U.S.C. §1665b, 25 U.S.C. §1665c) Establishes the authorities for comprehensive services and emphasizes collaboration among alcohol and substance abuse, social service and mental health programs.

- Mental Health Technician Program (25 U.S.C. §1665d). Comprehensive training of community mental health paraprofessionals, including Behavioral Health Aides under CHAP, to provide community based mental health care that includes identification, prevention, education and referral for treatment services and the use and promotion of traditional health care practices.

### 4. DENTAL HEALTH SERVICES +\$202,431,000 (47% INCREASE)

An increase of \$202 million to the Dental Services line item is requested. The need to improve oral health care delivery, workforce and prevention efforts is not understated. IHS conducted an Oral Health Survey in 2015, which compares 1999 data to current data. Key findings of the survey indicate the following for the Phoenix Area:

- 57% of AI/AN dental patients 35 years of age and older have untreated decay. AI/AN adult dental patients are almost 3 times more likely to have untreated decay than whites. In the Phoenix Area the percent of dental patients 35 years and older with untreated decay averages 63%.
- 17% of AI/AN adult dental patients compared to 10% of the U.S. overall population have severe periodontal disease.
- 83% of AI/AN adult dental patients (ages 40-64) have missing teeth compared to 66% of the U.S. overall population.

IHS reports that over 80 percent of AI/AN children ages 6-9 and 13-15 years suffer from dental caries, while less than 50 percent of the U.S. population in the same age cohort has experienced cavities. Despite these high rates, the 2016-2017 IHS Oral Health Survey of AI/AN elementary school children indicates that the caries rate has not increased significantly over the last 5 years. These are encouraging results which have been gained by widespread utilization of dental sealants and topical fluoride in our dental clinics. These applications have been made available to the youth at Tribal schools in many locations. Some dental programs have increased outreach efforts and some have involved CHR's and Health Educators.

Without overall increases Tribes discussed barriers to attracting dental professionals to work in Tribal communities. Hiring Dental Therapists and additional auxiliary staff are viable options to expand the Indian health care dental workforce. 25 U.S.C. §10221(d)(3)(A) requires that

the use of Dental Therapy services in the lower 48 states must be authorized by state law. IHS, Tribes and urban Indian health programs in Arizona and Nevada will begin to see the benefits of changes to state laws that now include scope of practice provisions for dental therapists.

The following IHCIA provision is a priority of the Tribes in the Phoenix Area:

Nationalization of the Community Health Aide Program (25 U.S.C. § 1616l (d)) CHAP would bring to the lower 48 states a program that's been successful in Alaska. It is comprised of well-trained para-professionals - Community Health Aides (CHAs), Behavioral Health Aides (BHAs) and Dental Health Aide Therapists (DHATs).

**5. INDIAN HEALTH PROFESSIONS  
+\$35,616,000 (45.9% INCREASE)**

Tribes in the Phoenix Area recommend a program increase of \$35.6 million in FY 2022 to the Indian Health Professions line item. These funds should be used to increase funding for scholarships and to expand loan forgiveness options to individuals seeking to work in IHS, Tribal and urban Indian facilities.

IHS and Tribes continue to struggle to recruit and retain qualified medical professionals to work in Indian Country. In 2018, it was reported that the estimated vacancy rates at federal/IHS sites, are as follows: Physicians - 34%; pharmacists - 16%; nurses - 24%; dentists - 26%; physician's assistants - 32%; and advanced practice nurses - 35%. Comprehensive efforts encouraging AI/ANs to enter into health careers are needed including accessing federal and state scholarships and loan repayment programs. Tribes also recommend that individuals who attend educational programs for dental therapy be eligible to receive these resources and that IHS expedite and elevate this as a priority change before October 1, 2021. Tribes seek measures to increase recruitment and retention of professionals and comprehensive efforts to encourage American Indian and Alaska Natives to enter into health careers.

The following IHCIA provisions are priorities that address staff shortage issues:

Indian Health Service Loan Repayment Program (25 U.S.C. § 1616a.) Scholarship and Loan Repayment Recovery Fund (25 U.S.C. § 1616a-1.) Recruitment Activities. (25 U.S.C. § 1616b.) Tribal Recruitment and Retention Program (25 U.S.C. § 1616c.)

Health Professional Chronic Shortage Demonstration Programs (25 U.S.C. § 1616p)

**6. HEALTH EDUCATION +\$35,247,000  
(44.8% INCREASE)**

In recognition of the important role of Health Educators and the need to elevate and enhance their efforts, a \$35.2 million increase is requested in FY 2022. Health Educators conduct important educational activities in tribal and urban Indian communities that include, general and specific school age health curriculum, education on commercial tobacco cessation, cancer prevention and screening, elder fall prevention, immunization to protect against Human Papilloma Virus (HPV), information on HIV/STD and HCV screening and treatment, as well as coordinating specialized or basic training within their communities for specified groups.

Tribes in the Phoenix Area recommend that Health Educators assist their communities address Rocky Mountain Spotted Fever (RMSF), mosquito and other vector borne diseases and challenges through environmental public health related activities and community education. The increase includes \$10 million for this purpose.

Numerous IHCIA provisions specify that health education is integral to the Indian Health Service and is factored in across all line items. The following IHCIA provision was cited as a valuable program in which Health Educators contribute:

Comprehensive school health education programs (25 U.S.C. § 1621n)

**7. URBAN HEALTH +\$46,314,000 (43.7% INCREASE)**

Tribal Leaders in the Phoenix Area support a long overdue program increase for the Urban Health line item of \$46.3 million. They recognize that the health issues of the American Indian population whether they reside on or off-reservation, are similar. Urban health programs, like the Tribes, have difficulty recruiting medical, dental, behavioral health and public health professionals that can uniquely respond to the health needs of the urban Indian population. It is recognized that access to health care is hampered by poverty in urban areas, limited and unreliable transportation, the lack of the full range of medical services in lower income areas and lack of optimal space for service delivery at urban Indian health programs.



There is now a requirement in the IHCA that requires IHS to confer with Urban Health programs (25 U.S.C. §1659). Other priority provisions of the IHCA that are relevant to this priority encompass all of Title 1 – Subtitle E. Health Services for Urban Indians, of which the following are of importance:

Facilities renovation (25 U.S.C. § 1659)

Expand program authority for urban Indian organizations (25 U.S.C. § 1660e)

Community Health Representatives (25 U.S.C. § 1660f)

## **INDIAN HEALTH FACILITIES**

### **1. EQUIPMENT + \$83,923,000 (297% INCREASE)**

Tribes in the Phoenix Area seek an \$83.9 million increase in the Equipment line item. The increases are needed to coincide with the requested amounts for Health Care Facilities Construction projects, including projects that are funded based on the current priority system, a new priority system that is forthcoming and small ambulatory construction projects that are requested by the Tribes.

Funding the Equipment line item is essential to maintain quality medical care by ensuring the routine replacement and repair of medical equipment to over 1,500 federally and tribally-operated health care facilities, by providing new medical equipment in tribally-constructed health care facilities; and by participating in TRANSAM, a program under which IHS acquires and distributes surplus medical equipment through the Department of Defense.

The IHCA contains the national policy statements: 25 U.S.C. § 1601. Congressional findings. This section states that the national goal of the United States is to provide the quantity and quality of health services to permit

the health status of Indians to be raised to the highest possible level

25 U.S.C § 1602. Declaration of national Indian health policy. This section ensures that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members

### **2. HEALTH CARE FACILITIES CONSTRUCTION (HCFC) + \$353,031,000 (INCLUDES \$50,000,000 FOR THE SMALL AMBULATORY PROGRAM) (75.4% INCREASE)**

Tribes in the Phoenix Area support a Program Increase of \$353 million in FY 2022 for the Facilities Construction line item. The amount of \$300 million is to address projects on the HCFC priority list and the amount of \$50 million is specifically for the Small Ambulatory Program. Tribes have long waited to alleviate lack of space and old infrastructure in order to increase access and improve patient health care. The current IHS HCFC Priority List, also known as the 5-year plan, was grandfathered into the *new construction priority system* established in the Indian Health Care Improvement Act in 2010.

The FY 2020 IHS Congressional Justification explains that each health care facility that is completed increases access to much needed health care services. Also, it is noted that the remaining health care facilities projects on the priority list, including those partially funded, totaled approximately \$2.02 billion as of April 2018. A new system includes the priority projects to be identified by each IHS Area that the Congress will consider funding in the future. The proposed FY 2020 IHS Budget Request would cut funding to this line item by \$77.6 million. Limited progress will be achieved if funds are redirected or reduced. Several IHS regions with projects on the priority list will be impacted, including, Phoenix, Navajo and Albuquerque IHS Areas.

The IHCIA provisions that require implementation and resources to address these Tribal concerns are:

- Health Care Facility Priority System (25 U.S.C. §1631(c) (1) (A))
- Priority of Certain Projects Protected (25 U.S.C. §1631(c) (1)(D), §1631(c)(2)(B), §1631(d)(1)(g))
- Indian Health Care Delivery Demonstration Projects (25 U.S.C. §1637)

**3. SANITATION FACILITIES CONSTRUCTION**  
**+ \$127,391,000 (44.2% INCREASE)**

Tribes in the Phoenix Area continue to prioritize the Sanitation Facilities Construction line item and request a **\$127.4 million** increase in FY 2022. As with other infrastructure issues in Tribal communities, the need for sanitation projects is great. The IHS reported in 2018, that the sanitation project backlog is approximately \$2.64 billion and affects several Areas of the IHS, including Alaska Area, Navajo Area, Oklahoma Area and Phoenix Area. The FY 2020 President’s Budget, with a proposed a \$1.2 million increase to this line item is wholly insufficient to address needed projects in rural areas that include water wells, onsite waste water systems, connecting homes to community water, and waste water facilities and upgrading the old existing water supply and waste disposal facilities. This request also considers the projected services that will be required for new Tribal housing in FY 2022.

# PORTLAND

The national budget mark for FY 2022 is 30% above the FY 2021 National Tribal Budget Workgroup recommendation. With the exception of a \$5 million increase for a Regional Specialty Referral Center, Portland Area Tribes do not support additional funding in Health Care Facilities Construction (HCFC) due to decades of non-funding for 43 Tribes in Portland.

<b>SUMMARY OF PORTLAND AREA NATIONAL BUDGET RECOMMENDATIONS</b> (Dollars in Thousands)	
	<b>NATIONAL FY 2021 RECOMMENDATION +30%</b>
Current Services (Fixed Costs)	377,084
Binding Obligations	480,835
Purchased and Referred Care	2,028,486
Affordable Care Act & Indian Healthcare Improvement Act	109,413
Long Term Care	129,605
Restoration of Pay Act	126,613
Facilities	136,946
Regional Referral Center	75,783
Information Technology & Electronic Health Record	38,439
Behavioral Health	85,966
EPI Center	12,000
<b>Total Current Service and Program Increases</b>	<b>3,601,170</b>

**CURRENT SERVICES**

**FUND PAY COSTS, INFLATION AND POPULATION GROWTH: +\$377 MILLION**

Portland Area continues to underscore the fact that IHS funded programs have had to absorb significant inflationary cost increases over the past twenty years. Federal and tribal programs struggle to absorb the real resource loss associated with inadequate funding for inflation, pay act increases and population growth. Therefore, Portland Area believes these mandatory costs must first be considered in the budget formulation process.

Portland Area supports fully funding federal and tribal pay costs, inflation and population growth. The fundamental budget principle for Portland Area is that these mandatory fixed costs must be funded in order to maintain the current levels of care and employee satisfaction. Otherwise, the tribes are concerned that the agency may

reduce services and lose its ability to recruit and retain a qualified workforce.

## **BINDING OBLIGATIONS**

### **STAFFING FOR NEW FACILITIES, HEALTHCARE**

#### **FACILITIES CONSTRUCTION & CSC: +\$480.8 MILLION**

The IHS worksheet for budget formulation suggests funding increases of \$75 million for staffing, and \$100 million for Health Facilities Construction. Portland Area does not support funding for facilities construction and related staffing under the premise that the facilities construction priority system disadvantages the Area in the overall resource allocation process. Additionally, the funding does not equitably benefit Areas nationally and has an adverse impact on available funding for inflation, pay costs and population growth. The Portland Area does support the increase for Contract Support Costs to ensure full funding to support contracted or compacted programs.

## **PROGRAM INCREASES**

### **PURCHASED & REFERRED CARE FUNDING: +\$2 BILLION**

Portland Area recommends a program increase for the Purchased and Referred Care (PRC) program of \$2.028 billion. Portland Area IHS does not have hospitals or specialty care centers. 30% of the Portland Area IHS budget is comprised of PRC. Tribes must rely on the PRC program for tertiary and inpatient care. For this purpose, \$125 million would assist tribes to purchase health insurance coverage for their members under Section 152 of the IHCA. The Portland Area Tribes also request legislation that gives IHS federally operated programs authority to purchase health insurance coverage for tribal members when beneficial to the program.

### **FUND ACA AND IHCA AMENDMENTS +\$109.4 MILLION**

The Affordable Care Act (ACA) includes amendments and a permanent reauthorization of the Indian Health Care Improvement Act (IHCA). Both the ACA and IHCA include authorities that benefit IHS, Tribal, and Urban (I/T/U) Indian health programs. The IHCA also provides authority to develop a grant program for technologically innovative approaches to assess, prevent and treat youth suicide. Portland Area recommends \$109.4 million to further implement the ACA and carry out new IHCA authorities with \$69.3 million allocated to the Urban Indian Health budget line to allow them to purchase insurance premiums for their users.

The Portland Area recommends a \$37.4 million increase to preventive health for education and grant programs directed towards prevention, per the IHCA, Section 111, to establish a Community Health Aide program and IHCA, Section 133, for prevention and control of communicable diseases.

### **LONG TERM CARE +\$129.6 MILLION**

IHCA Section 124 provides authority for IHS to carry out hospice care, long-term care, assisted living, and home and community based services in tribal communities. There is additional need for facilities and infrastructure to comprehensively support these types of programs, which can be cost prohibitive.

Portland Area recommends \$129.6 million to develop long term care programs, develop staffing programs and carry out home and community based services that are reimbursable under Medicaid and through qualified health plans on the insurance marketplace. The Portland Area Tribes believe this will allow these programs to become self-sustaining without major investments in facilities.

### **RESTORE PAY ACT INCREASES: +\$126.6 MILLION**

Portland Area recommends an additional \$126.6 million to restore past-years' unfunded pay costs resulting from a federal moratorium on pay act increases. Competitive compensation is required for IHS and tribes to retain employees. Reductions under sequestration in FY 2013 have not been fully restored, further eroding the purchasing power of the agency. Nationally, there is increased competition to recruit and retain qualified and competent providers, creating an increased need for recruitment and retention pay as well as additional market pay to attract applicants.

### **FACILITIES: \$136.9 MILLION**

Portland Area recognizes that past-years' budgets have not included increases necessary to address the ongoing backlog of facilities infrastructure. Recommended increases are \$80.8 million in M&I, \$37.7 million for the Sanitation and Facilities program and \$18.5 million for Equipment.

### **REGIONAL SPECIALTY REFERRAL**

#### **CENTER: +\$75.8 MILLION**

Portland Area recommends a \$5 million increase in Health Care Facility Construction to fund a Regional Specialty Referral Center under IHCA, Section 134, and Indian Health Care Delivery Demonstration Projects. The Area is also requesting an additional \$10 million in Hospitals and Health Clinics for a staffing package, \$4.9 million in the Facility Support Account for operations and \$12.2 million in Medical Equipment. The current IHS

Healthcare Facilities Construction Priority System does not provide a mechanism for funding regional specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project for tribes to test alternative health care models and means.

#### **HEALTH INFORMATION TECHNOLOGY (IT)**

##### **MODERNIZATION: +\$38.4 MILLION**

RPMS is now a legacy system and is inconsistent with emerging architectural standards and unable to meet evolving needs. Portland Area recognizes that the Veterans Administration's (VA) decision to move to a new Health Information Technology solution will create a gap for the parts of RPMS that are dependent on core coding from the VA. Substantial investment in IT infrastructure and software is needed to maintain RPMS or transition to another system.

Portland Area recommends a \$38.4 million increase to the Electronic Health Records System fund to cover this initiative. Software replacement requires features to integrate behavioral health and interoperability to work with standardized Health Information Exchange (HIE) platforms to ensure seamless data sharing across health systems. Tribes also request inclusion of Tribes who have already transitioned to a commercial off-the-shelf system for upgrades and maintenance costs.

##### **BEHAVIORAL HEALTH: +\$86 MILLION**

The provisions of IHCA allow for many expansions to the Behavioral Health programs which have not received substantial funding since enacted. The Portland Area recommends a \$42.9 million increase in both the Mental Health and Alcohol & Substance Abuse line items. Funding increases would be used to implement IHCA Section 702 to expand behavioral health care for prevention and treatment and Section 704 to provide more comprehensive care through detox, psychiatric hospitalization and community based education and rehabilitation programs. The Area would also like IHCA Section 705 funded to expand the use and dissemination of a Mental Health Technician Program to serve patients, as well as, Section 715 to expand Behavioral Health research grants to allow tribes to find more innovative and effective approaches to address issues like Indian youth suicide.

##### **TRIBAL EPIDEMIOLOGY CENTERS: +\$12 MILLION**

There are 12 IHS designated Tribal Epidemiology Centers (TECs) nationwide. TECs manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, respond to public health emergencies, and coordinate activities with

other public health authorities. TECs remain underfunded despite success in public health programs and delivery of unduplicated services. Increased funding would allow TECs to conduct the culturally attuned research, data, and evaluation services needed to perform their core functions as defined in 25 USC § 1621m. Tribes request an increase to baseline funding of \$1 million to the 12 TECs for a total budget request of \$12 million.

## **HEALTH PRIORITIES AND STATISTICS**

### **CANCER**

In the Portland Area, cancer is the leading cause of death for AI/AN aged 55-64 and the second leading cause of death for AI/ANs of all ages. AI/AN cancer mortality rates are approximately times higher compared to non-AI/AN in the region, with larger disparities observed for lung, colorectal, and liver cancers (1.5, 2.6, and 3.2 times higher for AI/AN). In 2018, less than 30% of Portland Area IHS patients received age-appropriate breast, cervical and colorectal cancer screenings. One factor contributing to these disparities is limited access to cancer screening.

### **BEHAVIORAL HEALTH**

#### a. Mental Health and Suicide Prevention

According to the 2014 trends in Indian Health, in comparison to other US races, AI/AN have a 60% greater chance of suicide. Suicide is the 7th leading cause of death among AI/AN in the Portland Area and accounts for 3.5% of all deaths among AI/AN. Suicide mortality rates for AI/AN are 60% higher compared to non-AI/AN in the region. AI/AN suicide mortality in the age group 10-29 is 2-3 times greater than that for non-AI/AN. AI/AN in the northwest are more likely to report depression or poor mental health than non-Hispanic whites. Over 30% of adult AI/AN in the Northwest report having been diagnosed with depression. AI/AN are less likely to report receiving mental health treatment, despite screening for depression in Portland Area clinics which meets or exceeds the IHS GPRA standard in most facilities.

#### b. Alcohol and Substance Use Disorders

In the Portland Area, AI/ANs are more than 3.5 times more likely to die from alcohol-related causes than non-AI/AN, and almost 2.5 times likely to die from a drug overdose than non-AI/ANs. Opioids are involved in almost 70% of AI/AN overdose deaths, and methamphetamine is involved in over 30% of AI/AN overdose deaths in the Northwest.

### c. Intimate Partner Violence and Sexual Assault

According to the US Department of Justice, AI/AN women are 2.5 times more likely to be raped or sexually assaulted than women in the US in general. 34.1% of AI/AN women will be raped during their lifetime. It is widely accepted that these statistics do not accurately portray the extent of the sexual violence against AI/AN women.

### d. Trauma

Up to 74% of AI/AN youth have experienced at least one traumatic event during childhood. AI/ANs are 2-3 times more likely to meet Post Traumatic Stress Disorder (PTSD) criteria compared to the US adult population. AI/ANs have 2.5 times greater risk than the national average of experiencing physical, emotional, and/or sexual abuse. AI/AN communities experience a layering effect of these conditions along with historical trauma.

### **DIABETES**

In the Portland Area, approximately 13% of AI/AN adults report having been diagnosed with diabetes. AI/ANs have twice the rate of avoidable hospitalizations for diabetes compared to non-Hispanic whites. Diabetes mortality rates for AI/ANs are twice the rate of non-AI/ANs in the region. The consequences of uncontrolled diabetes can affect the functioning of many different organ systems, primarily through chronic damage to blood vessels resulting in heart attacks, strokes, kidney failure, blindness, and amputations. AI/ANs not only have an increased prevalence of diabetes, they also have high rates of complications and uncontrolled diabetes and a higher rate of mortality as a result of diabetes.

### **INJURY PREVENTION**

Unintentional injuries are the leading cause of death for AI/ANs from age 1 to 44, and the third leading cause of death overall for AI/ANs in the Portland Area. The age adjusted unintentional injury death rate for Northwest AI/ANs was 2.2 times the rate for non-AI/ANs during 2014-2016. In the Portland Area, during 2014-2016, the leading causes of AI/AN unintentional injury deaths were motor vehicles (38%), falls (29%), accidental poisoning/overdose (27%) and accidental drowning (3%).

### **CARDIOVASCULAR, HEART DISEASE AND STROKE**

The prevalence of risk factors for cardiovascular disease (CVD) among AI/ANs is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors. In the Northwest, approximately 8% of AI/AN adults report ever having a heart attack. Although heart disease was once relatively uncommon in

AI/AN populations, it is now the leading cause of death for AI/AN in the Portland Area. AI/AN mortality rates from major cardiovascular diseases, including stroke, are 1.6 times higher compared to non-AI/ANs in the region. The sharp rise in diabetes prevalence unquestionably plays an important role in the increasing rates of heart and other cardiovascular diseases in Indian Country. Screening rates for key predictors of cardiovascular health has increased in Portland Area and the proportion of patients with these diseases are benefitting from treatment with greater percentages having blood pressure and cholesterol in the healthy range.

### **HEALTH PROMOTION/DISEASE PREVENTION AND CHILDHOOD OBESITY**

Two in five AI/AN children are overweight, and over 35% of AI/AN adults are obese.

Approximately 30% of AI/AN adults in the Northwest report being a current cigarette smoker. In 2018, 38% of AI/AN 12th graders in Washington reported using a vapor product in the past 30 days, the highest of all race/ethnicity groups in the state. Approximately 7% of AI/AN adults in Oregon report being a current e-cigarette user.

In the Northwest, childhood immunization rates have declined over the past decade and are currently among the lowest in IHS.

### **ORAL HEALTH**

Nationally, untreated tooth decay among AI/AN children is four times that of white children in the US. More than 1 out of 3 AI/AN children (37%) between 1-5 years of age have untreated decay. Almost 40% of AI/AN 2-year olds have experienced tooth decay, indicating the need for early prevention efforts.

Nationally, 66% of adolescent (ages 13-15) IHS patients have experienced tooth decay and 53% have untreated tooth decay. AI/AN dental patients are more than twice as likely to have untreated tooth decay compared to the general US population and are more likely to report poor oral health, mouth pain, and food avoidance due to mouth problems.

### **ELDER HEALTH – LONG TERM CARE**

The treatment and medication management that is unique to the elder population requires development of specialized geriatric capabilities within the I/T/U health care system. The care of elders is a culturally inherent trait for AI/ANs that provides an important part of maintaining cultural knowledge and wisdom to strengthen families and communities. Portland Area Tribes agree that, with

the expanded authority of Long Term Care under IHClA Section 124, Long Term Care needs to be fully funded.

### **MATERNAL CHILD HEALTH**

Causes of death and risk factors for infant mortality within the Northwest AI/AN population include congenital anomalies, Sudden Infant Death Syndrome (SIDS) and unintentional injuries. Nationally, AI/AN women are 1.8 times more likely to die from pregnancy-related complications than white women. AI/ANs experience some of the highest disparities in infant mortality in light of current medical and public health interventions within the Portland Area and across the country. Chronic maternal stress and acute life events during pregnancy may contribute to the racial disparity in infant mortality. An analysis of the Washington State Pregnancy Risk Assessment Monitoring Survey (PRAMS) from 2002-2006, showed a greater proportion of AI/AN women reported each stressor in the PRAMS survey (partner, emotional, traumatic or financial-related) compared to white women, and were 2.6 times more likely to experience five or more stressful life events during pregnancy than white women.

The rates of fetal and neonatal death, low birth weight, and babies born with developmental problems are also far higher among AI/AN women than the general US population. Another challenge facing AI/AN programs is the higher incidence of infants born to mothers abusing opioids with AI/AN children having up to 3 times the risk of developing neonatal abstinence syndrome resulting in higher costs for initial care and potential for negative health outcomes in the future.

### **LIVER DISEASE**

Chronic liver disease (CLD) is the 5th leading cause of death among AI/ANs in the Northwest. AI/ANs are 4 times more likely to die from chronic liver disease and cirrhosis compared to the general population. A majority of deaths are attributed to cirrhosis of the liver due to Alcoholic Liver Disease (ALD) or infection of hepatitis C. 25 to 44 year old women are 15 times more likely to die of CLD than whites. In the Portland Area, AI/ANs have 2 to 4.5 times the risk of dying from hepatitis C compared to non-Hispanic whites.

### **OTHER COMMUNICABLE DISEASES**

In 2016, 8.7% of AI/AN hospitalizations were due to infectious causes, compared to 6.4% for non-AI/ANs. AI/ANs are 1.6 times more likely to die from influenza and pneumonia compared to non-AI/ANs in the region. In 2017, AI/ANs in the Northwest were 2.6 times more likely to be diagnosed with chlamydia than Whites in the region. AI/AN women are especially vulnerable for

chlamydia infections, and are diagnosed at over 3 times the rate of their male counterparts. In 2017, Northwest AI/ANs were 3 times more likely to be diagnosed with gonorrhea than the general population.

In 2017, about 200 AI/ANs were living with HIV/AIDS in the Northwest. While the prevalence of HIV for AI/ANs was relatively lower, Northwest AI/ANs were 2.8 times more likely to die from HIV and its complications compared to the general population. A similar disparity in mortality was seen for deaths from viral hepatitis. These disparities point to the need for expanded prevention and treatment services, particularly for vulnerable groups such as persons who identify as LGBTQ2S and persons who inject drugs.

A 1991 study of AI/AN women in a Tribe in Washington State found the prevalence of rheumatoid arthritis to be 3.4% (compared to 1.5 % in women overall in the US population). Overall, AI/ANs experience not only higher rates of rheumatic diseases but tend to have more severe forms of disease and onset at younger ages.

### **CONCLUSION**

The budget request outlined in this document represents a consultative process that began many years ago between Portland Area Indian Health Service and Tribes.

The Portland Area IHS budget request demonstrates a commitment to maintain health programs by funding current services. The Portland Area recommendations fund initiatives to address the health disparities that exists for AI/ANs.

Fully funding the budget will further the goal of the IHS and the Portland Area Tribes to elevate the health status of AI/ANs.

# TUCSON

The Tucson Area budget priorities are Purchased/Referred Care, Hospital & Health Clinics, Health Care Facilities Construction, New/Replacement Equipment, Mental Health, Community Health Based Programs, Alcohol & Substance Abuse, Urban Program Services and Facilities, Long-Term Care/Assisted Services, Sanitation Facilities Construction and the 105 (I) Lease.

The Tucson Area is submitting a National Budget at the 30% increase over the FY 2021 National Budget Recommendations and strongly recommends the Indian Health Service budget allocation change from discretionary appropriations to mandatory entitlements and Advance Appropriations.

## TOP BUDGET PRIORITIES AND INCREASES

### 1. PURCHASED/REFERRED CARE (PRC) +\$768 MILLION

Purchased/Referred Care Services is ranked as the highest budget priority based upon the increased cost of contracted specialty services, lack of funding and limited scope of services provided at Tribal facilities. Needs for the Tucson Area regarding intervention, treatment, and prevention of commonly occurring diseases, such as diabetes, cancer, arthritis, hepatitis C, and HIV have not diminished. In addition, the designation of Arizona as a state-wide Purchase/Referred Care and Contract Health Service Delivery Areas (PRCDA) would also have a large impact on PRC expenditures. In order to ensure that the health care services provided to American Indians living on the reservation are not curtailed, additional funding would be required. The funding would be necessary not only to pay for services provided to newly eligible PRC patients, but also for new staff to address the additional workload. It is extremely important for federal and state agencies to respect the government-to-government relationship through consultation with Tribes as a failure to do so has adverse effects.

Healthcare inflation has doubled and the Bureau of Labor Statistic states the cost of providing healthcare has risen from 90.6% over 2000.

<b>2. HOSPITALS &amp; HEALTH CLINICS</b>	<b>+\$385 MILLION</b>
<b>DENTAL</b>	<b>+\$109 MILLION</b>
<b>EQUIPMENT</b>	<b>+\$109 MILLION</b>

The Tucson Area recommends an increase of \$603 Million to maintain current and expand new services under the new provisions of the Indian Health Care Improvement Act (IHCA). The access to quality health care requires an increase in H&HC funding. Additional H&HC funding would support expanding services in the IHCA (Sections 112, 123, and 124), which were authorized without appropriation. The number one health priority continues to be the prevention and treatment of Type 2 Diabetes and the promotion of healthy lifestyles. SDPI funding has not been sufficient and may not be available if not reauthorized to address all the health problems such as amputations, blindness, and disease caused by Type 2 Diabetes such as end stage kidney disease and heart health.

Equipment upgrades are needed throughout our facilities. Department areas of increased importance needing equipment are: the Emergency Room, Podiatry Department, Dental, and Nursing to name but a few.

### 3. HEALTH CARE FACILITIES CONSTRUCTION +\$274 MILLION

The Tucson Area continues to strongly support funding for new health care facilities. The Sells Hospital replacement remains on the IHS Health Care Facilities Planned Construction (HCFC) Budget priority list. The latest HCFC priority list shows funding that funding to begin the Sells Hospital replacement in FY 2020 is required. We recommend that this funding schedule be maintained to ensure progression and completion of the construction of the Sells Hospital as outlined within the five-year plan (version dated: April 3, 2018). We also recommend funding of \$450,000 for the Tohono O'odham Nation to develop a Program Justification Document (PJD) to determine cost for replacing the San Xavier and Santa Rosa Health Centers which are greater than 65 years old and not included on the I.H.S. Health Care Facilities Planned Construction Budget priority list. Outdated facilities prevent our members from receiving the care that they need and deserve.

### 4. NEW/REPLACEMENT EQUIPMENT +\$219 MILLION

Tucson Area recommends increasing funds for new and replacement equipment in order to provide quality medical service to diagnose and treat certain medical illnesses. Bio-medical life expectancy of current equipment



has been surpassed and does not meet current healthcare needs or accepted standards of care. Much needed new and replacement equipment includes: CT scanners, dental chairs, ophthalmology instruments, laboratory and X-ray equipment, central hospital sterilizers, pharmacy robots, and emergency response vehicles and ambulances. To maintain and operate new bio-medical equipment, IT plays an integral part in the operation. These funds would be used to purchase IT hardware and software such as: servers, software licensure, LAN connectivity, and communication systems. IT infrastructure is costly and requires constant upgrades due to technological advances in medical and dental care. Lack of IT staff to install critical updates on a timely basis which are necessary to maintaining an aging RPMS system.

##### **5. MENTAL HEALTH (MH) +\$219 MILLION**

Additional funding of \$219 Million is necessary to address the mental health needs for treating and expanding services. The additional increase would fund the new provisions in the IHCIA (Sections. 707, 708, 710, and 712) such as: Comprehensive Behavioral Health and Treatment Programs, Fetal Alcohol Spectrum Disorders Programs, Long-Term Treatment Programs for Women and Youth. The Current State Reimbursement Rates are inadequate for small programs to be self-sustaining and must be supplemented with Tribal funds. Additional funds would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs.

The recent increases in behavioral health funding has only been allocated through limited time sensitive competitive grants. There are time constraints in the grant process to award funding which creates a barrier to address behavioral health crisis and interventions. Due to limited services available, many individuals are not able to receive services for mental illness or emotional disorders and may use or abuse alcohol or drugs. According

to the CDC, the following factors increases the risk for numerous public health and social issues: young age, low income, low academic achievement, unemployment, and a number of other factors. Also, there are no facilities in the state of Arizona to specifically address the needs of high risk youth behavioral issues which require costly out of state treatment. The State of Arizona Chapter 14 Title 13 Criminal Code recognizes that adolescents can be charged for an array of sexual misconduct, yet adequate services are not available.

We recommend direct funding to implement new specialized providers, therapists, clinicians and physicians to enhance services; which include developing interventions for pre and post suicidal preventive programming. An increased budget allocation will establish an after-hour on-call crisis team, recruit case managers and develop a referral system for inpatient treatment, medical detox, and psychiatric hospitalization. Additional funds would be used to hire psychiatric providers and cover the cost of psychiatric medication for uninsured individuals and out of state treatment for youth.

It is recommended that an evaluation of the behavioral health needs be conducted. The residential treatment centers system is problematic, the length of treatment is not long enough, there are issues with the waiting list, and services are not sufficient. Funding is needed for aftercare and the current transitional treatment is inadequate.

##### **6. COMMUNITY HEALTH BASED PROGRAMS +\$164 MILLION**

Community Health Representatives (CHR) provide an array of community based services that target hard to reach medically underserved populations. Current funds do not support our community based programs which decrease the impact of future hospital/medical care costs and reduce readmissions. The Association of State and Territorial Directors of Nursing (2008), recommends



to establish a standard national Public Health Nurse to population of 1 Public Health Nurse to 5,000/population. Currently, these standards are not being met. With the continuous shortage of PHNs, the CHR's fill the gaps which are critical to address the population's health needs in rural areas.

The Tucson Area recommends additional funds to support and maintain current CHR. These programs are instrumental in providing preventative health screening services, wound care, community health education, delivery of medications, food handler training, home visits and the advocates for all health promotion and outreach. CHRs provide fundamental services and they both deliver and provide health care, health promotion and disease prevention, Native American members right to quality care would suffer and most individuals would be unable to access their healthcare system.

Tribal communities understand that the value of the CHR program is not limited to the services they provide during a transport, delivery or home visit but contributions that ensure culturally competent performances, services, functions and activities. CHR's are more likely to be trusted and considered members of the community. The CHR model continues to work for Tohono O'odham Nation because it is rooted in the understanding that CHR's know their communities best, it is a holistic approach to service.

**The Tucson Area does not support the Administration's recent attempts to defund and eliminate the CHR Program for the past 2 years. These actions by the Administration are unacceptable.**

#### **7. ALCOHOL & SUBSTANCE ABUSE (ASA) +\$164 MILLION**

Tucson Area recommends a budget increase of \$164 Million to expand current services and fund new programs related to Behavioral Health under the IHCIA (Section 127). The high prevalence of Alcohol & Substance Abuse such as the opioid epidemic which contributes to suicides and violence within the communities. Funding will expand the scope of treatment, establish group homes, inpatient treatment facilities and increase clinicians and case managers.

Surgeon General's report on alcohol and substance abuse (November, 2016) stated that "90% of people with substance abuse disorder are not getting treatment".

#### **8. EXPAND URBAN PROGRAM +\$30 MILLION URBAN FACILITIES RENOVATION +\$25 MILLION**

According to the 2010 US Census ACS and Indian Health Service National Urban Indian Health Needs Assessment, the Tucson Urban American Indian Population has grown significantly to 44,000 citizens. The health disparities within this population continues to increase, with health priorities that include diabetes & pre-diabetes, behavioral health, arthritis, and asthma. Additional funding would be utilized to implement new health activities to include primary care, behavioral health and community health programs that are desperately needed to meet the needs of the population (IHCIA Section 164). Additionally, funds for renovation of facilities is critical to maintaining a safe environment at TIC to provide and sustain services. For example, recent elevator repairs essential to transporting disabled, elderly and other clients cost over \$67,000 and are critical to continuing to safely provide multiple wellness services. And, this is just one of multiple repairs that are conducted annually at the TIC facility to ensure safety.

**9. LONG TERM CARE/ASSISTED LIVING SERVICES +\$55 MILLION**

The Tucson Area requests new funding to implement Long Term Care and Assisted Living Services (IHClA Section 124). The existing services on the Tohono O’odham Nation has limited capacity for assisted living and ancillary support services; the dire need for funding is required to cover and maintain services for the increasing elder population. The Pascua Yaqui Tribe is projected to have a limited long-term health care facility by the end of 2020. Most importantly, additional funding would allow an increase in case management and in-home support services, allowing elders and vulnerable adults to maintain their independence.

**10. SANITATION FACILITIES CONSTRUCTION +\$192 MILLION**

The Tucson Area requests additional SFC funding to continue meeting the backlog of projects for essential water and sewer needs in consultation within Indian Communities. The Tohono O’odham Nation is the second largest reservation in the United States in both population and geographical size, with a land base of 2.8 million acres and 4,460 square miles, approximately the size of the State of Connecticut. Most communities are in remote rural areas with challenges of providing access to clean water and sanitation facilities. Currently there are 41 homes that lack access to safe water or adequate sewer.<sup>31</sup> In addition, there are five homes that obtain water from sources that exceed the maximum contaminate levels for primary contaminants set by EPA.<sup>32</sup> Of the previously mentioned 41 homes, 35 are identified on the FY 2019 Sanitation Deficiency System (SDS) list that have no indoor plumbing or adequate sewer; water must be hauled and pit privies used for wastewater disposal.

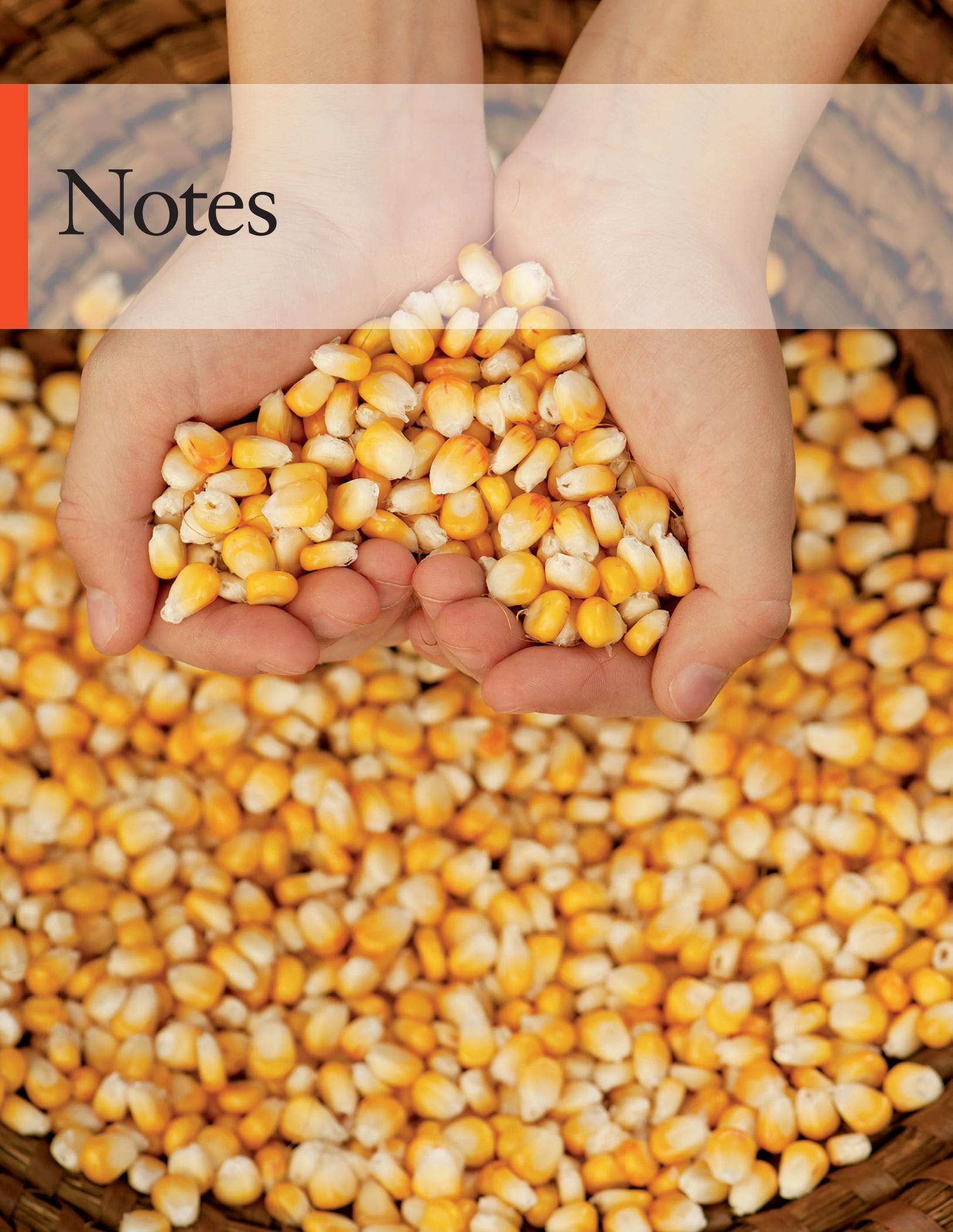
<sup>31</sup> Substance Abuse and Mental Health Services Administration (2019). 2018 National Survey on Drug Use and Mental Health

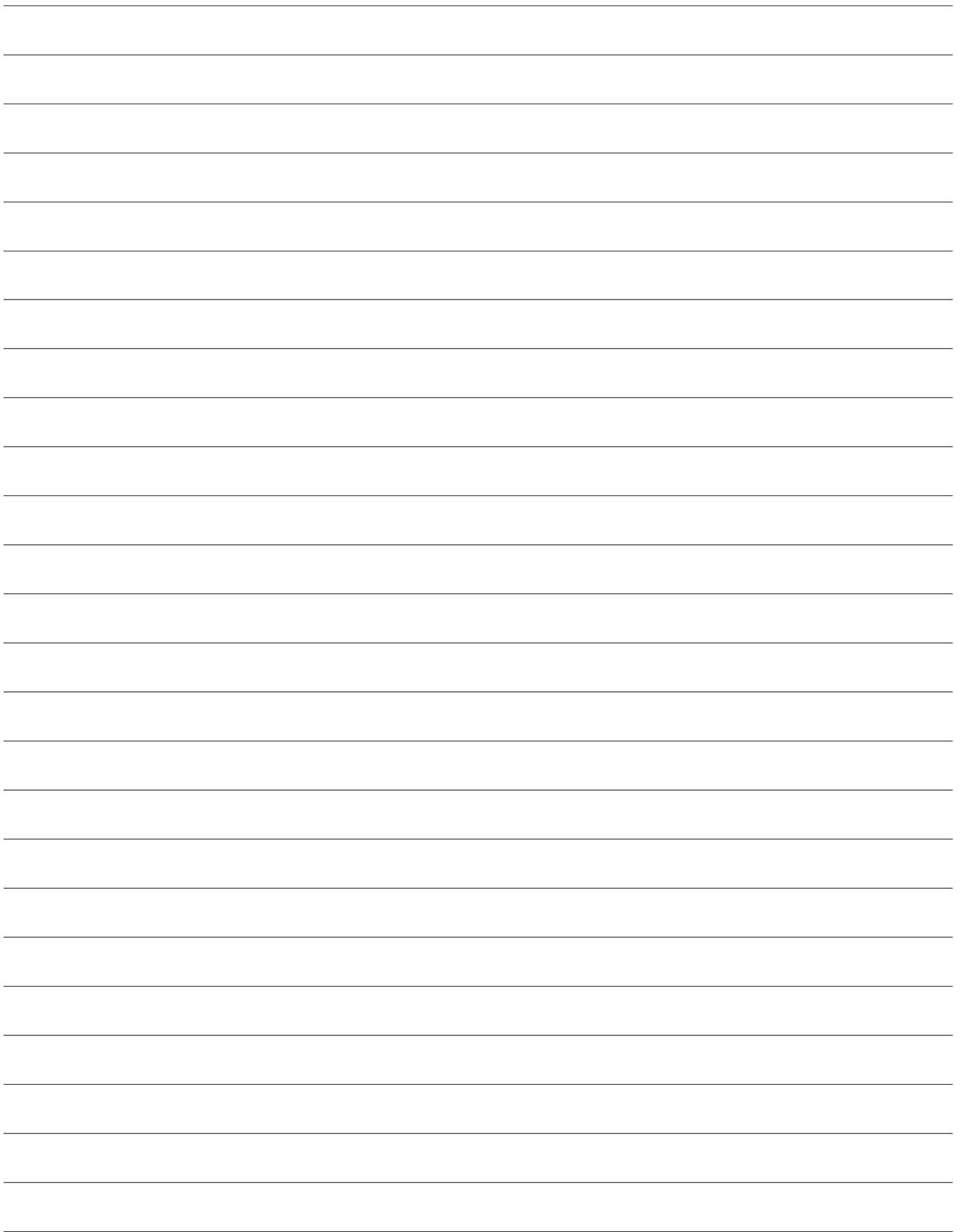
<sup>32</sup> Substance Abuse and Mental Health Administration (2014). SAMHSA American Indian/ Alaska Native Data

**11. 105(L) LEASE 1% = \$27 MILLION**

The Tucson Area request additional funding to the 105(l) Lease funding. Although, Congress appropriated \$125 million in FY 2020 to address the 105(L) Tribal Clinic operation requirements. Congress has expressed concern regarding the escalating requirements for Lease costs and the negative impact on the discretionary appropriations to support ITUs programs. The Tucson Area Tribes and Urban Program support the recommendation that 105(L) lease compensations should be funded with a separate, indefinite appropriation like contract support costs.

# Notes







# Reclaiming Tribal Health:

A National Budget Plan to Rise Above Failed Policies  
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**The National Tribal Budget Formulation Workgroup's Recommendations  
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