National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD FOR THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES 19TH ANNUAL TRIBAL BUDGET AND POLICY CONSULTATION

Thursday, March 30, 2017

On behalf of the National Indian Health Board (NIHB)[1] and the 567 federally-recognized Native Nations we serve, NIHB submits this testimony for the record on FY 2019 Tribal Budget priorities.

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives (AI/ANs). The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. As part of upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs.

In 2010, Congress reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). As part of the IHCIA, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives, declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." [2]

Yet, these resources are still not available in many Tribal communities leading to worse health outcomes for AI/ANs. Our people continue to suffer with significantly worse health outcomes than other Americans with an aggregate life expectancy 4.8 years less than other Americans. However, in some regions, life expectancy is even lower. For instance, the Montana Department of Public Health and Human Services, "white men in Montana lived 19 years longer than American Indian men, and white women lived 20 years longer than American Indian women."[3] In South Dakota, in 2014, "for white residents the median age was

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[1] The National Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. Because the NIHB serves all federally-recognized Tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. The NIHB is governed by a Board of Directors consisting of representatives elected by the Tribes in each of the twelve IHS Areas. Each Area Health Board elects a representative and an alternate to sit on the NIHB Board of Directors.

[2] 25 U.S.C. § 1602.

[3] "The State of the State's Health: A Report on the Health of Montanans." Montana Department of Public Health and Human Services. 2013. p. 11.

81, compared to 58 for American Indians."[4] Twenty-five (25) percent of AI/AN deaths were for those with ages under 45. This compared with fifteen (15) percent of black decedents and seven (7) percent of white decedents in 2008 who were under 45 years of age. [5]

Over the last several decades, starting with the Nixon Administration, the federal government had the policy of increased Tribal involvement and consultation, and empowering Tribal nations to take control of their own health systems. As a result, we have seen significant improvement of the health of Tribal nations across the country. Like state and territorial governments, Tribes have both the rights and responsibilities to provide vital public health services for their communities. To do this, they must also have the tools to carry out these functions.

Yet, IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, health promotion, education, research for disease, injury prevention, and promotion of healthy lifestyles. For example, federal block grants largely flow to states, leaving little opportunity for Tribal governments to receive this funding. Tribes are eligible to apply for many other federal grants that address public health and other issues, however, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to apply for the grants.

This means that Indian Country continues to lag far behind other communities in basic resources and services. The federal trust responsibility for health extends to all agencies of the federal government – not just the IHS. As we embark on a new Presidential Administration, this is an important opportunity to change the path of Indian Health programs throughout the entire Department of Health & Human Services (HHS) and ensure Tribal communities are included in all funding and block grants to states for basic infrastructure supports. At the very minimum, HHS should require that states consult with Tribes and demonstrate how federally appropriated dollars are reaching Tribes.

We look to the new Administration to propose a FY 2019 budget that continues to uphold the federal trust responsibility by proposing a bold increase for Indian health programs at the IHS and throughout HHS. By building on our binding government-to-government relationship, we can forge a new and viable pathway to finally fulfill the federal trust responsibility for health.

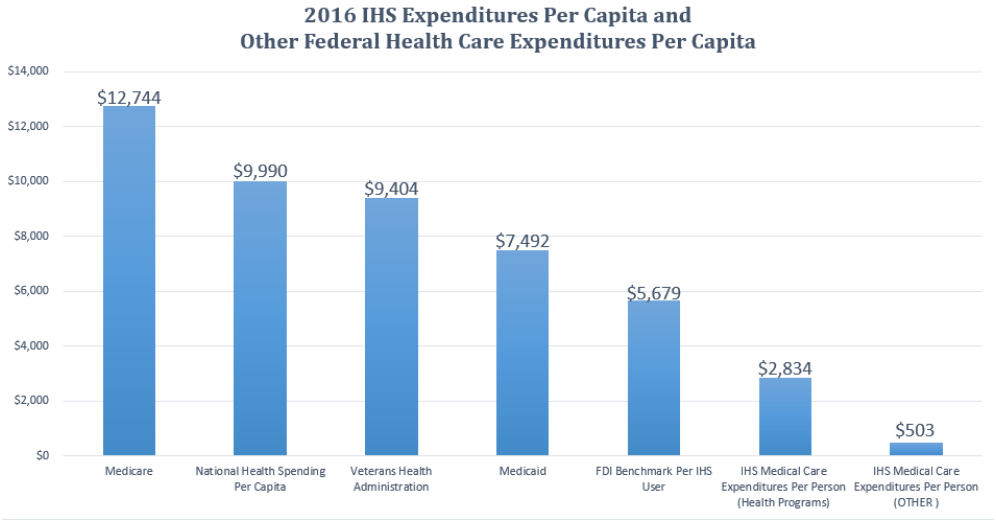
The following testimony will provide input on budget requests for the Indian Health Service; Centers for Medicare and Medicaid Services (CMS); Centers for Disease Control and Prevention (CDC); Substance Abuse and Mental Health Services Administration (SAMHSA); Health Resources and Services Administration (HRSA) and the Office of Minority Health (OMH).

[4] "2014 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators." South Dakota Department of Health. 2014. P. 62.

[5] Trends in Indian Health 2014 Edition." U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health Support, Division of Program Statistics. 2014. p 63.

THE INDIAN HEALTH SERVICE

The Indian health care delivery system, in addition to significant health disparities, also faces significant funding disparities, notably in per capita spending between the IHS and other federal health care programs. In 2016, the IHS per capita expenditures for patient health services were just $2,834, compared to $9,990 per person for health care spending nationally.



The truth is that funds necessary to eliminate the overwhelming health disparities of American Indian and Alaska Native people has never been properly appropriated. The IHS, and the Tribes administering their own health programs, are forced to operate within a base budget which is historically inadequate. The true needs-based budget, which would bring health resources to parity with the rest of the nation, is now at **$32 billion**. Compare this to an actual appropriation of less than **$5 billion.** While the IHS has received marginal increases in more recent years, these certainly have not been enough to effectively target chronically underfunded health priorities. This decision, intentional or not, which fails to resource even basic services for Indian people, has created the crisis situation we now see in almost all Tribal communities and reservations. The failing infrastructure creates unsafe and unsanitary living conditions and severely compromises the quality of care which can be provided.

Treatment of chronic diseases like diabetes, auto-immune deficiencies, cancer and heart disease quickly erode our limited resources leaving few dollars for prevention. Aging facilities and the lack of resources to modernize equipment and health information technology, has created a dire need for large investments in basic infrastructure, including housing for health professionals who want to work in our communities but have no place to stay.

NIHB supports the recommendations of the Tribal Budget Formulation Workgroup (TBFWG). These recommendations are made in a National Budget Formulation process where Tribes in each area establish budget priorities and then Tribal representatives from the respective areas come together and formulate recommendations on the national level. This statement includes the Workgroup's top-line increases for IHS for FY 2019.

NIHB was pleased to see the Indian Health Service listed among the Administration's "highest priorities" in the FY 2018 Budget Blueprint released on March 16, 2017. Because IHS provides direct care to patients, and in many cases is the *only* care in rural Tribal communities, it is critical that it remain a top priority in any budget request to Congress. These funds are literally a matter of life and death.

FY 2019 Tribal Budget Formulation Workgroup Request

The NIHB and the TBFWG continue to advocate for full funding of the IHS through the enactment of a true "Needs Based Budget." This includes amounts for personal health services, wrap-around community health services and facility investments. Top priorities are as follows:

- Fully fund IHS at $32 billion phased in over 12 years

- Increase the President's FY 2019 Budget Request for the IHS by a minimum of 33% **($6.4 billion)**:
  - +$169.1 million for full funding of current services
  - +$252.1 million for binding fiscal obligations
  - +$1.6 billion for program expansion increases. Top priorities for program expansion include:
    1. Hospitals & Health Clinics +$295.5 million
    2. Purchased / Referred Care +$278.6 million
    3. Mental Health +$122.6 million
    4. Alcohol & Substance Abuse +$114.8 million
    5. Dental Health +$ 67.2 million
    6. Health Care Facilities Construction +$ 59.3 million
    7. Sanitation Facilities Construction +$ 44.8 million
    8. Equipment +$ 32.4 million
    9. Maintenance & Improvement +$ 30.7 million
    10. Community Health Reps. +$ 29.5 million
    11. Public Health Nursing +$ 24.5 million
    12. Urban Indian Health +$ 20.2 million
    13. Health Education +$ 16.7 million
    14. Indian Health Professions +$ 13.3 million
    15. Facilities & Env. Health Support +$ 12.0 million

- Support the Preservation of the Indian Health Care Improvement Act and other Indian-specific provisions in the Patient Protection and Affordable care Act (P.L. 111-148)

- ❖ Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficiency of federal dollars at the local level

- ❖ Advocate that Tribes and Tribal programs be permanently exempt from sequestration

- ❖ Support Advance Appropriations for the Indian Health Service

The full TBFWG request for FY 2019 can be found at www.nihb.org.

Behavioral Health Requests

AI/AN children and communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma.[6] Where Tribal reclamation of these systems has been possible, it has led to effective service systems designed and implemented by and for AI/AN people, to promote cultural strength and healing. These Tribal systems have already begun to resolve the trauma left behind by federal policies and systems.

One of the key challenges with eradicating suicide in Indian Country is the fact that Tribes are forced to deal with inconsistent funding. As one Tribal leader told NIHB, "It's as if funds are awarded when rates spike, but return to complacency when rates fall somewhat. Programs cannot be sustained with uncertainty over funding from year to year." Therefore, NIHB requests that the Administration propose that Congress **create a program modeled after the Special Diabetes Program for Indians (SDPI) that would target suicide prevention in Indian Country**. The SDPI-model represents one of the most effective means of targeting a specific issue in Indian Country that we have ever seen. By providing rigorous program data, but also having the flexibility to operate programs based on local needs, SDPI has been successful in getting a handle on Type 2 diabetes. NIHB believes that the same model should be applied to suicide prevention. Suicide prevention programs funding should be allocated annually and long-term, not based on competitive grants, which is necessary to build expertise and retain key professionals and community leaders. By establishing a program that is consistent and operates outside of the yearly federal appropriations process, and is formula-based, I/T/U behavioral health systems may be able to make serious impact in the lives of AI/ANs.

Delivery of Healthcare at IHS-Operated Facilities

NIHB and Tribes hope to see strong leadership from the top levels of HHS and IHS in promoting the delivery of quality health care and sustaining that delivery over the long-run. For years, certain IHS Areas have seen poor quality in certain IHS facilities. Recently, several IHS-operated facilities in the Great Plains Area have been found deficient by CMS and the HHS Office of Inspector General (OIG) in 2015 and 2016. Each of these inspecting agencies found direct threats to patient care. As one Tribal leader

[6] Braveheart, M. Y. A., & DeBruyn, I. M. (1998). The American Indian Holocaust: healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2).

poignantly stated at a Senate hearing in February 2016, "It's been said in my community that the [IHS] Hospital is the only place you can legally kill an Indian."

However, almost 2 years later, according to Tribal leaders in the Area, the situation at these hospitals has not improved. The Winnebago Indian Hospital, for instance, still does not have authority to bill CMS after losing certification in July 2015. This is simply unacceptable. While NIHB applauds HHS for creating its Executive Council on Quality Care and IHS's commitment to developing a new Quality Framework, there have been few tangible changes in the Great Plains Area. NIHB strongly encourages the new Administration to act quickly and transparently to resolve the issues at the affected facilities. The cultural changes needed at IHS-operated facilities will take time, but IHS and other HHS agencies like HRSA should do all in their power to ensure that Great Plains Area facilities are adequately staffed and comply with safety measures in fulfillment of the United States trust responsibility to provide quality health care to AI/ANs.

Recruitment and Retention of Medical Professionals and Housing

One of the key challenges for improving health in Indian Country continues to be the ability for I/T/U sites to recruit and retain medical professionals. Of the over 600 facilities only 44 are hospitals and only 19 have operating rooms, which demonstrate the IHS focus on primary and community based care rather than secondary or tertiary care. Therefore, having a sufficiently staffed facility is key for preventing and treating disease before a patient seeks care outside of an IHS facility. According to the IHS FY 2017 Budget Justification, "IHS, as a rural health care provider, has difficulty recruiting health care professionals. There are over 1,484 vacancies for health care professionals… across the IHS system..." (P. 224). As a result, $72 million was spend to hire contract-based medical providers last year in the Great Plains Region alone.

In a 2003 report,[7] it was noted that IHS had a 12 percent vacancy rate for medical professionals. In its FY 2016 Budget Justification to Congress, IHS reported that physician and nurse vacancy rates are around 20 percent.[8] Clearly, more must be done to encourage additional staffing at IHS facilities. In FY 2019, NIHB recommends that HHS and IHS work to explore creative solutions, improve career pathways for AI/ANs to go into medicine (including avenues at IHS), and improve retention at IHS. It is critical that other federal agencies such as the Health Resources and Services Administration also put forward specific programs targeted at AI/ANs. NIHB also requests funds that would provide additional housing options for medical staff working in Tribal medical centers.

Infrastructure Investments

Health Infrastructure needs are also of critical importance for improving the health of AI/ANs. As the Administration considers recommendations on improving infrastructure nationally, Indian health

[7] "A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country." U.S. Commission on Civil Rights. 2003, pg. 47.
[8] Indian Health Service FY 2016 Budget Request to Congress, p. 198

programs should certainly be a part of that conversation. Federally operated IHS hospitals range in size from 4 to 133 beds and are open 24 hours a day for emergency care needs. IHS facilities offer a range of care, including primary care services, pharmacy, laboratory, and x-ray services. Therefore, IHS facilities infrastructure is directly tied to improved quality of healthcare for AI/ANs.

On average, IHS hospitals are 40 years of age, almost four times as old as other U.S. hospitals with an average age of 10.6 years.[9] 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% of need – 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.[10]

From 2010 to 2016, IHS facilities infrastructure construction budget has been about $76 million annually. At that rate, a new facility built today would not be replaced for another 400 years![11] Currently, IHS uses its Health Care Facility Construction (HCFC) appropriations to fund projects. This priority system was developed in the late 1980s at the direction of Congress. The original priority list was developed in the early 1990s with 27 projects on the list. There are still 13 remaining projects on this "grandfathered" list which is currently estimated to cost $2.1 billion. We must quickly finish these projects to show the need of healthcare improvements.

The Administration should also prioritize maintenance and improvement of current facilities. Maintenance is necessary to comply with hosptials and facility accreditation standards and meet basic safety codes, but since 2011, the agency has not received enough appropriations to keep up with need resulting in a $500 million backlog that will only increase the longer it is not addressed. By 2015, appropriations were only about 80% sufficient to cover the costs. Currently, Maintenance and Improvement is funded at $73.6 million. According to the OIG, some facilities have been cited for sewage leaking into an operating room and equipment that is no longer suited for a modern medical environment.[12] America is too great a nation

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[9] *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/

[10] *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 on November 7, 2016. p. 12

[11] *"Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare - The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2018 Budget."* June 2016. P. 64.

[12] 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, p.14-15.

to allow health facilities to languish in this condition. Congress must invest in keeping up with aging IHS facilities to ensure that our patients have basic, and safe delivery services.

Health IT

In addition to basic infrastructure needs, it is critical that Congress provide resources necessary for the IHS to make serious upgrades to their health information technology system. Failure to do puts patients at risk and will leave IHS behind unequipped for the 21st Century healthcare environment. When investing in infrastructure projects, the Administration should prioritize Health IT needs for health facilities in Indian Country. This includes allocating **$3.5 billion to replace the current Health Information System**, and other investments to increase network bandwidth.

The biggest barrier to achieving this has been the lack of dedicated and sustainable funding to adequately support health information technology infrastructure, including full deployment and support for Electronic Health Record (EHR). Resources, including workforce and training, have been inadequate to sustain clinical quality data and business applications necessary to provide safe quality health services to the 2.2 million AI/ANs. The IHS/Tribal/Urban health delivery system represents some of the most remote locations in the United States and many reservations and villages are further isolated by lack of roads and public utilities. A robust telecommunications infrastructure is critical to a modern health care delivery system, not just for providers but for patients and their families as well. The vast majority of IHS and Tribal health care facilities are in rural locations with connectivity that is much slower and less reliable than that available in urban settings. Capabilities such as telehealth, patient access to records, staff and patient education, clinical decision support, and transmission of medical data and images, are severely hampered by bandwidth insufficiency. Upgrading bandwidth can be extremely costly and often must be paid from the facility's health care operations budget.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

The Centers for Medicare and Medicaid Services (CMS) plays a critical role in the Indian health care delivery system. CMS third party-billing collected by the Indian Health Service, Tribes and Tribal organizations, and Urban Indian health centers (I/T/U) garners additional financial support for the Indian Health Care System and in upholding the federal government's trust reasonability. These vital funds must be protected and increased in Tribal communities by ensuring that all eligible users are taking advantage of these programs. As a result, CMS and Tribes must continue to engage and work together to better serve the needs of American Indians and Alaska Natives. The following recommendations describe budget and policy priorities for NIHB and the Tribes for this Administration.

Fully Fund the Administration and Operation of CMS TTAG and the Subcommittee Activities

The CMS established the Tribal Technical Advisory Group (TTAG) in 2004 to enhance the government-to-government relationship between Tribal Nations and the United States. The TTAG serves as an advisory group to CMS on policies and programmatic issues impacting AI/ANs served by Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The CMS is an integral part of the Indian health care delivery system and is critical to honoring the United States trust responsibility to provide healthcare to AI/ANs.

The TTAG developed and adopted the Strategic Plan for CMS in 2013 and ending in 2018. The purpose of the Strategic Plan is to help guide the development of a budget on AI/AN Medicare and Medicaid priorities for CMS. The Strategic Plan has seven objectives with detailed recommended funding levels per specific action steps.

While the TTAG is in the process of updating the Strategic Plan for 2018-2022, the following objectives require continued funding.

1. CMS engages in meaningful consultation with Tribes and works closely with the TTAG.
2. CMS enacts and implements policy though regulation, guidance, review and enforcement to align CMS programs to serve AI/ANs by improving enrollment processes, assuring access to care, having efficient payment systems, and increasing the I/T/U capacity to deliver integrated, comprehensive programs.
3. CMS improves and expands opportunities for development and delivery of Long Term Services and Support throughout Indian communities.
4. Through outreach and enrollment activities, all I/T/U programs are fully informed about CMS programs and AI/ANs know about benefits available to them.
5. Develop and improve CMS data systems to evaluate and expand the capacity of CMS to serve AI/ANs.

6. Assure that American Indians and Alaska Natives are able to enroll in state-based and federally-facilitated Marketplace plans and maximize participation by the I/T/U as providers in those plans.
7. Promote opportunities for I/T/Us to be included in new and innovative payment and service delivery models consistent with the rest of the health care system.

In order for the objectives of the Strategic Plan to be implemented, the CMS needs to fully fund the administrative and operation of the CMS TTAG and its subcommittee activities.

Support funding for Medicaid and CHIP Outreach and Education

Over 40 years ago, Congress amended the Social Security Act to authorize Medicaid reimbursement for services provides to eligible AI/ANs for services received through an IHS or Tribal health program facility. In 1976, the House report explained that "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…" As a result, Medicaid reimbursement to IHS and Tribal health program facilities is considered part of the trust responsibility. Today, Medicaid represents 67% of 3rd party revenue at the IHS, and 13% of overall IHS spending. However, this amount is just 0.15% of total national Medicaid spending.

Because Medicaid is so critical to fulfilling the United States trust responsibility and is an important supplement to the underfunded Indian health care delivery system, more resources are needed to ensure that Medicaid eligible AI/ANs are enrolling in health programs. This additional funding would be used to conduct training and webinars in Indian country in order to provide information on enrolling in Medicaid and the Children's Health Insurance Program (CHIP). Increased enrollment in these programs means fewer dollars expended by the Indian Health Service to provide services. More dollars for the Indian Health Service means more AI/ANs can receive care and puts less pressure on the limited resources of the Indian Health Service.

Maintain 100% FMAP and give full effect to CMS's recent State Health Official (SHO) Letter

In February of 2016, CMS issued a State Health Official (SHO) Letter extending 100% Federal Medical Assistance Percentage (FMAP) to services rendered by a provider that is not an Indian Health Service or Tribal provider so long as certain requirements are met. 100% FMAP ensures that the responsibility to pay for Medicaid services to American Indians and Alaska Natives remains with the federal government and is not shifted to the States.

Expanding 100% FMAP to cover Purchased and Referred Care (PRC) services benefits IHS and Tribal health programs by allowing States to expand coverage for AI/ANs, either by covering additional population groups or additional services. PRC funds are used to supplement and complement other health care resources available to Indians because IHS is not fully funded. However, payment for services under PRC is limited by what is appropriated by Congress. Therefore, it is a substantial benefit to have Medicaid

reimbursement expanded to cover PRC services received outside of IHS and Tribal facilities so that more PRC dollars are available to cover those AI/ANs that are not Medicaid eligible.
In addition, expanding 100% FMAP to cover Urban Indian Health Programs also increases access to and provides additional resources for much needed care for those Indians, almost 71% according to the 2010 Census, who live in urban areas.

Maintain Medicaid Protections for AI/ANs

Congress has enacted a number of Indian-specific Medicaid provisions that ensure that AI/ANs can continue to access the Medicaid program and are consistent with the federal trust responsibility. These protections must be preserved and protected in any type of health reform legislation or regulation. These provisions include protections from premiums and cost-sharing, prohibition of classifying trust lands and cultural and religious items as sources of income for eligibility purposes, and other protections.

In addition, Congress must ensure that no work requirements and co-pays are imposed on AI/AN. Such requirements would pose barriers to accessing Medicaid and would prompt AI/ANs not to enroll and rely on IHS coverage instead. This will lead to more uncompensated care being provided to otherwise Medicaid eligible individuals by the IHS, Tribes and non-Indian healthcare providers. Current law exempts American Indians and Alaska Natives from premiums, co-pays or cost sharing of any kind, and must be preserved. Furthermore, requirements such as these would be a direct abrogation of the federal trust responsibility for health care. Tribal communities are often located in the most remote areas of the country, with jobless rates reaching 80% in some areas, and are often disconnected from state unemployment services.

Payment Reform

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) helps transform the Medicare program to a system based on quality and health outcomes. On October 14, 2016, CMS released its final rule implementing MACRA and establishing the CMS Quality Payment Program for Medicare Part B payments made to qualifying "eligible clinicians" under the Physician Fee Schedule. Under this program, there are two paths that are designed to incentivize quality: (1) the Merit-based Incentive Payment System (MIPS); and (2) payments to incentivize participation in Advanced Alternative Payment Models (APMs). The final rule confirms that, as required by MACRA, $100 million in technical assistance will be available to MIPS eligible clinicians in small practices, rural areas, and practices located in Health Professional Shortage Areas (HPSAs), medically underserved areas, and practices with low composite MIPS scores. We request that IHS and Tribal health programs have access to these funds to ensure that they meet MACRA requirements and are not penalized. In addition, CMS has awarded contracts to provide technical assistance to practices with fewer than 15 clinicians. CMS needs to ensure that contractors provide adequate support for Tribal facilities. There is also a need for training and technical assistance to larger Tribal facilities. Tribes continue to ask CMS for assistance aligning GPRA measures and MIPS measures. Tribes also request hardship exemptions for any program that has the 2014 edition and needs to have the 2015 edition in 2018, which impacts the performance category: Advancing Care Information. In addition,

IHS functions off of RPMS and it is not considered an adequate EHR status, some Tribes don't have EHR to implement the law and they should be held harmless.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Centers for Disease Control and Prevention (CDC or Agency) is the nation's public health agency responsible for the public health of all populations. Furthermore, like all parts of the federal government, the Agency has a special duty to American Indian and Alaska Native (AI/AN) Tribes, to ensure the fulfillment of the federal government's trust responsibility. Despite these general and specific obligations, Tribes have struggled to secure even small and sporadic CDC funding, let alone the sustained and scaled investments required to bring Indian Country's public health infrastructure in line with non-tribal public health systems. In addition, Tribes often experience difficulty in incorporating traditional promising approaches when, as is often the case, these Tribally appropriate approaches have not been designated as evidenced based through western, empirical research studies.

To fully respond to Tribal needs and priorities, and to honor the sovereign status of Tribes, NIHB recommends a significant increase in funding set aside and provided directly to Tribes. With that funding, the Agency is advised to:

- Create an AI/AN public health block grant program that would be similar in purpose and flexibility to the Preventive Health and Health Services (PHHS) Block Grant, which provides funding to all 50 states, 8 territories and 2 Tribes. This AI/AN block grant could ensure that all Tribes receive either directly, or through Tribal consortia (if Tribes so choose), dedicated and sustained funding to support public health priorities determined by the Tribes.

- Create flagship funding for Tribal health departments for key public health issues in Indian Country. State health departments receive multi-year funding from the CDC for such issues as HIV, hepatitis C, diabetes, cancer, and sexually transmitted diseases. These funds are used to establish the state's own programming and presence around these issues. Tribes should be permitted the same opportunities through their own flagship awards.

- Each CDC center, institute, or office (CIO) operating significant programmatic outreach at the community level should create standing funding streams dedicated specifically to federally recognized American Indian and Alaska Native Tribes. Tribal leaders, through their CDC Tribal Advisory Committee leadership have recommended the Agency aim to set aside 2-4% of each CIO budget to support Tribal initiatives and programs.

- The CDC should dedicate funding and staffing resources to establish a Tribal budget formulation process that would actively seek out Tribal input during the Agency's internal budget negotiations and formulation. It is important that Tribal input is reflected in the budget that CDC prepares for the White House's initial proposal and all subsequent revisions. The Indian Health Service currently uses a Tribal budget formulation, one of many models CDC may want to consider as a possible framework. Any design or proposed process should incorporate direction and feedback from the Indian Country, through participation of the CDC Tribal Advisory Committee (TAC) and meaningful, robust and comprehensive Tribal consultation.

SUBSTANCE ABUSE MENTAL HEALTH SERVICES ADMINISTRATION

Nationwide, American Indians and Alaska Natives (AI/ANs) continue to experience some of the greatest disparities in access to mental and behavioral health services, including those that provide treatment and recovery services, along with substance abuse and suicide prevention programming. These challenges are evidenced by the distressingly high rates of suicide, substance use related overdoses, mental health problems, and chronic diseases, which together, paint a sobering portrait of the issues disproportionately affecting Native communities. NIHB is encouraged by the recent work of the Substance Abuse and Mental Health Services Administration (SAMHSA or Agency) in working to address the needs of Tribal communities, and we encourage the Agency to allocate additional resources to ensure those identified priorities are addressed.

Indian Health Care Improvement Act (IHCIA) – Prescription Drug Monitoring Program

The IHCIA authorized a number of activities targeting mental and behavioral health needs of Indian Country. In many cases, those authorizations were left unfunded, and in those cases, Tribes continue to experience a high level of need. Of particular importance is one authorization regarding opioid abuse.

Section 827

- Authorized the HHS Secretary, in coordination with the Secretary of Interior and Attorney General, to develop a prescription drug monitoring program across the Indian health system.

Tribes reiterate our continued support for a drug monitoring program across IHS that would be able to be integrated with State and local systems. The Administration should specifically propose funding dedicated to this purpose, with a plan of how it would work with other federal agencies to operationalize the drug monitoring program.

NIHB recommends that funds be set aside specifically for curtailing these substance abuse in Indian Country, and by increasing access to buprenorphine and naloxone. Tribes are in desperate need of

these funds, and the surest way to guarantee their access to these monies is through streamlining Tribes' ability to independently apply for funding.

Suicide Prevention

Although SAMHSA has put programming in place to address suicide ideation, intervention, and aftercare, disparities in this area continue to exist for American Indian and Alaska Native communities. More funding, training and technical resources need to be dedicated specifically to Indian Country with special attention to, and targeted at, historical and contemporary trauma, as historical trauma is a root cause of disparities, and had led to contemporary trauma for AI/AN populations. Until services for AI/ AN address this root cause and make use of trauma informed practices, we will continue to see striking disparities for AI/AN communities.

NIHB was pleased to see that that SAMHSA's Tribal Behavioral Health Grants (TBHG) were awarded an extra $10 million to combat these challenges in FY 2016 (bringing the total to $15 million) and that the draft FY 2017 House Labor HHS Appropriations Subcommittee Report[13] would increase this funding to $16 million.

- **For FY 2019, NIHB recommends that TBHG funding be increased to $50 million.** We also request that **funds to be appropriated for specific, predetermined issues:** namely, suicide interventions, expansion of mental health counseling capacity and infrastructure, and surveillance of and mediation for increasing levels of domestic violence.

Additionally, NIHB was pleased to see a Tribal set-aside of $5.2 million for the Zero Suicide Initiative in FY 2017 draft appropriations legislation.[14] This second program helps tribal communities facilitate the development and implementation of comprehensive and collaborative community-based prevention plans to reduce violence, bullying, substance abuse, and suicide among American Indian/Alaska Native (AI/AN) youth.

- **NIHB recommends continued support for a Tribal set-aside in the Zero Suicide Initiative and that any funds appropriated for this program at SAMHSA are closely coordinated with similar efforts at the IHS.**
- **In FY 2018, SAMHSA should continue to support the AI/AN Suicide Prevention Initiative with funding for $2.91 million.**

Integrating Cultural Practices

Behavioral health prevention, intervention, and aftercare services and programs could and should make use of strengths based approaches. Access to culturally competent prevention programs and treatment

[13] Departments Of Labor, Health And Human Services, and Education, And Related Agencies Appropriations Bill, 2017 – Report. H. Rept. 114-699, p. 79.
[14] *Ibid.*

centers will increase the efficacy of efforts for AI/AN populations. As sovereign nations, Tribes should have the authority and ability to select and implement culturally appropriate approaches even if these approaches have not been evaluated through western, empirical research studies. Although some Tribes may wish to undertake these types of evaluations (and should be supported to do so), other Tribes may consider cultural knowledge to be sensitive to the extent to recommend against formal, publically available studies. Furthermore, having controls that necessitate denial of promising approaches to those in need may conflict with Tribal values of providing for all in need.

NIHB continues to support the Circles of Care Program which offers three-year infrastructure/planning grants which seeks to eliminate mental health disparities by providing AI/AN communities with tools and resources to design and sustain their own culturally competent system of care approach for children. Behavioral health infrastructure is one of the key challenges for many Tribal communities when it comes to creating sustainable change for their communities. Circles of Care represents a critical part of this work.

- **In FY 2019, we recommend increasing Circles of Care funding by $2 million for a program total of $8.5 million**.

Behavioral Health Workforce

Increasing the availability of the behavioral health workforce is a critical component of getting higher access to doctors, nurses, social workers and so forth who directly work with reservation-based Native communities. However, NIHB again is discouraged by the lack of programs specifically devoted to increasing capacity in Indian Country, given the federal trust responsibility towards Tribes and the serious needs in the AI/AN community for these professionals.

In FY 2019, NIHB recommends a specific set-aside for Tribal communities to take advantage of these much-needed behavioral health workforce programs.

OFFICE OF MINORITY HEALTH

American Indians and Alaska Native (AI/AN) people occupy a unique space in the landscape of the American public life. Although many AI/AN individuals would be considered to be part of minority populations, many if not most of these same individuals hold membership as part of their Tribal nations, which accords them a special and significant political status, separate and unique from their status as minority group members. As members of Tribal nations, those individuals are entitled to certain services that flow from the government to government relationship between the United States federal government and federally recognized Tribes, and the trust responsibility between the U.S. and Tribes which came about from treaties, Supreme Court case law, legislation, and presidential executive orders.

AI/AN people are due consideration as minorities, but more importantly, are due services that will advance the trust responsibility of the federal government to ensure that AI/AN people achieve the highest health status possible. The Office of Minority Health (OMH) has the ability to recognize and address the unique needs of Indian Country through its programing, while also answering the special duties it has to AI/AN people as a result of the trust responsibility – a responsibility it does not have to any other minority group in the United States. To carry out these solemn responsibilities, OMH should work to increase funding that is specific to AI/AN populations; ensure that OMH staff are educated about the government to government relationship and trust responsibility; and ensure that the unique concerns of Indian Country are considered in programming to address Health equity and racial equity.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration (HRSA) is the primary federal agency for improving health through access to quality services, a skilled health workforce, and innovative programs. HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA has a number of programs that specifically target populations that are geographically isolated, and economically or medically vulnerable. HRSA is serving a critical role in helping to address the extreme vacancy rate at the Indian Health Service as well as IHS's challenges with delivering quality care in certain areas.

Bureau of Health Workforce

The Bureau of Health Workforce (BHW) supports the health care workforce across the entire training continuum – from the academic training of nurses, physicians, and other clinicians – to expanding the primary care workforce in underserved and rural communities across the United States. In fiscal year (FY) 2016, BHW provided funding for ten awards totaling $4.1 million for Tribal entities to fund health professions education. In addition to BHW's educational training programs, the National Health Service Corps (NHSC) offers financial support to primary care providers who agree to practice in areas of the country that have too few health care clinicians and are medically underserved. The Bureau of Primary Health Care (BPHC) funds health centers in communities, providing access to high quality, family oriented, comprehensive primary and preventive health care for people who are low-income, uninsured or living where health care is scarce. Health centers provide care on a sliding fee scale and see patients without regard for their ability to pay. Health Center Program grantees served over 282,000 American Indian/Alaska Natives (AI/AN) in the calendar year 2015.

These programs provide much needed health care providers to the Indian Health Service that has over 1,550 vacancies for medical professionals across the entire system. In October 2016, the Department of Health and Human Services Office of Inspector General reported a 33% vacancy rate for physicians in IHS hospitals. The Inspector General also found that "vacancies, use of 'acting' positions, and dependence on contracted providers impair hospital service stability and continuity of care. Access to these providers is critically important to the delivery of quality medical care to AI/ANs and we ask Congress to continue to fund these programs.