



## 2017 Legislative and Policy Agenda for Indian Health January 2017

Founded by the Tribes in 1972, the National Indian Health Board (NIHB) is dedicated to advocating for the improvement in the delivery of health care and public health services and programs to American Indians and Alaska Natives. To advance the organization's mission, the NIHB Board of Directors sets forth the following priorities that the NIHB will pursue through its legislative and policy work in 2017.

---

### **Legislative Requests:**

#### **Preserve the Indian Healthcare Improvement Act and Indian-specific provisions in the Affordable Care Act in any type of Healthcare Reform legislation**

The Indian Healthcare Improvement Act (IHCA) was enacted in 2010 as part of the Patient Protection and Affordable Care Act (ACA), though it is unrelated to the underlying healthcare reform legislation. It was tacked onto to the end of the law at Section 10221. The IHCA provides a wealth of new resources and opportunities for Tribal health care institutions, families, providers and patients. With the permanent reauthorization of the IHCA, the Indian health care system has begun a new chapter in the delivery of quality health care to American Indians and Alaska Natives (AI/ANs.)

In addition, there are Indian-specific provisions in the ACA other than the IHCA that provide important protections and funding opportunities for the I/T/U system.

- **Section 2901** which states that any I/T/U should remain the payer of last resort the payer of last resort for services provided by such notwithstanding any Federal, State, or local law to the contrary.
- **Section 2902** which granted I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.
- **Section 9021** ensures that any health benefits provided by a tribe to its members are not included as taxable income.

#### **Preserve Medicaid protections and expanded eligibility for American Indians and Alaska Natives**

The Medicaid program is vital in fulfilling the federal trust and legal responsibility toward AI/ANs. In 1976, Congress enacted Title IC of the IHCA which amended the Social Security Act to require Medicare and Medicaid reimbursement for services provided in IHS & Tribal health care facilities. This was intended to help fulfill the federal trust responsibility and bring additional revenue into the Indian health system. With discretionary appropriations consistently falling far short of need, Medicaid provides the Indian health system with much needed funding to provide basic healthcare services to AI/ANs. Expanded eligibility under the Medicaid program has allowed the I/T/U system to realize important financial gains that have allowed expanded access to care and helped alleviate pressure off of discretionary appropriations. Over 40 years ago, Congress amended Section 1905(b) of the Social Security Act to apply a 100 percent federal medical assistance percentage (FMAP) paid for by the federal government for services provided to AI/ANs that were received through an IHS or Tribally-operated facility. This ensures that IHS access to state Medicaid services does not burden the states with what is a federal responsibility.

- As Congress considers Medicaid reform, it is critical that AI/ANs retain 100% FMAP so Medicaid costs for AI/ANs are not shifted to the states
- Congress should consider special protections for AI/ANs for the Medicaid program in accordance with the federal trust responsibility

## **Phase in Full Funding for Indian Health Services and Programs for American Indians and Alaska Natives in the Indian Health Service (IHS) and Beyond**

Each year the National Tribal Budget Formulation Workgroup to the IHS works diligently to synthesize the priorities identified by Tribes in each of the health care delivery Service Areas of the IHS into a cohesive message outlining Tribal funding priorities nationally. These priorities are the foundation and roadmap for the work that NIHB does on behalf of Tribes in pursuit of much needed funding for health care services and programs for American Indians and Alaska Natives. In addition to advocating for these national Tribal priorities, NIHB will call on Congress and the Administration to:

- Phase in Full Funding of IHS - Total Tribal Needs Budget of \$30.1 Billion Over 12 Years
- Present a 37% increase in the overall IHS budget from the FY 2017 President's Budget request planning base for a total of \$7.1 billion for FY 2017
- Permanently exempt the Indian Health Service from sequestration cuts
- Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act (IHCIA).

## **Enact Mandatory Appropriations for the Indian Health Service**

In addition to fully funding the Indian Health Service, NIHB and Tribes are committed to seeing IHS treated as 'mandatory' spending. The federal trust responsibility toward the Tribes is not an optional line item, and it should not be treated this way during the annual budgeting process. To reaffirm its commitment to the Tribes, ***IHS funding should be treated as mandatory spending*** so that fulfillment of the U.S. government's treaty responsibilities is not a victim of unrelated political battles.

## **Increase Appropriations to Indian Country outside of the IHS**

Tribes and Tribal organizations receive a disproportionately low number of Department of Health and Human Services (HHS) grant awards. One significant obstacle for Tribes to receive adequate funds for these programs is the fact that block grant funds typically flow directly to states who then must pass funding on to Tribes. Sadly, these funds often do not make it to the Tribal level. Without having a state intermediary, Tribes would not only receive more adequate funding but could more easily tailor program needs to their people. Therefore, Congress should:

- Grant awards should not pass through states but should be awarded directly to Tribes.
- Create set-asides for HHS block grants so that Tribal communities have access to these funds on a recurring basis
- Where states receive funds to pass through to Tribes, Congress should require Tribal consultation on the use of those funds.

## **Build Capacity of Tribal Public Health**

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. Currently, Tribes are regularly left out of state- run public health programs and simultaneously, are routinely overlooked by federal agencies during funding decisions for public health initiatives.

Congress should:

- Ensure that Tribes gain access to needed funding through a Tribal set aside, made available directly to Tribes, as part of the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant and Public Health Emergency Preparedness Cooperative Agreement.
- Ensure that Tribes are eligible for all existing and new CDC funding streams open to states, territories and local public health departments. Wherever practicable, funding should provide Tribal set asides.
- Create flagship funding for Tribal health departments for key public health issues in Indian Country.

- Direct CDC should work directly with Tribes to seek out Tribal input during the internal budget negotiations and formulation.
- Ensure that Tribes have a voice in decisions regarding local water supply and other environmental impacts on or near their lands.

### **Seek Long-Term Renewal for the Special Diabetes Program for Indians at \$200 Million**

NIHB is asking Congress to pass legislation by this year to renew the Special Diabetes Program for Indians. Funding for this vital program for at least 5 years at \$200 million per year. The current authorization expires on September 30, 2017. The Special Diabetes Program for Indians (SDPI) has not received an increase in funding since 2002; the program has effectively lost 23 percent in programmatic value over the last 12 years due to the lack of funding increases corresponding to inflation. 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. The incidence of end-stage renal disease (ESRD) due to diabetes in American Indians and Alaska Natives has fallen by 29% - 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.

### **Enact Special Suicide Prevention Program for AI/ANs**

AI/AN 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. According to the Substance Abuse and Mental Health Services Administration, suicide is the 2nd leading cause of death – 2.5 times the national rate – for AI/AN youth in the 15 to 24 age group. Congress should:

- Enact a program to target suicide prevention program for Indian Country that would be modeled off of the Special Diabetes Program for Indians.
- Create an American Indian and Alaska Native mental health block grant to be administered by the Substance Abuse and Mental Health Services Administration.
- Increase appropriations across the federal government for Tribal behavioral health programs and empower Tribes to operate those programs through Tribal Self-Governance contracts.

### **Provide Continued Oversight and Accountability on the IHS**

The Indian Health Service has recently come under scrutiny by inspectors at the Centers for Medicare and Medicaid Services (CMS) as well as the Office of Inspector General at the Department of Health and Human Services due to decreased accountability at certain IHS-operated hospitals. Reports of agency mismanagement, and lack of enforcement of quality measures, have resulted in patient safety violations and in some cases, even death. While the agency is working to correct these deficiencies, it is critical that Congress continue to provide oversight of the agency so that AI/ANs feel confident in the healthcare being provided.

- We request that Congress continue oversight of the IHS as they work to improve quality healthcare delivery at the federally-operated hospitals and clinics
- Congress should enact legislation that would ensure that the IHS undertakes serious reforms when it comes to quality of care health delivery.

### **Secure Advanced Appropriations for the Indian Health Service**

NIHB is asking *Congress to enact advanced appropriations for IHS*. If IHS had received advance appropriations, it would not have been subject to the government shutdown or automatic sequestration cuts as its FY 2014 funding would already have been in place. Adopting advance appropriations for IHS results in the ability for health administrators to continue treating patients without wondering if –or when– they have the necessary funding. Additionally, 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 the results of Congressional decisions funnel down to the local level.

### **Workforce Development for Indian Health and Public Health Programs**

Closely connected with quality of care issues, are workforce challenges within the Indian health system. The Indian Health Service, Tribal health providers, and Tribal public health programs continue to struggle to find qualified medical and public health professionals to work in facilities or programs serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: Physicians 34%; pharmacist 16%; nurse 24%; dentist 26%; physician's assistant 32% and advanced practice nurse 35%. Current vacancy rates make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners is at an all-time high, the situation is unlikely to improve in the near future. What we do know, is that the IHS has been unable to meet the workforce needs with the current strategy and IHS must improve its ability to address workforce challenges if the care needs of AI/ANs are going to be met. Therefore Congress should:

- Provide funding for programs designed to recruit and mentor AI/AN youth who are interested in health and public health professions.
- Provide better incentives for medical professionals who want to work at IHS and Tribal sites, including support for spouses and families, and better housing options.
- Enact proposals to provide medical professionals with more equitable pay and benefits in order to incentivize working for the IHS.
- IHS student loan repayment should be tax exempt so that the agency can provide more opportunities for this program. Expand the categories of eligible health professionals to include public health practitioners.

### **Expand Tribal Self Governance at the Department of Health and Human Services**

For over a decade, Tribes have been advocating for expanding self-governance authority to programs in the Department of Health and Human Services (DHHS). Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696 - Department of Health and Human Services Tribal Self-Governance Amendments Act- that would have allowed demonstration projects to expand self-governance to other DHHS agencies. This proposal was deemed feasible by a Tribal/federal DHHS workgroup in 2011. Therefore, in 2016, NIHB recommends that Congress:

- *Expand statutory authority for Tribes* to enter into self-governance compacts with HHS agencies outside of the IHS.

### **Preserve Key Public Health Provisions in the ACA**

The Affordable Care Act not only brought significant improvements to the Indian healthcare delivery system, but also made substantial contributions to Tribal public health systems and infrastructure development. These improvements included funding for Tribal public health accreditation, workforce development, nutrition and physical activity programs, community health aide programs, and maternal and child health programs. Congress should preserve:

- Section 4302 which made data collection and analysis on health disparities available to IHS and epidemiology centers funded under IHCIA.
- Section 5204 which established a new loan repayment program to address health/public health workforce shortages such as those existing in Tribal public health programs.

### **Regulatory / Administration Requests**

### **Educate Members of the new Administration on Tribal Sovereignty and the Trust Responsibility**

Many federal officials don't understand that Indians are not just racial entities but political entities, sovereign nations, with their own laws, cultures, and constituents. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples. Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the United States has "moral obligations of the highest responsibility and trust."

- Provide Members of the new Administration with Memos/Fact Sheets on Indian Country, the Trust Responsibility, and Tribal Sovereignty
- Educate the new Administration that the Trust Responsibility extends to the entire Federal Government, not just within HHS. Federal Agencies must work collaboratively to address the health needs of AI/AN.

### **Preserve and Expand Tribal Consultation**

On November 6, 2000, President Clinton issued Executive Order 13175 that set forth clear definitions and frameworks for consultation, policymaking and accountability in order to support the following aims: (1) strengthen the government-to-government relationship between the United States and Indian Tribes (2) establish meaningful consultation with Tribal officials in the development of federal policies and (3) limit the number of unfunded mandates imposed on Indian Tribes. In 2009, President Obama issued an Executive Memorandum that called for the head of each federal agency to submit to the Director of the Office of Management and Budget (OMB), within 90 days, a "detailed plan of actions the agency will take to implement the policies and directives of Executive Order 13175." Moreover, President Obama's Executive Memorandum directs each agency head to submit annual progress reports, with updates on the status of each item listed in the agency's action plan, as well as information on any proposed changes to its plan. What followed was an astonishing seventeen agencies that created or updated Tribal consultation policies. Many of these consultation policies also created Tribal advisory committees to assist the department in the development of policies and regulations that have an impact on Tribes.

- Preserve the Executive Order on Tribal Consultation
- Ensure that Tribal Consultation is meaningful and done in a timely manner that provides for informed Tribal Engagement
- Preserve Tribal Consultation Advisory Committees

### **Ensure and improve access to culturally competent quality health care for Native Veterans.**

American Indians and Alaska Natives (AI/ANs) serve in the U.S. military at higher rates compared to any other ethnic group, and have a higher concentration of female service members. AI/AN Veterans are more likely to lack health insurance, and have a disability, service-connected or otherwise, than Veterans of other races. Many AI/AN Veterans experience various challenges in receiving VA health care benefits in remote environments. AI/AN Veterans experience health disparities and barriers to access quality health care service due to factors such as distance, poverty, mental health symptoms, historical mistrust, and a limited number of culturally competent providers.

- Maintain and Strengthen the Implementation of the Memorandum of Understanding Agreements between the U.S. Department of Veterans Affairs, the Indian Health Service, and Tribal Health Programs.



- Creation of a VA Tribal Advisory Health Care Committee to properly ensure that the VA fulfills its trust responsibility to AI/AN Veterans in a culturally competent manner.

### **Support IHS Efforts to Expand the Community Health Aide Program (CHAP)**

CHAP has an enormous amount of potential for Tribes and AI/ANs outside of Alaska. This potential was recognized during the reauthorization of the Indian Health Care and Improvement Act (IHCIA). Tribal advocates supported the ability of IHS to expand CHAP to Tribes outside of Alaska and the support, coupled with the successful history of the program, had widespread lawmaker support along with language included in IHCIA ensuring that IHS had the authority to expand the CHAP outside of Alaska. As IHS moves forward with pursuing a national CHAP, careful consideration and Tribal consultation must take place on the parameters and scope of the program, the amount of flexibility that I/T/Us will have in growing the program, and where the funding comes from. Because there is much undetermined about what the program will be, NIHB strongly recommends that IHS work closely with Tribes, Tribal organizations, Urban Indian programs to ensure that the CHAP is implemented in a thoughtful and considerate manner that respects Tribal sovereignty and authority as well as delivers quality, culturally-competent care for AI/ANs.

- Request to be a part of IHS/Tribal Workgroup to develop a policy to expand CHAP
- Provide technical assistance to Tribes and IHS in expanding CHAP

### **Change IHS' Interpretation of the Definition of Alternate Resources**

In January, 2016, IHS released a proposed rule to implement Catastrophic Health Emergency Fund (CHEF). In the proposed rule, IHS included "Tribal" as part of the list of primary payers in the "alternate resource" definition. The provision states "any Federal, State, Tribal, local, or private source of reimbursement for which the patient is eligible. Such resources include health care providers, institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e. Medicare and Medicaid), other Federal health care programs, State, Tribal or local health care programs, Veterans Health Administration, and private insurance." The preamble also states that IHS considers Tribal self-insured plans to be "private insurance." The inclusion of Tribal self-insurance as an alternate resource prior to CHEF reimbursement is intolerable. Tribal governments and Tribal programs will be burdened with a substantial negative impact on Tribal health service programs. The Indian Health Service (IHS) has recognized the importance of preserving Tribal resources for decades. In previous IHS payor of last resort regulations, as well as policy guidance in the IHS Manual, IHS specifically provided that certain Tribally-funded health insurance plans "would not be considered "alternate resources" under IHS' payor of last resort regulations in an effort to be consistent with Congressional intent not to burden Tribal resources. This drastic change in IHS policy is a clear violation of the government's Trust responsibility to provide health care to Tribes.

- Tribes should never pay primary to the federal government and IHS must not move forward with its proposed definition of alternate resources.