



## **2018 Legislative and Policy Agenda for Indian Health**

### **January 2018**

Established by the Tribes to advocate as the united voice of federally recognized American Indian and Alaska Native (AI/AN) Tribes, the National Indian Health Board (NIHB) seeks to reinforce Tribal sovereignty, strengthen Tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for our People. 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 during 2018.

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### **Introduction:**

There is a special and political relationship between the United States and Tribes that creates a trust responsibility to provide American Indians and Alaska Natives with access to and delivery of quality health care. This special trust responsibility provides the legal justification and moral foundation for health policy making specific to Tribes and American Indians and Alaska Natives. This obligation to carry out the federal trust responsibility to Indians is rooted in the United States Constitution, treaties, judicial pronouncements, Acts of Congress, Executive Orders, regulations, and the ongoing course of dealings between the federal government and Indian Tribal governments. As such, it is firmly acknowledged that the federal government's obligation to carry out its trust responsibility applies to all departments and agencies of the federal government.

In pursuit of its authority under the Constitution and the trust responsibility, Congress has enacted many Indian-specific laws and included Indian-specific provisions in general laws to address Indian participation in federal programs. This special treatment of Indians has been confirmed to be that of a political class based on the government-to-government relationship and not one based on race. For decades, the Executive and Legislative branches of the United States government have implemented policies and legislation on this basis.

In 2018, NIHB will continue to advocate for the fulfillment of the trust responsibility by the federal government and honoring the political government-to-government relationship by working with both the Legislative and Executive branches of government to effectuate the delivery of quality healthcare for American Indians and Alaska Natives and relevant meaningful systems-level change that will improve the health status for all American Indians and Alaska Natives.

Therefore, we believe the following specific actions can be undertaken to achieve these goals.

### **Legislative Requests**

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

The Medicaid program is vital to 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.

In 2017, Congress undertook efforts to reform Medicaid into a block grant system. The draft legislation also included incentives for states to implement Medicaid work requirements and would allow for the expansion of 100% Federal Assistance Percentage rate (FMAP) to all AI/ANs, not just to those who receive services in connection with an Indian health provider. Some Congressional leaders continue to advocate for Medicaid reform efforts in 2018. Should these efforts progress in Congress, NIHB will advocate for:

- AI/ANs to retain 100% FMAP so Medicaid costs for AI/ANs are not shifted to the states
- Congress to enact special protections for AI/ANs for the Medicaid program in accordance with the federal trust responsibility including exemptions from work requirements, cost-sharing, caps, and other provisions designed to limit program participation.
- All AI/ANs should be able to receive Medicaid benefits at 138% or less of the Federal Poverty level
- Congress should direct Medicaid benefits to AI/ANs should be uniform across the states
- Expansion of 100% FMAP to Urban Indian Health Programs
- NIHB shall oppose expansion of 100% FMAP to non-Indian Health Providers

### **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 (TBFWG) 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:

- Further requests to be completed when TBFWG completes their request in February 2018

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

In addition to fully funding the Indian Health Service, NIHB and Tribes believe that funding for IHS should be treated as “entitlement” or “mandatory spending.” This would be in alignment with the federal trust responsibility for health which is the direct result of treaties, federal law, and Supreme Court Cases. In order for this to be implemented, Congress should enact legislation to create a Tribally-driven feasibility study in order to determine the best path forward to achieve mandatory appropriations for the IHS.

### **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, or specific block grant program, 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. This grant should be awarded on a formula, and non-competitive basis.
- 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 (SDPI). Funding for this vital program for at least 7 years at \$200 million per year. The current authorization expires on March 31, 2018. SDPI has not received an increase in funding since FY 2004 which means the program has effectively lost 25 percent in programmatic value over the last 14 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 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. For 2018, NIHB request that Congress:

- Enact long-term or permanent renewal of SDPI for at least 7 years
- Increase funding for SDPI to \$200 million, or minimally, tie yearly increases to the rate of medical inflation

### **Create Specific Funding to Address the Opioid Crisis in Indian Country**

AI/ANs face opioid related fatalities three times the rate for Blacks and Hispanic Whites (Murphy et al., 2014). The Centers for Disease Control and Prevention (CDC) further reported an opioid overdose rate of 8.4 per 100,000 for AI/ANs, second only to Whites. As sovereigns, Tribal Nations are left out of statewide public health initiatives such as the prevention and intervention efforts created through the new opioid crisis grants. Therefore, NIHB requests that Congress:

- Establish Tribally-specific funding streams to address the opioid epidemic in AI/AN communities including in the State Targeted Response to Opioid Epidemic grants and any other opioid related legislation advancing in Congress.
- In coordination with Tribes, establish trauma-informed interventions to reduce the burden of substance use disorders including those involving opioids.

### **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 Indian Health Service - Quality**

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 HHS 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. Yet, years after these findings have occurred, there is little evidence that IHS has undertaken measurable improvements in the program.

- 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, with full participation of Tribes including both Direct Service and Self-Governance Tribes.

### **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 2018, NIHB recommends that Congress:

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

### **Provide Resources to Improve the Health Information Technology (IT) system at the IHS**

It is critical that Congress provide resources necessary for the IHS and other federal health providers like the Department of Defense (DoD) and Veterans' Administration (VA) 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. 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. The information systems that support quality health care delivery are critical elements of the operational infrastructure of hospitals and clinics. The current IHS health information system is called the Resource and Patient Management System (RPMS), and is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most Tribal facilities, from patient registration to billing. The explosion of Health IT capabilities in recent years, driven in large part by federal regulation, has caused the IHS health information system to outgrow the agency's capacity to maintain, support and enhance it. Therefore we request that Congress:

- Should provide a separate, dedicated funding stream to improve Health IT at IHS
- Should provide dedicated authorized funding for major Health IT and Telehealth upgrades at IHS
- Congress should require IHS to work closely with the Veterans Administration (VA) to coordinate on upgrades for the EHR systems at the respective agencies, and make upgrades in tandem

### **Improve Care for Native Veterans**

The federal government's trust responsibility to provide health care to all AI/ANs extends across all departments and agencies of the United States and includes VA. And yet, although AI/ANs serve in the U.S. military at higher rates than any other race, they are underrepresented among Veterans who access the services and benefits they have earned. AI/AN Veterans are also more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other races. The Tribal memoranda of understanding (MOUs) between the VA and the Indian Health Service, Tribes and urban Indian health care providers authorized under the Indian Health Care Improvement Act are ideal mechanisms for the federal government to preserve and build on the existing excellent relationships that the VA has with IHS and Tribal Health Programs. Yet, these agreements are at risk. To improve care to Native Veterans, we request:

- Congress reaffirm and that the VA maintain the current IHICIA Section 405 agreements between VA and IHS and Tribal Health Programs (THPs) on a permanent basis
- IHS and Tribal providers should be exempted from any value-based reimbursement scheme for other VA providers
- Exempt all Native Veterans from copays and deductibles at the VA in accordance with the federal trust responsibility
- Allow IHS and Tribal providers to be reimbursed by the VA for services provided under the purchased/referred care program

### **Ensure the Inclusion of Tribal Priorities in the Farm Bill**

As Congress works to update the Farm Bill in 2018, it is critical that Tribal priorities are included in this significant legislation. For many Tribes, the right to cultivate traditional foods is not only an expression of

their inherent culture and their identity, but also of their sovereignty. Tribes are constantly reclaiming their sovereignty and inalienable right to self-determination. The right to retain traditional food practices has been codified in various treaties and Supreme Court cases between Tribal Nations and the United States especially with regard to hunting and fishing rights, further showcasing that the right to food sovereignty has been integral to Tribal and federal relations for generations. NIHB supports the work of the Native Farm Bill Coalition and recommends that Congress:

- Allow Indian Country to lead consistent, comprehensive, and Tribal-led approach to tailor federal food assistance programs to the specific needs of Tribal communities and citizens, including the prioritization of traditional food cultivation and promotion
- Allow Tribes the option to enter into Self-Determination Contracts pursuant to P.L. 93-638 for administration of the Supplemental Nutrition Assistance Program (SNAP) and all other federal feeding programs.
- Improve the funding, flexibility and infrastructure of the Food Distribution Program on Indian Reservations (FDPIR).
- Require a CBO or CRS inquiry into the impact of drastic cuts or elimination of food assistance programs on the overall agricultural economies of Tribes.

### **Support Native Youth Policy Agenda**

NIHB fully supports the work of Native Children's Policy Agenda. Four national Native organizations – the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), the National Indian Child Welfare Association (NICWA), and the National Indian Education Association (NIEA) – have come together to create the First Kids 1st Initiative, a joint effort to improve the social, emotional, mental, physical, and economic health of Native children and youth to allow them to achieve their learning and developmental potential. First Kids 1st gives voice and support to Native children and youth and their Tribal communities so they can grow and thrive for years to come. Policy changes NIHB supports include:

- Improving access to health services through full funding of the IHS and authorizing programs for school based health clinics
- Supporting workforce development programs for Indian health and public health systems
- Developing systems-level improvements to support traditionally and locally produced foods, especially in school-based lunch programs
- Improving the behavioral health and wellbeing of native youth by increasing access to services and the creation of programs targeted at Native youth
- Advocate for funding after-school programs and summer activities for children on reservations and in Alaska Native villages
- Supporting alcohol and drug free communities by increased funding for Department of Justice, Substance Abuse and Mental Health Services Administration, and the Indian Health Service alcohol and drug treatment programs currently serving Native communities.
- Increasing funding to combat illegal drugs, including funding for police, special drug task forces, lab cleanup, and drug treatment programs.

## **Regulatory / Administration Requests**

### **Educate Members of the 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 Administration with Memos/Fact Sheets on Indian Country, the Trust Responsibility, and Tribal Sovereignty
- Educate the 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 Meaningful Federal 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 and provide technical support

### **Ensure and Facilitate Meaningful Tribal Consultation with the states**

The current administration is promoting more flexibility and authority for states that receive federal funds or grants to operate their programs. Too often, states are not consulting with Tribes in the allocation and use of these funds even though many states use Tribal statistics to apply for these funds and services. In addition, On December 10, 2015 the Centers for Medicare and Medicaid Services (CMS) released an updated Tribal Consultation Policy. The biggest change to the policy is the addition of Section 8 which incorporates existing state Tribal consultation requirements from the American Recovery and Reinvestment Act (ARRA) and the 2001 State Medicaid Director. CMS compiled all existing requirements together and incorporated them into the new policy. Section 8 also explains the process for CMS review of a Medicaid/CHIP waiver once it is received and provides a means for further Tribal consultation on the waiver. For example, if it is determined at the regional level that consultation did not occur, the waiver is considered incomplete and returned back to the state for Tribal consultation. During consideration of the waiver, CMS can, at any point, consult directly with Tribes or encourage the state to conduct consultation. At any point in the process, a Tribe may invoke CMS Tribal consultation and request consultation with CMS directly before a final decision is made on a waiver or State Plan Amendment.

- Work with Federal agencies to require Tribal consultation when States receive funds or services from the federal government
- Facilitate Tribal consultation when possible between Tribes, states, and federal governments

### **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 IV 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.

In 2017, the Administration undertook efforts to reform Medicaid by issuing guidance and supporting states that wish to implement Work Requirements and Community Engagement as conditions of eligibility for the Medicaid Program.

- Request that the Administration maintain current special protections for AI/ANs in the Medicaid Program
- Oppose any efforts the administration and states that would pose a barrier for AI/ANs to enroll in the Medicaid Program
- Ensure that IHS and Tribes continue are not adversely affected by changes to the Medicaid program
- Advocate for Tribal consultation before any policy changes to the Medicaid program are made
- Expand services eligibility for Medicaid reimbursement
- Provide technical assistance and training for enrollment in Medicaid
- All AI/ANs should be able to receive Medicaid benefits at 138% or less of the Federal Poverty level
- The Administration should direct Medicaid benefits to AI/ANs be uniform across the states
- Expansion of 100% FMAP to Urban Indian Health Programs

### **Improve the Health Information Technology (IT) system at the IHS**

On June 26, 2017, IHS issued a Dear Tribal Leader Letter (DTLL) announcing that it would be holding listening sessions related to the RPMS to seek input and recommendations on how best to modernize and improve the IHS's electronic health record (EHR) system. In the DTLL and the listening sessions, IHS announced that the U.S. Department of Veterans Affairs (VA) has announced plans to modernize their EHR by shifting away from the Veterans Information System and Technical Architecture (Vista) and adopting the MHS GENESIS, which is used by the Department of Defense (DoD). IHS explained during its listening sessions that RPMS shares much of Vista's infrastructure and that IHS benefits from the work the VA does to maintain and update Vista, adapting Vista software to the RPMS. During the listening sessions, IHS announced that for the VA the transition will take 8 to 10 years and will cost between \$19 and \$35 billion. NIHB attended the IHS listening sessions and welcomes this opportunity to comment as IHS considers the future of its EHR system.

- Encourage IHS to seriously explore working with the VA and DoD on adequate appropriations to ensure that the systems continue to operate together, and to increase the likelihood of achieving this result.
- Request the agency to prioritize interoperability between the IHS Health IT system and the systems that Tribes adopt
- Request continued Tribal consultation over this transition to a new health IT system.

### **Ensure Tribal Access to Data**

Resources will continue to be needed to ensure that IHS include and work collaboratively with Tribes to further develop its Information Data Collection System Data Mart and ensure that Tribes can access their co-owned data. Doing so will improve overall clinical data reporting and provide the most accurate data for developing budget priorities, while allowing Tribal leaders and administrators the most accurate data in determining resource allocation and program development.

- Advocate for Timely access to and ownership over Tribal data

- Ensure adequate protections in place for Tribal and Patient data
- Recommend that IHS, along with other federal agencies compile health data to evaluate the health effects and impacts on community; and partner with each other to explore additional funding options to address the health needs exposed through the data.

**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.

- Educate VA officials about the unique of the Indian health care system and ensure that any policy changes do not adversely affect the Indian health care system
- 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 (IHCA). 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 IHCA 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
- Advocate for appropriate Medicaid reimbursement of the CHAP program

**Change IHS's 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. In 2014, Redding Rancheria filed a complaint against IHS over the denial of repayments from CHEF and the change in their definition of Alternate Resources. A federal judge ruled in Favor of the Tribes in November, 2017.

- Continue to track and monitor the Redding Rancheria case and inform Tribes
- Continue to advocate for a change in IHS’ current definition of Alternate Resources