National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD FOR THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES 18TH ANNUAL TRIBAL BUDGET AND POLICY CONSULTATION

Thursday, March 3, 2016

On behalf of the National Indian Health Board (NIHB)[1] and the 567 federally-recognized Tribes we serve, NIHB submits this testimony for the record on FY 2018 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 passing the Affordable Care Act (ACA), Congress also 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, still 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]

The Obama Administration, and especially, the leadership Department of Health and Human Services (HHS) has shepherded in a new era of Indian health that has focused on upholding the trust responsibility, increased Tribal involvement and consultation, and empowering Tribal nations to take control of their own health systems. Due to bold funding requests from the Administration, Congress has been able to increase the budget for IHS substantially since FY 2010, and seen the introduction of the full funding of Contract Support Costs, as well as increased priority focus on behavioral health and purchased/referred care. Additionally, the passage of the Affordable Care Act and the Indian Healthcare Improvement Act has meant new health care opportunities for AI/ANs.

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. This means that Indian Country continues to lag far behind other communities in basic resources and services. The federal trust responsibility for health does not begin and end with the Indian Health Service. It is critical that other federal agencies continue to work with Tribes to fulfill the obligations for health toward AI/ANs through ensuring that grants Administered by HHS through the states are reaching Tribal communities, and applying additional outreach efforts to Tribes for federal grant applications. Though Tribes are eligible to apply for a wide array of federal grants that address public health issues, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even apply for the grants.

But we still have a long way to go before Tribes can realize health systems that are equal to those that most Americans enjoy. We look to the next Administration to propose a FY 2018 budget that continues the work of the President 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 fulfil our generations-long quest for Equitable and Quality Indian Health Care.

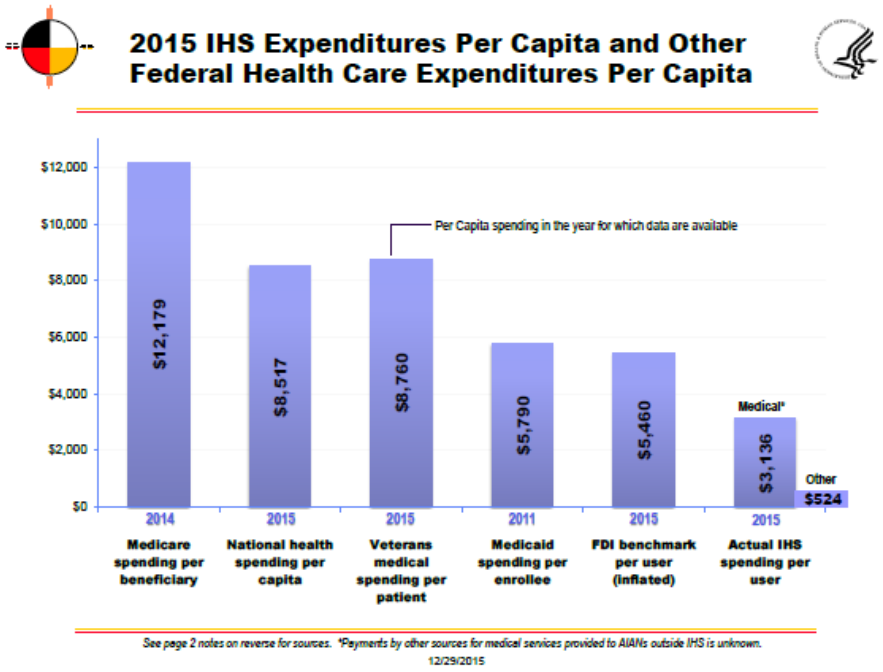
The following testimony will provide input on budget requests for the Indian Health Service; Centers for Medicare and Medicaid Services (CMS); Centers for Disease Control and Prevention (CDC); Substance Abuse Mental Health Services Administration (SAMHSA); and the Office of Minority Health (OMH).

[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 2015, the IHS per capita expenditures for patient health services were just $3,136, compared to $8,517 per person for health care spending nationally.



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. The Workgroup will make an extended presentation to the Department of Health and Human Services later this spring, but this statement includes the Workgroup's top-line increases for IHS for FY 2018.

<u>FY 2017 President's Budget Request</u>

The administration has proposed $5.2 billion in discretionary appropriations for FY 2016.[6] This is a $377 million (7.28%) above the FY 2016 level. Overall, NIHB believes that this is a strong budget for IHS, and appreciates the priority given to behavioral health initiatives, continued support for the full and mandatory funding of Contract Support Costs (CSC).

[6] NIHB was disappointed to see that the FY 2017 HHS "Budget in Brief" document summarized the FY 2017 request for IHS as $6.6 billion (Pgs. 3, 32). This number is very misleading because it includes $1.2 billion in Third Party collection estimates. IHCIA prohibits the use of any collections revenues for budgeting purposes (See: 25 U.S.C. 1621f(b)). NIHB requests that HHS be more transparent in FY 2018 about its budget request and include only discretionary funding requests in any summary documents.

It is an important caveat that these increases, while very welcome, do not necessarily represent true increased funding. On the surface, it appears as though the Indian Health Service funding has increased by about 30%, when comparing the FY 2009 Enacted budget to the FY 2017 proposed budget. When considering staffing for new facilities, inflation, medical inflation, population growth, and Contract Support Cost obligations, the effective increase which would allow Tribes the resources necessary to actually improve health care, is minimal. This would explain why the reported net effect of these increases on the actual level of need, as calculated by IHS, is still hovering at a flat 56-59%. This is unacceptable and Tribes are asking that rather than comparing appropriations levels, that it be pointed out that the President's FY 2017 budget is proposed to be $5.2 billion compared to the Tribal Recommended full funding level of $30.8 billion for FY 2018. The proposed budget amount is actually 17% of the total needed to adequately fund the Tribal Health system in a manner which would bring parity with the rest of the nation.

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. For FY 2018, we are requesting **$30.8 billion**.

For FY 2018, to begin the 12 year phase-in of the full needs of IHS, Tribes recommend **$7.1 billion,** or a 37% over the FY 2017 planning base**.** Within the $7.1 billion, Tribes have several priorities including:

- *Purchased/Referred Care (PRC)* - + $422.5 million over the FY 2017 request
- *Hospitals and Clinics* - + $422.5 million over the FY 2017 request
- *Mental Health* + $186.8 million over the FY 2017 request
- *Alcohol & Substance Abuse Services* + $155.9 million over the FY 2017 request
- *Dental Health* + $80.4 million over the FY 2017 request

Tribes have also set forth priorities this year to ensure funding of new provisions of the IHCIA. This historic law has meant many great new opportunities in for the Indian health system, but not all provisions have been equally implemented representing yet another broken promise to Indian Country. With the passage of the ACA, the American health care delivery system has been revolutionized while the Indian health care system waited for the full implementation of the IHCIA. For example, mainstream American health care increased focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Replicating these same improvements for Tribes in the IHCIA was a critical aspect of the reauthorization effort. Tribes fought for nearly two decades to renew and modernize IHCIA and it is critical for Congress and the Administration to ensure that the full intentions of the law are realized. For FY 2018, TBFWG has set forth five priority areas for funding in the new law:

- Section 205: Funding for Long-term care services ($37 million)
- Section 704: Comprehensive Behavioral Health Prevention and Treatment Program ($20 million)

- Section 204: Diabetes Prevention, Treatment, and Control ($20 million)
- Section 123: Health Professional Chronic Shortage Demonstration Project ($15 million)
- Section 705: Mental Health Technician Program ($5 million)

Adding these important provisions to the FY 2018 budget request will begin to ensure that the promises made by IHCIA are not forgotten and that Indian Country can fully realize the true effect of these important authorities.

NIHB also is pleased to see other legislative proposals that would streamline the definition of Indian in the Affordable Care Act, enact Medicare Like Rates for non-hospital purchased/referred care, create tax exempt status for IHS student loan repayment and scholarships in the FY 2017 budget request. Though it has not been formally vetted with Tribes, it is likely that they will also support the permanent enactment of the Special Diabetes Program for Indians (SDPI). However, it is disappointing to see that this strong proposal was weakened by requesting only $150 million/ year which has been the program level since 2002. Permanently setting a cap on this highly effective and important program does a disservice for future generations of Tribal members who are suffering from the complications and risks of Type 2 diabetes. Tribes have historically requested $200 million/ year for this program. NIHB continues to support this request.

Tribes also continue to request that the Administration support **Advance Appropriations for IHS** in its FY 2017 budget. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. While this tactic will not solve the complex budget issues at IHS, it will be an important first-step in ensuring that AI/ANs receive the health care they deserve. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. As we saw in the FY 2014 with the government-wide shutdown, failure to fund critical health care needs for AI/ANs was a damaging consequence of this unrelated political battle. These delays make it very difficult for IHS/ Tribal/ or Urban (I/T/U) Indian health sites to adequately address the health needs of AI/ANs. Though IHS is a mandatory obligation that the government has made, it is still a discretionary program. That's the reality we live in. We request that the FY 2018 Budget Request include this legislative proposal.

<u>Behavioral Health Requests</u>

Tribes and NIHB are pleased to see additional funding requests for behavioral health in the FY 2017 President's Budget Request. 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.[7] Where Tribal reclamation of these systems has been possible, it has led to effective service

[7] 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).

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.

Priority funding for the Zero Suicide Initiative and Substance Abuse and Suicide Prevention Program are most welcome. NIHB is especially pleased to see Behavioral Health Integration funding requested in the FY 2017 request and continue to support this in FY 2018. NIHB also encourages the Administration to develop a plan for FY 2018 to ensure that various funding streams at the IHS, SAMSHA, OMH and elsewhere operate in close coordination so as to avoid duplication of effort and provide AI/ANs with a seamless continuum of care for behavioral health services.

One of the key challenges with eradicating suicide in Indian Country is the fact that Tribes are forced to deal with with inconsistent funding. As one Tribal leader told NIHB, "It's as if funds are awarded when rates spike, but return to complacency with alarming rates 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 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 should be allocated annual and long-term funding and 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.

The mandatory funding proposals in the FY 2017 Budget Request for the Behavioral Health Professions Expansion Fund and the Tribal Crisis Response fund also represent important needs for the Tribes. However, given the difficulty of enacting mandatory programs in the current political climate, for FY 2018, NIHB asks that IHS find pathways to request this funding through discretionary authorities already contained in the IHCIA.

<u>Delivery of Healthcare at IHS-Operated Facilities</u>

One area where NIHB and the Tribes hope to see additional leadership from the top levels from IHS and HHS is in reform to IHS-operated health facilities. In the last year, several hospitals serving Tribes in the Great Plains region of the Indian Health Service have lost, (or received threats of revocation) their ability to bill CMS. This not only severely hampers the critical 3rd Party Revenue on which these facilities depend, but it also raises serious questions about the quality of health care at IHS facilities. These recent developments in the Great Plains region have exposed a systemic lack of quality care being provided in several hospitals being run by the Indian Health Service. At the Winnebago Indian Hospital, Pine Ridge

Indian Hospital and the Rosebud Indian Hospital the deficiencies in question are simply unacceptable and more must be done to ensure that IHS management never allows this to happen again. It was said by a Tribal leader in a recent Senate Committee on Indian Affairs hearing that "The IHS is the only place it is still legal to kill an Indian."

To make matters worse, all these issues were identified in a 2010 report issued by the Senate Committee on Indian Affairs. It appears that, no major changes were put in place by IHS or Congress to correct these problems on a system-wide level during this time. During the next year, NIHB will be seating a "Task Force" that will examine the critical reforms needed to ensure quality patient care at IHS. This group will have representatives from Indian Country, health professions, and elsewhere to determine the much needed reforms that must come to IHS.

In the meantime, NIHB requests that IHS and HHS embark on a comprehensive investigation of how to improve management and patient care at the Indian Health Service so that the deaths recently documented by CMS at these hospitals never occur again. The first Americans should not be the last when it comes to health standards and we believe that HHS and IHS must make a commitment to serious managerial reform to realize full change to the system.

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 sufficient well-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,[8] 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.[9] Clearly, more must be done to encourage additional staffing at IHS facilities. In FY 2018, NIHB recommends that HHS and IHS work to explore creative solutions improve pipelines 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.

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

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. The Affordable Care Act provides new opportunities for CMS to better engage with Tribal communities and provide outreach, assistance, and support for the delivery of health care in Tribal communities. Changes in eligibility rules, benefits packages, cost-sharing requirements, provider payment rates, and financing, all have an impact on Indian health 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 both the remainder of FY 2017 and for the FY 2018 President's Budget Request.

Enrollment Problems

More enrollment resources need to be made available for outreach. The Navigator grants have been limited in Indian Country. A hundred grants were released for Navigator programs and the Tribes and Tribal Organizations only received fifteen grants. The Children's Health Insurance Program Reauthorization Act (CHIPRA) funding has had good results in AI/AN communities because it encouraged assisting all family members to acquire coverage. We request that CMS consider providing grant funding to Indian Country that is structured like the successful CHIPRA grants.

- In FY 2018, we request dedicated funding improved training/education for Non-native Certified Application Counselors and Navigators on the special protections and provisions for AI/ANs. In the process of signing people up in the Marketplace, we are in need of information clearly communicated from CMS on the federally- facilitated marketplace (FFM) enrollment website showing a summary of benefits including cost sharing reductions for Indians.

Support funding for Medicaid and CHIP Outreach and Education

The Medicare Access and CHIP reauthorization Act of 2015 (MACRA) provides for an addition $100 million for FY 2016 and FY 2017. Within this law, $10 million of the $100 million is dedicated to outreach and enrollment of AI/AN children. This additional funding has been integral to conducting training and webinars in Indian country designed to provide information on enrolling in Medicaid and CHIP programs.

- We ask that this funding continue for FY 2018. Increased enrollment in these programs means less 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.

Indian-Specific Call Centers

We have reported to CMS numerous times that AI/ANs continue to experience poor assistance when contacting the marketplace call center for help. Issues range from technicians having no knowledge of the Indian-specific protections like exemptions and tax credits, to technicians being rude and having no patience to walk elderly consumers through the troubleshooting process.

Because AI/AN consumers continue to receive such poor customer service we have suggested before and continue to suggest that CCIIO establish an Indian-specific call center to respond to questions and provide technical assistance to AI/ANs, as well as non-native enrollment assisters such as Navigators and Certified Application Counselors. We also believe that an Indian-specific help desk would be better equipped and more sensitive to the needs of AI/AN consumers.

Section 10221 of the ACA contains numerous Indian-specific provisions that expand the reach of CMS programs for AI/ANs. The Administration's proposed FY 2017 budget provides for the creation of a "Tribal Resource Center", or other Tribal specific project, where staff would be trained and skilled in responding to inquiries from the Tribal community relating to enrollment into the full range of CMS health insurance programs. Federal delivery of health services and funding of programs to maintain and improve the health of AI/AN are consonant with and required by the Federal government's historical and unique legal relationship with Indian Tribes, as reflected in the Constitution of the United States.

- Continued support for this provision in for FY 2018 and future years is crucial to ensure AI/AN enrollment in state/Federal private health insurance plans, Medicaid/CHIP, and new benefits and services under Medicare.

Increased Oversight of Qualified Health Plans is Needed

We appreciate CMS putting into regulations the provisions in the 2015 Issuer Letter requiring Qualified Health Plan (QHP) Issuers to offer contracts to all Indian Health Care Providers that operate in the QHP's service area and to do so by including the QHP Indian Addendum with "good faith" payment provisions. However, Tribes are concerned, that the QHP Issuers may not be complying with the requirement. Findings from a study being conducted by the Tribal Self-Governance Advisory Committee indicate that compliance is mixed. Depending upon the region of the country, some QHP issuers are offering contracts, but in other regions, QHP issuers do not appear to be offering contracts to Indian Heath Care Providers.

- We request that HHS provide CMS and the Center for Consumer Information and Insurance Oversight (CCIIO) with funding to provide better oversight in FFM states and that the contract requirement be extended to State-based Marketplaces to ensure Indian Health Care Providers are included in plan networks in those states.

Issues concerning the Exemption Waiver

There is a lack of coordination between CMS/CCIIO and CMS Tribal Affairs on the training and education for Business Office staff, certified application counselors (CAC), Navigators, benefit coordinators, Tribal leaders, and Health Directors, on the Marketplace filing process for an Exemption Certification Number. Some Regional Health Board's believe that they can file for the Exemption from the Shared Responsibility Payment through the Marketplace. When consumers contact the help line for assistance, they are being given incorrect information. We have spoken to CMS about this issue and they have assured us that efforts have been made to resolve this issue but want to reiterate that this is still an ongoing issue and we appreciate CMS's ongoing efforts to address this.

Marketplace Data

There are several metrics that can and should be used to measure the efficacy of efforts to enroll AI/ANs in Medicaid and through the Marketplace. The paramount measure of the success of the ACA in Indian Country will be the number of AI/ANs who have successfully enrolled and utilize the benefits.

For more than two years, NIHB and its partners in the Tribal Technical Advisory Group (TTAG) to CMS, have made repeated requests for access to current AI/AN enrollment data. Instead, the only data that has been made available has been on a piecemeal basis and is often out-of-date by the time they get it. In September 2014, a formal letter was written to Marilyn Tavenner, Administrator of CMS, to request the data again. This time Technical Advisors to CMS and NIHB had a conference call with the data team from CCIIO. We were assured that our data request would be delivered in October 2014. The data was not delivered until April of 2015. The data that was provided has been used to understand a number of key issues but it is limited and more is needed. Since that time, TTAG has repeatedly requested updated and expanded reports. For example, TTAG has requested 1) data for a full year, not just 4 months, 2) information on Tribal member enrollment in health plans without AI/AN cost sharing (zero or limited), and 3) validation of Tribal enrollment to ensure access to AI/AN protections.

The data we have requested from CMS is critical in allowing Tribes to know what is or is not working with their people. We cannot know if we are making gains without knowing the baseline from which we are starting. We sincerely hope CMS will make greater strides to provide us with the data we so desperately need.

- For FY 2018 we recommend that there are increased efforts to prioritize the collection and dissemination of this data.

Support Expansion of 100% FMAP

We are thankful and supportive of the administration that it reconsidered its policy position that 100% federal Medicaid reimbursement for Medicaid eligible AI/ANs only applied to care provided inside the four walls of IHS facilities. We are thankful that the President's proposed FY 2017 budget provides for extending 100 percent federal Medicaid reimbursement to all Indian Health Programs.

Expanding 100% FMAP to cover Purchases and Referred Care (PRC) services will benefit IHS and Tribal health programs by allowing States to expand coverage for AI/ANs, either be 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 are limited by what is appropriated by Congress. Therefore it would be a substantial benefit to have Medicaid reimbursement expanded to cover PRC services received outside of IHS and Tribal facilities so that more PRC dollars would be available to cover those AI/ANs that are not Medicaid eligible.

We are grateful that the administration understands how important Urban Indian Health Programs are. Expanding 100% FMAP to cover Urban Indian Health Programs will increase access to and provide additional resources for much needed care for those Indians, almost 71% according to the 2010 Census, who live in urban areas.

- We applaud CMS for the decision to continue this policy and urge that it be continued to be supported in FY 2018.

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. As a result, large-scale healthcare delivery stem reform such as implementing the new Merit-based Incentive Payment System (MIPS) to help reward physicians and other practitioners for high quality care is occurring. Any new reforms or measures must be careful to take Indian specific considerations into account. For example, the rural nature of many Tribes and Tribal health providers means unreliable or non-existent internet service. Performance measures in systems like MIPS can create barriers to care.

- For the remainder of this Administration and in the FY 2018 budget, we ask that funding for any such measures be allocated with Indian country's unique considerations taken into account and that there be Tribal consultation on how to make this system work effectively in Indian Country.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Overview:

The President, through his fiscal year 2017 budget proposal to Congress, is requesting total funding of $11,868,182,000 in discretionary budget authority and Affordable Care Act Prevention and Public Health Fund (PPHF) for CDC. This is an overall increase of $87,302,000 above the fiscal year 2016 funding level. With this proposed increase, there exists a critical opportunity to address some public health issues and concerns that have plagued Indian Country for decades.

This budget analysis is conducted through the lens of predominant health issues and systems-level concerns. There is an acknowledgement that in every budget year, there are fluctuations in funding. However, NIHB, the Tribes, and partners would like to work with the CDC to ensure that these fluctuations do not, at the detriment of AI/AN health and wellness, weather away the trust responsibility the federal government has to provide for the health and well-being of American Indian and Alaska Native peoples.

Overall, Indian Country is desperately in need of increased public health infrastructure and support. While federal, state, and local actors have strongly established public health systems in place that were established well before the Indian health system, Tribal communities are lacking this basic support for disease prevention and control. The federal government's trust responsibility for health does not end with the IHS. CDC must take a more active role in promoting the health of AI/AN people through all of its Centers. This means creating special funding for Tribes to support infrastructure and ensuring that at least 5% of all CDC funds are allocated to Tribal communities. Without robust, long-term support from the CDC, AI/ANs will never experience a reduction in health disparities that have sadly become endemic in our communities.

Good Health and Wellness in Indian Country (+$15.0 million)

FY 2016 Enacted	FY 2017 Presbud	+/-
$14,000,000	$29,000,000	+$15,000,000

Comments

In FY 2017, CDC requested $15,000,000 in dedicated funding to expand its current Good Health and Wellness in Indian Country program. This program, operated through the National Center for Chronic Disease Prevention and Health Promotion, has been lauded for its innovative funding and evaluation structure. The programs allows Tribes to create their own local programs to impact policy, systems and/or environments to address chronic diseases, as well as depression and mental health, suicide, substance use, and alcohol-related motor vehicle injuries.

Recommendations

- This proposed increase should be used to fund additional Tribes directly to allow for a broader programmatic reach and scope.
- A portion of this proposed increase should be used to fund the production of materials that will allow Tribes that are not funded by Good Health and Wellness in Indian Country to benefit from the initiative (i.e., social marketing materials, national prevention materials) and those outside of Indian Country to understand the nature of the program (i.e., success stories, lessons learned, spotlight stories).
- The FY 2018 request should include an additional $15 million to support component 1 awardees, Tribes.

Prescription Overdose (+$10.0 million)

FY 2016 Enacted	FY 2017 Presbud	+/-
$70,000,000	$80,000,000	$10,000,000

Comments

Indian Health Service data indicate that the rate of drug-related deaths among American Indians and Alaska Natives increased from five per 100,000 population in 1989-1991 to 22.7 per 100,000 in 2007-2009. According to the CDC, deaths of American Indian and Alaska Native people from prescription opioid overdose has increased almost four fold from 1.3 per 100,000 in 1999 to 5.1 per 100,000 in 2013. With high rates of chronic disease, cancer, and other health conditions in AI/AN communities, many AI/AN people are on prescribed pain relievers, consequently creating a heightened availability of prescribed pain relievers at the community level. There are clearly many factors contributing to the rise in prescription overdose, and this proposed increase could help to emolliate the disparity in AI/AN communities.

Recommendations

- NIHB recommends that the **CDC use a portion of these funds proposed to develop, evaluate, and publicly disseminate clinical decision support tools include a module on working with Tribal communities**. This should include culturally appropriate strategies in both the development of the tool and dissemination strategies.
- In FY 2018, NIHB recommends that the CDC and SAMHSA collaboratively implement demonstration projects to create an evidence base for culturally-based substance use prevention programming and homegrown interventions in Indian Country. These additional FY 2018 funds should include a youth and adult component.

Mental Health-Mandatory Funding-Evaluation of Suicide Prevention Programs (+$30.0 million)

FY 2016 Enacted	FY 2017 Presbud	+/-
N/A	$30,000,000	+$30,000,000

Comments

It has been long documented and publicly understood that American Indians and Alaska Natives consistently have the highest rates of suicide in the United States. Communities are plagued with what is now an epidemic, especially among the youth. Increased suicidal risk factors are aligned with rampant disparities seen in the social determinants of health in Indian Country. While efforts from the Indian Health Service and the Substance Abuse and Mental Health Service Administration has done well to create solid prevention programming, there has been little commitment from the CDC to address this epidemic in Indian Country.

Recommendations

- NIHB recommends that the CDC use a portion of the $30 million proposed increase to create and fund a demonstration project to address social determinants of health in Indian Country contributing to the high rates of suicide.
- The FY 2018 budget request should include funds to disseminate the demonstration projects widely across Indian Country and evaluate their effectiveness, in a culturally appropriate way.

Viral Hepatitis (+5.0 million)

FY 2016 Enacted	FY 2017 Presbud	+/-
$34,000,000	$35,000,000	$5,000,000

Comments

In the US, an estimated 75% of hepatitis C (HCV) occurs among persons born between 1945 and 1965, most of whom do not know they are infected. Recent data from the Department of Veteran Affairs (VA) showed that 10% of veterans born from 1945 to 1965 were confirmed positive with HCV. This is true for AI/AN veterans as well. Based on these and other national data, there are many tens of thousands of HCV patients in Indian Country, with a high proportion of them undiagnosed. In 2012, the rate (per 100,000) of new hepatitis C diagnoses among AI/AN people was also the highest, and more than double that of the population with the second highest.

The rate of hepatitis C-related deaths (per 100,000) among American Indians and Alaska Native peoples in the United States between 2009 and 2013 was 12.2. This figure is the highest among reported races or ethnicities, with the second highest rate being among the African American community at 8.35. The rate among AI/ANs is 46% higher than the subsequent rate.

More recent pharmacological treatments have few side effects and shortens treatment times to 8 to 12 weeks. It can cost up to $1,000 per pill – meaning that a full course will cost more than $100,000. Insurance companies, state Medicaid programs, the VA, and Indian Health Service (IHS) cannot afford the high cost of treatment for large numbers of patients, which has resulted in only those patients with the most severe liver disease qualifying for HCV treatment.

Recommendations

- The CDC should allocate funds for an HCV prevention and screening effort to increase the capacity of Tribal employees to screen for HCV.
- NIHB requests that the CDC allocate funds in FY 2017 to create a national HCV prevention effort that seeks to increase awareness, and community-based screening efforts for HCV in Tribal communities.
- NIHB requests that the CDC leverage its market influence and relationships with the pharmaceutical industry to find ways to reduce the costs of new HCV treatments.
- Furthermore, NIHB recommends that in FY 2018 the Centers for Disease Control and Prevention work with the Indian Health Service to construct a targeted action plan for promoting the prevention of hepatitis C, increasing hepatitis C screening efforts, and increasing access to treatment.

Human Immunodeficiency Virus (HIV) ($20.0 million)

FY 2016 Enacted	FY 2017 Presbud	+/-
$0	$20,000,000	+$20,000,000

Comments

The FY 2017 budget proposal includes $20 million in additional grant resources for a new demonstration project to increase availability and improve utilization of HIV pre-exposure prophylaxis (PrEP) in high-burden communities. American Indians and Alaska Natives have exhibited the largest increase in HIV incidence in recent years, and the refusal of the Centers for Disease Control and Prevention to designate this population a high risk or high burden population continues to deprioritize HIV as a public health concern – both in the eyes of the community and the federal funders. HIV PrEP has become a key prevention strategy although its uptake has been slow. PrEP has been shown to reduce the risk of HIV infection by greater than 90 percent when taken as prescribed. AI/AN communities may lack access to PrEP because of challenges or confusion with Indian Health Service formularies, remote and rural locations inhibiting easy access to pharmacies, lack of provider knowledge, and the unwillingness of providers to prescribe PrEP.

Recommendations

- NIHB recommends that the CDC use a portion of this proposed increase to create a demonstration project in collaboration with the Indian Health Service to see if supplementation of IHS funds to support HIV PrEP prescription and medications would increase uptake at the clinical and population levels.
- The CDC should include additional funding in the FY 2018 request to ensure Indian Country receives access to the information and medications.

Gun Violence Prevention Research ($10.0 million)

FY 2016 Enacted	FY 2017 Presbud	+/-
N/A	$10,000,000	+$10,000,000

Comments

Crime victimization rates in American Indian and Alaska Native communities are higher than they are among the general population, and suicide attempts in AI/AN communities has been linked to gun availability. AI/AN youth ages 15-25 have the highest rates of suicide by firearm compared to any other racial group at 7.2 per 100,000 and the second highest rates of homicide by firearm at 5.6 per 100,000. Still, limited data on gun violence among American Indian and Alaska Natives prevents a more comprehensive understanding of the problem.

Recommendations

- NIHB recommends that the Centers for Disease Control and Prevention create a demonstration project that explores effective prevention strategies through innovation development and implementation of policy and environmental approaches to gun violence prevention in American Indian and Alaska Native communities.
- The FY 2018 budget request should include specific funding to ensure culturally appropriate research is being conducted in Tribal communities.

National Violent Death Reporting System (NVDRP) (+$7.570 million)

FY 2016 enacted	FY 2017 Presbud	+/-
$16,000	$23,570	+$7,570

Comments

The existence of accurate data and access to that data continues to be a significant barrier in American Indian and Alaska Native communities. National datasets and repositories are often difficult to access, and may not capture AI/AN-specific data. Some estimates place racial misclassification for AI/AN as high as 60%.

Recommendations

- The CDC should link NVDRS data with Indian Health Service records for decreased racial misclassification, including flag for correction.
- Additionally, the CDC needs to work with the Tribal Epidemiology Centers to ensure easy access to the NVDRP.

Cancer Prevention and Control (+$3.789 million)

FY 2016 enacted	FY 2017 Presbud	+/-
N/A	$3,789,000	+$3,789,000

Comments

Cancer is the leading cause of death for American Indians and Alaska Natives. If detected early enough, cancer is preventable and/or treatable. Colorectal cancer is the leading cause of new cases of cancer among Alaska Native people. However, lack of screening equipment and lack of access to screening opportunities and facilities yield low screening rates for AI/AN people. Efforts to detect cancer earlier and create bridges to care need to be created specifically for Indian Country.

Recommendations

- We request that the CDC use a portion of the $3.8 million to support Tribal members direct screening and diagnostic services.
- The FY 2018 request should propose to increase funds direct to Tribes to provide opportunities to their Tribal members to receive prevention information and diagnostic testing.

CDC Preparedness and Response Capability (+$5.366 million)

FY 2016 enacted	FY 2017 Presbud	+/-
$161,800,000	$167,166,00	+$5,366,000

Comments

Indian Country is uniquely positioned to bear a disproportionate brunt of many natural disasters and emerging biological threats. Many Tribes are situated in rural and remote areas, sit across international and state jurisdictional boundaries, and there are some Tribes that do not have an operational public health emergency plan and have little to no formal relationship with state preparedness units. Emerging and existing zoonotic agents – from Zika Virus to Rocky Mountain spotted fever – all pose a threat to Indian Country. Support needs to be provided so that Tribes are equipped with plans and resources to confront these concerns.

Recommendations

- In FY 2017, NIHB requests that a portion of the $5.4 million proposed increase be used to expand preparedness planning at the Tribal level, and increase coordination between Tribal, local and state jurisdictions.
- For FY 2018, NIHB requests dedicated funds to evaluate coordinated Tribal, local and state preparedness and response. Findings should be disseminated widely.

Hearing Loss (+$10.0 million)

FY 2016 enacted	FY 2017 Presbud	+/-
N/A	$10,000,000	+$10,000,000

Comments

According to CDC, American Indian and Alaska Native individuals had the highest rates of deafness and/or some self-identified trouble hearing from 2000 to 2006. Adults with hearing loss are more likely to be current smokers, have had five or more drinks in one day in the past year, do not engage in leisure-

time physical activity, and sleep less than the recommended number of hours. This increases their risk for multiple chronic and acute conditions. The risk for hearing loss due to exposure to noise is especially high among factory and heavy industry workers, transportation workers, construction workers, miners, and farmers – all industries with a large American Indian and Alaska Native labor force. This makes hearing loss a significant risk factor that should be addressed in Indian Country.

Recommendations

- NIHB recommends the CDC allocate a portion of this proposed increase to create a culturally appropriate targeted occupational and worker's safety campaign aimed at decreasing work-related hearing loss.
- The FY 2018 budget request should increase fund to evaluate the campaign and disseminate it widely.

PROPOSED DECREASES

Preventive Health and Health Services Block Grants (-$160.0 million)

FY 2016 enacted	FY 2017 Presbud	+/-
$160,000,000	$0	-$160,000,000

Comments

As independent, sovereign nations, Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Tribes are regularly left out of statewide public health plans and federal funding decisions for public health programs. Without a local tax base and little (if any) outside funding, Tribal communities are often the most in need of public health dollars. Tribes were ignored during the formulation of the US public health system, and it is now time to redress this wrong.

Tribal communities must cobble together public health funding from a variety of federal, state, local, and private funding sources. State governments receive base operational and programmatic funding through the large flagship federal grants and the Preventive Health and Health Services Block (PHHS) grant program, while Tribes are either not eligible to compete for the funding or are woefully underrepresented in the grantee pool. This leads to rampant unpredictability and inconsistency among Tribal public health initiatives.

Recommendations

- The Preventive Health and Health Services Block Grants *must* be reinstated in FY 2018. There should also be a set-aside is created for Tribal communities through the PHHS grant program by allocating at least 5 percent directly to Indian Tribes.

Cancer Prevention and Cancer Screenings (-$57.79 million)

FY 2016 enacted	FY 2017 Presbud	+/-
$266,499,000	$208,706,000	-$57,790,000

Comments

The proposed budget cuts prostate ($13.205 million), breast and cervical cancer ($40.796 million), and colorectal cancer ($3.789 million) programs. This is problematic as cancer continues to be the leading cause of death among AI/ANs. Healthy People 2020 goals state that at least 70% of eligible people receive a colorectal cancer screening, however less than 35% of eligible AI/AN patients received this screening through Indian Health Service in 2013-2014. Healthy People 2020 aims for at least 93% of adult women aged 21 to 64 years old receive cervical cancer screening, however only 55% of AI/AN women received that in 2013-2014 from the Indian Health Service. While the ACA has increased access to cancer screening services, many AI/AN do not received the recommended screenings because they receive their care directly through the Indian health system, not 3rd party payers. A misconception is being proliferated that since the ACA will provide coverage for more cancer screenings, that other federal agencies can withdraw their funding support from prevention and screening efforts. In reality, this funding needs to remain intact and be used for supplementary and complimentary activities – such as community-based prevention, norm-based change promotion, facilities and equipment upgrades, and workforce capacity building. The proposed increase (of $3.89 million) to all other cancers will not accommodate the proposed decreases to these cancer screening efforts.

Recommendations

- NIHB recommends that the proposed decrease for cancer screenings be reversed and that the funding be restored, and furthermore that five percent of the total allocation for cancer screenings be set aside for the community-based promotion of cancer screenings.
- In FY 2018 the CDC should focus on re-instating colorectal cancer screening efforts in Alaska.

Occupational Safety and Health – Education and Research Centers (-$28.5 million)

FY 2016 enacted	FY 2017 Presbud	+/-
$28,500,000	$0	-$28,500,000

Comments

The Mountain & Plains Education and Research Center (MAP ERC) has taken a leadership role in developing an American Indian and Alaska Native initiative in partnership with the CDC's National Institute of Occupational Safety and Health, Western States Division. This is a groundbreaking effort that is seeking to promote worker safety and health at the Tribal level, and ultimately the creation of Tribal occupational health programs. This program is in its infancy and this proposed decrease threatens to eradicate the progress that has been made in the past two years.

Recommendations

- NIHB recommends that the proposed decrease be re-evaluated and that funding to support the Education and Research Centers' work to promote Tribal occupational safety and health remain intact.
- The Education and Research Centers should be supported again in FY 2018. A portion of this funding should go to recruiting and retaining Tribal members in occupational safety and health careers.

Racial and Ethnic Approaches to Community Health (-$20.95 million)

FY 2016 enacted	FY 2017 Presbud	+/-
$50,950,000	$30,000,000	-$20,950,000

Comments

The Racial and Ethnic Approaches to Community Health (REACH) is one of the few CDC directly funded programs where a significant portion of the funds goes directly to AI/AN Tribes. Currently, five out of the 49 REACH awardees serve American Indians and Alaska Natives (while this number could conceivably be larger, as it stands this is a significant investment in community-based and culturally-based health services).

Recommendations

- NIHB recommends that the REACH program be restored and that 5% of the total REACH allocation is directed specifically to Tribes.
- The FY 2018 funding request should be restore REACH to at least the FY 2016 funding level and should prioritize Tribal organizations or those with a focus on American Indian and Alaska Natives.

SUBSTANCE ABUSE MENTAL HEALTH SERVICES ADMINISTRATION

Nationwide, AI/ANs continue to experience some of the greatest disparities in access to mental and behavioral health treatment and recovery services. These challenges, are evidenced by the distressingly high rates of suicide, substance use related overdoses, mental health problems, and chronic diseases, paint a sobering portrait of the issues disproportionately affecting Native communities. Despite the uncertainties of funding and the ever-imminent need for better public health infrastructure, NIHB is encouraged by the recent work of the Substance Abuse and Mental Health Services Administration to continue to advocate on behalf of Tribal communities and are allies in the fight for better quality of life in Indian Country.

In FY 2018, NIHB encourages SAMHSA to continue its focus on improving mental health and substance abuse services in Indian Country. Broadly, this means setting aside Tribal specific funding for grant programs, concentrating programming on the areas with the greatest need, improving requirements and enforcement of Tribal/state consultation on mental and behavioral health issues, and providing technical assistance to Tribes and Tribal organizations to write strong, competitive grant applications.

<u>Mental Health</u>

Suicide, depression and other preventable mental health related issues continue to devastate Tribal communities at increasingly higher rates than non-Native communities. For example, suicide is the eighth leading cause of death in Indian Country overall. AI/AN youth ages 8-24 are beset by suicide, their second leading cause of mortality. NIHB was happy to see that that SAMHSA's Tribal Behavioral Health Grants (TBHG) were awarded an extra $10 million to combat these challenges in FY2016 (bringing the total to $15 million).

- **For FY 2018, 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 commends the Administration for proposing a $5.2 million Tribal set aside in the Zero Suicide Initiative in FY 2017, and continued support for the AI/AN Suicide Prevention Initiative. 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 94 (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.**

In addition, NIHB is encouraged by the news that SAMHSA has worked for greater cooperation between other federal agencies with key stakeholders in Native communities: namely, the CDC, as well as the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor and Justice. NIHB firmly believes that the greater the alliance between federal agencies against the disparities ravaging Native communities, the more likely these disparities will be reduced or eliminated. We look forward to observing the beneficial outcomes of these new cooperative agreements.

Special attention needs to be given to the consequences of traumatic histories and systemic degradation of Native culture, which have significantly contributed to many of the behavioral health disparities we experience today. These harsh realities must be taken into consideration when drafting policies and initiatives, especially because cultural and linguistic revitalization remain a key goal for Indian Country. Several key steps can be taken to ensure these goals come into fruition.

- **SAMHSA should take a more active role in engaging Tribal communities in talking circles and consultations when brainstorming new behavioral health programs.** Solutions should come from Tribes, while federal agencies and their affiliates provide key stakeholder support.
- **Funding that is intended for Tribal communities should be <u>directly</u> administered to Tribes instead of through state governments.** Tribes have a special government-to-government relationship with the federal government, and this should be recognized in funding relationships. In many instances, states and Tribes have historically strained relationships that make transfer of funds a difficult bureaucratic challenge. This poses an obstacle for Tribal communities when accessing comprehensive care for mental and behavioral health.

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 2018, we recommend increasing Circles of Care funding by $2 million for a program total of $8.5 million**.

<u>Substance Abuse Prevention</u>

Of the challenges facing American Indian and Alaska Native (AI/AN) communities and people, few challenges are greater or more far reaching than the epidemics of alcohol and substance abuse. AI/ANs

are consistently over-represented in statistics relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues.

NIHB was disappointed to see the apparent lack of explicit funding for the specific issues affecting Tribal communities in the FY 2017 Budget request: namely, Fetal Alcohol Spectrum Disorder (FASD), prescription opioid overdoses, methamphetamine and heroin overdoses, drug use amongst pregnant women, and alcoholism**.** Although SAMHSA has advocated for an extra $559 million in both mandatory and discretionary funding for FY 2017, these funds are reserved for states with no guarantees that Tribes will also benefit. These new funds will play a vital role in fighting the over-prescription of narcotics, improving access to medication-assisted treatment protocols such as the opioid-substitute buprenorphine, and increasing access to the overdose-blocking drug naloxone.

- **NIHB recommends that funds be set aside specifically for curtailing these diseases 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.
- Additionally, given the headway made in terms of cooperation between different agencies under Health and Human Services (HHS) and beyond **NIHB requests a joint effort between CDC and SAMHSA to implement demonstration projects and create an evidence-based and culturally appropriate prevention program that will lead to homegrown interventions within Indian Country.** This will ensure that efforts are attuned to the specific needs of Tribal communities.

One of the most pressing concerns affecting Tribes applies to a systematic lack updated statistics of behavioral health issues, which contribute to the shortages in funding. This is a particularly insidious problem because when surveillance is lacking, Tribal governments and federal agencies are only able to make ballpark estimates of severity and need, and thus funding measures correspond to these rough estimates instead of being based on reliable, factual data that *quantify* the severity and the need. Lack of adequate surveillance of mental health diagnoses, suicide rates, and opioid overdoses effectively blindfolds the community, forcing them to rely largely on anecdotal, qualitative data. Indian Country is in significant need of greater data collection regarding overdose and suicide deaths, drug use and addiction rates, diagnoses of mental illnesses, and incarceration rates.

- **In FY 2018, SAMHSA should request funds for expanding surveillance measures for behavioral health issues.** This will ensure that funds are being utilized towards improving specific public health crises, and opens the door towards targeted approaches based in empirical data. This will have to be a concerted, wide-ranging effort involving multiple federal constituents.

Substance Abuse Treatment

NIHB supports SAMHSA's overall FY 2017 budget increase in the buprenorphine prescribing authority initiative and targeted capacity expansion for medication-assisted treatment (MAT); however, NIHB remains disappointed by the reductions in the treatment systems for the homeless, criminal justice activities, and the screening, brief intervention and referral to treatment (SBIRT) program.

Additionally, NIHB and Tribes are discouraged by the apparent lack of funds directly allocated for Tribal communities, as Tribes will have to coordinate with states to receive these services—a process that rarely results in sufficient funding reaching Tribal communities. Tribes are in dire need of greater representation in federal budget analyses, and need to play a more active role in budget determination, execution and appropriation. While SAMHSA has done an impressive job rallying for a more inclusive, public health related approach to substance use rehabilitation and treatment, without a concerted emphasis on Tribal communities, health outcomes for substance abuse will continue to be marginal and insufficient; and, more importantly, systemic inequities will endure.

- **NIHB recommends that SAMHSA establish yearly consultations with Tribal leaders in order to increase awareness of and insight to specific Native issues that require immediate intervention.**

With only 12.6% of Native youth who are in need of alcohol or substance use treatment receiving necessary services, nearly 50% of substance abuse treatment admissions coming from the criminal justice system, and alcoholism rates at six times the national average, Native Americans are embattled by unprecedented health disparities that necessitate an overhaul of treatment measures.

Behavioral Health Workforce

NIHB is pleased to see increases in funding requests for programs such as the Minority Fellowship, Peer Professional Workforce Development, and Behavioral Health Workforce Data and Development in the FY 2017 Budget Request.

Increasing the availability of the behavioral health workforce is a critical component of getting higher access to doctors, nurses, social workers and so forth whom 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 2018, NIHB recommends a specific set-aside for Tribal communities to take advantage of these much-needed behavioral health workforce programs.**

OFFICE OF MINORITY HEALTH

Budget Request

The FY 2017 President's Budget request for $56,670,000 for the Office of Minority Health (OMH) is equal to the FY 2016 Enacted Level. Though OMH has been flat funded for the past three years, there is opportunity for OMH to amend the agency's strategic goals and make allocations that would support program activities specifically for AI/ANs to achieve more effective coordination of federal efforts related to health disparities in Tribal communities and urban settings.

In order to combat extreme disparities, AI/AN health and public health programs need improved means of data collection and surveillance, the ability to recruit and retain a qualified workforce, and adequate healthcare facilities. The only way to accomplish better health outcomes and improved infrastructure for AI/AN public health is to provide direct funding to Tribes and to utilize existing federal policies and programs in a more focused, effective way that is culturally appropriate for AI/AN communities.

The National Indian Health Board is grateful that the FY 2017 President's Budget Request recommends an $800,000 increase in OMH's American Indian and Alaska Native Partnership. This increased funding aligns with former budget recommendations put forth by NIHB and the Tribes, and will improve Tribes' and Tribal organizations' capacity to collect disease surveillance data, conduct epidemiologic analysis, and develop culturally appropriate disease control and prevention strategies. Another area in which OMH has made strides in its work with Indian Country is in allowing Tribes and Tribal organizations to compete with states in the State Partnership Initiative to Address Health Disparities. For the FY 2015-2020 grant period, two Tribal organizations have been included to receive a total of $399,446.

The National Indian Health Board and the Tribes have developed the following FY 2018 budget recommendations for the Office of Minority Health to strengthen the relationship between Tribes and the federal government and combat the severe health disparities in Indian Country:

Recommendations

- **We recommend the OMH establishes an application requirement for the states that participate in the State Partnership Initiative to Address Health Disparities Program to have a meaningful consultation process with Tribal entities.** While we commend OMH for upholding the federal trust responsibility and including Tribes and Tribal organizations as direct recipients of the State Partnership Program, there are still gaps in health services and infrastructure in Tribal communities that are not directly receiving this funding. To bridge these gaps, the State Offices of Minority Health should be required to provide evidence of how they will include Tribes in funding and resource distribution based on the results of the required consultation. Furthermore, the absence of federally recognized Tribes in a state should not absolve the agency of its obligations

to make a reasonable and good faith effort to identify Indian Tribes or Urban Indian programs that would have interest in participating in public health decision making.

- **We recommend that a portion of the $3,000,000 for the Addressing Childhood Trauma (ACT) grants be directed to Tribes and Tribal organizations and that this is specifically outlined in the FY 2018 budget.** American Indians and Alaska Natives have long known that for health and wellness efforts to have truly meaningful impact in Tribal communities, they must seek to address the traumas that have occurred for generations that are the root cause for many of the high rates of behavioral health issues and chronic in Indian Country, today. There is now growing research and recognition that support these beliefs. This grant program will allow Tribes to create and sustain innovative programming to promote healthy behaviors to Native youth by providing funding and a framework for trauma informed public and behavioral health services.

- As racial and ethnic populations have the highest rates of being uninsured, understanding the Indian Health provisions in the ACA by Native people are key to increasing access to affordable healthcare for American Indians and Alaska Natives. In order to close the enrollment gap in the Health Insurance Marketplace, **NIHB recommends that OMH leverage funds to increase the number of navigators trained to serve the unique needs of American Indians and Alaska Natives in FY 2017 and explicitly identify funding for AI/AN navigators in the FY 2018 budget request.**

- For the FY 2015-2020 grant period, **we recommend that the National Workforce Diversity Pipeline Program (NWDPP) include annual process and outcome evaluations to monitor AI/AN participation and completion to reach set goals.**

- **NIHB recommends that a portion of the $2,000,000 of the Re-entry Community Linkages (RE-LINK) Program be directed toward Tribes.** Compared to non-Hispanic white juvenile offenders, American Indian and Alaska Native youth are 1.5 times more likely to be incarcerated and referred to the adult criminal system. This "school to prison pipeline" trend is unacceptable to Indian Country and we must do better for Native youth. The RE-LINK grant program would provide crucial resources for Tribal communities to establish culturally sensitive transition programs for youth, ages 18-26, re-entering communities after incarceration.

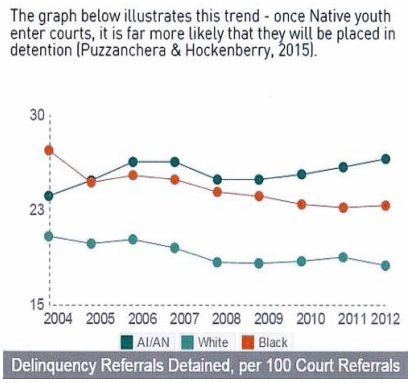


Figure 1: *National Congress of American Indian Policy Research Center,*

- **NIHB recommends that the OMH dedicate FY 2018 funding to update the Annual Health Research Report.** The Annual Health Research Report, a product of the United States Department of Health and Human Services (HHS) American Indian and Alaska Native Health Research

Advisory Council, is intended as a resource to share research topics, findings, and available federal programs with Tribes. However, the report has not been updated since FY 2013.

- **Furthermore, OMH should develop a comprehensive communication plan to disseminate real time HHS research and project information to Tribal communities.** For example, the communications plan would outline how OMH will distribute announcements, updates, evaluation results, success stories, tools and resources among Tribal communities. The primary audience should be Tribal communities and members of Tribal nations but should also be relevant to regional and national organizations, institutions of higher education and other federal agencies. This will increase information access at the Tribal level and allow the benefits of HHS projects and initiatives to have a broader reach across Indian County.

- **NIHB recommends that the Social Determinants of Health Collaborative Network take a community-based participatory approach (CBPA) to identifying what a "culture of health to address health disparities" means from the AI/AN perspective.** This would require community–based methods to understand how a "culture of health to address health disparities" might be envisioned by AI/AN communities, thus allowing for participatory planning and resulting in practical and meaningful applications to systems change.

- As OMH support projects that enhance Tribes/Tribal organizations' capacity to carry out disease surveillance through the American Indian/Alaska Native Health Equity Initiative (AI/AN HQI), which is currently slated to operate through FY2017, **NIHB recommends that OMH assess the initiative's impact on the overall capacity of Tribes to deliver all of the 10 Essential Services of Public Health.** This assessment will provide information that can guide future initiatives aimed at building comprehensive capacity in Tribal public health systems.

- **We recommend that across all HHS agencies, when citing national population health statistics by race, all racial classifications are accounted for or an explanation be provided of why that classification was excluded.** Notations explaining the reasons for not including AI/AN or other racial classification data, whether due to small numbers, lack of data or racial misclassification, for example, should be clearly conveyed. This practice would serve to educate the users of the data on the challenges of accurately representing AI/ANs and other populations.