

Health Reporter

WELCOME...

to this special Spring 2020 edition of the Health Reporter! Keep reading for a special retrospective on all that the National Indian Health Board and the Tribes accomplished over the past decade!

Spring 2020

A Look Back at the Affordable Care Act and Indian Health Care Improvement Act

With the impeachment trial behind us, and the presidential and congressional elections ahead, 2020 looks to be a dynamic year. In the health care realm in particular, a number of critical policy and legal issues face Indian Country. Advocates should remain vigilant as harmful policies, tricky regulations, and disadvantageous court decisions continue to threaten hard won health gains like the American Indian and Alaska Native (AI/AN) specific provisions in the Affordable Care Act (ACA). As advocates for AI/ANs, we must elevate the conversation around these threats and ensure that the administration, Congress, and the courts understand the potential impact to Indian Country, and the federal government's duty to the Tribes.

An issue of utmost concern for Tribes has been the potential invalidation of the Affordable Care Act by the Fifth Circuit Court of Appeals

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Health IT Modernization in Indian Country: Where Do We Go From Here?

The National Indian Health Board (NIHB) continues to support Tribes as they journey toward achieving a modernized Health IT system for Indian Country. NIHB has heard from Tribes that they desire a widely adaptable Health IT system that reflects the Tribal priorities for Indian health.

Tribes have made it clear: Indian Country needs comprehensive funding and support to modernize our health information technology (IT) systems. As Tribes advocate to the Congress and the Trump Administration for continued and greater investment, Tribal proponents can take heart in their successful efforts to date which include a new Electronic Health Record (EHR) line item in the IHS budget for Fiscal Year 2019 (FY 19). Also, in November of 2019, the Indian Health Service (IHS) released its highly anticipated Health IT (HIT) Modernization Final Report and IHS Health IT Strategic Map which informs IHS efforts to modernize its EHR and the information technology systems necessary to support it.

The recently released Health IT Modernization Report and the IHS Health IT Strategic Map are the result of a year-long effort, during which officials from IHS and the U.S. Department of Health and Human Services (HHS) assessed current health IT capabilities at IHS. The two worked together to develop a project planning roadmap, and to incorporate elements that Tribes have long advocated for: an improved Health IT system and greater transparency in the distribution of IT Tribal shares at the IHS. The project team which created both the Health IT Modernization Report and IT Strategic Map included members from HHS and IHS and utilized a Human Centered Design (HCD) analysis approach. The HCD team invited NIHB to join the project to provide cultural sensitivity training, fact checking, and also serve as a bridge to Tribal hospital staff and patients participating in interviews which informed the work of the HCD.¹

¹ With the help of NIHB, the HCD team conducted interviews with a total of 123 IHS/Tribal organization/urban Indian program (I/T/U) staff members from 37 I/T/U facilities and 2 Area offices across all 12 IHS Areas. The team also conducted interviews with 17 I/T/U patients and 8 Tribal leaders. The final product weaved a series of narratives centered on the American Indian/Alaska Native (AI/AN) clinical experience.

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THE NATIONAL INDIAN HEALTH BOARD

MISSION STATEMENT: ESTABLISHED BY THE TRIBES TO ADVOCATE AS THE UNITED VOICE OF FEDERALLY RECOGNIZED AMERICAN INDIAN AND ALASKA NATIVE TRIBES, 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.

The National Indian Health Board (NIHB) represents Tribal governments — both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS).

Located in Washington DC on Capitol Hill, the NIHB, a non-profit organization, provides a variety of services to tribes, Area Health Boards, Tribal organizations, federal agencies, and private foundations, including:

- Advocacy
- Policy Formation and Analysis
- Legislative and Regulatory Tracking
- Direct and Timely Communication with Tribes
- Research on Indian Health Issues
- Program Development and Assessment
- Training and Technical Assistance Programs

PROJECT MANAGEMENT

The NIHB continually presents the Tribal perspective while monitoring federal legislation, and opening opportunities to network with other national health care organizations to engage their support on Indian health care issues.

RAISING AWARENESS

Elevating the visibility of Indian health care issues has been a struggle shared by Tribal governments, the federal government and private agencies. The NIHB consistently plays a major role in focusing attention on Indian health care needs, resulting in progress for Tribes.

The NIHB advocates for the rights of all federally recognized American Indian and Alaska Native Tribes through the fulfillment of the trust responsibility to deliver health and public health services. Since 1972, the NIHB has advised the U.S. Congress, IHS federal agencies, and private foundations on health care issues of American Indians and Alaska Natives.

The NIHB staff maintains communication with Area Health Boards, national Indian organizations, Tribes along with American Indian and Alaska Native people. The NIHB gives voice to American Indian and Alaska Native health policy concerns through participation in national organizations ranging from the Association of State Medicaid directors to the Indian Health Service Leadership Council.

A SHARED GOAL — QUALITY HEALTH CARE

The future of health care for American Indians and Alaska Natives is intertwined with policy decisions at the federal level and changes in mainstream health care management. The NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions. The NIHB provides a vehicle to keep the flow of health care information in front of policy makers and Tribal governments manifesting progress in health care and strengthening Tribal sovereignty.

FROM THE CHAIRPERSON



VICTORIA KITCHEYAN

DEAR INDIAN COUNTRY LEADERS, FRIENDS, AND ADVOCATES,

Welcome to a special Spring 2020 edition of the National Indian Health Board's (NIHB) *Health Reporter*!

At NIHB, not only are we eager to continue the work of our mission, “to advocate as the united voice of federally recognized American Indian and Alaska Native Tribes, 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,” but we are also excited to share with you a retrospective reflection of all that NIHB and Indian Country have accomplished over the past decade — for the health of our people. We are pleased to see many of you in my home state of Nebraska this March for the 11th Annual National Tribal Public Health Summit! With all our heart, we offer a big THANK YOU to our partners in the Great Plains who have helped make this event possible — especially the Great Plains Tribal Chairmen’s Health Board.

As Indian Country enters a new decade full of potential, I am eager to continue the fight to restore the health of our people. I am grounded every day in the knowledge and faith that better health for Indian Country and expanded Tribal public health infrastructure and systems are possible. The NIHB Board of Directors will continue to look to the Tribes for guidance as we, together, fight to improve the health of our people through public health systems.

This past decade brought unprecedented progress to Tribal health. From the permanent reauthorization of the Indian Health Care Improvement Act to the impact Medicaid expansion has had on Tribal health systems, Indian Country has made enormous progress since 2010. More Tribes have accredited public health programs than ever before, and Tribes are increasingly using our traditional healing methods in behavioral and public health programs.

However, the past decade also brought challenges old and new to our people. From an Administration initiative to block grant Medicaid,

to continued attacks on the Affordable Care Act and the collateral damage it can bring to the Indian health system, to the chronic underfunding of the Indian Health Service, it is clear that Indian Country still has much to do over the next decade to secure our people’s rightful health.

The 2020s promise to be a decade of change. We, as Tribes, will use every tool at our disposal to confront behavioral health, substance use disorder, injury incidence, the HIV epidemic, and other public health challenges. NIHB will also work to ensure Tribes have the resources you need to overcome increasing environmental health challenges as climate change adaptation becomes even more urgently needed throughout Indian Country. In the area of health care, NIHB stands ready to meet the challenge of improving Native Veterans’ care, improving access to dental health care, and ensuring the Indian health system has world-class Health Information Technology at its disposal.

In this edition of the *Health Reporter* you will read about all of these efforts, as well as the importance of the national Census conducted every decade to health care funding, the future of the Special Diabetes Program for Indians, and the rise of E-cigarettes among Tribal youth. NIHB continues to remain engaged with policymakers in Congress and the Administration to ensure these issues are addressed and that the trust responsibility is met.

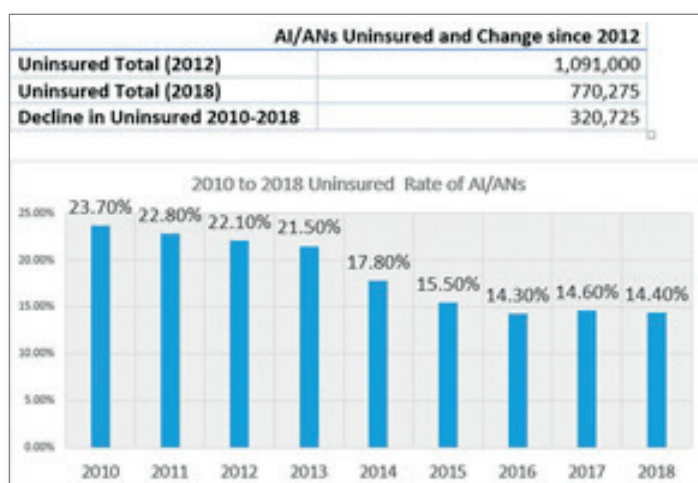
You can learn about all these issues and more in this special edition of the *Health Reporter*. We encourage you to provide input on this publication and all issues concerning the health and wellness of our people. NIHB is here to serve you, the Tribes.

Victoria Kitcheyan
Chairperson
National Indian Health Board



How Much Did the Affordable Care Act Contribute to the Reduction of Uninsured American Indians and Alaska Natives?

The number of uninsured American Indians and Alaska Natives has dropped from over 1.1 million (1,091,000) to 770,275, a decline of 320,725 from 2012 to 2018. A close look at the change in the uninsured rate identifies two years, 2014 and 2015 as the years of the greatest decline as most coverage gains from Medicaid expansion began in January of 2014. The smaller increase in 2015 was followed by three years of stagnant coverage gains with the uninsured rate holding steady at 14.3% in 2016, 14.6% in 2017 and 14.4% in 2018. The all races uninsured rates have increased in the past two years, but this is not true for AI/ANs as enrollment gains have continued.



The results for AI/ANs follows the overall pattern nationwide for all races. However, a look at the states with the greatest gains since 2013 suggests that AI/AN enrollment has fared better than the all-races totals. Nine of the states with the largest percentage increase in Medicaid have

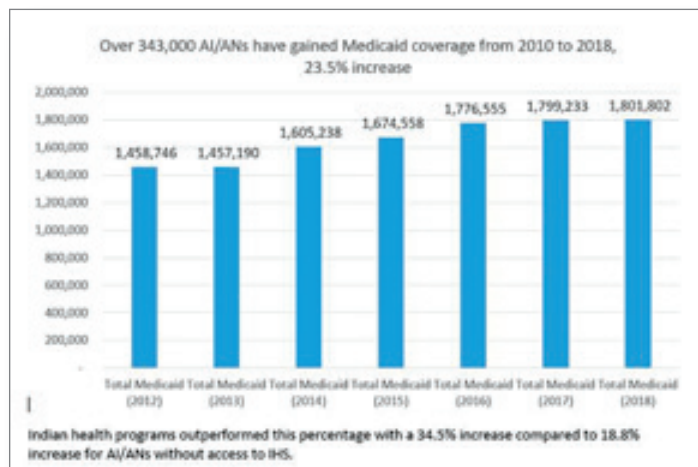
a large AI/AN population, but contrary to the trend of decreased insurance coverage, American Indian and Alaska Native coverage continues to increase while the all-races enrollment declined by as much as 4% in Colorado, 3.5% in Nevada and even California (2.6%) and Washington (2%) saw declining enrollment from 2018 to 2019.

MEDICAID'S ROLE IN INCREASED HEALTH INSURANCE COVERAGE AND DECLINE IN UNINSURED.

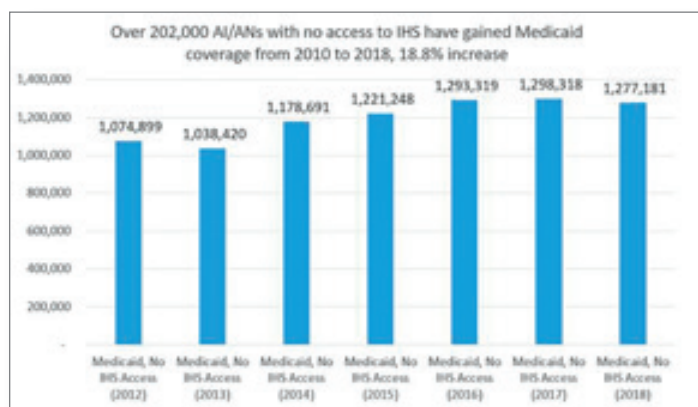
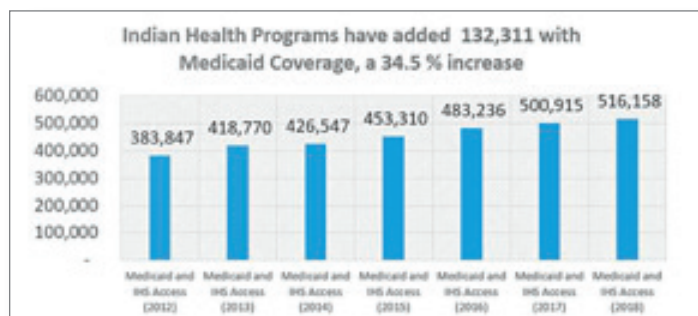
Medicaid Increase All American Indians and Alaska Natives 2012 to 2018		
Medicaid Increase All AI/AN Natives 2012 to 2018	343,056	23.50%
Medicaid Increase with IHS Access 2012 to 2018	132,311	34.50%
Medicaid Increase with No IHS Access 2012 to 2018	202,282	18.82%

Medicaid coverage of AI/ANs is the main reason for the decrease in the number of Uninsured. In 2018 an estimated 1.8 million AI/ANs had

Medicaid coverage compared to 1.45 million in 2012. Overall enrollment of all AI/ANs increased by 343,000 or 23.5% from 2012 to 2018. This is evidence perhaps of both larger numbers uninsured at IHS funded programs, but also successful outreach and enrollment activities targeting Indian communities.



Indian health programs outperformed this percentage with a 34.5% increase compared to 18.8% increase for AI/ANs without access to IHS.



WILL THE INCREASES IN COVERAGE AND DECLINE OF THE UNINSURED CONTINUE?

It is not a coincidence that the decline in the number of uninsured AI/ANs, 320,725, is roughly the same as the 343,000 increase in Medicaid coverage. Medicaid is the main reason for the welcome decline in the number uninsured.

770,000 AI/ANs or 14.4% remained uninsured in 2018. Medicaid itself is not likely to play as important a role in securing coverage to lower this rate as it did from 2012 to 2018. In all but the states who have recently or are soon to expand Medicaid, future gains in health insurance coverage will come from subsidized Health Exchange plans or increased coverage in Employer-based health insurance.

While there is evidence that Outreach and Enrollment to AI/ANs who have access to IHS has been well-targeted and has succeeded, the basis of Medicaid as a means-tested program means the level of effort must be maintained to continue the coverage gains and enroll all who are eligible. 🇺🇸

Source: American Community Survey Estimates 2012 to 2018, 1-year survey.
National Indian Health Board Data Visualizations located at:
<https://public.tableau.com/profile/edward.fox#!/>



E-Cigarettes: Appealing Flavors Hide Potential Dangers for Youth

Electronic cigarettes (also known as e-cigarettes or e-cigs) came onto the market in 2007.

Despite being marketed as a commercial tobacco cessation tool, e-cigarettes have not been proven to help in cessation or approved by the U.S. Food and Drug Administration (FDA) as a cessation aid.¹ Prior to 2016, e-cigarette regulation varied across the country. In 2014, the U.S. Food and Drug Administration (FDA) proposed new commercial tobacco regulations that included e-cigarettes. The proposed regulation on e-cigarettes would require the ingredients of e-cigarette liquids

to be disclosed, safety of the ingredients, and regulating e-cigarette devices². On August 8, 2016, the FDA finalized a rule that extended regulatory authority to all tobacco products, including electronic nicotine delivery systems (ENDS), which include e-cigarettes.³

Studies have shown that e-cigarettes contain harmful chemicals and can be dangerous to one's health. When a person is "vaping" they are inhaling a liquid that is heated into an aerosol instead of smoke, which happens when smoking a conventional cigarette. This aerosol can contain toxic chemicals in addition to nicotine, which is highly addictive. This is particularly alarming due to the rise in e-cigarette use among youth. From 2017 to 2018 the percentage of youth using e-cigarettes increased 78%.⁴ Some attribute this increase to advertisements and e-cigarette flavors appealing to youth.

Youth are exposed to e-cigarette advertisements on social media, in stores, television as well as newspapers and magazines. Marketing exposure has increased since 2014.⁵ These advertisements can be a reason for concern due to the history of tobacco companies targeting American Indian and Alaska Native (AI/AN) communities through promotions, sponsorships, and marketing campaigns. For examples, companies such as JUUL have used techniques similar to Big Tobacco as a way to try and make inroads into Indian Country, such as contacting National Tribal Organizations, give-a-ways and/or offering

money to Tribes. In addition to the increased advertisement companies are creating and marketing flavors such as bubble gum and birthday cake that appeal to young people. Flavors such as these and the many others available have been cited by youth as a reason to vape.⁶ The dangers of e-cigarettes became apparent late summer 2019 with the outbreak of e-cigarette, or vaping, product use-associated lung injury (EVALI).

What began as individuals showing up at Emergency Departments with illness related to using e-cigarettes or vaping product drastically increased in August 2019 and peaked in September 2019. According to the Centers for Disease Control and Prevention (CDC), data indicated that most of the EVALI cases were related to e-cigarette or vaping products that contained THC.⁷ EVALI cases are currently on the decline; however, more than 2,000 hospitalizations and 60 deaths were due to e-cigarette or vaping product usage as of January 2020. The e-cigarette related lung injury led to many states and Tribes declaring states of emergency or developing policies and/or resolutions in response to EVALI. Below are some of the Tribal policies that were enacted.

POLICIES AND RESOLUTIONS

- **September 12, 2019:** The Iipay Nation of Santa Ysabel announced that they were temporarily suspending the sales of all cannabis-containing vaping products at a dispensary on Tribal lands in light of the recent outbreak of vaping-related lung injuries and deaths.
- **September 24, 2019:** The Oglala Sioux Tribal Council passed an ordinance to ban all electronic smoking devices on the Pine



Harmful chemicals found in e-cigarette aerosol.
Source: Centers for Disease Control and Prevention

2 Deeming Tobacco Products To Be Subject to the Federal Food, Drug, and Cosmetic Act, as Amended by the Family Smoking Prevention and Tobacco Control Act; Regulations on the Sale and Distribution of Tobacco Products and Required Warning Statements for Tobacco Products Federal Register. United States Food and Drug Administration. 79 (80): 23142–23207. 25 April 2014.

3 U.S. Food and Drug Administration. (2020). Vaporizers, E-Cigarettes, and other Electronic Nicotine Delivery Systems (ENDS). Retrieved from <https://www.fda.gov/tobacco-products/products-ingredients-components/vaporizers-e-cigarettes-and-other-electronic-nicotine-delivery-systems-ends>.

4 American Cancer Society. (2018). FDA Proposes Regulations as Teen E-Cigarette Use Skyrockets 78% in 1 Year. <https://www.cancer.org/latest-news/fda-proposes-regulations-as-teen-e-cigarette-use-skyrockets-78-percent-in-1-year.html>.

5 American Cancer Society. (2018). Report: More and More Teens Seeing E-Cigarette Ads. <https://www.cancer.org/latest-news/report-more-and-more-teens-seeing-e-cigarette-ads.html>.


6 Villanti AC, Johnson AL, Ambrose BK, et al. Use of flavored tobacco products among U.S. youth and adults; findings from the first wave of the PATH Study (2013–2014).

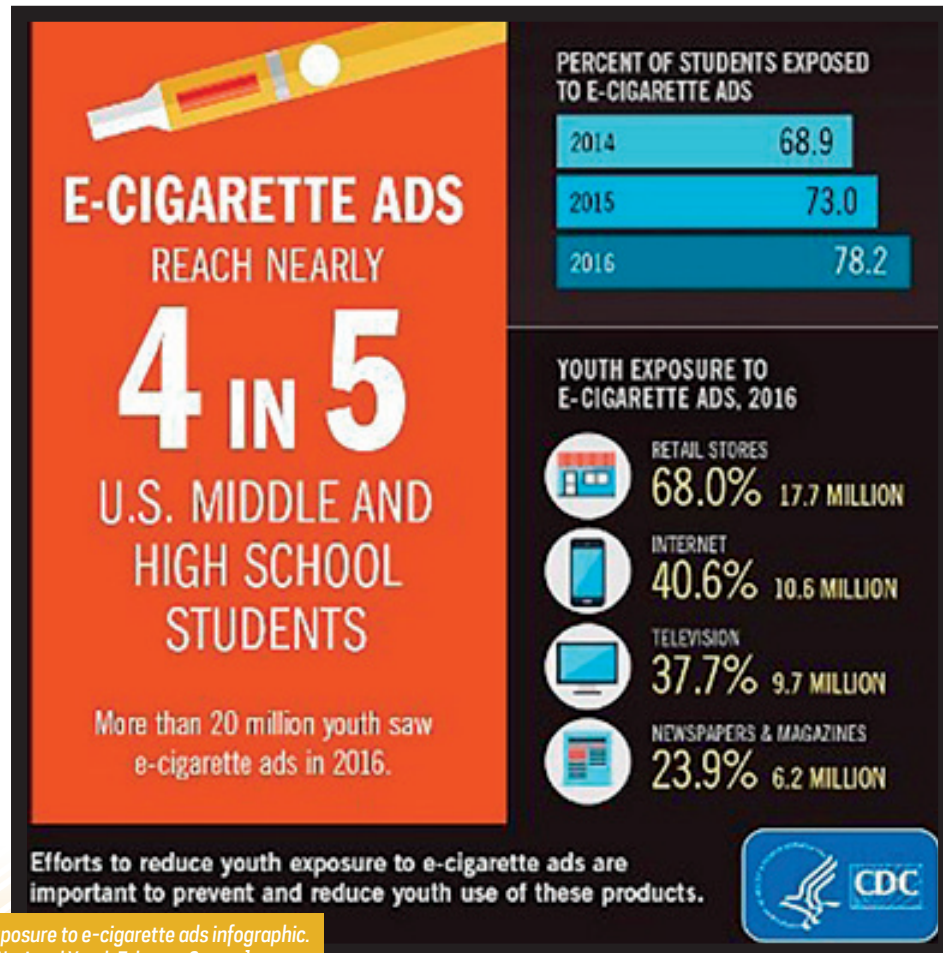
7 The Centers for Disease Control and Prevention. (2020). Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html.

E-cigarette health risks infographic. Source: American Academy of Pediatrics, Julius R. Richmond Center of Excellence

Ridge Reservation. The ban took effect immediately but prosecution for violations was delayed for 30 days after enactment. Unlike the temporary state action taken recently in response to the outbreak of vaping-related lung injuries and increase in youth e-cigarette use, the ban enacted by the Oglala Sioux Tribe is permanent.

- **October 7, 2019:** The Lac Courte Oreilles Tribal Governing Board voted unanimously to ban vaping product sales in all Tribal retail outlets and use of vaping products on all Tribal property. This ban is permanent.
- **October 11, 2019:** The Puyallup Tribal Council instituted a ban on the sale of flavored vaping products, including both tobacco and marijuana, which will last for 100 days. The ban went into effect for flavored marijuana vaping products on October 11, 2019 and for flavored tobacco vaping products on November 1, 2019.
- **October 24, 2019:** It was reported that Turtle Mountain Band of Chippewa Tribe decided to ban the sale of all vaping products on Tribal land; use of vaping products will remain lawful on the reservation. The ban went into effect at the end of October 2019 and places a permanent restriction on vaping product sales.
- **November 5, 2019:** The Muckleshoot Tribal Council banned the sale of flavored vaping products. Additionally, it decided to restrict sales of tobacco products, including vaping products, to those who are 21 or older. This vaping product ban is permanent.

E-cigarette and other vaping product usage should continue to be monitored as more information about the long-term health impacts become available. 



Youth exposure to e-cigarette ads infographic. Source: National Youth Tobacco Survey

The State of the Special Diabetes Program for Indians



BACKGROUND ON SDPI'S SUCCESS

There is no public health program quite like the Special Diabetes Program for Indians (SDPI). Having existed for 22 years, and with over 300 Tribal and urban Indian grantees across 35 states under its belt, SDPI sits in a league of its own as the most successful type II diabetes prevention and treatment initiative ever implemented in Indian Country. As a community-driven program, SDPI stands on the ground of Tribal sovereignty. Each SDPI

SDPI continues to save lives and improve health outcomes.

program is uniquely tailored to address the chronic disease challenges and priorities of the respective Tribal or urban Indian community, guided by culturally and linguistically appropriate activities and services that focus on addressing the root causes of diabetes in American Indian and Alaska Native (AI/AN) communities.

SDPI continues to save lives and improve health outcomes. From 1996 to 2013, rates of End Stage Renal Disease (ESRD) among AI/ANs plummeted by 54%. Similarly, diabetic eye disease rates fell by half during the same time period. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimates that SDPI has been responsible for up to 2,600 fewer cases of ESRD within Tribal and urban Indian communities – a significant

feat that speaks volumes about how SDPI continues to improve the health and well-being of AI/AN Peoples.

SDPI's success in improving health outcomes has also yielded significant cost savings. In a 2019 federal report, SDPI was estimated to save Medicare up to \$52 million per year. This is because there are many co-occurring ailments that patients with ESRD are also likely to experience such as muscle cramps, heart disease, bone disease, nerve damage, and other ailments. Hence, with SDPI leading to fewer and fewer ESRD cases, the health benefits extend beyond just the reductions in rates of kidney failure – which means SDPI's cost savings are likely even higher.

Because of its immense benefits, SDPI holds strong bipartisan support in Congress. In 2019, leadership on the House and Senate Diabetes Caucus circulated a letter to sign-on to all members of Congress asking for their support for reauthorization of SDPI. With support from Tribes, National Indian Health Board (NIHB), and sister advocacy organizations, the letter garnered signatures from 87% of the House of Representatives – 379 out of 435 members. In the Senate, 68% of Senators signed on. No other public health program can achieve this level of bipartisan and bicameral support – further demonstrating how SDPI speaks for itself.

ONGOING CHALLENGES

But despite SDPI's enormous success, the program continues to face many challenges. For example, SDPI has been flat funded at \$150 million since 2004, and has lost over a third of its buying power to medical inflation during that time frame. In fact, in order for SDPI to have the same buying power it had

sixteen years ago, program funding would need to be increased to \$247 million. With less buying power, SDPI grantees are forced to stretch every dollar to maintain services and operations with less and less money available to make operational improvements or expand delivery of health services.

Because of stagnant funding, current grantees are forced to make sacrifices everyday about what to prioritize with their limited dollars – whether it is purchasing critical new medical equipment; expanding the types of activities and services that are offered; or addressing staffing vacancies. In addition, stagnant funding has meant that very few new Tribes are able to join and benefit from the program despite having a strong interest.

Over the past several years, SDPI has been subject to reoccurring short-term reauthorizations lasting from only two years to as short as only 29 days. These short-term extensions have not only curtailed grantees' ability to engage in long-term program planning, but have also caused significant disruption for Tribes in the present. For instance, just since September 30, 2019 SDPI has been reauthorized *three times* – once from September 30, 2019 to November 21, 2019; then from November 21, 2019 until December 20, 2019; and finally until its current expiration date of May 22, 2020.

However, in the meantime, Tribal and urban Indian SDPI grantees have lost providers because of the uncertainty of continued funding availability. Purchases for necessary medical equipment like dialysis machines and glucometers have been put on hold. Program officials have been forced to continuously delay the launch of new services or activities because of a lack of funding certainty.

Unfortunately, it has also forced IHS to initiate the application process for the next five-year grant cycle beginning in calendar year 2021 in the absence of a congressional reauthorization and guarantee of funding for SDPI, in order to avoid procedural delays in reviewing and awarding the next round of SDPI funds.

In December 2019, lawmakers on the House Energy and Commerce Committee and the Senate Health, Education, Labor and Pensions Committee announced a bipartisan and bicameral deal that would fund SDPI and other expiring health extenders for a period of five years. A five-year reauthorization would provide the longest stretch of guaranteed funding in over a decade. Tribes and NIHB are pushing fervently for Congress to swiftly pass the five-year deal that was already negotiated. Back in December, NIHB led a sign-on letter demanding long-term reauthorization of SDPI that included 17 national Tribal and non-Tribal partners. NIHB coordinated another letter to congressional leadership in February, 2020 that included 54 Tribal and non-Tribal partners. NIHB continues to prioritize a five-year reauthorization of SDPI as among the top legislative priorities for this year.

Current grantees are forced to make sacrifices every day due to uncertainty over SDPI's future.

MOVING FORWARD

Of course, SDPI's challenges are not limited to short-term extensions and stagnant funding. Over the years, Tribes have continuously noted procedural, structural, and technical issues with how SDPI is currently operated. For instance, Tribes have repeatedly outlined concerns with SDPI's burdensome grant reporting requirements that detract from patient time and service delivery. Other concerns include limitations on use of program dollars, worsened by procedural delays in getting newly proposed activities approved by IHS before they can be launched. Some Tribes have also

highlighted concerns with the methodology behind the national funding formula used to calculate the amount of SDPI dollars distributed to each grantee. Specifically, some Tribes have voiced the need for updates and adjustments to user population and disease burden estimates used to calculate SDPI funding distribution, with a strong caveat that proposed adjustments do not adversely impact any current grantees. Recently, many Tribes have also raised concerns over the amount of program dollars retained at IHS headquarters for administrative support and data infrastructure management that Tribes would prefer be spent on community-directed programs.

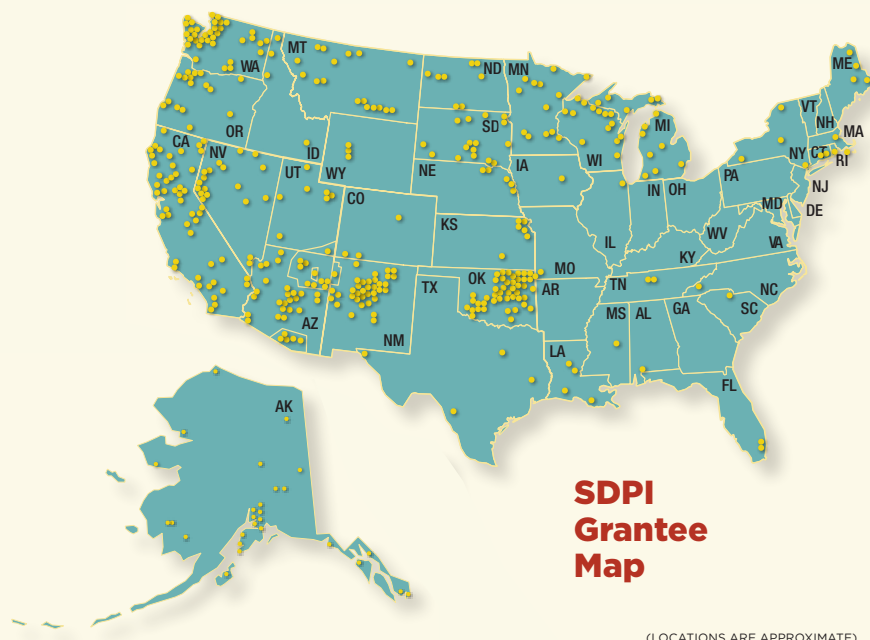
But beyond these noted concerns, Tribes are looking to restructure SDPI to ensure that program dollars are delivered in ways that respect Tribal sovereignty and affirm the government to government relationship between Tribal Nations and the United States. Over the years, Tribes have repeatedly conveyed that the federal trust responsibility cannot be honored or fulfilled through grant-based funding mechanisms. Competitive grants force Tribes to compete not only with each other for critical funds, but also with state and local, and county governments. As such, Tribes have called on Congress and the federal government to devise ways of providing sufficient, reoccurring, and sustainable funding streams to Tribal governments and organizations *directly* as opposed to through grants.

To that end, Tribes are engaged in national advocacy efforts before Congress to amend SDPI's governing law in order to

restructure the program and allow dollars to be delivered through self-determination and self-governance contracts and compacts. This would ensure stronger Tribal control of SDPI operations, and provide Tribes with greater flexibility to design the program to best meet the needs of their communities. Changing SDPI's structure to allow funds to travel through self-determination and self-governance contracts and compacts is strongly supported by Tribes across Indian Country, including by NIHB, because it affirms Tribal sovereignty and ensures that the Tribal voice is guiding SDPI's future. However, Tribes have been clear that this proposed change should not harm continued access to SDPI for Direct Service Tribes and urban Indian organizations that either elected against, or are ineligible to receive program funds outside of a grant structure.

But beyond reforming SDPI's structure, it is long past due that Congress enact a **permanent reauthorization** of SDPI so that Indian Country does not have to continuously fight for a program that has already demonstrated unparalleled success. It is long past due that Congress enact a significant and **permanent funding increase for SDPI** that ensures program funds are automatically adjusted each year to match increases in medical inflation rates.

SDPI continues to save lives and improve health outcomes across Indian Country — it is long past due for Congress to do its part and ensure SDPI remains successful in perpetuity. 🏞️



Ponca Tribe of Nebraska

The Ponca Tribe of Nebraska provides key diabetes prevention and management services across 13 different counties. They offer a variety of services, including diabetes education, care management, foot care, physical activity classes, diabetes prevention activities, and healthy events. However, with a best practice of nutrition education, much of the focus is on teaching community members about eating a healthy diet while incorporating traditional indigenous foods.

The Ponca Tribe of Nebraska Diabetes Program is currently offering a 6-week cooking series where they are featuring a Tribal guest-chef in addition to sharing nutritional recipes identified by program staff. They are teaching attendees how and where to find the ingredients for each meal, and focus on recipes that are both healthy and affordable. Tribal citizens are also invited to share recipes, and the nutritionist recommends complimentary foods to go with what they are serving. Recipes shared during the class often include indigenous foods and traditional Ponca foods such as prairie turnips, the three sisters (corn, beans and squash), juniper berries, sunflower seeds, salmon, and wild rice.

The Tribe also raises their own grass-fed buffalo. The SDPI program is able to offer buffalo meat from this herd as a nutrition incentive for those participating in the diabetes education program. This program has been successful in incentivizing participants to attend diabetes education sessions.

In addition to the focus on nutrition, the SDPI program holds several events annually that promote health and prevention. At the Ponca Tribe's Annual Healthy Living Powwow, there

are informational booths on each of the health programs available to Tribal citizens. Dancers are encouraged to participate as a healthy way to engage in both traditions and physical activity. The Tribe also hosts a Diabetes Day event at all service sites, which include screenings, activities, games, and cooking demonstrations.

The Ponca Tribe of Nebraska's program has been extremely successful. In the last 5 years they have seen an increase in the percentage of patients engaged in diabetes education, increased the percentage of patients receiving foot and eye exams, and have recorded an improvement in blood pressure for their patients with diabetes. A1 C levels have also been improving, and patients have recorded behavior changes towards a healthier lifestyle.

However, despite the success of their programs, over the last several years, the Ponca

Tribe's diabetes prevention and management efforts have faced several challenges related to delays in congressional renewal of the program at the federal level. This year, the Tribe did not receive a Notice of Award (NOA) until after January 1st. While the Tribe has offsets to fund them for the full year, there is uncertainty for the rest of the cycle. "How do we plan for the future when we are not entirely sure of funding?" asked Sarah Pfeifer, SDPI Project Director, "Particularly with staffing... with all these late NOA's and reauthorizations, this definitely creates stress and challenges."

SDPI is currently only renewed until May 22, 2020. Without long term renewal, the program faces instability, and grantees are unable to focus on building and strengthening their workforces and programs. SDPI needs to be renewed long-term by Congress to ensure that each community SDPI program can focus on providing services that save lives. 🍴

Ponca Tribe's nutrition education activities



THREE SISTERS MASH

Serves 4 to 6

INGREDIENTS:

- 1 to 2 T. sunflower oil
- 1 wild onion or large shallot, chopped
- 1 small summer squash or zucchini, cut into 1-inch pieces
- 1 cup beans
- 1 cup sweet corn kernels
- ½ cup cooked hominy
- 2 T. maple syrup
- 2 tsp. chopped sage
- 1 T. chopped mint
- Generous pinch salt

DIRECTIONS:

1. Film a large skillet with oil and set over medium heat.
2. Cook the onion or shallot until tender, about 3 to 5 minutes. Add the squash and continue cooking until tender, stirring often, about 5 minutes.
3. Stir in the beans, corn, and hominy and cook until corn is bright and tender, about 5 minutes.
4. Then stir in maple syrup, sage and mint. Season with salt. Serve warm or at room temperature.

Recipe adapted from *The Sioux Chef's Indigenous Kitchen*



SDPI SPOTLIGHT



Ponca Tribal citizens discuss indigenous plants as part of their diabetes prevention and health promotion activities



The Ponca Tribe of Nebraska's Annual Health Living Powwow



The diabetes prevention program promotes physical activities for all different ages and levels of fitness.



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the
DATE**

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14-17, 2020
ANCHORAGE, ALASKA
DENA'INA CONVENTION CENTER**

**37th Annual
NATIONAL INDIAN HEALTH BOARD
National Tribal Health Conference**

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NATIONAL INDIAN HEALTH BOARD

A DECADE

of Overcoming Challenges and Making Progress in Indian Health

2010

2011

2012

2013

2014

- *Indian Health Care Improvement Act Permanently Reauthorized as Part of the Patient Protection & Affordable Care Act*

- *Secretary's Tribal Advisory Committee Created at the Department of Health & Human Services*

- *National Indian Health Board Holds First Annual National Tribal Public Health Summit*

- *Tribal Voluntary Public Health Accreditation Begins*

- *NIHB Hosts National Tribal Health Reform Implementation Summit*

- *NIHB Launches Special Diabetes Program for Indians Resource Center*

- *Centers for Disease Control and Prevention Creates Tribal Advisory Committee*

- *NIHB Leads Tribal Campaign to Stop Sequestration Cuts to Indian Health Service*

- *NIHB Creates Regulation Review and Impact Analysis Report*

- *Violence Against Women Act Reauthorized with Tribal Provisions*

- *Congress Begins Fully Funding Contract Support Costs within IHS's budget*

- *Sequestration In Effect, IHS Budget Automatically Cut by \$220 Million*

- *NIHB Testifies at First Ever Congressional Hearing on Advance Appropriations for IHS*

- *CDC Begins Good Health and Wellness in Indian Country Program*

- *Health Resources and Services Administration Implements Tribal Consultation Policy*

WELCOMING 2020

And Looking Back on Our Accomplishments of the Last Decade

In the last 10 years, the National Indian Health Board (NIHB) has been everywhere. NIHB has been in the halls of Congress protecting and expanding support for Tribal health programs. At the table with federal agencies advocating for Tribal priorities in policy, regulations, and programs. Side-by-side with Tribal leaders and health advocates developing strategies and implementing those plans. And in Native communities supporting the work of Tribal staff as they strive to ensure the health and wellness of their Tribal citizens. Since 2010, NIHB — Indian Country's top health advocate — has been on a mission and that mission is to reinforce Tribal sovereignty and strengthen Tribal health systems. Like a trusted friend, NIHB is always there for Tribes.

"It's amazing to see NIHB's work over the last 10 years. From legislative victories — like the permanent reauthorization of the Indian Health Care Improvement Act, to our regulatory tracking and advocacy — which helps to ensure legal benefits and protections for Indians are implemented, to our program activities — like our community education on the ACA and insurance enrollment toolkits, the work that we do is truly meaningful," said NIHB CEO Stacy A. Bohlen. "In recent years, NIHB has grown our staff, expanded our scope and increased our reach to areas and populations of need. As an organization and a team, we are dedicated to achieving systems of change that will improve quality, access and delivery of Indian health care for all federally recognized American Indian and Alaska Native Tribes. And of course, we do not do this work alone — we do this work in partnership with Tribes and Tribal organizations all across Indian Country."



"The Affordable Care Act started a new chapter in the delivery of quality health care to Indian Country," said NIHB Chair and Great Plains Representative Victoria Kitcheyan. "NIHB led the advocacy efforts for the ACA's special protections for American Indians and Alaska Natives, and after the ACA became law, NIHB stood ready, willing and eager to deliver information to the Tribes about health reform. NIHB worked to ensure that Tribal populations realized the full benefit of the law."

Almost as quickly as the ACA became law, it faced a host of legal challenges, mainly around the constitutionality of the law's individual mandate directing citizens to obtain health insurance. Medicaid expansion also featured prominently in the legal challenges to the law. Eventually, the Supreme Court was called to examine the constitutionality of those provisions of the law and the severability of those provisions from the rest of the ACA.

In 2011, NIHB joined forces with other Tribal organizations to develop and submit an amicus ("friend of court") brief that argued that the IHCA and the ACA's Indian specific provisions were independent from the individual mandate. Although the Supreme Court determined that mandatory Medicaid expansion was a federal overreach, it ruled that the individual mandate was allowed under the federal government's tax and spend power. Importantly, the IHCA and Indian specific provisions of the ACA remained intact.

KICKING OFF THE DECADE: THE AFFORDABLE CARE ACT AND REAUTHORIZATION OF IHCA

NIHB's work since 2010 has largely been shaped by one swift stroke of a pen — namely — President Obama's signing into law the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. This piece of legislation significantly impacted Indian Country because it permanently reauthorized the Indian Health Care Improvement Act (IHCA), marking a victory for NIHB and Tribal health advocates that worked tirelessly to get IHCA reauthorized. Along with fighting for permanent reauthorization of the IHCA, NIHB and Tribal allies also advocated for and secured Indian specific provisions in the ACA, including authorization for third-party reimbursement to the Indian health system through Medicaid, designating the Indian Health Service as the payor of last resort, and zero-cost sharing for premiums and co-pays for the Health Insurance Marketplace and Medicaid.

ACA OUTREACH AND EDUCATION TO TRIBES

That same year, NIHB expanded efforts to share information about health reform and created a comprehensive digital platform — the NIHB Tribal Health Care Reform Resource Center website.

Drawing upon and complementing its face to face work in community, NIHB set out to create an online center that would provide

information and technical assistance to every Tribe in the country seeking support. In addition to information on insurance, Medicaid, the special Indian protections and benefits of the ACA, the website also provides policy information and resources from the Medicare, Medicaid and Health Reform Policy Committee (MMPC) and the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS).

From 2013 to 2017, NIHB partnered with federal agencies and Tribes to develop ACA toolkits for special Tribal populations, such as youth and elders, outlining the benefits of having health coverage. NIHB encouraged Indian Health Service and Tribally operated facilities to utilize the toolkits, which included videos, brochures, posters and even a bingo game for Tribal elders to educate them on Medicare benefits.

During the 2015–2016 open enrollment period, then Health and Human Service (HHS) Secretary Burwell challenged every Tribe to host an enrollment event, and NIHB was there to help. NIHB traveled across the country for the HHS ACA Outreach and Education Tribal Days of Action. NIHB was everywhere. From Alaska to Florida, from California to Maine and all of the places in between, NIHB was set on reaching as many Tribes as possible. On one trip, NIHB crossed the Navajo Nation in one week making stops in five communities. Nearly every year since 2010, NIHB's annual conferences also served as ideal venues to provide presentations on topics that ranged from "Affordable Care Act 101" to "Special Provisions" and "Exemption Waivers" for American Indians and Alaska Natives.

Efforts by NIHB and the Tribes have reaped tremendous benefit. Since 2010 enrollment in various insurance programs, particularly Medicaid have lowered the number of uninsured dramatically. The total number uninsured AI/ANs declined from 1.1 million in 2010 to 770,000 in 2018. The uninsurance rate for AI/ANs is now 14.8% as of 2018 compared to 23.7% in 2010. Importantly, third party billing infused much needed funding support into the system. A 2019 GAO report stated that, "Federally operated IHS facilities' third-party collections — that is, payments for enrollees' medical care from public programs such as Medicaid and Medicare, or from private insurers — totaled \$1.07 billion in fiscal year 2018, increasing 51 percent from fiscal year 2013."¹ The report also shared that Tribally operated facilities experienced increases in collections over the period, although exact figures were not available.

ON THE FRONT LINES OF INDIAN HEALTH

In 2012, NIHB celebrated its 40th year anniversary by redoubling efforts to secure increased funding and long term authorization of the Special Diabetes Program for Indians (SDPI). NIHB launched the SDPI Resource Center and gathered success stories from across Indian Country to compliment the impressive data on the program and demonstrate the need for continued Congressional commitment. This work and advocacy remains a top priority, as NIHB builds on successful campaigns for longer terms of authorization and continuation of

the program. Also in 2012, NIHB defended the Indian Health Service (IHS) program funding by initiating a "Stop the Sequestration" campaign that urged Congress to protect Tribal health programs by exempting IHS funding from sequester like it had for the Veterans Administration.

"The federal government has a trust responsibility to Tribes, and this duty includes an obligation to ensure Tribal people have quality health care and the funding that makes that possible. NIHB works every day to see this commitment fulfilled and to track and counter threats to our programs — like sequestration. NIHB works every day to protect our Tribes," said NIHB Chairperson Kitcheyan.

NIHB'S WORK TO STRENGTHEN TRIBAL PUBLIC HEALTH

While NIHB worked to support Tribal health systems, the organization also looked to expand its efforts in the area of Tribal public health. NIHB and Tribal allies advocated for additional funding to support Tribal health promotion and prevention efforts, and argued for greater Tribal control of available resources.

In 2013, those efforts brought promising policy changes, notable among them — the Sandy Recovery Improvement Act, a law,

which among other things, gave federally-recognized Tribes the option to make a request directly to the President to declare an emergency or major disaster and request support. This amended the Stafford Act and allowed Tribes the ability to by-pass the process of running the request through their state/s.

In 2014, NIHB was encouraged to see the Centers for Disease Control and Prevention (CDC) respond to NIHB and Tribal requests and recommendations, as they introduced the Good Health and Wellness in Indian Country program, which specifically focused on Indian Country and provided funding for Tribal grantees to develop public health programs. NIHB successfully secured additional funding for the program in 2018. In recent years, NIHB has defended the popular program from the President's budget recommendation, which has zeroed out funding for the program.

NIHB STANDS WITH TRIBES CALLING FOR QUALITY CARE

In 2014, understaffing and poor management led to a crisis in care at some IHS facilities in the Great Plains Area. Physicians and nurses' positions were unfilled. Patients were misdiagnosed. Tragically, some lives were lost. The Winnebago Tribe needed help and NIHB was there. NIHB testified to the Congress on the issue and passed resolutions that supported Tribes in the Great Plains Region as they advocated for safe, reliable healthcare at the IHS-operated facilities, and in particular, supported the Winnebago Tribe and the Omaha Tribe in their plight to restore quality services to the Winnebago IHS Service Unit. The spotlight and call for change resulted in deployments from IHS



¹ <https://www.gao.gov/products/gao-19-612>

headquarters, assessments to identify causes for the crisis, and development of strategies to turn the situation around.

With workforce as an important focus that year, NIHB and Tribal allies reminded all operating divisions of HHS of their obligation to uphold the Trust Responsibility and to meaningfully engage with Tribes. That year, after working with NIHB to gain Tribal input, the Health Resources and Services Administration (HRSA) announced release of its updated Tribal consultation policy.

“The Trust Responsibility, a solemn obligation to Tribes, runs from the all of the federal agencies to the Tribes. We tend to immediately think of IHS, but all of the operating divisions at HHS have a duty to bring their resources to bear to fulfill the government’s Trust Responsibility. Having Tribal consultation policies in place makes this responsibility more explicit and can help to strengthen the engagement between Tribes and the federal government,” said CEO Bohlen.

CALLING FOR INVESTMENT IN INDIAN COUNTRY’S YOUTH

In 2015, NIHB joined with the National Congress of American Indians, National Indian Child Welfare Association and the National Indian Education Association to release the 2015 Native Children’s Policy Agenda. In addition to setting out a comprehensive set of recommendations that highlight needed investments in Native children and youth, NIHB individually developed a plan to help grow and support the next generation of Tribal health policy leaders.

This plan came to fruition in 2017, as NIHB welcomed its inaugural class of the NIHB Youth Health Policy Fellowship. Over the course of a year, fellows worked directly with their Tribal leadership to identify one priority health issue. With the support of NIHB and program mentors, fellows learned how to analyze policy, create informed recommendations, present their findings to national and Tribal decision makers, and lead advocacy efforts for change. Fellows caught the attention of lawmakers and their efforts paved the way to the introduction of a bill modeled on the SDPI, which would provide scaled and sustained resources for Tribes to support a Behavioral Health Program for Indians. Although the legislation did not pass during that session, lawmakers have reintroduced the bill, and NIHB is hopeful in its prospects.

NIHB is now in its third year of the fellowship program, with fellows from all classes making impressive contributions in the fields of Tribal health, public health, and public policy.

SETTING THE TRIBAL BEHAVIORAL AGENDA

Throughout the decade, NIHB’s work focused heavily on Congressional and Administrative advocacy, and health reform outreach and education, but Tribal leaders also were calling for coordination and collaboration among stakeholders to address pressing behavioral health issues in Tribal communities. NIHB was there to

facilitate that call and passed a resolution supporting the development of a Tribal behavioral health agenda.

In 2015, NIHB worked to gather feedback and input from all across Indian Country, compiling information from Tribal leaders, citizens, healers, behavioral health experts, elders and youth. The result, released in 2016, is a Tribal Behavioral Health Agenda (TBHA) that serves as a collaborative blueprint for Tribal, federal, state and local governments and other stakeholders. It identifies foundational elements supporting health, such as healing from historical and intergenerational trauma and prevention and recovery support.

“The Tribal Behavioral Health Agenda provides a clear, national statement about the extent of behavioral health-related problems and their impact on the well-being of Tribal communities,” said CEO Bohlen. “The TBHA reflects a true voice of concern from Tribal leaders about substance abuse and mental health issues within their communities, and Tribal recommendations that can improve policy and programs.”



A NEW ADMINISTRATION

In 2016, a newly-elected President and Administration prompted NIHB to convene a Presidential Transition Summit that brought together representatives from all regions of Indian Country to strategize on the best approaches to protect Tribal health programs and their funding.

Also that year, NIHB and Tribal leaders met with the CDC Director to present a host of Tribal public health recommendations and highlight the pressing need for substantial and sustained investment in Tribal public health, on par with what the agency provides to states, cities and counties.

SUPPORTING INNOVATIVE WORKFORCE MODELS

NIHB has long championed the innovative work that Tribes have done in the health care space, including in the realm of oral health. In addition to supporting Tribal sovereignty and self-determination generally, over the last ten years NIHB has advocated for the right of Tribes to determine whether they want to utilize mid-level providers such as Dental Health Aide Therapists (DHATs).

In 2016, NIHB was excited to share news and support the Swinomish Tribe as it unveiled its Dental Health Aide Therapy program — the first Tribe to implement the DHAT program outside of Alaska. That same year, the NIHB Board of Directors formed the Tribal Oral Health Initiative to bring together Tribes, Tribal health organizations, and oral health advocates to identify solutions to Indian Country’s oral health crisis. Not surprisingly, the DHAT program and dental therapy topped the list of promising approaches.

Since that time, the Initiative has worked to educate Tribes on the success of dental therapy in Alaska Native communities and Tribes in the Pacific Northwest. Through partnerships with the Pew Charitable

Trusts and the W. K. Kellogg Foundation, NIHB has offered financial support to Tribal campaigns to expand access to dental therapy. Thirteen states now have some sort of mechanism for Tribes to utilize dental therapy, should they so choose.

RESPONDING TO THE OPIOID CRISIS

The later part of the decade saw increased attention to the opioid crisis. Communities reported opioid misuse, addiction and overdose at alarming rates. Like a tidal wave, the opioid crisis rolled through communities across the nation, leaving devastation in its wake. This emerging problem in America had been going on for years in Tribal communities, and the new attention to the problem highlighted the fact that American Indians and Alaska Natives were dying from opioids at higher rates than their white counterparts. Despite this greater level of need, Tribes were not included in the 2017 State Targeted Response to the Opioid Epidemic grants.

NIHB made this oversight an area of special focus. Working with Tribal allies, NIHB took every opportunity to educate lawmakers and administration officials on the need for dedicated funding for Indian Country. Those efforts paid off in 2018 when President Trump signed into law the Support for Patients and Communities Act which reauthorized the State Targeted Opioid Response Grants for an additional two years and included a 5% set aside of 50 million dollars for Tribal Nations.

The opioid epidemic has also triggered significant increases in rates of infectious diseases such as Hepatitis C (HCV) among American Indians and Alaska Natives. In 2018, NIHB's successful advocacy efforts on HCV in Indian Country led to the addition of the drug "Harvoni" to the IHS formulary. This is an effective treatment for specific HCV genotypes, and at the time of its addition was the only drug available with high cure rates (96-99%). Other therapies have existed prior to Harvoni but were ineffective cures.

GOVERNMENT SHUTDOWN AND SEQUESTRATION

December 22, 2018 marked the beginning of the longest government shutdown in history. Much like sequestration, IHS was the only federal healthcare entity to be shut down. This partial government shutdown lasted 35 days and had severe effects in communities across Indian Country. NIHB rallied to address the crisis.

NIHB convened meetings, shared information, collected impact stories and served as a direct channel to members of Congress and the Administration so that those parties could understand the unacceptable impacts Indian Country faced as the shutdown continued. The shutdown ended on January 25, 2019, and NIHB called on Congress to pass long term protections from future disruptions — such as advanced appropriations for the Indian Health Service. Those efforts remain ongoing and critically important to Indian Country.

DEFENDING ACA AND IHCA

In 2018, the ACA was challenged again and NIHB joined with Tribes and Tribal organizations to submit another amicus brief supporting the Indian specific provisions of the ACA and laying out a compelling argument for the severability of the IHCA from the ACA, should the law be found unconstitutional. NIHB remains vigilant in efforts to track developments, share the latest information with Indian Country, and advocate for the IHCA as both a pillar of the Indian health system and law that pre-existed the ACA. NIHB also advocated to the administration to stand with Indian Country, to distinguish and defend the IHCA as part of its trust responsibility to Tribes.

PROTECTING INDIAN COUNTRY FROM HARMFUL CHANGES TO THE MEDICAID PROGRAM

In 2018, as part of its administrative advocacy, NIHB led Tribal efforts and presented compelling arguments to CMS, as the agency sought to encourage states to use Medicaid work and community requirements as a condition of eligibility for some Medicaid beneficiaries. Although CMS did not promulgate a blanket Indian exemption as called for by Tribal advocates, the agency agreed it could approve proposals from states which included exemptions for Tribal members or IHS eligible beneficiaries.



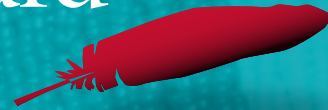
CMS initiatives to transform the Medicaid program did not end with the push for work requirements however. In 2019, CMS announced its intention to release guidance which would outline a permissible path for states to block grant a portion of their Medicaid programs. Again NIHB and Tribal partners advocated to CMS for an Indian exemption to any Medicaid block grants which states might propose. This time, CMS included a specific mention of Tribes in their written guidance clarifying that services provided through IHS and Tribal health clinics could not be used to calculate a state's funding cap, and reiterating the 100% FMAP for those services would remain untouched by the block grant scheme. While NIHB is encouraged by these measures which will mitigate some of the possible impacts a block grant may bring, NIHB continues to press for additional assurances and protections.

LOOKING FORWARD

NIHB looks forward to standing with Tribes for another decade and beyond.

NIHB will continue to work with Tribal leaders, citizens and allies to advocate for improvements to the Indian health system. In the immediate term, this includes every effort to defend the Indian Health Care Improvement Act, secure increased funding for the Indian Health Service, secure reauthorization of the Special Diabetes Program for Indians, and realize advance appropriations for the Indian health system. We hope you will join us in this work.

National Indian Health Board



2015

2016

2017

2018

2019



- NIHB Launches Zika Project
- NIHB and Partners Launch First Kids First Initiative
- Centers for Medicare and Medicaid Services Implements Tribal Consultation Policy

- NIHB Publishes Tribal Behavioral Health Agenda
- Swinomish Indian Tribal Community Hires First Tribal Dental Therapist Outside of Alaska
- NIHB Launches Tribal Oral Health Initiative to Support Tribes Interested in Dental Therapy
- NIHB's Climate Ready Tribes Project Begins Funding Tribal Climate Health Activities

- Congressional Efforts to Repeal and Replace the Patient Protection & Affordable Care Act Fail
- Medicaid Work Requirements Implemented in Multiple States for First Time
- NIHB Publishes Video Examining Dental Therapy's Impact on Alaska Native Children

- Tribal Opioid Response Grants Created, Providing Funding Directly to Tribes in Accordance with the Tribal Behavioral Health Agenda
- Hepatitis C Drugs Added to IHS Formulary
- NIHB Files Amicus Brief in Opioid Manufacturers and Distributors Lawsuit
- Longest Government Shutdown in American History Lasts 35 Days and Harms Indian Health for Months After

- Sequestration Budget Mechanism Eliminated in Congressional Budget Deal
- NIHB Testifies at First Congressional Hearing on Native Veterans Health in Over Three Decades
- NIHB Co-Chairs National Partnership for Dental Therapy with Community Catalyst and the National Coalition of Dentists for Health Equity
- NIHB Co-Hosts Congressional Roundtable on Tribal Public Health

► Continued from page 1 – **Health IT Modernization in Indian Country: Where Do We Go From Here?**

Although the HCD team designed the Final Report to inform federal decision makers of the state of Health IT in Indian Country, Tribes may also benefit from the information in the report. The Final Report includes the following findings and recommendations:

Modernize outdated IHS HIT Infrastructure	<ul style="list-style-type: none"> • Report recommends that IHS work to ensure interoperability by choosing the fewest possible technology suites and address the infrastructure concerns by working with consulting groups for guidance. • For the road ahead, the agency has committed to perform ongoing, in-depth analysis of the current IT landscape; augment and reference initial findings; and actively engage with I/T/U partners at each step of the way.
Create an Engaging, Modern, Convenient System for Patients	<ul style="list-style-type: none"> • Facilities using the current HIT system offer patients access to the Personal Health Record (PHR). However, it is not being well utilized and is not even available at many sites. • Report recommends the creation of user-friendly ports so that patients can be given tools to be able to easily understand and access their medical information from any location. • The system should also allow patients to access their records, manage their appointments, have access to education materials, and be able to contact their care team.
Ensure Consistent, Effective and Efficient Organizational Governance for Leadership	<ul style="list-style-type: none"> • The report recommends that the governing body behind the creation of this project be both small and representative of the stakeholders involved and that there be regular interaction with stakeholders groups, through both formal Tribal Consultation and informal meetings. • Historical experiences of Indian Country support the conclusion that effective and representative governance is more important than the specific technology platforms selected.
Engage End Users to Understand Their Needs	<ul style="list-style-type: none"> • The current system was developed with input from end users but the explosion of advances in HIT and the imposition of unfunded mandates has resulted in an antiquated, disjointed, and error-prone system. • To help facilitate the creation of the system, the report recommends using the data collected by the Modernization Project as the foundation or a list of user-identified system requirements to be developed, and ensure availability of user-centric training and support.
Provide Full Support for Data Exchange and Interoperability Between IHS Systems and Components	<ul style="list-style-type: none"> • The ability to share information across applications must be improved. Under the current system, many facilities are stuck with the time consuming task of manually transferring information between applications or facilities. • Report recommends that a road map be established to allow patients to move across facilities and that policies be developed to ensure that systems that are purchased support interoperability. It also calls for ensuring that historical data is available and implemented into future systems.

Medicaid Work Requirements: Their Past, Present, and Future

In April 2018, President Donald Trump issued an executive order in which he called for work requirements as a condition for participation in social programs.¹ This Executive Order marked the formalization of a policy that the Administration had already been pursuing. Just three months earlier, the Center for Medicaid and Medicare Services (CMS) had issued a “Dear State Director” letter that invited states to apply for a Section 1115 waiver in order to implement work requirements in their states.² Within days, the agency began to issue its first approvals. Kentucky and Indiana were the first states to be approved. Arkansas was the third state to be approved but would ultimately be the first to implement its work requirement.

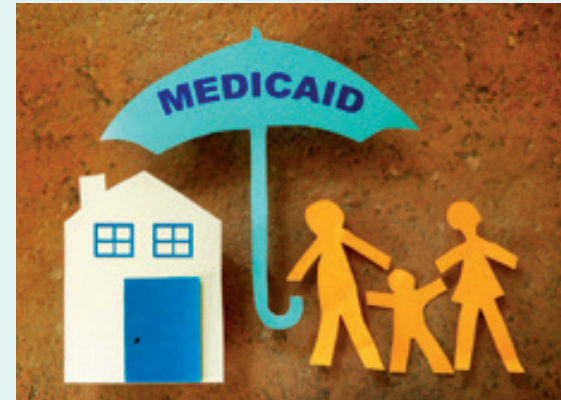
Arkansas’s implementation of the work requirement was fraught with issues. Many reported difficulties in accessing the software that the state used to track compliance so even people who were compliant found themselves losing coverage. In all, approximately 18,000 people would ultimately lose coverage before a federal court in Washington, DC struck down the work requirement. A similar fate awaited beneficiaries in New Hampshire, which saw similar issues with noncompliance. However, the state decided to delay the suspension of Medicaid for non-compliance and then a federal judge struck down their requirements before they could resume. Work requirements did not fare much better elsewhere; federal courts struck down Kentucky’s work requirements before they could be implemented. Indiana and Arizona would respond to these decisions by suspending their own requirements. Clear patterns began to emerge in these lawsuits and many of the plaintiffs in these lawsuits shared similarities. For example, many had difficulty accessing the technology needed to report their compliance and some lived in rural communities where finding employment was difficult.

Despite these setbacks, states continue to seek to implement work requirements. In fact, their implementation has recently been a point of compromise. In Virginia, Governor Ralph Northam compromised with the legislature and attached work requirements to his state’s Medicaid expansion. In states where the state government refused to expand Medicaid

through the legislative process, people took to ballot petitions in order to force the state to do so. In Maine, Idaho, Utah, and Nebraska, voters voted to expand Medicaid and the state governments, who reluctantly had to figure out how to implement the expansion, opted to use expansion as an opportunity to implement work requirements.


How have AI/ANs been affected by these work requirements? After all, many Tribal communities are in very rural spaces where it might prove difficult to comply with these requirements. Some states have sought to exempt AI/ANs and we can look at CMS approvals to find patterns in what is being approved. In South Carolina, the state initially sought to only exempt the Catawba, the only federally recognized tribe in the state whereas in Arizona, they sought to exempt all AI/ANs. In their approvals, CMS approved an exemption for “members of federally recognized tribes.” There are currently five states (Montana, Idaho, Oklahoma, Nebraska, and Mississippi) who have requested an AI/AN exemption and are pending acceptance. Much like South Carolina, Mississippi seeks an exemption for a single tribe: the Mississippi Band of Choctaw, the only federally recognized tribe in Mississippi.³

As CMS issues approvals and as advocates file lawsuits, the landscape of Medicaid work requirements evolves. Many ballot petitions, such as those in Missouri, Florida, and Oklahoma, seek to preempt the imposition of work requirements on the expansion population by inserting language into their petitions



that codify a ban against doing so. Some states propose novel approaches, such as Nebraska which proposes a two-tier system where you do not lose benefits for not satisfying the work requirement, you only obtain more benefits (such as access to dental care and over the counter medication) for fulfilling them. If approved, Nebraska may offer a blueprint to other states on how to implement a work requirement that may survive court scrutiny.

Other states are retreating from work requirements, largely due to political pressures. In 2019, new Maine Governor Janet Mills informed CMS that Maine would not be implementing work requirements, which had been approved mere weeks before. In Kentucky, new governor Andy Beshear withdrew Kentucky’s request to implement work requirement. In Virginia, Governor Ralph Northam responded to his party winning control of the state legislature by announcing that he would no longer negotiate with CMS over the state’s Medicaid work requirement.

The landscape of work requirements continues to change and evolve. Some states are continuing to seek them while others are starting to retreat. NIHBB will continue to track these waiver requests and advocate for Tribal interests and ensure that AI/ANs are protected. 

1 “Executive Order Reducing Poverty in America by Promoting Opportunity and Economic Mobility,” issued on April 10, 2018, <https://www.whitehouse.gov/presidential-actions/executive-order-reducing-poverty-america-promoting-opportunity-economic-mobility/>

2 “RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries,” issued on January 11, 2018, <https://www.medicare.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf>

3 “State of Mississippi Medicaid Reform Demonstration Project 1115 Revised Demonstration Waiver Application,” filed with the Center for Medicare and Medicaid Services on January 26, 2018. <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa3.pdf>

Integrating Culture into Recovery: A Behavioral Health Model for Indian Country

Implementation of traditional cultural practices in Indian Country is used as a therapeutic method in the biosphere of psychological and emotional well-being known as mental health and maladaptive behaviors known as behavioral health, specifically during recovery to restore healing and harmony of an individual. These therapeutic methods consist of various practices such as renewal ceremonies and healing rituals which can include the use of ceremonial objects with devotions, tunes, and songs. There are dissimilar practices throughout Indian Country that have been effective for individuals during the recovery process. Each of these practices has its own purpose, set of rituals, and structure.

For illustration, the sweat lodge seems to be the most frequent modality for healing purposes through purification. The sweat lodge is performed by a person who has earned the right to conduct the ceremony. With this guidance, ceremonial objects are used during prayers, songs, and chants. Certain herbs can be used such as sweet grass, cedar, and tobacco depending on the purpose. The intention of this ceremony is to restore harmony and the focus is on the “whole” (spiritual, mental, and physical) well-being through cleansing by removing negative toxins from the



physical being. The experience is different for each person. This ceremony is used at many treatment facilities across Indian Country as a form of treatment. Furthermore, treatment facilities now have Traditional Practitioners who provide treatment using traditional cultural practices depending on needs. These practitioners have different disciplines they were ordained with. For instance, on the Navajo Nation, practitioners will perform what is called a “crystal gazing” ceremony, which they seek guidance from the Holy People in treating an illness. The Holy People will instruct the Medicine Man on how to “cure” the illness. In some instances, the Holy People will instruct the Medicine Man to perform a physical extraction to remove toxins caused by the illness. These types of ceremonies have a sacred status and incorporate a communication channel between the Holy People and Medicine Man. In this tradition, the line of communication has to be done in reverence because the Holy People are the ones who heal and if not done in reverence, further illness may occur in the person or those involved. The focus of the ceremonies

is to reestablish self-image, self-identity, and self-awareness.

Other forms of treatment consist of American Indian cultural teachings in a group psycho-education setting, spiritual circle, medicine wheel, smudging ceremony, and use of nature. All ceremonies are done with good intentions to the Higher Power, Great Spirit, or Holy People in hopes of finding balance to live a prosperous life. Due to the effectiveness of these ceremonies among Indian Country and credentials to practice, a price has to be paid. In the “old way” and seldom done today, the price is paid in form of sacred objects. This price is paid to keep the balance of all elements and obedience of all natural laws in alignment. Due to modernity, money is now accepted as payment to cover sacrifices made by the Traditional Practitioner because he is subjected to illness he attempts to cure for being the interpreter for the Higher Power, Great Spirit, or Holy People. This payment also is for services performed. Additionally, integrated care between physicians and Traditional Practitioners have been acknowledged, and many physicians are now using Traditional Practitioners as part of treatment. Thus, Traditional Practitioners like physicians have earned their credentials; therefore, need to be able to bill for services and reimbursed just as physicians. However, this is not the case for reasons not clear to Indian Country. Indian Country will continue to advocate for this implementation due to effectiveness and use of “old ancient medicine” practiced for generations. It is the way. 📖

New Decade Brings New Opportunities for Dental Therapy Advocates



Dental Therapists Robert Curtis, Stephanie Wood, Conan Murat, and Lillian McGilton are honored at the 2019 National Dental Therapy Convening for their bravery and commitment as the first group of dental therapists to practice in the United States.

As the 2010s came to a close, dental therapy's momentum reached new heights. More Tribes than ever before are now using this innovative workforce model to fill in the gaps of Indian Country's existing oral health provider network. And in 2019, an unprecedented five states passed legislation authorizing dental therapy! All in all, thanks to work done over the past decade, thirteen states have authorized dental therapists to practice.


Dental therapists are focused providers whose scope of practice include routine preventative and basic restorative procedures. These providers treat patients in a variety of settings, such as schools and senior centers. Their scope of practice is able to meet between half and two-thirds of patient need, allowing the dentist to focus on patients with more complex issues. In Tribal communities, dental therapists are uniquely able to offer high quality, culturally competent oral health care. Dental therapists have practiced in Alaska since 2004 and in Tribal communities in the Pacific Northwest since 2016.

As the 2020s show a clear path forward for Tribal dental therapy, many more opportunities await. The Alaska Dental Therapy Education Program's application for accreditation is pending, and once that program receives accreditation, many other educational institutions will be able to follow. These programs will be able to meet the pent up demand for dental therapists throughout the country. As more dental therapists practice, the profession will become more familiar and established. More states will then want to implement dental therapy in their own communities.

The next decade will also see the long-awaited expansion of the Community Health Aide Program (CHAP) to Tribes outside Alaska. Dental therapists in Alaska work under CHAP to provide oral health care services in Alaska Native communities. CHAP expansion to Tribes throughout the country will make Tribal utilization of dental therapy more streamlined and efficient for Tribes in states with dental therapy, and the Indian Health Service's expansion of CHAP will see more dental therapists serving Indian Country.


While much of the 2010s was devoted to legislative advocacy to get dental therapy licensure passed into law in the states, the 2020s will see additional efforts in Indian Country on an equally important task: ensuring dental therapy is *implemented* in a way that benefits Tribes. Equally important to the legislative effort is the regulatory effort; and as a state passes dental therapy into law, Tribes must work to ensure the regulations the state creates are developed with input from the Tribes so that they can replicate the success of dental therapy as we see in Alaska.

National Indian Health Board is committed to breaking down the barriers between American Indians/Alaska Natives and quality, culturally competent oral health care. Dental therapy is a holistic solution to this challenge, and NIHB will work to ensure every Tribe that wants dental therapy is able to utilize it.

For more information on dental therapy, visit the National Indian Health Board's Tribal Oral Health Initiative at www.nihb.org/oral-healthinitiative 

New 2020 Tribal Public Health Profile Coming Soon



In 2009, the National Indian Health Board (NIHB) conducted a scan to better understand the capacity of Tribal public health, with the results released in a document the following year titled, *Tribal Public Health Profile: Exploring Public Health Capacity in Indian Country*. This profile was foundational in describing the important public health activities and services provided by Tribal health organizations. NIHB has been working on a follow up project, the Public Health in Indian Country Capacity Scan (PHICCS), to build upon that baseline to provide a more recent, comprehensive picture of the capacity of public health in Indian Country. After launching the PHICCS instrument at the end of 2018, NIHB received responses from 134 Tribal health directors across Indian Country. The results from this Indian Country-wide scan will culminate in the forthcoming 2020 Tribal Public Health Profile Report. The 2020 report will support and guide essential public health work in Indian Country, especially in the areas of Tribal public health practice, technical support, and assessing priority areas related to improving Indian health. It will also be a valuable resource to strengthen efforts to educate Congress, federal agencies, private foundations, and policy makers on the resources needed to build the capacity of Tribal public health, ultimately leading to improved health and well-being for American Indians and Alaska Natives. 

Violence Prevention and Injury Surveillance

WHY ARE VIOLENCE AND INJURY PREVENTION IMPORTANT IN AI/AN COMMUNITIES?

Violence prevention (VP) and injury surveillance (IS) are priority public health prevention areas for American Indian and Alaska Native (AI/AN) peoples. According to an analysis by the National Institutes for Justice, more than four in five AI/AN women and men have experienced any violence – including sexual or physical assault, intimate partner violence, stalking, and mental or verbal abuse – in their lifetimes.⁽¹⁾ Injuries (unintentional and intentional) are the leading cause of death for AI/AN between age 1–4.⁽²⁾ There is growing need to develop violence prevention strategies that are tailored to AI/AN and build on the inherent strengths and resiliency of AI/AN communities. Strengthening injury prevention and surveillance systems help support the foundation of robust Tribal health systems and overall wellness.

OUR REVIEW

To understand the current federal VP and IS activities for AI/AN, we mapped key federal groups and agencies who are engaged in this work. We compiled an initial list of stakeholders based on consultation with individuals familiar with federal funding, as well as through prior partnerships. We conducted a qualitative review of grey literature (including websites, reports, and data repositories) published on the internet to understand the scope of each stakeholder's roles, responsibilities, and current and/or previous programs. We categorized their work into one of five categories, based on available information: Data collection/analysis/repository; Funding; Research; Service delivery; Training. Below is a brief description of each stakeholder group's activities on VP and IS. ***Note that this list is not exhaustive; additional (non-federal) groups not listed may be engaged in violence prevention or injury surveillance.***



TYPES OF ACTIVITIES

- **Data collection/analysis/repository:** The group maintains data and/or interpretations of data related to VP or IS. These data may or may not be available to the public.
- **Funding:** The group provides funds to organizations (Tribal and non-Tribal) for VP or IS programming or research.
- **Research:** The group conducts and/or publishes research specific to VP or IS in Tribes.
- **Service delivery:** The group provides VP or IS services (including healthcare, social services, case management) to Tribes.
- **Training:** The group engages in capacity building activities on VP or IS with Tribes.

KEY STAKEHOLDERS

Two federal departments primarily engage in VP and/or IS activities for AI/AN: the Department of Health and Human Services (HHS) and Department of Justice (DOJ) (Table 1). Within those departments, five agencies or offices provide a variety of AI/AN-focused services and activities:

Department of Health and Human Services

- The Administration for Children and Families

- The Centers for Disease Control
 - National Center for Injury Prevention and Control
- The Indian Health Service

Department of Justice

- The National Institute of Justice
- The Office of Violence against Women

You can find a brief description of each agency or office's VP- or IS-related activities in Table 1. These descriptions are based on publicly available information and may not capture all VP- and IS-related activities that these or other agencies conduct.

LOOKING AHEAD

This Spring and Summer 2020, NIHB will be hosting several exploratory sessions to understand key topics and priorities in VP and IS. Through discussions with Tribal members, community-based organizations, practitioners, and knowledge holders, we hope to gain a better understanding of the priorities and key issues in violence prevention and injury prevention and surveillance for Tribes.

If you are interested in participating, please visit our website for more details.

REFERENCES

1. Rosay AB. Violence Against American Indian and Alaska Native Women and Men. National Institute of Justice Journal. 2016(277).
2. Weahkee MD, RADM, Frazier F, CAPT, Greenway K, Hartz GJ, McMahon D, Bill NM. Indian Health Focus: Injuries 2017 Edition. Indian Health Service, US Department of Health and Human Services.

ORGANIZATION/UNIT	PARENT AGENCY	ACTIVITIES	ROLE
National Institute of Justice	DOJ	<ul style="list-style-type: none"> ▪ Funding ▪ Research 	Research, development and evaluation arm branch of for DOJ. Has funded studies and published reports/articles on AI/AN issues.
Office of Violence Against Women	DOJ	<ul style="list-style-type: none"> ▪ Funding ▪ Training 	The Tribal Affairs Division within OVM administers grant and technical assistance programs on domestic violence, dating violence, sexual assault, and stalking for AI/AN populations and Tribes.
Administration for Community Living	HHS	<ul style="list-style-type: none"> ▪ Funding 	Administers funding to support nutrition, supportive services, and caregiver services to AI/AN communities. Previous grants (2018) awarded for Elder Justice.
Family & Youth Services Bureau	HHS (ACF)	<ul style="list-style-type: none"> ▪ Funding 	Supports funding through the Family Violence Prevention and Services Act "to ensure provision of emergency shelter and other non-shelter support services, such as victim advocacy, crisis counseling, safety planning, support groups, information and referrals, legal aid, and housing assistance to address domestic violence and dating violence."
National Center for Injury Prevention and Control, Division of Injury Prevention	HHS (CDC)	<ul style="list-style-type: none"> ▪ Data collection/analysis/repository ▪ Research ▪ Training 	Primarily roles related to Tribal health are training and data collection/analysis. CDC maintains the Web-based Injury Statistics Query and Reporting System (WISQARS) a database for injury-related morbidity and mortality statistics and visualizations that include AI/AN-specific data.
National Center for Injury Prevention and Control, Division of Violence Prevention	HHS (CDC)	<ul style="list-style-type: none"> ▪ Data collection/analysis/repository ▪ Research 	We could not find publically available information on direct programming for AI/AN communities. NCIPC has published several non-AI/AN technical packages on violence. AI/AN specific data may also be collected through CDC national surveys, including the National Violent Death Reporting System (NVDRS).
Surveillance Resource Center	HHS (CDC)	<ul style="list-style-type: none"> ▪ Data collection/analysis/repository 	Houses data from CDC national surveys.
Indian Health Service	HHS (IHS)	<ul style="list-style-type: none"> ▪ Data collection/analysis/repository ▪ Service delivery 	"Provides federal health services to American Indians and Alaska Natives", including preventative and community health. Maintains several VP- and IS-related programs, including Domestic Violence Prevention program (DVP) and the Substance Abuse and Suicide Prevention (SASP, formerly MSPI) program.
Indian Health Service Domestic Violence Prevention Program	HHS (IHS)	<ul style="list-style-type: none"> ▪ Funding ▪ Training 	The DVP Program supports funding on two purpose areas: Domestic and Sexual Violence Prevention, Advocacy, and Coordinated Community Responses, and Forensic Healthcare Services. The program also provides technical assistance to grantees and links to DVP resources. Program is classified under Behavioral Health.
Indian Health Service Injury Prevention Program	HHS (IHS)	<ul style="list-style-type: none"> ▪ Funding ▪ Training 	Injury-specific program within IHS. Key activities are training and funding via the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP).



Tribal Consultation: Where Are We Now?

Chances are that if you attend conferences hosted by the National Indian Health Board, you have participated in at least one Tribal Consultation session. Tribal Consultations provide Tribes the opportunity to participate in the federal policymaking process by sharing Tribal priorities, guidance and recommendations in a government-to-government convening.

HOW DID FORMAL TRIBAL CONSULTATION, AS CURRENTLY PRACTICED, BEGIN?

Although the federal government engaged with Tribes in many different ways over the course of the nation's history, a series of recent Executive Orders largely shape the contours of formal Tribal Consultation as it is currently practiced.¹ These Executive Orders the federal government's commitment to ensuring ongoing, meaningful engagement with Tribes in light of the special government-to-government relationship Tribes have with the federal government.

This relationship, and the federal government's recognition of Tribal sovereignty, traces its roots to back to the period of

treaty-making. The Constitution gives specific authority for the unique relationship between the federal government and Tribes, with additional defining details flowing from hundreds of years of Supreme Court case law, statutes, regulations, Executive Orders, and administrative guidance.

Tribal Consultation is "an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues."²

While it is easy to understand why Tribal consultation is important, there is no universally

accepted criteria for *meaningful* Tribal consultation. Here, we hope to explore meaningful Tribal consultation through the lens of current federal agencies' Tribal consultation policies.

HOW DO WE ENSURE THAT CONSULTATION IS MEANINGFUL?

- 1. Provide adequate notice:** Tribes should receive at least 30-60 days' notice that consultation is taking place
- 2. Provide relevant information and materials ahead of time:** The federal government should link relevant documents in the consultation notice so that Tribal leaders and citizens are adequately prepared for consultation

¹ Executive Order 13175 was established on November 6, 2000, and it supersedes previous Executive Orders on Tribal Consultation

² According to IHS Circular 2006-01

3. Increase accessibility: Meetings should include call-in lines for virtual participants

4. Specific requirements for Consultation: Calling a meeting and inviting Tribes to participate is not the same as conducting Tribal Consultation

5. Listen and be proactive: Many federal health policies are not created with the Tribal health system in mind. This is what makes guidance from Tribal leaders and representatives so valuable, because their experience helps federal officials better understand how health programs work on the ground in Indian Country.

CONSULTATION ACTIVITIES

While Tribal consultation is not limited to budget-related matters, one of the prime examples of consultation in action is the Tribal budget formulation process.³

Every year, a specially selected group of Tribal representatives work on the Tribal budget formulation process and sit on the IHS Tribal Budget Formulation Workgroup. The workgroup diligently gathers and synthesizes the priorities identified by the Tribes in each of the 12 IHS Areas. They work to build consensus across all the Tribes so they can create a cohesive message outlining Tribal funding priorities nationally. Once they reach a consensus position, the workgroup prepares a final set of Tribal budget recommendations which they present to the IHS Director and to senior officials of the Department of Health and Human Services (HHS) during an annual national consultation. IHS and HHS use the Tribal budget recommendation to shape their annual funding requests, which the President uses to create the President's annual budget proposal. The President sends this budget proposal to Congress for consideration during its federal appropriations process. The Tribal budget formulation process identifies benchmark information like the level of need for the Indian Health System.


IHS also conducts Tribal consultation at the Area level on a variety of topics. Tribes have the right to request formal Consultation if

a critical event occurs that elicits a need for government-to-government convening.

A LOOK AT CONSULTATION IN SEVERAL FEDERAL AGENCIES

HHS last updated its Tribal consultation policy in 2010. In 2018, the agency gathered feedback from Tribes as part of its process to update the policy, but to date the Agency has not released a new policy nor taken additional steps to present proposed revisions to the Tribes as part of Tribal consultation. Unfortunately, the slow progress is impacting other federal health agencies which look to develop or update their individual Tribal consultation policies, as called for under Executive Order 13175. Many operating divisions within HHS indicated in 2019 that they would not be updating their own Tribal consultation policies before HHS updates its policy. It is understandable that agencies within the Department do not want to proceed with Tribal Consultation policies that would likely need to be rewritten once HHS revises its own Tribal consultation policy. However, given that the HHS policy is 10 years old, it is time for the Department to devote time and resources into revising and strengthening the policy.

In response to the HHS request for input, the NIHB and the National Congress of American Indians (NCAI) submitted a joint response to HHS, with several recommendations. These included both simple changes, like renumbering the subsections to make the document easier to reference, to more substantive changes like recommending that HHS develop mechanisms to improve its accountability and transparency when following up on Tribal consultation requests. As of the date of this publication, HHS has not provided a written response to this comment letter.

NIHB and the Tribes will continue to advocate for improvements to the Agency's consultation policy and practice, hopeful that, with additional Tribal feedback and guidance, HHS can look back at the lessons of the past decade and identify and incorporate the best practices in Tribal consultation, to set a high standard for achieving Tribal health goals in years ahead. 

Upcoming Events in Indian Health

National Institutes of Health Tribal Advisory Committee Meeting
March 26-27, 2020
Research Triangle Park, NC

National Census Day
April 1, 2020

Department of Health and Human Services Budget Consultation
April 8-9, 2020
Washington, DC

Direct Service Tribes Advisory Committee Meeting
May 4-5, 2020
Richmond, VA

Secretary's Tribal Advisory Committee Meeting
May 6-8, 2020
Washington, DC

National Indian Health Board Quarterly Board of Directors Meeting
June 17-19, 2020
Washington, DC

Tribal Self-Governance Advisory Committee Meeting
July 15-16, 2020
Washington, DC

NIHB Medicare and Medicaid Policy Reform Committee
July 21, 2020
Washington, D.C.

CMS Tribal Technical Advisory Group Meeting
July 22-23, 2020
Washington, DC

National Indian Health Board 37th Annual National Tribal Health Conference
September 14-18, 2020
Anchorage, AK

Election Day
November 3, 2020

³ Reauthorized in 2010 as part of the passage of the Affordable Care Act, the Indian Health Care and Improvement Act (IHCIA) requires the federal government to consult with Indian Tribes and Tribal Organizations as it implements activities authorized by IHCIA, including the development of the budget for the Indian Health Service.

Improving Care for Native Veterans — Legislation before the 116th Congress

After years of continued advocacy by Tribes and the National Indian Health Board, Congress is making steady progress to improve health care access for Native Veterans.

The federal government has a dual obligation to American Indian and Alaska Native (AI/AN) Veterans – one obligation due to their political status as members of federally-recognized Tribes, and one obligation specific to their service in the Armed Services of the United States. National Indian Health Board (NIHB) continues to advocate for improved health care for Native Veterans and affirms that the federal government's trust responsibility extends across all departments and agencies of the United States, including the Department of Veterans' Affairs.

By current estimates from the VA, there are roughly 146,000 AI/AN Veterans, with Native Service members enlisting at higher rates than any other ethnicity nationwide. Indeed, the Department of Defense continues to acknowledge the indispensable role of AI/AN Service members throughout American history. Native Veterans are highly respected throughout Indian Country, in recognition of what they have sacrificed to protect Tribal communities and the United States. Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services.

On Wednesday, October 30, 2019, the House Veterans' Affairs Subcommittee on Health scheduled its first oversight hearing in decades specifically to examine issues related to health care access for AI/AN Veterans within both the Department of Veterans' Affairs (VA) and the Indian Health Service (IHS). Former

NIHB Member-at-Large and Portland Area Representative, Andrew Joseph Jr., testified on behalf of NIHB before a panel that included Tribal and urban Indian leaders from across Indian Country. The hearing brought awareness to lawmakers on the unique obstacles facing health care access and outcomes for Native Veterans, and provided an opportunity for Tribal leaders and Native Veterans to present legislative solutions.

Lawmakers are listening and responding to the ongoing challenges facing health care access for Native Veterans. As of the time of this writing, the 116th Congress has introduced seven bipartisan bills that would improve systems of care and quality for Native Veterans. For example, Senator Tester (D-MT) and Rep. Haaland (D-NM) introduced legislation that would **establish a Tribal Advisory Committee at the Veterans Administration**. This would

elevate the concerns and priorities of Tribal leaders and Native Veterans to the highest echelons of VA leadership. It would also provide a forum for direct engagement with the VA Secretary on the policy, programmatic, and service-based priorities of Native Veterans.


Another significant bill, introduced by Representative Gallego (D-AZ), would **exempt Native Veterans from copays and cost-sharing for services received through the VA**. The federal government has a trust obligation to provide quality and comprehensive health services for all AI/AN Peoples, including Native Veterans. This legislation would ensure that Native Veterans do not have out-of-pocket costs for their care, and would have the VA absorb those costs in recognition of their trust responsibility. Thus, coverage of copays for Native Veterans would not shift to the Indian Health Service or Tribal governments.

116TH CONGRESS: NATIVE VETERANS HEALTH CARE LEGISLATION

TYPE OF LEGISLATIVE PROPOSAL	SENATE BILL NUMBER AND TITLE	HOUSE BILL NUMBER AND TITLE
Authorizes the VA to compensate the construction of Tribal nursing homes on Tribal lands and reservations	S. 2555: <i>Nursing Home Care for Native American Veterans Act</i>.	H.R. 4532: <i>Nursing Home Care for Native American Veterans Act</i>.
Establishes a Tribal Advisory Committee (TAC) at the VA.	S. 524: <i>Department of Veterans Affairs Tribal Advisory Committee Act of 2019</i>.	H.R. 2791: <i>Department of Veterans Affairs Tribal Advisory Committee Act of 2019</i>.
Ends the practice of charging Native Vets a copayment for healthcare services received through the Veterans Health Administration (VHA) and requires the VHA to absorb those costs.	Senate bill not yet introduced.	H.R. 4908: <i>Native Veterans Parity in Access to Care Today Act-Native PACT Act</i>.
Authorizes Urban Indian Organizations (UIOs) to share medical services and facilities with the VA.	S. 2365: <i>Health Care Access for Urban Native Veterans Act of 2019</i>.	H.R. 4153: <i>Health Care Access for Urban Native Veterans Act of 2019</i>

▶ Continued from page 1 – **A Look Back at the Affordable Care Act and Indian Health Care Improvement Act**

NIHB is also working with the office of Rep. Gallego to introduce legislation clarifying the need for the VA to reimburse IHS and Tribes for all health services authorized under Purchased/Referred Care (PRC). The permanent reauthorization of the Indian Health Care Improvement Act enshrined IHS as the payer of last resort; however, IHS and Tribes continue to face challenges in being fully reimbursed by the VA for all PRC authorized services. Clarifying this requirement in law would ensure that the VA is providing full reimbursement to IHS and Tribes for all PRC authorized services, and would further preserve limited PRC dollars.

The chart below outlines each of the bills introduced so far this Congress related to health care for Native Veterans. NIHB has created template support letters and suggested talking points for Tribes and Tribal organizations to use with their Representatives and Senators to advocate on these significant bills. To access this information, contact NIHB Director of Congressional Relations, Shervin Aazami, at saazami@nihb.org 

and the Supreme Court in the case of *Texas v. United States*. The Tax Cuts and Jobs Act of 2017 eradicated the financial penalty associated with the individual health insurance mandate. *Texas v. United States* addresses whether the ACA is constitutional, since the Congress eliminated the individual mandate. In December 2019, the Fifth Circuit held that the ACA individual mandate is unconstitutional and remanded to the District Court the question of whether or not the remaining portions of the law are constitutional. Despite the public outcry and mobilization of health advocates across the United States to maintain the ACA status quo, the Fifth Circuit rejected a request to reconsider its decision that declared the individual mandate unconstitutional. The Supreme Court has postponed considering this case until at least October 2020, so any decision on the ACA would be made only after the presidential election.


It remains unclear how a Supreme Court ruling in favor of the Fifth Circuit decision will impact the future of the Indian Health Care Improvement Act (IHCIA). Originally enacted in 1976, the IHCIA was included in the ACA and permanently reauthorized when President Obama signed the ACA into law in 2010. Affirming the lower court's ruling could put IHCIA in legal jeopardy and also impact the provisions around Medicaid expansion that have contributed to roughly 300,000 AI/ANs obtaining health coverage. Regardless of the case outcome, the Indian Health Services (IHS) and Tribal health programs would still be able to deliver health care services under the Snyder Act, the underlying authority for the IHS.

AI/ANs have seen tremendous gains in the years since the ACA authorized states to expand access to Medicaid and offer health insurance through the exchanges. The percent of AI/AN in the general population with health insurance has increased. The percent of nonelderly AI/ANs with health insurance

coverage increased from 70 percent in 2013 to 78 percent in 2017.¹ In addition, the percentage of patients who showed up at IHS facilities with health insurance rose from 64% in 2013 to 78% in 2018, according to the Government Accountability Office.² Despite the gains, however, the share of people without insurance at the 73 IHS facilities in 2018 still amounted to more than double the national average for health care coverage that year. We can do better than that!

Health insurance provided AI/ANs with options to obtain care outside of federally operated or Tribally-operated facilities, including more comprehensive health services, wherever available in their communities. In addition, Tribal health programs, urban Indian centers, and the IHS were able to collect more insurance revenues and reinvest those into expanding services. Tribal advocates must protect *both* laws so Tribes can continue progress with increasing revenue and building successful, thriving programs that serve our people. Fighting for IHCIA and the ACA is the way we will exercise our Tribal sovereignty, this year and beyond.

The National Indian Health Board (NIHB) has consistently maintained that the IHCIA is separate from the ACA, even filing an amicus brief to affirm our position. Whereas IHCIA built on the provisions of the Snyder Act, the ACA added additional protections that built on IHCIA. However, while the IHCIA stands on its own, outside of the individual mandate, Tribal advocates must be certain to also champion the ACA as a whole as we await the Supreme Court decision on whether to consider *Texas v. United States*.

NIHB remains committed to fighting to preserve IHCIA and we encourage everyone to join us in this fight. The IHCIA advances the federal government's trust responsibility to Tribes and provides critical supports to the Indian health system. We hope that the Courts will find that IHCIA stands on its own, distinct and separate from the other provisions of the ACA. 

1 GAO, Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections (Sept. 2019), <https://www.gao.gov/assets/710/701133.pdf>

2 *Id.*



National Indian Health Board

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Health Reporter

SPRING 2020

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