National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
LESTER SECATERO, CHAIRMAN
HOUSE APPROPRIATIONS COMMITTEE - SUBCOMMITTEE ON LABOR, HHS, EDUCATION AND RELATED AGENCIES
FY 2017 WRITTEN TESTIMONY FOR THE RECORD

Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee, thank you for the opportunity to offer this testimony for the record. On behalf of the National Indian Health Board (NIHB) and the 567 federally recognized Tribes we serve, I submit this testimony on FY 2017 budget for the Department of Health and Human Services (HHS).

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace.[1] In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives (AI/ANs), declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians – to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." [2]

Yet, devastating consequences from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. AI/ANs have a life expectancy 4.2 years less than other Americans, but in some areas, the life expectancy is far worse. For instance, in Montana, "white men …lived 19 years longer than American Indian men, and white women lived 20 years longer than American Indian women."[3] In South Dakota, in 2014, "for white residents the median age [at death] was 81, compared to 58 for American Indians."[4] AI/ANs also suffer significantly higher mortality rates from suicide, type 2 diabetes, and heart disease than other Americans. According to CDC data, 45.9 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. AI/AN children have an average of six decayed teeth, when other US children have only one. These health statistics reflect the shocking disparity that exists in per capita spending of the Indian Health Service (IHS) and other federal health care programs. In 2015, the IHS per capita expenditures for patient health services were just $3,136, compared to $8,097 per person for health care spending nationally.

The obligation to provide healthcare to AI/ANs does not extend only to the IHS. The federal trust responsibility is the responsibility of all government agencies, including others within HHS. Agencies like the Centers for Disease Control and Prevention (CDC); Substance Abuse and Mental Health Services Administration (SAMHSA); and Centers for Medicare and Medicaid Services (CMS) all must play a crucial role in ensuring that Indian Country receives both preventative and

[1] The Snyder Act of 1921 (25 U.S.C. 13) legislatively affirmed this trust responsibility.
[2] 25 U.S.C. 1602
[3] "The State of the State's Health: A Report on the Health of Montanans." Montana Department of Public Health and Human Services. 2013. p. 11.
[4] "2014 South Dakota Vital Statistics Report: A State and County Comparison of Leading Health Indicators." South Dakota Department of Health. 2014. P. 62.

direct access to health services. Tribal health systems are simply left out of many funding streams within HHS for a variety of reasons. Federal block grants flow to states, leaving little opportunity for Tribal governments to receive this funding. Tribes may be eligible to apply for federal grants that address public health and other issues, however, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even competitively apply for the grants. Unlike state health departments which employ teams of people to write grant applications, few Tribes have enough staff to conduct basic programming, let alone work on competitive grant applications.

NIHB respectfully requests that the committee consider providing additional direct funding to Tribal communities through the use of "set asides" for Indian Country to ensure that Indian Country is not left out of federal funding opportunities. Without direct funding, Tribes are unable to develop sustainable infrastructure for public health and behavioral health programs, leading to an inconsistent and unreliable service delivery system. The federal trust responsibility requires consistent and effective investment in Tribal communities, and it is the only way that we will begin to tackle the health disparities felt by so many AI/ANs.

Centers for Disease Control and Prevention

Public Health Services Block Grant: Public health infrastructure in Indian Country is one of the most severely underfunded and under developed areas of the health service delivery system. IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, health education, research for disease, injury prevention, and promotion of healthy lifestyles. This means that Indian Country continues to lag far behind other communities in basic resources and services. Our communities are therefore more vulnerable to increased health risks and sickness.

As independent, sovereign nations, Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Tribes are regularly left out of statewide public health plans and federal funding decisions for public health programs. Without a local tax base and little (if any) outside funding, Tribal communities are often the most in need of public health dollars. A complex public health system exists in the US that includes a funding stream between the federal and state governments that largely support the national public health infrastructure – Tribes were excluded from this system. Tribes do not receive the federal funding that allows state health departments to function. It is time to examine how Tribes can be integrated into the US public health system, and redress this wrong.

Tribal communities must cobble together public health funding from a variety of federal, state, local and private funding sources. State governments receive base operational systems and programmatic funding through the large flagship federal grants and the Public Health and Health Services Block (PHHS) grant program, while Tribes are either not eligible to compete for the funding or are woefully underrepresented in the grantee pool. This leads to rampant unpredictability and inconsistency among Tribal public health initiatives, and leaves Indian Country with little public health infrastructure. Consequently, significant gaps exist when it comes to health education, emergency preparedness, community healthcare services and basic healthcare screenings. Therefore, NIHB requests that, in FY 2017, ***Congress create base funding for Tribal***

communities through the PHHS grant program by allocating at least 5 percent to Indian Tribes directly, annually. This will enable public health systems in Indian Country to access consistent, sustainable, public health infrastructure dollars so that Tribal communities can begin to catch up to other Americans when it comes to public health.

Hepatitis C Treatment in Indian Country: According to the CDC's most recent surveillance report on hepatitis C, in 2013, AI/ANs were the population with the highest hepatitis C-related mortality rate at 12.2 deaths per 100,000 people. This is 46% higher than the next highest population death rate. And between 2009 and 2013, the hepatitis C-related mortality rate among American Indians and Alaska Natives increased by 23.2%. The hepatitis C (HCV) scourge among AI/AN communities continues to grow out of control with no substantial dedication of resources or commitment by HHS to provide for targeted prevention, capacity building, and treatment. Treatment, that very nearly mirrors a cure, is readily available; however, community members may not be sure how to access the treatments, and Tribes have competing priorities and are reticent to utilize scarce IHS resources to secure the treatment. Even more so, prevention efforts to promote HCV screening have not been bolstered in Tribal communities, service providers have not been trained to talk to their patients about hepatitis risks and testing options, nor have efforts existed to educate the community and high risk populations about their ability to minimize their risks for exposure to HCV.

Therefore, NIHB recommends that ***Congress direct the CDC to create a grant program specifically for AI/ANs that will provide monies for community-based prevention and screening efforts for HCV.*** Furthermore, we request that CDC be instructed to work with IHS to ***construct a targeted action plan for promoting the prevention of hepatitis C***, increasing screening efforts and increasing access to treatment.

Public Health Emergency Preparedness: The Public Health Emergency Preparedness (PHEP) Cooperative Agreements at CDC provide base funding to states, territories and major cities to upgrade their ability to respond to a public health crises. But again, Tribal communities do not receive this funding directly, and few, if any, see any support from their state programs. Some Tribal reservations reach across state boundaries and others occupy land areas larger than many states. Without federally-supported infrastructure support for prevention and rapid response to natural disasters, bioterrorism and outbreaks in Indian Country, the impacts on American Indians and Alaska Natives (and others) could be enormous. And with the looming threat of the Zika Virus, this is even more urgent – as a significant percentage of Tribes occupy those lands projected to be in danger due to the habitat of the mosquito that transmits the virus. Failure to fund Tribal communities and reservations could mean that large land areas of this country are not covered for emergency infrastructure support, causing a domino effect throughout the rest of the nation when it comes to disease outbreaks or natural disasters. NIHB requests that ***Congress direct 5% of PHEP funds to Tribes so that they can develop serious and achievable response plans for public health crises.***

Substance Abuse and Mental Health Services Administration

Nowhere is the issue of lack of solid infrastructure support more acute than mental and behavioral health services. AI/AN children and communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or

harmful human service systems have left AI/AN communities with unresolved historical and generational trauma.[5] Where Tribal reclamation of these systems has been possible, it has led to effective service systems designed and implemented, by and for AI/AN people, to promote cultural strength and healing. These Tribal systems have already begun to resolve the trauma left behind by federal policies and systems. But access to behavioral health services is limited. In a study of 514 IHS and Tribal facilities, 82% report providing some type of mental health service such as psychiatric services, behavioral health services, substance abuse treatment, or traditional healing practices, and to improve access 17% (87) have implemented telemedicine for mental health services.[6] However, none provide inpatient psychiatric services.[7] Without access to care, persons in psychiatric distress often end up at the hospital emergency room.[8]

Tribal Behavioral Health Grants and Zero Suicide: At the Substance Abuse and Mental Health Services Administration, several programs specifically target Tribal communities. NIHB was pleased to see that Tribal Behavioral Health Grants (TBHG) received a substantive increase in the final FY 2016 appropriation. This critical program is designed to address the high incidence of substance use and suicide among AI/AN populations and it is a vital component of ensuring that behavioral health challenges are addressed across Indian Country. In FY 2017, NIHB requests ***funding of $50 million for the TBHG program***. We also request that ***funds to be appropriated for specific, predetermined issues*****:** namely, suicide interventions, expansion of mental health counseling capacity and infrastructure, and surveillance of and mediation for increasing levels of domestic violence. NIHB also ***supports the Administration's FY 2017 request for $5.2 million in a Tribal set-aside to implement the Zero Suicide Initiative***.

Circles of Care: NIHB continues to support the Circles of Care Program which offers three-year infrastructure/planning grants and seeks to eliminate mental health disparities by providing AI/AN communities with tools and resources to design and sustain their own culturally competent system of care approach for children. Behavioral health infrastructure is one of the key challenges for many Tribal communities when it comes to creating sustainable change for their communities. Circles of Care represents a critical part of this work. ***In FY 2017, we recommend increasing Circles of Care funding by $2 million for a program total of $8.5 million.***

NIHB also encourages Congress to conduct oversight over SAMHSA, IHS and other federal agencies to ensure that the work being done to address behavioral health issues in Tribal communities is coordinated, effective, and non-duplicative, as laid out in the Tribal Behavioral Health Agenda being released by SAMHSA this coming summer.

Centers for Medicare and Medicaid Services

Definition of Indian in the Affordable Care Act: The Affordable Care Act (ACA) (PL 111-148) contains several important provisions for American Indians and Alaska Natives including

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

[6] Urban Indian Health Institute. (2012). Addressing depression among American Indians and Alaska Natives: A literature review. Seattle, WA: Urban Indian Health Institute.

[7] Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf

[8] *Ibid*

permanent reauthorization of the Indian Health Care Improvement Act. However, certain portions of health care reform contain different definitions of "Indian" which led to conflicting interpretations of eligibility for benefits and requirements for coverage. These definitions are different than those used by IHS and the Centers for Medicare and Medicaid Services and require that an individual be a member of a federally recognized Tribe.

NIHB requests a legislative fix to streamline these definitions. Specifically, we request that Congress ***insert the text of S. 2114 into the FY 2017 Labor, HHS, Education and Related Agencies Appropriations bill.*** Despite efforts by Congress to provide instructions to the agency in FY 2016, the Administration has refused to correct this inconsistency through regulation. This fix will not change who is eligible to receive IHS services, but will ensure that the benefits and protections in the law are provided to those for whom they were intended. Without a fix, many AI/ANs will be left out of benefits intended for them in the law, which includes bringing 3rd party revenue into an already underfunded IHS. Without a fix, the federal government will essentially create class of "sometimes Indians" who are eligible for some benefits (e.g. IHS) but not others (those in the ACA). This fix is supported in the FY 2017 President's Budget request to Congress.

American Indian/ Alaska Native Call Center for the Health Insurance Marketplace: AI/ANs continue to experience poor assistance when contacting the marketplace call center for help. Issues range from technicians having no knowledge of the Indian-specific protections like exemptions and tax credits, to technicians being rude and having no patience to walk elderly consumers through the troubleshooting process. Because AI/AN consumers continue to receive such poor customer service that exhibit little or no knowledge about AI/AN-specific provisions in the ACA, NIHB has requested that the Center for Consumer Information and Insurance Oversight (CCIIO) establish an Indian-specific call center to respond to questions and provide technical assistance to AI/ANs, as well as non-native enrollment assisters such as Navigators and Certified Application Counselors. We also believe that an Indian-specific help desk would be better equipped and more sensitive to the needs of AI/AN consumers.

The Administration's proposed FY 2017 budget provides for the creation of a "Tribal Resource Center," or other Tribal specific project, where staff would be trained and skilled in responding to inquiries from the Tribal community relating to enrollment into the full range of CMS health insurance programs. NIHB recommends that Congress ***provide funding for the Tribal Resource Center at the Center for Medicare and Medicaid Services at $500,000 as requested by CMS***.

Conclusion:

Thank you again for the opportunity to offer this written statement. As noted above, the federal trust responsibility for health extends beyond the IHS to all agencies of the federal government. While Tribes have made important gains in recent years in terms of funding, consultation and increased awareness throughout all of HHS, there is still a long way to go before health systems in Indian Country are on par with those enjoyed by other Americans.

We urge this Committee to create Tribal-specific streams of funding for these "flagship" grant programs that go to the state governments, so that Indian Country can access federal funds that are desperately needed to build a strong, consistent, health delivery system. Please do not hesitate to contact our offices directly if you have any questions or if you require additional information.