In January of this year, the Centers for Medicare and Medicaid Services (CMS) issued a letter to state Medicaid directors inviting states to create Medicaid work requirements without specific exemptions for Tribes. States can do this by submitting Medicaid waiver applications that are reviewed and approved by CMS. In a subsequent letter to Tribal leaders, CMS stated that they could not approve a Tribal exemption to state imposed work requirements because it would unfairly favor a group of people based on their race (a civil rights violation).

Tribes were immediately alarmed at CMS’ incorrect interpretation that such an exemption would be based on race rather than political status as recognized by statutes, regulations, Executive Orders, and Supreme Court case precedent. In addition, Tribes were also distressed that the Agency did not fully understand the role that Medicaid plays in supplementing the chronic underfunding of the Indian health system and that the loss of revenue generated from Medicaid reimbursement would have a devastating effect on the Indian health system.

The authority to bill Medicaid was given to IHS and Tribal providers in 1976 as a means to help supplement the woefully underfunded Indian health system.
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. NIHB consistently plays a major role in focusing attention on Indian health care needs, resulting in progress for Tribes.

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, NIHB has advised the U.S. Congress, IHS federal agencies, and private foundations on health care issues of American Indians and Alaska Natives.

NIHB staff maintains communication with Area Health Boards, national Indian organizations, Tribes along with American Indian and Alaska Native people. 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. NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions: 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

DEAR INDIAN COUNTRY FRIENDS AND ADVOCATES,

Welcome to the Fall 2018 edition of the National Indian Health Board’s (NIHB) Health Reporter! As always, we are excited “to advocate 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.” We are excited to see many of you in Oklahoma City, Oklahoma this month for the National Tribal Health Conference! We also offer a big THANK YOU to our partners in the region who have made this event possible – especially Southern Plains Tribal Health Board.

The last several months have brought exciting progress but also challenges for Indian Health. In March, NIHB was pleased to learn that Congress provided $50 million in a Tribal set aside in the State Targeted Response to Opioid grants in the FY 2018 funding law. That same law also provided a $5 million Tribal set-aside for Medication Assisted Treatment programs. This has been part of a long-time advocacy effort. Legislation that is (at the time of this writing) being debated by Congress would continue to provide that set-aside. NIHB continues to work to see this and other provisions added to the final opioid legislation this fall. NIHB was also excited to learn that advocacy efforts paid off for the Good Health and Wellness in Indian Country program! The House of Representatives legislation providing funding for this program was doubled in the FY 2019 draft bill! See a full report on this on page 4.

Despite these successes, there continue to be challenges for Indian health. As you will read about on the cover page, the Centers for Medicare and Medicaid Services (CMS) has declined to grant an exemption from work and community engagement requirements under the Medicaid program which will have serious consequences on the fiscal stability of the Indian health system. Instead, the agency has shared that such an exemption for American Indians and Alaska Natives would be an impermissible differential treatment based on race. The determination from CMS ignores longstanding and settled federal Indian law which recognizes Indian Tribes as sovereign Nations and political entities, not racial groups. NIHB, along with our partner organizations across Indian Country, continue to advocate for a re-examination of the issue, and application of the proper legal framework, which would uphold a government-to-government relationship between the federal government and Tribal Nations.

This summer we also welcomed our latest cohort of Native Youth Health Policy Fellows! This diverse group of talented Native young adults will work alongside Tribal leaders, policy specialists, and public health experts to develop feasible Indian health policy solutions. Throughout the year-long fellowship, Fellows will work directly with their Tribal leadership to identify one priority health policy issue affecting their community. Learn more about their work on page 15.

You can read about all these issues and more in this edition of 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.

Vinton Hawley
Chairperson
In a Time of Budget Cuts, Some Hope for Tribal Public Health

In 2014, Congress established the Good Health and Wellness in Indian Country (GHWIC) program within the Centers for Disease Control and Prevention (CDC). The 5-year initiative was planned to provide critical support to Tribes, Tribal organizations, and Tribal epidemiology centers (TECs) in administering public health activities in order to accomplish:

- Reducing rates of death and disability from tobacco use by 5%;
- Reducing the prevalence of obesity by 3%;
- Reducing rates of death and disability from diabetes, heart disease, and stroke by 3%.

Currently, twelve Tribes, eleven Tribal organizations, and twelve Tribal Epidemiology Centers receive funding through GHWIC. This funding helps build Indian Country’s public health capacity and has been effective at developing strategies focusing on diet and physical activity, reducing tobacco use, and reinforcing collaborative team-based health care. The flexibility of the program also allows the administrators to utilize culturally competent, locally informed solutions to meet these public health goals.

As of this writing, Congress has not yet agreed to next year’s budget level for the program, which is funded through the Labor-Department of Health and Human Services (HHS) Appropriations, Education and Related Agencies Appropriations Bill. The Congressman who crafted that bill in the House is Tom Cole (R-OK), a member of the Chickasaw Nation. The National Indian Health Board testified before the House Appropriations Committee that the program should receive $32 million in FY 2019. The House’s legislation accepted that recommendation and added funding to that program doubling it for next fiscal year.

This significant increase did not meet with any opposition from House members. The Senate’s language is less clear on program funding levels, but it is important to note that the President’s Budget Request to Congress completely eliminated the program, threatening to undo all the progress made!

The Senate and House are in the process of negotiating a final spending level for all programs funded through the Labor-HHS Appropriations Bill. NIHB encourages Tribes to weigh in with their Members of Congress to support the House’s funding level for GHWIC. The time is NOW to build on the momentum and advocate for the House’s $32 million funding level for Good Health and Wellness in Indian Country in 2019.
Native Veterans Color Guard presents the Colors at NIHB's 2017 Tribal Public Health Summit in Anchorage

Legislation Introduced to Create Tribal Advisory Committee at VA

Tribes have long known that the federal government’s responsibility to provide healthcare to American Indians/Alaska Natives (AI/ANs) does not belong solely to the Indian Health Service. Rather, it is borne by the entire federal government. A new bill filed in the U.S. Senate would build on that truth by establishing a Tribal Advisory Committee (TAC) at the Department of Veterans’ Affairs (VA). The bipartisan bill was introduced by the Ranking Member on the Senate Veterans’ Affairs Committee, Jon Tester (D-MT), and supported by Sens. Tom Udall (D-NM), Lisa Murkowski (R-AK), and Dan Sullivan (R-AK). The Department of Veterans Affairs Tribal Advisory Committee Act of 2018, or S. 3269, is currently awaiting a hearing before the Senate Committee on Veterans’ Affairs.

Although American Indians and Alaska Natives serve in the U.S. military at higher rates than any other demographic, they are underrepresented among Veterans who access the services and benefits they have earned. Native American Veterans are also more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other demographics. The National Indian Health Board continues to advocate for the health of Native American Veterans, arguing that, since Tribes prepaid for healthcare through the treaty process, they should be exempted from co-pays and other costs the VA charges its beneficiaries.

This bill, if enacted, would ensure the Tribes have the ear of the entire VA, including the Secretary. The TAC members, nominated by the Tribes for up to four year terms, would meet twice yearly, hold monthly conference calls, and would be responsible for the following duties:

• To advise the Secretary on ways the Department can improve its programs and services to better serve Native American veterans.
• To identify relevant evolving issues for Tribes and Native American veterans.
• To propose clarifications, recommendations, and solutions to address issues raised at Tribal, regional, and national levels, especially regarding the Annual Tribal Consultation Report.
• To provide a forum for Tribes and the Department to discuss issues and proposals for changes to Department regulations, policies, and procedures.
• To identify priorities and provide advice on appropriate strategies for Tribal consultation on issues at the Tribal, regional, or national levels.
• To ensure that pertinent issues are brought to the attention of the Tribes in a timely manner, so that Tribal feedback can be obtained.
• To encourage the Secretary to work with other Federal agencies and Congress so that Native American veterans are not denied the full benefit of their status as both Native Americans and veterans.
• To highlight contributions of Native American veterans in the Armed Forces.

This is a unique opportunity to ensure Tribes and Native American Veterans receive the respect and care they deserve at the VA. While the TAC would not focus solely on health issues, because the VA’s mandate is primarily healthcare, the TAC would bring a wealth of Tribal health knowledge to the Department. Tribes have seen the benefit of Tribal Advisory Committees at several agencies within the Department of Health and Human Services, and a TAC at the VA would ensure Indian Country’s veterans finally receive the care and dignity due to them.

NIHB is currently working with the bill’s authors to ensure that additional Tribal perspectives are reflected in the final legislation.
Tribes in Arizona Eager to Utilize State’s New Dental Therapy Law

Tribes in Arizona are one step closer to improving oral health in their communities. On Friday, August 3, 2018, Arizona became the latest state to license dental therapists. Tribes in the state now have another tool at their disposal to meet chronic oral health challenges and provider shortages.

Governor Doug Ducey had signed HB 2235 – allowing for the practice of dental therapists – into law on May 16, 2018.

Dental therapists are focused oral health providers and licensed to perform basic preventative and restorative care. Through their training, they are able to meet the majority of patient needs and often work in settings that have struggled historically to retain consistent dental providers. Tribes in Alaska have used dental therapy since 2004, and an ever growing number of Tribes in the Lower 48 are using the innovative oral health provider model.

The Arizona bill codifying dental therapy underwent intense scrutiny by the legislature in the 2018 session, including no fewer than five legislative hearings. There were several moments during the legislative session when the bill’s prospects were in doubt, but thanks to the tireless efforts of the Tribes and their advocates in Phoenix, the bill finally passed the Senate in a 30-0 vote and the House in a 47-13 vote.

But the battle is not over. The state still has to finalize rules governing how dental therapists can practice in the state. Issues such as the Medicaid reimbursement rate for services performed by a dental therapist still need to be finalized via the rulemaking process. Tribes must remain vigilant throughout this process so that no unnecessary rules adding barriers to adequate oral health access are put in place.
The new law allows state licensed dental therapists or IHS-certified dental therapists to practice within the scope of their license at public health facilities, including Federally Qualified Health Centers, Tribal clinics, and Urban Indian Health facilities in the state. This means that the Tribes in Arizona could hire dental therapists licensed under the Community Health Aide Program, which is currently only operating in Alaska.

The Tribes in Arizona came together in August to discuss implementing dental therapy in their own communities. Tribal leaders spoke on the need for more oral health providers and the difficulty Indian Country has had historically in recruiting and retaining dentists. Several community colleges also expressed interest in developing training programs so that Tribal members interested in becoming dental therapists can complete all the education requirements without having to go far from home.

The National Indian Health Board has long advocated for innovative solutions to reduce oral health disparities in Indian Country. Tribes in Alaska, Washington State, and Oregon are already using this workforce model of focused oral healthcare providers, and many Tribes across the country have expressed a desire to bring dental therapy to their communities. There is much more work to be done to ensure Tribes in every state have this tool at their disposal. It is only by ensuring that the Tribal voice is unified and amplified that these victories happen.
Medicaid Coverage for American Indians and Alaska Natives: The Impact of the Affordable Care Act on American Indian and Alaska Native 19-35 Year Olds

Abstract
Before the passage of the Affordable Care Act (ACA) in 2010, young adults were among the largest group of uninsured people. In this article, we examine the experience of 19-35 year-old American Indians and Alaska Natives (AI/ANs) to determine if the ACA resulted in significant enrollment gains in Medicaid coverage. A review of findings from the American Community Survey depicts success for states that expanded Medicaid and lower levels of increase, with a few exceptions, in enrollment for states that did not expand Medicaid. Nationally, nearly 100,000 or 41% of 19-to-35 year old AI/ANs gained Medicaid coverage from 2012 to 2016.

Methodology
The National Indian Health Board examined the American Community Survey’s State Medicaid Enrollment estimates to determine whether or not the expected gains in coverage for this age group occurred. Caution is advised for many of the states since the small sample size of many states results in a large sampling error rate. These surveys, conducted at the household level (where the respondent is the head of household, not each individual in the household), are conducted annually by the Census Bureau. Approximately 16,000 AI/ANs annually answer these surveys.

FINDINGS
A review of the findings depicts a disparate experience with enrollment gains and declines. In states with Medicaid expansion (and likely aggressive outreach and enrollment), there were large increases in enrollment. States that did not expand, e.g. Wisconsin and Oklahoma, saw decreases in enrollment or modest increases. Exceptions do exist with some non-expansion states experiencing large increases and some expansion states only modest increases – in some cases this is explained by Medicaid expansion prior to 2012, e.g. in Minnesota and Arizona.

Did the ACA result in increased Medicaid coverage for young AI/ANs age 19 to 35?
The evidence is clear that national Medicaid enrollment for young adults increased from about 242,000 to 342,000; a 100,000-person or 41% increase. Male enrollment increased by 54% and female enrollment by 33%. Male enrollment, as expected, increased with the expansion of eligibility to ‘childless adults’.

ENROLLMENT IN MEDICAID NATIONALLY

<table>
<thead>
<tr>
<th>Total Medicaid</th>
<th>2012</th>
<th>2016</th>
<th>Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male with Medicaid</td>
<td>91,674</td>
<td>140,798</td>
<td>49,124</td>
<td>53.6%</td>
</tr>
<tr>
<td>Female with Medicaid</td>
<td>151,268</td>
<td>201,521</td>
<td>50,253</td>
<td>33.2%</td>
</tr>
</tbody>
</table>

ENROLLMENT IN MEDICAID IN THE STATES
There is tremendous variation between states in their enrollment gains for this age group. NIHB created digital data briefs that allow the viewer to further understand the data available. The Digital Data Brief below rank orders the increase in enrollment with color codes; blue for non-Expansion and orange for Expansion states where the greatest increases occurred.
The following table lists the percentage increase for states that have IHS-funded health care services.

<table>
<thead>
<tr>
<th>Rank Order of Increase in Medicaid Enrollment for Young Adult American Indians and Alaska Natives Aged 19 to 25 (not inclusive of 26)</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>Medicaid Expansion</td>
</tr>
<tr>
<td>Arkansas</td>
<td>yes</td>
</tr>
<tr>
<td>Mississippi</td>
<td>no</td>
</tr>
<tr>
<td>New Mexico</td>
<td>yes</td>
</tr>
<tr>
<td>Washington</td>
<td>yes</td>
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<tr>
<td>Connecticut</td>
<td>yes</td>
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<tr>
<td>Oregon</td>
<td>yes</td>
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<tr>
<td>Indiana</td>
<td>yes</td>
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<tr>
<td>Colorado</td>
<td>yes</td>
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<tr>
<td>Utah</td>
<td>no</td>
</tr>
<tr>
<td>California</td>
<td>yes</td>
</tr>
<tr>
<td>South Carolina</td>
<td>no</td>
</tr>
<tr>
<td>North Dakota</td>
<td>yes</td>
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<tr>
<td>Montana</td>
<td>yes</td>
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<tr>
<td>Rhode Island</td>
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<tr>
<td>Louisiana</td>
<td>yes</td>
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<tr>
<td>Illinois</td>
<td>yes</td>
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<tr>
<td>US</td>
<td>yes</td>
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<tr>
<td>Michigan</td>
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<tr>
<td>New York</td>
<td>yes</td>
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<tr>
<td>Alaska</td>
<td>yes</td>
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<tr>
<td>Alabama</td>
<td>no</td>
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<tr>
<td>South Dakota</td>
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<tr>
<td>Oklahoma</td>
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<tr>
<td>Nebraska</td>
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<tr>
<td>Arizona</td>
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<tr>
<td>Texas</td>
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<tr>
<td>Florida</td>
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</tr>
<tr>
<td>Nevada</td>
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</tr>
<tr>
<td>Massachusetts</td>
<td>yes</td>
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<tr>
<td>Minnesota</td>
<td>yes</td>
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<tr>
<td>Wisconsin</td>
<td>no</td>
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<tr>
<td>North Carolina</td>
<td>no</td>
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<tr>
<td>Iowa</td>
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<td>Maine</td>
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<td>Maine</td>
<td>no</td>
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<tr>
<td>Kansas</td>
<td>no</td>
</tr>
<tr>
<td>Wyoming</td>
<td>no</td>
</tr>
</tbody>
</table>

MALE AND FEMALE ENROLLMENT IN MEDICAID

Enrollment in Medicaid increased nationally by 53.6% for males and by 33% for females. This 20% difference indicates that Medicaid expansion was reaching the population of childless adults (more often males) most of whom were not eligible for coverage prior to the Affordable Care Act. Since females are far more often in their same household as their children, many males – regardless of parental status – were not eligible before the ACA. Although data exists for each state’s male and female population (see the table above), it is unwise to treat these estimates for very small populations as valid or reliable. With small populations, it’s hard to make reasonable estimates (validity) and comparisons over time will vary wildly due to the small numbers (reliability).

The two maps below depict this variation in graphic form; first for expansion states and secondly for non-expansion states.

ENDNOTES

1. There is no one definition of “young adult.” This paper sets the range from age 19 to age 34 inclusive, i.e., 19 to 35. At age 19, a person is no longer eligible under their parent’s household income eligibility for Medicaid so this is the best lower threshold for the age category “young adult.” The Centers for Medicare and Medicaid (CMS) treats young adults as 18 years old to age 26, but most tribal communities view a wider range, some less than this analysis (19 to 35) and sometimes more. One of the reforms of the ACA was extending to age 26 coverage for a household for an employer-paid health plan.

2. Childless refers to no dependent child residing in the same household.

CONCLUSION

Since 2012, the age group with the highest pre-ACA uninsured rate has made substantial gains in coverage in Medicaid. An overall 41% increase in coverage between 2012 and 2016 means an additional 100,000 young adults now have access to comprehensive health care services. Since this age group is generally healthy the increase in expenditures may not be large on a per-capita basis. However, for the subset of this population that struggles with addictions or substance use disorder (including opioid use disorder) Medicaid coverage is the difference between access to medically assisted treatment and no access to health care services. Healthier young adults will be better able to enter adulthood ready for further education, for employment and ready to contribute to their communities.
While there has been steady increases in the IHS Budget since FY 2009, more remains to be done. The TBFWG estimates that full funding for IHS is around $32 billion, yet the FY 2018 IHS Budget is only funded at $5.5 billion. Additional advocacy with the Administration and Congress is needed to move the IHS budget forward.

Congress has also taken steps to address budgetary and other issues at the IHS. In May 2017, House Energy and Commerce Committee Chairman Greg Walden (R-OR) and Ranking Member Frank Pallone, Jr. (D-NJ) announced the creation of the Indian Health Service Task Force. The Task Force was created to inform Members of Congress on the current state of IHS and the public health programs that serve Tribal Communities. The Co-chairs of the Task Force, Markwayne Mullin (R-OK) and Raul Ruiz (D-CA) stated after the creation that “The Indian Health Service is an important program that often flies under the radar. It’s imperative that members have a thorough understanding of the IHS and the work it does.” These members of Congress have a direct impact on policy impacting Tribal communities and as recently as July 2018, met with the TBFWG to discuss a path forward on how to improve IHS.

The creation of the Task force and the work of the TBFWG offers Tribes an opportunity to find solutions to the chronic underfunding of the Indian Health Service. Members of the Task force have stated in meetings with the Work Group that they want to create a clear path forward to improving health care delivery for AI/AN and they are looking to the Tribes to provide guidance on how to get there.

In the July meeting, the TBFWG recommended that the IHS funding recommendations created by the Work Group be included within the Agency’s yearly budget justification. The IHS congressional justification is submitted to Congress and reviewed by members responsible for funding the agency. The inclusion of the TBFWG’s yearly budget recommendations would ensure that funding needs of IHS do not go unnoticed by members of Congress and elevate the conversation at the national level. Also suggested at the meeting was creating a Tribal Liaison position within the Office of Management and Budget (OMB). OMB is responsible for implementation of the federal budget and this position would ensure that the Tribal recommendations for IHS are understood by the office as it compiles the President’s Budget Request to Congress each year.

Engagement with Members of Congress is a critical part of accomplishing the goals of the TBFWG and IHS funding. Members of the Congressional IHS Task Force are looking for all Tribes to reach out with examples of how the budget process and IHS funding impacts Tribal communities. The National Indian Health Board is dedicated to this mission and will work collaboratively with members of the Task Force and the TBFWG to ensure that the steps taken to address IHS funding are positive, and ultimately lead to healthier Tribal communities.

According to data from the Indian Health Service website, Medicaid and other third party revenue brought in approximately $1.02 billion to the Indian Health Service. The funding it has provided has helped extend scarce IHS discretionary appropriations, including Purchased/Referred Care (PRC) funding. PRC funding is used to cover the cost of care by providers outside the IHS system when an IHS or Tribal facility cannot provide the service itself. Medicaid helps extend PRC funding, which otherwise routinely runs out before the end of the year.

In several meetings between Tribal leaders and Agency officials, Tribes pointed out that CMS has ample legal authority to provide accommodations for American Indians and Alaska Natives (AI/AN) under the Constitution when doing so is rationally related to the United States’ unique obligation to AI/ANs. These accommodations are not based on racial status nor do they create a suspect classification under the Constitution. Tribes are sovereign political entities that existed before the founding of the United States. As political entities, they entered into treaties and other agreements with the United States through which they bargained for what they could in exchange for portions of their land and other concessions. In return, the United States has always dealt with Tribes as political entities and, by extension, it has dealt with AI/ANs generally and individually as persons with political status. This was confirmed by the Supreme Court in Morton v. Mancari, 417 U.S. 535 (1974). This principle continues to be recognized and supported in many contexts as well as through federal agencies’ actions, and the Department of Justice has routinely and successfully defended it.

Over the past few months, as Tribes have educated HHS and CMS, federal officials said that they could give states flexibility and discretion to implement work requirements with respect to Tribal members and encouraged Tribes to work with their states. While this position still did not address the Tribal concerns outlined above, there were some states who did provide accommodations and exemptions for AI/ANs in their waiver applications. Unfortunately, CMS has recently retreated to their initial position, stating that the agency would not likely approve those waivers that included such accommodations because they, as CMS leadership described “amounted to a creative way to get an exemption” which they will not approve because of continued civil rights concerns.

Tribes must continue to educate HHS and CMS about the impact the loss of Medicaid will have on their health system as well as reach out to their members of Congress to let them know the impact as well. CMS’ reach in this regard is far beyond health care and, rather, strikes at the heart of Tribal sovereignty.

The National Indian Health Board will continue to keep Tribes informed as this issue unfolds. Together, we must continue to educate and inform the federal government what their responsibility is and the impact the loss of Medicaid will have on the Indian health care system.
It’s Time We Had a Serious Discussion About RPMS

Yes, it’s time we had a serious discussion about RPMS: The Resource and Patient Management System is the Electronic Health Record (EHR) system utilized by the majority, but a shrinking number of Indian health programs. RPMS is still the mainstay of all health programs operated by the Indian Health Service (IHS). A growing minority of self-governance Tribes have abandoned RPMS in favor of some of the other leading commercial medical software. Nearly all Tribes, however, still provide certain reports (e.g. Active User Population) to the Indian Health Service using RPMS even if their medical records are now maintained by a proprietary software program.

Indian health providers have long complained about RPMS. The challenges they have identified include: the ad hoc nature of many of its attempts to keep up-to-date with features like reminders; managing chronic disease and having a graphical user interface; and a rudimentary 3rd party billing capability. Despite the fact that RPMS gets a reasonable grade as a clinical record system, it lags much farther behind other systems when it comes to practice management. Because of its failings in billing and management reporting many Tribes have contracted for billing services or added software to complete these tasks.

VA’S MOVE TO A NEW ELECTRONIC HEALTH RECORDS SYSTEM

RPMS has been able to approximate many of the advances found in off-the-shelf programs thanks to its link to the Veteran’s Health Administration’s (VA) electronic health records system, known as VistA. In the coming years, however, that link will be broken. In 2018 the VA began the transition to Cerner, following the lead of the Department of Defense after DOD chose Cerner over Epic (2015); another leading software solution. VA will undoubtedly continue to support VistA until Cerner is fully implemented at a date 5 to 10 years from now, but serious development of state of the art features will likely suffer as the complete termination of support looms with full implementation.

WHAT ARE THE OPTIONS FOR FUTURE ELECTRONIC HEALTH RECORDS AND INDIAN HEALTH?

The challenges facing RPMS are serious and growing, but the solution is not apparent or fully understood. It is likely that billions of dollars of investment will be required to fully modernize the Health IT landscape of the Indian health system. This means, increasing substantially increasing Congressionally-appropriated dollars for Health IT over and above the annual IHS funding level. In the Tribal Budget Formulation Workgroup’s FY 2020 Budget Request they recommend that the IHS include additional Health IT allocation in the agency’s annual budget request to Congress. Congress, for its part, has noted that they are awaiting additional information from IHS before they provide additional funding for EHR enhancement.

Among the options is sustaining and improving RPMS. It is not likely that RPMS will serve all Tribes, nor is it likely that IHS will follow DOD and VA and adopt just one proprietary software solution. It is highly likely that multiple solutions will be adopted in alignment with local and regional needs and familiarity with the regional health care systems accessed by Indian health programs. However, thorough engagement and consultation with the Tribes will be essential before moving any solution forward.

WHAT ARE THE NEXT STEPS TO ADDRESSING THE CHALLENGE TO RPMS?

With the VA's recent announcement of their transition to Cerner, Tribes have begun to discuss their options. As the scope of the cost of addressing this new challenge to RPMS rises to the agenda of Tribal leaders, they will expect a decision making process that follows their expectation for full consultation for a change of this magnitude. While to a certain extent that discussion has begun, a vigorous engagement in full consultation with Tribes and the Indian Health Service, needs to be supported with adequate funding for the planning effort that is equal to the challenge we face.

Not all of the issues Tribes will address are unique to RPMS or to Indian health. Interoperability of health record software and the need for common standards across all types of health providers is another critical concern. As that discussion progresses nationally, it is critical that Tribes – and the IHS – are part of the conversation.
In Crandon, Wisconsin, the Forest County Potawatomi (FCP) Tribal Community Health Department serves the FCP community, promoting health through prevention, healthcare, and public health services. The diabetes program offers support to those at risk or diagnosed with diabetes, including self-management, and education on diabetes prevention.

According to Medicare enrollment data, the diabetes prevalence for American Indians and Alaska Natives (AI/ANs) in Wisconsin is double that for non-Hispanic Whites and in Forest County alone, AI/ANs have a prevalence of diabetes that is 35% more than all county residents. Fortunately, the Special Diabetes Program for Indians (SDPI) supports the Tribe’s prevention and intervention efforts which are making a positive impact on the health of FCP citizens. SDPI is a mandatory spending program authorized by Congress, and coordinated through the Indian Health Service.

When the FCP diabetes program began, it initially focused on two best practices: case management and A1C control. However, audit data pointed to another major need in the community – foot care. After identifying this need, the program shifted its focus to providing foot care to diabetic patients. In addition the diabetes program currently offers education on a wide variety of prevention topics, including nutrition and physical activity. FCP staff also host health promotion events, and provide comprehensive case management and home visitation, which helps many of their patients achieve excellent health outcomes.

FOOT HEALTH
Cathy Chitko, a Community Health Representative (CHR) with the FCP diabetes program, is a certified shoe fitter. She uses her skills to fit shoes for Tribal citizens with diabetes to keep their feet healthy. Each patient is given 2 pairs of extra depth shoes and 2 orthotics each year. Cathy helps patients choose their shoes by completing a foot exam, creating a foot impression, finding a shoe that fits the patient’s needs, and sending in a request for a custom shoe. As poor shoe fitting footwear has been identified as a risk factor for patients with diabetes-related foot disease, proper shoe fitting can help prevent diabetes related foot complications, such as ulcers, which lead to an increased risk of amputation in diabetic people.

The diabetes program works to ensure that foot care best practices are accessible to all patients with diabetes in FCP. Foot exams allow providers to assess a patient’s foot health, make recommendations for preventive care, trim toenails, and remove corns and calluses in order to prevent foot disease. Podiatry is available at the FCP health center twice a week, but this has not been enough to ensure foot exams for all diabetic patients.

The program also conducts outreach and promotes foot exams in partnership with other FCP programs, departments, and meetings – they even host spa-themed foot care clinics to encourage community participation. There is evidence that massage can improve range of motion and foot sensation in patients with peripheral neuropathy, which affects 50% of patients over 60 years old with diabetes. Offering these services have also incentivized patients to have their foot exams completed.

COMPREHENSIVE DIABETES PREVENTION SERVICES
In addition to foot care, FCP provides a variety of services aimed at promoting health for patients with diabetes and pre-diabetes. Anne, the FCP Diabetes Coordinator, and Cathy both provide case management and home visits to encourage patients to engage in healthy behaviors. This intervention as met with remarkable success. Some patients are now able to manage their diabetes with
Foot care helps elders retain their mobility and access these programs.

SDPI MAKES THIS WORK POSSIBLE
SDPI community-directed funds are used to support many of the services at FCP, and have been integral to getting programs off the ground. Without SDPI, staff shared they would struggle to support their programs.

Anne Chrisman, the FCP Diabetes Coordinator started with the program 5 years ago. Although her background is in nursing, this was Anne’s first community health experience. The available education and support for diabetes prevention and treatment staff was helpful to her development with the program. Anne shared that, “SDPI has been wonderful to learn from since there is a lot of education for new coordinators.”

SDPI is currently funded at $150 million through FY 2019, and funds approximately 300 Tribes. NIHB has long advocated for an increase of SDPI funding, which has not increased since 2004. NIHB also supports long term reauthorization of SDPI (in recent years Congressional authorization has been for one and two year periods only). Increased funding and certainty on continuity will allow programs like FCP’s diabetes program to continue and expand their successful programing to improve and elevate the health of Native people.

FOOTNOTE:

Foot care helps prevent diabetes-related amputations.

Patients can also engage in self-management each day to prevent disease. Managing other aspects of diabetes, including maintaining healthy blood sugar levels, can reduce foot-health complications. Patients should also examine their own feet regularly for irregularities and injuries, particularly if they have reduced sensation in their feet. Patients should keep feet clean, moisturize their feet to prevent skin cracking, wear socks and comfortable shoes, and stay active to keep blood flowing to their feet. Many patients can also manage calluses and toenails with emery boards and pumice stones.

Engaging in foot care can keep diabetes from knocking you off your feet! Preventing diabetes-related foot disease can help patients stay mobile, comfortable, and healthy. Foot care should be a part of everyone’s diabetes management practices.
The Opioid Crisis in Indian Country: Is it Increasing the Risk of HIV and Hepatitis C?

American Indians and Alaska Natives (AI/ANs) have been disproportionately impacted by the opioid overdose epidemic. In 2016, the Centers for Disease Control and Prevention (CDC) reported that AI/ANs had the second highest opioid overdose death rate of any group at 13.9 deaths per 100,000. In recent years, the epidemic has been largely driven by the increased availability and consumption of illicit opioids such as heroin and fentanyl, as opposed to prescription opioid medications. Of the 72,000 drug overdose deaths overall in 2017, heroin and fentanyl were responsible for a combined 63% (45,368) of those deaths. While little research has been done on fentanyl-related mortality in Tribal communities, research has shown that AI/ANs experience the second highest heroin overdose death rate at 5.0 deaths per 100,000.

The stronger potency and relative inexpensiveness of heroin and fentanyl have fueled demand, while increased provider education and federal scrutiny of prescribing patterns have reduced the quantity of prescription opioids available for misuse. However, investments in provider and community education on the potential dangers of prescription opioids have successfully reduced prescribing rates but at the same time they have done little to reduce opioid overdose rates overall. According to the Centers for Disease Control and Prevention (CDC), heroin-related deaths increased more than fivefold from 2010 to 2016, while fentanyl related deaths increased by 264% from 2012 to 2015. Use of injection opioids increased 93% from 2004 to 2014, while opioid prescribing fell 22% from 2013 to 2017.

As the dynamics of the crisis continue to shift, greater attention should be paid to reducing the harm associated with injection opioids such as heroin and fentanyl. In particular, there is a strong need for greater national attention to co-occurring infections of HIV and Hepatitis C (HCV), which have increased significantly as a result of increased injection drug use.

Across all demographics, incidence rates of acute HCV increased 133% from 2004 to 2014, with significant disparities between groups. AI/ANs have the highest incidence rate of HCV nationwide, and the highest HCV-related mortality rate of any group at 12.95 deaths per 100,000. Roughly 31% of HIV diagnoses among AI/AN women had injection drug use as the mode of transmission, compared to 12% among all women. Research has demonstrated that increased incidence of acute HCV follows the same trajectory as the opioid epidemic. In fact, injection drug use now represents the most frequent mode of transmission for HCV.

While HIV transmission via injection drug use has not increased at the same rate as HCV, there is significant increased risk for an HIV outbreak given the increased prevalence of injection drug use overall. According to the CDC, 220 counties and 33 states nationwide are at increased susceptibility to an HIV outbreak as a result of increased injection drug use in those areas.

WHAT CAN BE DONE?

There are proven evidence-based interventions to prevent HIV and HCV transmission among people who inject drugs. Harm reduction-based practices and policies such as syringe service programs, Good Samaritan laws (which provide legal protections to people who inject drugs seeking medical attention during an overdose), and medication-assisted treatments have all been shown to reduce transmission of HIV and HCV. In addition, harm reduction policies have been shown to increase treatment-seeking behaviors, and even reduce drug use over time.

Many Tribal Nations have exercised their sovereignty by innovatively applying harm reduction strategies to improve health outcomes. For instance, the Port Gamble S’Klallam Tribe developed the Tribal Healing Opioid Response (THOR) Project, which combines cultural and traditional healing and wellness activities with Western-based interventions such as syringe exchange. The program utilizes an integrated approach that involves every sector of government and the community including the Tribal council, police force, health services divisions, youth workers, wellness staff, and community members. Similarly, the Pascua Yaqui Tribe has been operating a medication-assisted treatment clinic for several years. The Tribe offers traditional healing services such as a sweat lodge along with substance abuse counseling and inpatient services.

These examples demonstrate the unique ways Tribes have intervened to improve health outcomes related to the opioid crisis. By applying integrated approaches that bridge Tribal culture and wisdom with western practices, Tribes have implemented programs and policies best suited to address their community needs. As more Tribes develop such initiatives, there have been increased efforts to facilitate the sharing of best practices in order to ensure program sustainability. These efforts can be further assisted by increased technical and capacity building assistance from federal agencies such as the Center for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration. The federal government’s trust and treaty obligations to Tribal Nations requires provisions of healthcare and public health services. By providing sustained and direct public health funding to Tribes, the federal government can uphold its trust responsibility and ensure that Tribes have the resources they need to continue developing innovative harm reduction programs towards the goal of turning the tide on the opioid epidemic.
Growing the Next Generation of Indian Health Policy Advocates

Native youth are engaged, strong, resilient, and acutely aware of the political and social tides shaping Indian Country. Some are participating in grassroots movements, exercising their voices at Standing Rock and organizing to protect Bears Ears. Others are taking on leadership roles in their communities and committing themselves to learning the ins and outs of governance. Several are running for political office.

The National Indian Health Board, inspired by the strength and optimism of our youth, has committed to providing the tools, resources, and mentorship to grow the next generation of Indian health advocates.

NIHB HEALTH POLICY FELLOWSHIP

The National Indian Health Board (NIHB) Health Policy Fellows are a diverse group of talented Native young adults who work alongside Tribal leaders, policy specialists, and public health experts to develop feasible Indian health policy solutions.

Throughout the year-long fellowship, NIHB Health Policy Fellows work directly with their Tribal leadership to identify one health policy priority affecting their community.

Then with the support of NIHB mentors, Fellows:
- Conduct research and analysis
- Develop policy papers with recommendations for change
- Present their work to Tribal leadership (and national audiences)
- Lead advocacy efforts to advance the health of their communities
- Educate Congressional and Tribal leaders on important health policy issues
- Grow their team-building, Indigenous leadership, and consensus-building skills

WELCOMING THE CLASS OF 2018-2019

NIHB was pleased to welcome the second class of NIHB Health Policy Fellows during a five-day training in Washington DC. This gathering, which took place June 27th through July 1st, was the first of three in-person and five web-based trainings.

This year’s NIHB Health Policy Fellows are a diverse group of talented young women from across Indian Country. Please join us in celebrating their dedication to advancing the health of their communities.

Danielle Antelope...... Eastern Shoshone Tribe
Onaleece Colegrove... Hoopa Valley Tribe
Mandy Dazen ............ White Mountain Apache Tribe
Nachya George ........... Yakama Nation
Ryann Monteiro ....... Wampanoag Tribe of Gay Head Aquinnah
Mariah Sharpe......... Colorado River Indian Tribes (Mohave and Chemehuevi)
Shelbie Shelder......... Little River Band of Ottawa Indians
Carmelita Shouldis.... Sicangu Lakota Rosebud Sioux Tribe
Jolie Murray............... Beaver Village
Betsy Waller .............. Chickasaw Nation, Choctaw Nation
Tia Yazzie ................. Navajo Nation

GETTING CONNECTED

If you have any questions about the NIHB Health Policy Fellowship or would like to submit an application to join next year’s cohort, please contact NIHB’s Native Youth Engagement Manager, Dr. Wendee Gardner at wgardner@nihb.org or (202) 507-7297.

To learn more and stay connected, follow NIHB on Facebook and twitter where we will highlight program participants and their achievements, provide tools and resources for engaging in health policy, and announce the launch of our new NIHB Health Policy Fellowship page, as well as mini-grant opportunities for youth!
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