National Indian Health Board

Our Vision: One Voice affirming and empowering American Indian and Alaska Native Peoples to protect and improve health and reduce health disparities.

2016 Legislative and Policy Agenda

January 21, 2016

Founded by the Tribes in 1972, the National Indian Health Board (NIHB) is dedicated to advocating for the improvement in the delivery of health care and public health services and programs to American Indians and Alaska Natives. To advance the organization's mission, the NIHB Board of Directors sets forth the following priorities that the NIHB will pursue through its legislative and policy work in 2016.

Phase in Full Funding for Indian Health Services and Programs for American Indians and Alaska Natives in the Indian Health Service (IHS) and Beyond

Each year the National Tribal Budget Formulation Workgroup to the IHS works diligently to synthesize the priorities identified by Tribes in each of the health care delivery Service Areas of the IHS into a cohesive message outlining Tribal funding priorities nationally. These priorities are the foundation and roadmap for the work that NIHB does on behalf of Tribes in pursuit of much needed funding for health care services and programs for American Indians and Alaska Natives (AI/ANs). NIHB will call on Congress and the Administration to:

- Phase in Full Funding of IHS - Total Tribal Needs Budget of **$30.8 Billion** Over 12 Years
- Present a 37% increase in the overall IHS budget from the FY 2017 President's Budget request planning base for a total of **$7.1 billion**
- Advocate that Tribes and Tribal programs be permanently exempted from sequestration
- Provide funding for new authorities in the Indian Healthcare Improvement Act. Top priorities include:
    - Section 205: Funding for Long-term Care Services
    - Section 704: Comprehensive Behavioral Health Prevention and Treatment Program
    - Section 204: Diabetes Prevention, Treatment, and Control
    - Section 123: Health Professional Chronic Shortage Demonstration Project
    - Section 705: Mental Health Technician Program

Enact Mandatory Appropriations for the Indian Health Service

In addition to fully funding the Indian Health Service, NIHB and Tribes are committed to seeing IHS treated as 'mandatory' spending. The federal trust responsibility toward the Tribes is not an optional line item, and it should not be treated this way during the annual budgeting process. To reaffirm its commitment to the Tribes, ***IHS funding should be treated as mandatory spending*** so that fulfillment of the U.S. government's treaty responsibilities is not a victim of unrelated political battles.

Seek Long-Term Renewal for the Special Diabetes Program for Indians at $200 Million

NIHB is asking Congress to pass legislation by this year to renew funding for this vital program for at least 5 years at $200 million per year. The Special Diabetes Program for Indians (SDPI) has not received an increase in funding since 2002; the program has effectively lost 23 percent in programmatic value over the last 12 years due to the lack of funding increases corresponding to inflation. Few programs are as successful as SDPI at addressing chronic illness and risk factors related to diabetes, obesity, and physical activity. SDPI has proven itself effective, especially in declining incidence of diabetes-related kidney disease. The incidence of end-stage renal disease (ESRD) due to diabetes in American Indians and Alaska Natives has fallen by 29% - a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost $90,000 per patient, per year, so this reduction in new cases of ESRD translates into significant cost savings for Medicare, the Indian Health Service, and third party payers.

Secure Advanced Appropriations for the Indian Health Service

NIHB is asking ***Congress to enact advanced appropriations for IHS***. If IHS had received advance appropriations, it would not have been subject to the government shutdown or automatic sequestration cuts as

its FY 2014 funding would already have been in place. Adopting advance appropriations for IHS results in the ability for health administrators to continue treating patients without wondering if –or when– they have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when the results of Congressional decisions funnel down to the local level.

Seek a Legislative Fix of the Definition of Indian in Affordable Care Act

NIHB is asking for a legislative fix of the "Definition of Indian" in the Patient Protection and Affordable Care Act (ACA). The "Definition of Indian" in the ACA are not consistent with the definitions already in place and actively used by the Indian Health Service (IHS), Medicaid and the Children's Health Insurance Plan (CHIP) for services provided to AI/ANs. The ACA definitions, which currently require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act (ANCSA) corporation, are narrower than those used by IHS, Medicaid and CHIP, thereby leaving out a sizeable population of AI/ANs that the ACA was intended to benefit and protect. Congress should:

- ***Enact legislation that would clarify the definitions in the ACA*** to align with other definitions used by federal providers

Promote Better Public Health Outcomes for AI/ANs through Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is the nation's public health agency responsible for the public health of all populations, however, their actions on American Indian and Alaska Native health have not demonstrated a firm commitment to fulfilling the trust responsibility that the federal government has to maintain the health and well-being of Tribal citizens. The CDC's past efforts, although lauded and appreciated, have been indicative of a both a 'helicopter' and 'band-aid' mentality – serving often to micromanage Tribal health programs and only seeking to solve symptomatic issues, rather than improving whole health systems. Efforts, more specifically funding streams, have been temporary and have only served to draw fleeting attention to bigger and broader issues. The funding creates fruitful and effective programs within the Tribal communities (i.e. traditional foods, motor vehicle safety, HIV capacity building), however these programs are woefully dismantled upon the termination of the funding. This only reinforces a lack of long-term and sustainable commitment to American Indian and Alaska Native communities. The funding is not sufficient enough to create systemic change, embed a community consciousness aligned with public health goals, re-align programming and governance to longer-term public health strategies, and address tribal priorities. There needs to be a significant increase to the CDC's bottom line budget, and then that increase used to:

- ***Create an American Indian and Alaska Native public health block grant*** administered through the Tribal Support Unit within the Office of State, Tribal, Local and Territorial Support.
- ***Create flagship funding for Tribal health departments*** for key public health issues in Indian Country. State health departments receive multi-year funding from the CDC for such issues as HIV, hepatitis C, diabetes, cancer, and sexually transmitted diseases. These funds are used to establish the state's own programming and presence around these issues. Tribes should be permitted the same opportunities through their own flagship awards.
- Each institute, office or center operating significant programmatic outreach at the community level should create ***standing funding streams dedicated only to federally recognized American Indian or Alaska Native Tribes.***
- The CDC should ***work directly with the CDC Tribal Advisory Committee meeting to establish subcommittee that will actively seek out Tribal input during the internal budget negotiations and formulation***. It is important that Tribal input is reflected in the budget that CDC prepares for the White House's initial proposal and all subsequent revisions.

Achieve Medicare-like Rates for the IHS

NIHB is requesting Congress to extend the Medicare-like rate cap on Purchased and Referred Care (PRC) (formerly Contract Health Services) referrals to all Medicare participating providers and suppliers. The IHS-

operated PRC program alone would have saved an estimated $31.7 million annually if Medicare-like Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually. On December 5, 2014, IHS released a proposed rule that would amend the IHS PRC regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital based services that are either authorized under such regulations or purchased by urban Indian organizations. The National Indian Health Board, along with multiple Tribes and other Tribal organizations submitted comments supporting the Proposed Rule as long as any regulation is flexible enough to allow Tribes to opt out of the regulations requirements if they so choose. While NIHB is generally supportive of the proposed rule, it recognizes that the proposed rule has no enforcement capability. As a result, NIHB is still calling on ***Congress to pass legislation to extend the Medicare-like rate cap on PRC***.

Seek an Exemption for American Indians and Alaska Natives from the Employer Mandate Requirement

The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers with 50 or more employees must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule even though they are not specifically listed in the language of the statue. Yet, AI/ANs are exempt from the Individual Mandate to purchase health insurance. Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself. NIHB has reached out to members of Congress to educate them on this important issue and it has garnered some interest and support. However, given the political climate, NIHB believes that a regulatory fix would be more likely to succeed than a congressional one. However, NIHB continues to advance both strategies in 2015.

- The Administration should ***exempt AI/AN employees from the Employer Mandate*** through a regulatory fix
- If the Administration can't exempt AI/AN employees from the Employer Mandate altogether, ***Tribal consultation needs to occur on how to mitigate the impact that the Employer Mandate*** has on Tribes
- ***Congress should explicitly exempt AI/AN employees from the Employer Mandate*** to purchase health insurance under the ACA

Improve Recruitment and Retention of Medical and Health Professionals at the Indian Health Service

Like most rural health providers, IHS has difficulty recruiting and retaining medical staff at many of its sites. As a result, patients experience very long wait times, and serious illness is often left untreated. Congress and the Administration must do more to ensure that providers are seeking out the IHS as a desirable place to work. Recommendations include:

- Securing tax exempt status for IHS student loans
- Engaging in formal Tribal consultation on how to better recruit and retain medical staff
- Shortening hiring times for medical professionals
- Increasing funding to build staff housing on reservations
- Create specialized residency programs within IHS to attract a service provider corps with more diversified professional expertise
- Increase professional development opportunities for existing staff

Enact Special Suicide Prevention Program for AI/ANs

AI/AN communities grapple with complex behavioral health issues at higher rates than any other population. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma. According to the Substance Abuse and Mental Health Services Administration, suicide is the 2nd leading cause of death – 2.5 times the national rate – for AI/AN youth in the 15 to 24 age group. Tribes have noted that federal support seems to increase whenever there is an acute crisis, but then dwindles over time, preventing long-term, sustainable improvement in mental and behavioral health systems. The Attorney General's Advisory Committee on AI/AN Children Exposed to

Violence, describes the foundation that must be put in place to treat and heal AI/AN children who have experienced trauma: "We must transform the broken systems that re-traumatize children into systems where [AI/AN] tribes are empowered with authority and resources to prevent exposure to violence and to respond to and promote healing of their children who have been exposed."[1] NIHB recommends that:

- Congress should ***enact a program to target suicide prevention program for Indian Country*** that would be modeled off of the Special Diabetes Program for Indians
- ***Create an American Indian and Alaska Native mental health block grant*** to be Administered by the Substance Abuse and Mental Health Services Administration
- Congress and the Administration should ***require that states engage in meaningful Tribal Consultation with Tribes*** within their borders in order to receive any funds under the Mental Health Services Block Grant
- ***Increase appropriations across the federal government*** for Tribal behavioral health programs and empower Tribes to operate those programs through Tribal Self-Governance contracts
- Congress ***pass statutory language supporting traditional and cultural healing*** practices in any national mental health reform legislation

Repeal Language in the Indian Health Care Improvement Act Limiting the Use of Dental Therapists in Tribal Communities

Tribal communities suffer from some of the worst oral health disparities in the United States. AI/AN children have an average of 6 decayed teeth, while the same age group in the U.S. population overall has only one. For over a decade, Tribes in Alaska have successfully employed Dental Health Aide Therapists (DHATs), who have expanded oral health services to over 40,000 Alaska Natives. These safe and effective mid-level oral health providers deliver basic and routine services (i.e. cleanings, fillings, simple extractions, oral health education, sealants, etc.) to communities who do not have access to a regular dentist. However, when Congress passed the Indian Health Care Improvement Act in 2010, language was included that would limit the use of DHATs outside of Alaska within the Community Health Aide Program unless a state legislature approves. NIHB believes that this is a direct violation of the principle of Tribal sovereignty, and that Tribal governments, not state legislatures, should dictate who is able to deliver care in their community. Therefore, we recommend that:

- Congress should ***repeal Section 119 of the Indian Health Care Improvement Act*** which bans the expansion of Dental Health Aide Therapists (DHATs) to Tribes in the lower 48 within the Community Health Aide Program at the Indian Health Service unless approved by a state legislature
- Congress should ***pass legislation that would express support for the use of DHATs*** in Tribal communities outside of Alaska

Expand Tribal Self Governance at the Department of Health and Human Services

For over a decade, Tribes have been advocating for expanding self-governance authority to programs in the Department of Health and Human Services (DHHS). Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696 - Department of Health and Human Services Tribal Self-Governance Amendments Act- that would have allowed demonstration projects to expand self-governance to other DHHS agencies. This proposal was deemed feasible by a Tribal/federal DHHS workgroup in 2011. Therefore, in 2016, NIHB recommends that Congress:

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

[1] U.S. Department of Justice. (2014) "Attorney General's Advisory Committee on American Indian and Alaska Native Children Exposed to Violence: Ending Violence so Children can Thrive," p. 7.

Improve Enrollment through the Federal and State-based Insurance Marketplaces

NIHB is committed to working with CMS to set goals for enrollment and measure progress towards those goals. It has been estimated that about 460,000 AI/AN are eligible for tax credits or premium assistance yet only about 24,000 AI/AN have enrolled. There are a number of ways to increase enrollment of AI/ANs.

- ***Funding for enrollment assistance for the I/T/U***. Navigator grants have been limited to only a few regions in the country; and the rules associated with Navigator grants make them unattractive to some Tribes and Tribal organizations, which are in the best position to do outreach, education, and enrollment assistance. NIHB needs to work with CMS to consider alternatives for funding for enrollment assistance that is specifically designated to reach the I/T/U.
- ***Change the rule for AI/AN in family plans***. A regulatory decision was made in the first year that everyone on a family plan would get the least generous cost sharing reduction that anyone qualified to receive. NIHB will recommend that a family plan includes one person who is eligible for Indian-specific cost sharing reductions, then others who are in the tax-filing unit who are eligible for the Indian Health Service will get the same cost-sharing reduction as the person with Indian Status.
- ***Access to analytics to manage enrollment for AI/AN***. To manage the problem of increasing enrollment requires a system of reporting and analyzing enrollment data in a regular and consistent way that allows us to better understand the impediments and the approaches that are successful. NIHB and TTAG have made recommendations about the most useful types of information and how they can be retrieved from existing data files and we intend to follow up with CMS until we receive access to the data that we need.

AI/AN-Specific Call Centers

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

Because AI/AN consumers continue to receive such poor customer service we have suggested before and continue to suggest that the Center for Consumer Information and Insurance Oversight (CCIIO), in CMS, ***establish an AI/AN-specific call center to respond to questions and provide technical assistance to AI/ANs***, as well as enrollment assisters such as navigators and certified application counselors. We also believe that an AI/AN-specific help desk would be better equipped and more sensitive to the needs of AI/AN consumers.

Support Increased Oversight of QHPs

CMS put into regulations the provisions in the 2015 Issuer Letter requiring Qualified Health Plan (QHP) Issuers to offer contracts to all Indian health care providers that operate in the QHP's service area and to do so by including the QHP Indian addendum with "good faith" payment provisions. However, not all QHP Issuers are complying with the requirement. Depending upon the region of the country, some QHP issuers are offering contracts, but in other regions, QHP issuers do not appear to be offering contracts to Indian health care providers. NIHB is advocating and working with CCIIO to provide better oversight in federally facilitated marketplaces (FFM) states and that the contract requirement be extended to state-based Marketplaces to ensure Indian Health Care Providers are included in plan networks in those states.

For a variety of reasons, an I/T/U may be unable to join the network of plan providers or chose not to do so. In any case, if the I/T/U is an out-of-network provider, AI/AN will continue to seek the I/T/U for many of their health services. CMS should ensure that:

- ***Marketplace plans make accurate and timely payments to the I/T/U for services to people enrolled in the Marketplace plans***, and that the cost sharing reductions for AI/AN are handled properly at the time of service.

Meaningful Use of Electronic Health Records

Meaningful Use (MU) of electronic health records (EHR) requires both changes in technology and changes in business practices. For a variety of reasons, this has been difficult to accomplish in many places within the I/T/U. Now Indian health providers are threatened with reduced revenues for lack of progress on MU. In addition, many I/T/U facilities are small and located in extremely rural areas where it is difficult or impossible to attract and retain the kind of personnel who can understand, implement and manage the new requirements for reporting that result in Medicare payments being reduced. ***NIHB will advocate for exemption to these requirements.***

Support Medicaid Expansion and 100% FMAP Policy

Medicaid Expansion is a shared partnership between states and the federal government. Under Medicaid, AI/ANs are eligible for a 100 percent federal match (also known as 100% FMAP), meaning that the money spent by a state Medicaid program is fully reimbursed by the federal government. Medicaid reimbursement is a significant source of third party revenue that is essential to supplementing the limited resources of the Indian health system. In states that have expanded Medicaid, like Washington, as much as $2 billion has been added to the Indian Health System. A recent White House report estimates that 5,200 deaths could be avoided annually if those 16 remaining states that have stated that they are not expanding Medicaid continue to do so. NIHB must continue to advocate and provide technical assistance for those states that wish to expand Medicaid.

In addition, CMS recently proposed updating its policy concerning the circumstances under which a 100 percent federal match can be applied. CMS proposes expanding the match to include services furnished outside an IHS or Tribal health facility. This would have substantial benefits to Indian Country and the revenue generated from expanding the federal match could be used to expand Medicaid in the state, as South Dakota has proposed. NIHB will continue to advocate for this expansion and provide all necessary technical support.

Public Health Infrastructure Workforce Development

AI/AN communities have some of the largest public health disparities in this country, with disproportionately higher rates of depression, suicide, HIV, motor vehicle accidents, other accidental deaths, sexually transmitted diseases, viral hepatitis, substance use, tobacco use, and cancer when compared to other reported races and ethnicities. Indian Country does not have the established public health infrastructure that exists within state governments or even local or country systems. This lack of infrastructure and accompanying workforce will only continue to perpetuate the disparities, and quite possibly compound them. The recent movement to accredit the public health operations of health departments has proven quite successful but uptake has been slower in Tribal communities, primarily because the lack of public health infrastructure makes public health accreditation seem unachievable. An effective public health system, especially the practices of disease surveillance and prevention, can save hundreds of thousands of dollars in health care costs to Indian Health Service, Veteran's Administration, Medicaid, and third party payers. In order to bolster the public health infrastructure and workforce of Tribes, NIHB recommends:

- IHS create ***targeted capacity building to Indian Health Service medical providers*** on the integration of public health and behavioral health services into clinical settings.
- ***Congress re-instate the CDC's National Public Health Improvement Initiative*** (NPHII) which was discontinued in 2015, as this funding was solely for the purpose of strengthening gaps in public health services or systems, as identified by the funding recipient. However, the re-instatement of this program should include a Tribal set-aside, as data clearly indicates that not only are health disparities greater, but the infrastructure is weaker within Tribal communities than their non-Tribal counterparts.
- Indian Health Service ***create a health education certification program*** for Tribal and IHS employees.
- That Congress require the ***Indian Health Service and the CDC to report to Congress every two years how it supports the creation and effective implementation of the ten essential services of public health*** within AI/AN communities.