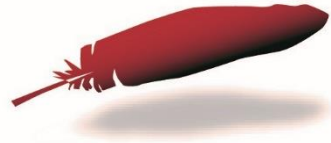


National Indian  
Health Board



# **LEGISLATIVE HOT TOPICS**

*SEPTEMBER 19, 2019*

Shervin Aazami, Deputy Director of Congressional Relations, NIHB  
Brett Weber, Congressional Relations Manager, NIHB

# Presentation Overview

1. Appropriations for 2020
2. 105(L) Leases
3. Advance Appropriations
4. Special Diabetes Program from Indians
5. Surprise Billing
6. AI/AN Medicaid Legislation
7. Broken Promises Legislation
8. Native Veterans
9. Tribal Oral Health Initiative



# Appropriations for 2020

- 2 of 12 Appropriations Bills are relevant to Tribal health: Interior and Labor-HHS
  - House passed both bills in June

## Interior

- IHS Funded at \$6.3 billion
  - Hospitals and Clinics: increased to \$2.42 billion overall
  - \$53 million to help address 105(1) leases
  - \$62.9 million for Community Health Representatives

## Labor-HHS

- Good Health and Wellness funded at \$21 million
- Tribal Behavioral Health Grants funded at \$40 million



# Budget Deal & FY 2020 Appropriations Cont.

- Senate did not begin work on 2020 appropriations until September
  - Did not know how much money would be available
  - Budget deal passed August 1 set spending levels for 2020 and 2021
- Bipartisan Budget Act of 2019:
  - Raises defense & non-defense spending caps
  - Raises the debt limit through at least July 2021
  - **Permanently ends discretionary sequestration!**
  - \$77 billion in offsets
- With budget deal in place, Senate Appropriators began work



# Appropriations & Next Steps

- Subcommittee spending allocations (302b) released
  - Interior allocation only about \$200 million over 2019
  - Labor-HHS allocation roughly \$1.9 billion over 2019
- Continuing Resolution (CR) vote in the House today
  - Keeps government open through November 21
  - **Special Diabetes Program for Indians is included!**



# Appropriations & Next Steps

- Senate FY 2020 Labor-HHS bill released yesterday
  - Maintains funding levels for Tribal Behavioral Health, Tribal Opioid Response, AI/AN Suicide Prevention
  - Unfortunately zeroes out Good Health and Wellness in Indian Country (GHWIC)
    - GHWIC is single largest investment into public health for Tribes from the Centers for Disease Control and Prevention (\$21 million)
    - NIHB fighting to make sure it is reinstated as Senate and House appropriators negotiate on the final bill
  - **Reach out to your member to demand GHWIC continue to be funded!!!**



# Appropriations: 105(I) Leases

- Currently funded through IHS services line item
  - House Interior report requests IHS to examine whether 105(I) leases should be a separate line item funded similarly to CSCs
    - House-passed bill included \$53 million for 105(I) leases (\$42 million above budget request and \$17 million above 2019 enacted level)
  - Senate Interior appropriators have indicated they are prioritizing CSC, 105(I), facilities, and professions
- With Senate subcommittee allocations now set, NIHB working to secure dedicated funding for 105(I) leases
  - IHS must report level of funding needed to Congress



# IHS Advance Appropriations

- Three bills introduced for Advance Appropriations
  - S.229 / H.R. 1128 – Indian Programs Advance Appropriations Act
    - Sponsors: Sen. Udall (D-NM)/ Rep. McCollum (D-MN)
    - IHS Services and CSC as well as BIA
  - H.R. 1135 – IHS Advance Appropriations Act
    - Sponsor: Rep. Don Young (R-AK)
    - IHS Services and Facilities, not BIA



# IHS Advance Appropriations

## Activities:

- March letter to House Budget Committee with 60 bipartisan signatories
  - **House Natural Resources Subcommittee on Indigenous Peoples hearing on Advance Appropriations Tuesday, September 25 at 2:00pm**
  - **NIHB Chairwoman Victoria Kitcheyan testifying**
- Outreach & education with members on relevant committees (Budget, Natural Resources, Energy & Commerce)

## Actions needed!

- Request that your member co-sponsor HR 1135 and HR 1128
- Government shutdown impact stories



# IHS Advance Appropriations

- How do we get Advance Appropriations?



- Budget Resolution – exemptions list
  - House Rules for 116<sup>th</sup> – Budget Committee Chairman must comply
  - **Advance Appropriations not included in 2019 budget deal**



- Enacting law – S.229/ H.R. 1128/ H.R. 1135



# Special Diabetes Program for Indians

- **SDPI attached to continuing resolution through Nov. 21, 2019 - continued fight for long-term renewal**
- Working with partners at American Diabetes Association, Juvenile Diabetes Research Foundation and the Endocrine Society to ensure long-term renewal
- Senate introduced a 5-year renewal for SDPI at the current \$150 million/ year
  - Voted out of Committee without amendment
- Rep. O'Halleran (D-AZ) introduced House bill
  - H.R. 2680: \$200 million/year for 5 years
  - BUT: House amended to \$150 million for 4 years
  - H.R. 2328 includes SDPI renewal in public health extenders package



# SDPI Developments in 2019

- NIHB helped draft and circulate letters from House and Senate Diabetes Caucuses
  - Letters showed support for SDP and SDPI
  - Members could choose to sign on
- 379 House members (85%) signed the letter!!
- 68 Senators!!
- HHS issued report showing SDPI's impact
  - 2,200-2,600 people avoided needing dialysis over 10 years
  - Medicare cost savings are up to \$52 million/year

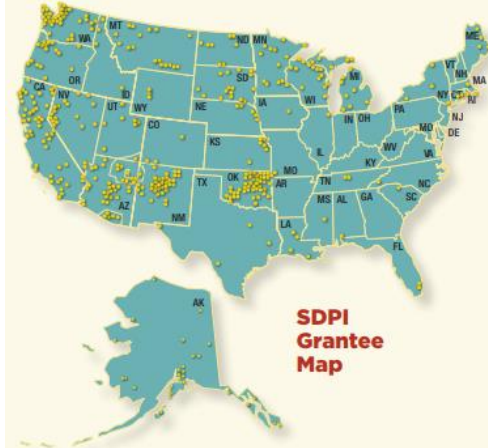


# NIHB Efforts to Renew SDPI

- Both House and Senate flat funding SDPI
  - Increase impossible without a way to pay for it
  - Medicare savings (up to \$52 million/year) don't count
- Tribes wanted funding increase as a priority
  - NIHB identified the fourth year of funding in the House as the pay for
  - Asked House to consider amendment \$200 million for 3 years
- Unfortunately, House allies told NIHB that deal was probably too fragile to reopen
- \$150 million for 4 years most likely outcome, which is still a victory
- **Timely renewal is not assured; time is running out!**

SDPI programs are successful because they fuse community-based cultural practices with evidence-based diabetes intervention strategies. By empowering patients to take control of their health by providing resources and guidance for diabetes management and prevention SDPI has been able to change the course of type 2 diabetes in Indian Country.

In the last two decades prevalence of End Stage Renal Disease (ESRD) (a complication of type 2 diabetes) has decreased by 54% among AI/ANs — a greater decline than any other ethnic group. ESRD is one of the largest drivers of Medicare costs.



SDPI Grantee Map

(LOCATIONS ARE APPROXIMATE)

**SDPI**  
SPECIAL DIABETES PROGRAM  
FOR INDIANS



# Reforming SDPI's Structure

## §254c-3. Special diabetes programs for Indians

### (a) In general

The Secretary shall make grants for providing services for the prevention and treatment of diabetes in accordance with subsection (b).

- Grant structure not good for all Tribes
- Significant support for 638-ing SDPI in Indian Country
- NIHB facilitating conversations to explore questions
  - How would data be collected? How would Direct Service Tribes be impacted?
  - Diabetes Summit on Thursday 9/19!
- Current SDPI legislation does **not** address this issue
- NIHB will work on legislative language once renewal is finalized!



CONGRESS ESTABLISHED THE SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI) IN 1997 AS PART OF THE BALANCED BUDGET ACT TO ADDRESS THE GROWING EPIDEMIC OF DIABETES IN AMERICAN INDIAN AND ALASKA NATIVE (AI/AN) COMMUNITIES.

The Special Diabetes Program for type 1 Diabetes (SDP) was established at the same time to address the opportunities in type 1 diabetes research. Together, SDP and SDPI have become the nation's most strategic, comprehensive and effective effort to combat diabetes and its complications.

SDPI CURRENTLY PROVIDES GRANTS FOR **301 PROGRAMS** IN **35 STATES** AND SERVES **780,000 PEOPLE** EACH YEAR

At a rate of 2 times of non-Hispanic whites, AI/ANs have the highest prevalence of diabetes. But since the beginning of SDPI, blood sugar levels have decreased, risk factors of cardiovascular disease have been reduced, diabetes-related kidney disease has been cut by more than half, and primary prevention and weight management programs for Native youth have increased. This success is because communities design and implement diabetes interventions that address locally identified community needs.



# Surprise Billing

- Bipartisan push to address surprise medical bills in both House and Senate
  - **Surprise billing legislation is also the current vehicle for SDPI renewal**
- House Energy and Commerce and Senate Health, Education, Labor, and Pensions are the two committees of jurisdiction
  - Committee leaders in both chambers prefer establishing a methodology for median in-network reimbursement
    - This approach shown to reduce deficit by \$25 billion over 10 years
- However, bipartisan resistance to median rate approach among rank and file members is threatening to derail the package
  - Some rank and file prefer an arbitration model
    - Leaked CBO estimates show that arbitration may increase deficit by \$1 billion
- **CRITICAL:** If arbitration were to get a leg-up, it would likely take away the cost savings necessary to renew SDPI and other extenders



# Surprise Billing

## Senate:

- HELP Committee passed **S. 1895 – Lower Health Care Costs Act** –requires establishment of a benchmark rate (median in-network) by geographic area for reimbursing providers/facilities
  - Applies to emergency, non-emergency, and air ambulance services (including diagnostic/lab services)
  - Patient only pays in-network share of copay/deductible (no patient balance billing)
- Requires HHS Secretary to, through rulemaking, establish methodology for calculating the median rate
- Establishes a \$10,000 penalty for providers/facilities that charge patients more than their in-network copay/deductible, or fail to notify and obtain consent of patient after they've been stabilized (emergency) for out-of-network services
- Does not preempt state surprise billing laws



# Surprise Billing

## House:

- Energy & Commerce Committee passed **No Surprises Act** which requires establishment of a benchmark rate (median in-network) by geographic area
- Applies to emergency and non-emergency services (including diagnostic/lab services)
  - Patient only pays in-network share of copay/deductible (no patient balance billing)
  - House bill requires the median rate to be adjusted every year based on CPI
- Requires HHS and Labor Secretary to, through rulemaking, establish methodology for calculating median rate by July 1, 2020
- Requires health plans to:
  - Update provider directory info every 90 days
  - Respond to patient queries about in-network providers within 1 business day
  - Establish a public database that lists their in-network providers
- Requires States to enforce compliance with law; if states fail, Secretary can intervene and impose the \$10,000 penalty
- Does not preempt state surprise billing laws



# Surprise Billing – Surprise!

## House:

- Rep. Ruiz (D-CA) & Rep. Bucshon (R-IN) arbitration amendment passed E&C Committee
- Requires HHS and Labor Secretary to establish, through rulemaking, a process for an independent dispute resolution backstop in cases where the median in-network rate **exceeds** \$1,250
  - IDR claim must be made within 30 days of receipt of payment
- Amendment was included after Rep. Ruiz threatened a revolt & introduced entirely separate surprise billing legislation modeled off New York state law
- Insurers & lobbyists slammed the amendment, provider/hospital advocacy groups lauded it



# Medicaid Legislative Initiative

1. Allow states to extend Medicaid eligibility to all AI/ANs under 138% of the federal poverty level.
2. Authorize all providers in Indian health system to receive Medicaid reimbursement for services authorized under IHCIA.
3. Extend 100% FMAP to Medicaid services furnished by Urban Indian providers to AI/ANs.
4. Establish restrictions on state Medicaid waiver authorities to protect Indian-specific provisions within federal Medicaid law
5. Address the “four walls” limitations on IHCP “clinic” services by removing restriction prohibiting billing for services provided outside a clinic facility.



# Medicaid Legislative Initiative

- Seeking Senate Republican Lead on Finance committee
  - Daines (MT), Thune (SD), Enzi (WY), Roberts (KS), Lankford (OK)?
- Resolutions of Support from Area Indian Health Boards and Tribal Nations
  - Cortez Masto (NV) interested in being lead in Senate
  - Lujan (NM) lead in House
- NIHB has met with Senate Finance Committee and numerous congressional offices to build support
  - Arranging meeting with external stakeholders (Families USA, National Health Law Center, Center on Budget and Policy Priorities)



# Broken Promises Report and Legislation

- December 2018 report from U.S. Commission on Civil Rights detailing “Broken Promises” of federal government to Tribal Nations and Native Peoples
  - Report is in follow-up to 2003 “Quiet Crisis” report
- Highlights continued abrogation of Treaty and Trust obligations across wide swath of policy areas, with health being one of them
- Offices of Senator Elizabeth Warren (D-MA) and Representative Deb Haaland (D-NM) have requested the feedback of NIHB and other national Tribal orgs on legislation addressing the findings of “Broken Promises” report



# Broken Promises Report and Legislation

- Legislative Proposal from Senator Warren/Rep Haaland released in early August, 2019
  - Originally intended to release formal draft legislation – ultimately chose a more measured and collaborative approach after feedback from Tribes and Tribal organizations including NIHB
- Current proposal includes many outstanding Tribal health priorities including:
  - Advance appropriations of Indian programs
  - Full funding and mandatory appropriations for IHS
  - Public health infrastructure development
  - 10-year reauthorization and needs-based funding for Special Diabetes Program for Indians



# Native Health Priorities at VA



- Working with House VA Committee on legislation -
  - Exempting Native Veterans from copays and deductibles in the VA system;
  - Including Tribal Nursing Homes in definition of U.S.C. that outlines Veterans' benefits;
  - Clarifying the VA's reimbursement requirement to the IHS for Purchase Referred Care (PRC) services.



# VA Tribal Advisory Committee Act

- S. 524 introduced in February
  - Tester (D-MT), Sullivan (R-AK), Udall (D-NM), Murkowski (R-AK)
  - House companion bill H.R. 2791
- Introduced last year in different form, current bill more strongly reflects NIHB's asks:
  - 15 members– one from each IHS area + 3 at large
  - ½ of VA TAC membership is comprised of Native Veterans
  - Subcommittee membership extended to Technical Advisors
  - Provides recommendations to VA on Native Veteran issues, including behavioral health challenges
  - Bi-annual Committee reports to Congress on activities
- Replicates the success of TTAG and other committees that have been created by HHS



# Tribal Oral Health Initiative



- Coordinated **Dental Therapy Advocacy with Tribes at State Level**
  - Oneida Nation of WI and Intertribal Council of AZ
- Offered **Technical Assistance to Tribal partners in California, Nevada, and Wisconsin**
- Continued **coordination of National Partnership for Dental Therapy with non Tribal organizations**
  - [www.dentaltherapy.org](http://www.dentaltherapy.org)
- Created **Stories from Indian Country: Oral Health at the Fort Peck Reservation**
  - THANK YOU, Councilwoman Walette and Ft. Peck community members!



## Stories from Indian Country: Oral Health on the Fort Peck Reservation

### Introduction

The National Indian Health Board's (NIHB's) Tribal Oral Health Initiative is committed to elevating the oral health needs of American Indians and Alaska Natives and pays particular care to the needs of more vulnerable groups. On June 17, 2019, the National Indian Health Board (NIHB) hosted discussion groups on the Fort Peck Reservation with community members to discuss oral health and access to oral health care. Specifically, NIHB wanted to hear from youth and elders about their opinions and experiences. These two groups are often the most underserved by the current oral health care system, and much need has been identified around reducing barriers to care and incorporating generation specific solutions. This brief captures some of what was shared with NIHB staff during those groups and highlights some important health care needs in Indian Country.

The Fort Peck Indian Reservation covers an area approximately 80 miles long and 40 miles wide. It is one of seven reservations in the state of Montana, and is home to the Fort Peck Tribes of Sioux and Assiniboine people. There are approximately 12,000 enrolled Tribal citizens, of whom approximately 6,000 reside on or near the reservation. The total population of the reservation is about 10,250 people, and the IHS User Population is approximately 8,400 people.



*The Fort Peck Reservation covers a large expanse in a rural part of Montana.*

As in many other Tribes, Fort Peck's oral health care network is chronically underfunded by the federal government. The dental clinics on the reservation are in Poplar and in Wolf Point, the reservation's largest town. The clinics make dental appointments on a monthly basis beginning on the first day of that month. The appointment slots are booked very quickly, and participants in the discussion groups said that people can wait from six months to one year for a dental appointment.



National  
Partnership *for*  
Dental Therapy

National Indian  
Health Board



# What Else?

- What is happening in your community that requires a national solution?
- Does your Tribe have a health problem that Congress can fix?
- NIHB exists to fight for the Tribes!



# Thank you!

Shervin Aazami, [saazami@nihb.org](mailto:saazami@nihb.org)

Brett Weber, [bweber@nihb.org](mailto:bweber@nihb.org)

National Indian  
Health Board



National Indian  
Health Board

