Good Morning Chairman Calvert, Ranking Member McCollum, and Subcommittee Members: My name is Dr. Shaquita Bell, and I am here today on behalf of the American Academy of Pediatrics, which represents 64,000 pediatricians around the country. I serve on the AAP's Committee on Native American Child Health, a group of leading national experts on this issue. In addition to my role within the AAP, I am a practicing pediatrician at Seattle Children's Hospital, and a Clinical Associate Professor in the University of Washington School of Medicine's Department of Pediatrics. Through my work at the Odessa Brown Children's Clinic a Community health clinic, I work closely with the Seattle Indian Health Board in helping care for their child patient population.

I am extremely grateful for the opportunity to testify today on behalf of the AAP to discuss the critical importance of federal investment in American Indian and Alaska Native (AI/AN) child health. For 50 years, the AAP has formally conducted work on AI/AN child health. Our commitment to these issues is embodied in the work that we do through a contract with the Indian Health Service (IHS). Each year, our Committee conducts annual site visits to review all aspects of child health services and public health programs at four sites in a different IHS Area. Our experts provide immediate technical assistance to sites to support improved care, working closely with Tribal and IHS facility leadership and child health staff. In addition, we provide guidance to IHS on facilities' model programs that the Agency can promote and disseminate, and the key challenges they face.

Most recently, I led a team up to Minneapolis to visit the Minneapolis Indian Health Board (MIHB). This was a particularly moving experience for me. I am Cherokee, and as a youth, I lived in the nearby community of Little Earth, and I myself received care at MIHB. Returning home, it was tough to see some of the serious challenges my community faces, such as rising incidence of neonatal abstinence syndrome. However, it was also inspiring to see the critical work MIHB continues to do to better the lives of the community. This includes a model behavioral health program that is culturally competent and trauma-informed, as well as a strong tobacco cessation clinic to reduce high smoking rates. Wherever we travel across the country, this is the story in Native communities; serious challenges, but also inexhaustible and committed people who are making a major difference in the lives of those for whom they care. Any of those children may one day take my place in this very seat. This energy and hope drives the work I do, and is what brings me here today.

We appreciate that through a constrained fiscal environment this Subcommittee has continued to recognize the importance of investing in the IHS and other programs serving the needs of AI/AN children. However, at current funding levels there is still significant unmet need, and the health disparities Native children face represent a crisis we must address. Even with the increases in the President's proposed IHS budget, the Agency will still fall significantly short of meeting the health needs of its patient population. The AAP urges the Subcommittee to maintain its commitment to AI/AN child health needs in FY 2017 with strong investments in the IHS, including the provision of at least the $5.185 billion in President Obama's proposed budget.

Challenges to the Provision of Care to AI/AN Children: We know that Native children face substantial health disparities, many of which are rooted in social determinants of health that stem from the historical trauma Native communities have faced throughout our history. Poverty, alcoholism, substance abuse, chronic illness, child abuse, and other poor health and social conditions are the symptoms of these underlying health crises in Native communities, not the cause of them. In medical terms these are the preventable diseases that we can intervene on. We

know that children thrive when they have safe, stable, and nurturing relationships with the adults in their lives. It is essential that public policy support Native children by providing access to services to meet their health and developmental needs. We must also endeavor to lift children and their families out of poverty to support their lifelong health.

I see the health crises that arise from these social conditions firsthand. As an inpatient attending physician, I had the heartbreaking experience of caring for a 16 year old who overdosed on heroin. As a pediatrician, I never anticipated that my job would require expertise in managing drug overdoses and certainly not that young. In caring for Native children, we face these challenges in an environment of extreme resource scarcity. Medical and public health professionals are doing amazing work to improve the health of Native children and their families. I would like to share with you some stories about my own patients that illustrate the impact of high-quality health services, and the need to provide robust resources to support the work my colleagues and I are able to do.

Success in Serving AI/AN Children*:* I recently saw a three-year-old Native patient of mine who has made tremendous progress from her initial health challenges. Her parents provided the best they could for her after she was born, but were so impoverished that she was sleeping with them on a mattress in a one-bedroom apartment that they shared with six other people. She ate whatever her family could afford. When she first came to me at 2 years old, she was malnourished and developmentally delayed; she could not walk, talk, or feed herself. Her parents did not have health coverage, but gained it through Affordable Care Act and were able to access care for their daughter. We were able to get her specialty care and assistive ambulatory devices to help her walk. My clinic has a federal grant allowing us to provide patients like her with prescriptions for fresh produce through the Supplemental Nutrition Assistance Program (SNAP), which doubles the value of their benefit to facilitate nutritious eating. Access to coordinated health and social services has created major improvements in her health and wellbeing in just one year.

I have another patient for whom I care, in coordination with SIHB. He could walk, but at two years old had not yet started to talk. Through SIHB and their United Indians of All Tribes programs he has been able to access speech and occupational therapy services. Now I can't get a word in edgewise during our visits! A crucial component of these services is that they are provided in the home. This prevents the need for transportation and additional time off from work and school. But even more importantly, it allows therapists to teach children and families the skills they need in the environment in which they will actually use them, making them practically applicable and easy to implement.

I share these stories to demonstrate that despite the many challenges facing the Native children I and my colleagues care for, there are opportunities to support their health and wellbeing and ensure they can thrive. We already know what works, we just need to do more to support it.

FY 2017 Appropriations: The AAP supports the provision of at least the IHS funding requests outlined in the President's proposed FY 2017 budget, which would provide $5.185 billion in discretionary authority to IHS. The proposed $377 million increase above the FY 2016 enacted level is an important increase, but as we all well know it still leaves substantial unmet need in the Agency's ability to meet the health needs of those for whom it cares, particularly children. While we are aware of the constrained fiscal environment in which you operate, we urge the

Subcommittee to provide robust increased funding to IHS to support the health needs of Native children. I will also highlight key programs and policies that the AAP supports to improve Native children's health.

Youth Suicide Prevention

Native youth suicide is a health crisis that I am passionate about addressing. I serve on the King County Child Death Review Committee, and I have personally reviewed dozens of youth suicide cases. It is so painful to see after the fact that the young people who seemed like the life of the party on the outside were struggling with unmet mental health needs on the inside that led them to take their lives. Youth suicide is a crisis we can prevent, and the AAP strongly supports the Administration's proposals to address youth suicide, including the $3.6 million for the Zero Suicide Initiative and $15 million to expand the Substance Use and Suicide Prevention Program. While these are by no means a panacea, they represent important efforts to support the mental health needs of Native youth.

Advance Appropriations for IHS: Given the critical nature of the work IHS does, its significant impact on Native children, and the unique federal trust responsibility underlying this work, the AAP strongly supports the provision of advance appropriations to IHS. Advance appropriations would also enable IHS to augment the value of its funding through longer term planning, improved budgeting, and better contracting options. These improvements would benefit children through better health service delivery and more cost-effective public health programming. Advance appropriations would enable IHS to better recruit and retain pediatric health care providers. This policy would generate important child health benefits without additional cost to the federal government, as demonstrated by the Veterans Health Administration since 2009.

IHS Workforce Recruitment and Retention: Effective recruitment and retention programming is central to ensuring IHS has the workforce necessary to meet the health needs of Native children. I teach and mentor Native students at the University of Washington interested in practicing pediatrics. The burden of student loan debt is a clear and compelling factor in the decisions they make. We were extremely pleased to see that the IHS budget proposal would make the Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program tax exempt. Doing so would bring the status of these programs in line with the National Health Service Corps and Armed Services Health Professions scholarships. We urge you to fully fund these programs and to support their tax exemption. There are nearly 1,500 health professionals vacancies in IHS, indicating significant unmet need. With a budget impact of only $11 million, this policy offers a high-value outcome at a low cost. [i]

The federal government has done a tremendous job making education available to Native students. To build upon this success, we suggest further efforts to work with educational institutions to ensure that their student bodies accurately reflect the patient populations they serve. Federal funding to educational institutions offers important opportunities to ensure that our medical schools are intentional in building a diverse next generation of health care providers.

100% FMAP: The AAP strongly supports the new U.S. Centers for Medicare and Medicaid Services (CMS) policy to expand 100 percent Federal Medical Assistance Percentage (FMAP) eligibility for providers caring for AI/AN individuals. This policy will: enable Urban Indian Health Programs access to needed higher reimbursement rates; expand access to transportation

services; and provide flexibility to allow optimal billing arrangements for specialty care. Working frequently with the fantastic providers at SIHB, I know firsthand how important Urban Indian Health Programs are. Urban Indian children are at increased risk for serious mental health and substance abuse issues, suicide, gang activity, teen pregnancy, and maltreatment. Disrupted ties to familial and traditional cultural environments, elders and their ceremonies, have an additional impact on the support structures available to children to mediate these health risks.[ii] For these reasons, we also support the measure in the President's proposed budget to expressly extend 100 percent FMAP to Urban Indian Health Programs. Improved reimbursement will make this critical network of community providers more sustainable and support their important child health services. This is critical since over 70% of AI/AN individuals live in urban areas.

Purchased and Referred Care: Purchased and Referred Care (PRC) is a critical component of the federal trust responsibility to provide health care for Native Americans. These funds ensure access to services not otherwise available at IHS/Tribal/Urban Indian (I/T/U) programs. However, the funds within PRC are consistently inadequate to meet the need for services. Once PRC funding is expended in a given fiscal year, there are no remaining funds for Native children and their families to access services. Limited funds make many services from which Native children would benefit, including behavioral health services, unavailable within PRC. When I worked at Lame Deer, I sat in on a difficult meeting where their leadership had to decide whether to use their entire PRC budget to save one elder's life with a surgical procedure. Access to care for Native children is critical. This is especially true for those with disabilities, who face higher risks for poor outcomes than non-Native children with disabilities.

Given the need to maximize the purchasing power of federal government dollars under PRC, the AAP strongly supports the implementation of Medicare-like rates for PRC, including for all physician and other health care professional services and non-hospital-based services. Harmonizing PRC payment with Medicare rates will improve the capacity of the PRC program and improve access to care for children, particularly for specialty care. The U.S. Government Accountability Office (GAO) has determined that the IHS PRC program would have saved $32 million in 2010 just on physician services through the use of Medicare payment methods.[iii] Such a policy must not reduce children's access to needed health services, and therefore we also believe that any such policy must include exceptions that take geography and the availability of specialty care into account. We also urge you to fully fund the PRC program in FY 2017.

Conclusion: Thank you again for the opportunity to provide public comment today on the important issue of AI/AN child health needs. Native children need the important health services and public health programs funded through IHS. While there are challenges to improving AI/AN child health, it is clear that there are many successful examples of ways to do so that are cost-effective. We thank you again for your ongoing commitment to Native communities and families like my own, and urge you to provide the funding necessary to meet the health needs of AI/AN children. I would be happy to answer any questions that you may have for me.

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[i] Department of Health and Human Services. *Fiscal Year 2017 Justification of Estimates for Appropriations Committees- Indian Health Service*. January 11, 2016. Retrieved from https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2017CongressionalJustification.pdf

[ii] U.S. Department of Health and Human Services Indian Health Service (2015). Urban Indian Health Program Fact Sheet. Retrieved from https://www.ihs.gov/newsroom/factsheets/uihp/

[iii] U.S. Government Accountability Office. *Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*. Report to Congressional Addressees. April 2013. GAO-13-272.