National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
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HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON LABOR, HHS, EDUCATION
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Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board (NIHB) and the 566 federally recognized Tribes we serve, I submit this testimony on FY 2016 budget for the Department of Health and Human Services (HHS). The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace.[1]

Devastating consequences from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indians and Alaska Natives (AI/ANs) have a life expectancy 4.2 years less than other Americans[2] and suffer significantly higher mortality rates from suicide, type 2 diabetes, and heart disease than other Americans. According to CDC data, 45.9 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. AI/AN children have an average of six decayed teeth, when other US children have only one. These health statistics are no surprise when you compare the per capita spending of the IHS and other federal health care programs. In 2014, the IHS per capita expenditures for patient health services were just $3,107, compared to $8,097 per person for health care spending nationally.

While IHS is the primary agency providing health care delivery for AI/ANs, the federal trust responsibility is the responsibility of all government agencies, including other departments within HHS. During the last several years, Tribes have developed a strong working relationship with HHS leadership and its agencies. While these

[1] The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people. In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to AI/ANs, declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." (Indian Health Care Improvement Act, §103(2009).)

[2] On some reservations, life expectancy is over ***20 years less*** than that of the general population.

conversations are frequently productive, much remains to be done as Tribes are consistently left-out of key funding opportunities. The reasons for this are multi-faceted. For example, many Tribal communities do not meet stringent eligibility criteria for certain federal grants or do not have the staff or capacity to write grant applications that are competitive with state agencies or large universities. NIHB respectfully asks this committee to consider using the appropriations process to develop Tribal "set-asides" at HHS in order to ensure that the First People of this nation receive a fair share of the grants coming from agencies across HHS.

NIHB also supports Tribal requests to expand Tribal Self-Governance to agencies at HHS beyond the IHS. A 2003 study done by the agency determined this was feasible. The Obama Administration reopened this dialogue with Tribes and convened a workgroup to discuss this further. The workgroup determined self-governance expansion was feasible but that legislation would be needed to move forward with expanding self-governance at HHS. Tribes are eager to work with HHS on the development of a legislative proposal that would expand self-governance. For many Tribes, the choice to self-govern ensures efficiency, accountability and best practices in managing and operating Tribal programs and administering federal funds at the local level. For FY 2016, we request that the Committee direct the HHS to reconvene the Self-Governance Tribal Federal Workgroup in order to develop legislative language that would expand self-governance within HHS.

Center for Disease Control and Prevention (CDC): The CDC leadership has made important gains in fostering communication between agency and Tribal leaders and, as a result, the agency has been more responsive to the Tribes. However, these improvements have not had a big impact on funding decisions at the agency. For example, the CDC has funded organizations in the past specifically to work with American Indian and Alaska Native communities on HIV prevention, and this funding has helped to establish and re-affirm national leaders in HIV prevention, care and treatment in Indian Country. However, during the last round of funding for five-year grants, CDC did not fund *any* AI/AN-specific organization to provide support or capacity building.[3] We

[3] See: PS14-1403, "Capacity Building Assistance for High-Impact HIV Prevention." This failure to fund Tribal organizations is especially troubling when considering the rates of HIV incidence in American Indian and Alaska Native communities has continued to rise over the past decade while the rates have fallen in other communities.

respectfully request that the Committee use its authority to ensure that Tribes and Tribal organizations are receiving important capacity building funding streams.

The CDC puts forth significant funds to support data and surveillance activities, but only at the state and national level. The CDC has done little to invest in a surveillance system that honors Tribal sovereignty, successfully navigates jurisdictional competition, and supports respectful and reliable data collection methods. *Tribal Epidemiology Centers (TECs)* work in partnership with the area Tribes to improve the health and well-being of their Tribal community members by offering culturally-competent approaches that work toward eliminating health disparities that are experienced by AI/AN populations. The CDC, as written into the Indian Health Care Improvement Act,[4] has an obligation to support TECs in their role as public health authorities to the Tribes in their areas. CDC is the most appropriate agency to support these centers. TECs are already nominally funded at approximately $360,000 each year by the Indian Health Service. CDC should use its authority to support TECs through specific funding streams and request that CDC fund TECs directly, as CDC does for all 50 states.

The Administration has not requested any additional funding for the CDC's unintentional injury program in the FY 2016 request. This is problematic for Tribes, as unintentional injury is the third leading cause of death among AI/AN people and we experience injury mortality rates that are ***2.4 times greater*** than other Americans. Opportunities to expand these prevention efforts into Indian Country will be severely limited by flat funding. Congress should allocate a funding stream dedicated to Tribes for motor vehicle accident prevention and this funding should **not** be a component of a state plan or state grant.

Substance Abuse and Mental Health Services Administration (SAMHSA): Mental and behavioral health issues are among some of the most serious issues experienced by Tribal communities. AI/ANs struggle with complex behavioral health issues at significantly higher rates than other Americans. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved

[4] 25 U.S.C. § 1621q

historical and generational trauma.[5] Native youth experience suicide at rates 2.5 times the national average, with suicide the second leading cause of death for AI/AN youth. This disproportionate burden of mental health issues is further complicated by the fact that many Tribal communities lack access to quality mental health care.

Tribal Behavioral Health Grants ("Native Connections") are critical to improving mental health in Indian Country. According to SAMHSA, the goal of this program is to "reduce the impact of substance abuse, mental illness, and trauma on AI/AN communities through a public health approach." These are competitive grants designed to target Tribal entities with the highest rates of suicide per capita over the last 10 years. The FY 2016 request includes a $25 million increase for this program for a total of $30 million. This investment is critical; the seriousness of mental health and substance abuse issues in Indian Country cannot be exaggerated. NIHB and Tribes recommend funding this program at $50 million for FY 2016 to address this crisis in Indian Country.

Tribes encourage the Committee to provide oversight to ensure that mental health and substance abuse funds are coordinated across agencies. Tribes have asked that the Administration develop a plan of action, led by HHS, which will demonstrate how programs for mental health and substance abuse serving AI/ANs are coordinated across agencies. SAMHSA leadership has responded that they will pursue this effort, and we look forward to working with them to carry this out in order to improve and increase coordination for mental health services across government agencies. NIHB recommends that the Committee request that HHS provide a report on what it is doing to coordinate treatment for mental and behavioral health across federal agencies.

NIHB also supports the *Circles of Care* program at SAMHSA. Circles of Care is designed to help Tribal communities plan and develop programs to model for children with mental health challenges and their families. It is the only other program outside the Tribal Behavioral Health Grants that allows Tribes and Tribal organizations to apply for funding without competing with other governmental entities. There are currently 11 Tribal entities

[5] Brave Heart, Maria Yellow Horse; DeBruyn, Lemyra M. "The American Indian Holocaust: Healing Historical Unresolved Grief." *American Indian and Alaska Native Mental Health Research,* v8 n2 p60-82 1998.

with Circles of Care funding. We recommend increasing funding to $8.5 million to ensure that more Tribes have access to this critical program.

Center for Medicare and Medicaid Services: NIHB would like to reiterate its request from FY 2015 for the Committee to streamline *the definition of Indian in the Affordable Care Act (ACA).* The law's definitions require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act corporation in order to receive certain benefits and protections under the law including monthly enrollment periods, cost-sharing protections and an exemption from the individual mandate.[6] These definitions are narrower than those used by IHS and CMS, thereby leaving out a sizeable population of AI/ANs that the ACA was intended to benefit and protect. NIHB is grateful for the language contained in the FY 2015 Explanatory Statement that requested that CMS and the Internal Revenue Service write a report detailing these varying definitions. We believe that CMS and IRS also have the authority to adjust this through regulatory means and respectfully request that the Committee clarify Congressional intent on this matter. Failure to clarify these definitions will result in a class of "sometimes Indians" who are eligible for certain services but not others, thereby creating confusion and inconsistent application of federal benefits for AI/ANs.

Tribes have also made numerous requests of CMS for several other ACA-specific implementation issues. NIHB and Tribes have requested that the agency provide AI/AN-specific staffing at Health Insurance Marketplace call centers. This would allow an individual to speak with someone that is familiar with not only the AI/AN benefits under the ACA, but also the Indian health system, leading to less confusion and increased access to health services for AI/ANs. NIHB would appreciate assistance from the Committee to address that request.

Thank you for the opportunity to offer this statement. We look forward to working with the Appropriations Committee as Congress considers FY 2016 Appropriations. If you have any questions, please do not hesitate to contact the National Indian Health Board.

[6] In June 2013, HHS did issue a "Hardship Exemption" for these individuals from the individual insurance mandate.