National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
VICTORIA KITCHEYAN, GREAT PLAINS AREA REPRESENTATIVE
HOUSE APPROPRIATIONS COMMITTEE - SUBCOMMITTEE ON LABOR, HHS, EDUCATION AND RELATED AGENCIES
FY 2018 APPROPRIATIONS TESTIMONY – MARCH 8, 2017

Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee, thank you for the opportunity to offer this testimony. On behalf of the National Indian Health Board (NIHB) and the 567 Tribal Nations we serve, I submit this testimony on FY 2018 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] In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives (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." [2]

Today, however, the federal government has not done its part to live up to the responsibility to provide adequate health services to AI/ANs. Though the Indian Health Service (IHS) was founded in 1955 to help the federal government fulfill the trust responsibility for health, Congress has never provided IHS with enough funding to meet the needs of Indian Country. As a result of this underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer some of the worst health disparities. AI/ANs live 4.5 years less than other Americans, but in some states life expectancy is 20 years less. Suicide rates for AI/ANs are four times higher than the national average and suicide is the second leading cause of death for Tribal youth between the ages of 15 to 24.[3] AI/AN populations are also approximately twice as likely to die of alcohol-related causes than the general population.[4] According to CDC data, 45.4 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. American Indian / Alaska Native children have an average of six decayed teeth, when other US children have only one.[5]

But, the obligation to provide healthcare to AI/ANs does not extend only to the IHS. The federal trust responsibility is the responsibility of all government agencies, including others within HHS.

---

[1] The Snyder Act of 1921 (25 U.S.C. 13) legislatively affirmed this trust responsibility.

[2] 25 U.S.C. 1602

[3] United States. Department of Health and Human Services, Indian Health Service. (n.d.). Trends in Indian health, 2002-2003. Rockville, MD: Indian Health Service

[4] Centers for Disease Control and Prevention. (2008). Alcohol-attributable deaths and years of potential life lost among American Indians and Alaska Natives—United States, 2001-2005. MMWR. Morbidity and Mortality Weekly Reports. Available online at: https://www.cds.gov/mmwr/preview/mmwrhtml/mm5734a3.htm

[5] Indian Health Service FY 2016 Budget Request to Congress, p. 78.

Agencies like the Centers for Disease Control and Prevention (CDC); Substance Abuse and Mental Health Services Administration (SAMHSA); and Centers for Medicare and Medicaid Services (CMS) all must play a crucial role in ensuring that Indian Country receives both preventative and direct access to health services.

NIHB would first like to thank the subcommittee for the work it has done to increase the profile of AI/AN issues over the last several years. Addressing AI/AN concerns directly with agency leaders and including Indian-specific report language to the FY 2017 committee report have been enormously helpful as we work with the agencies to improve the health status of AI/ANs. For example, NIHB has long-advocated for a Hepatitis C program targeted at Indian country and we were pleased to see that as a priority last year. We are also very encouraged by the continuous direction to CDC to provide a more comprehensive public health infrastructure in Tribal communities. Commitment to improving mental health services in Tribal communities through Tribal Behavioral Health Grants, Garrett Lee Smith Grants and the Zero Suicide Prevention Initiative is critical in ensuring that that AI/ANs receive access to these services. Again, thank you for your steadfast commitment to these issues.

However, there is much work to be done so that AI/ANs can enjoy the same type of public health system and services available to other Americans. Generally speaking, Tribal health systems are simply left out of many funding streams within HHS for a variety of reasons. Federal block grants flow to states, leaving little opportunity for Tribal governments to receive this funding. Tribes are eligible to apply for many other federal grants that address public health and other issues, however, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to apply for the grants.

Centers for Disease Control and Prevention

Preventive Health and Health Services (PHHS) Block Grant: Public health infrastructure in Indian Country is one of the most severely underfunded and under developed areas of the health service delivery system. Like state and territorial governments, Tribes have both the rights and responsibilities to provide vital public health services for their communities. To do this, they must also have the tools to carry out these functions. Currently, Tribes are regularly left out of state- run public health programs and simultaneously, are routinely overlooked by federal agencies during funding decisions for public health initiatives. Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Without a local tax base and with little outside funding, Tribal communities are often the most in need of public health dollars.

During the country's establishment of its public health infrastructure, Tribes and Tribal communities were largely left behind. Most of the health disparities Tribal communities currently face—such as obesity, diabetes, heart disease, and cancer—are largely preventable chronic conditions. Treating these chronic health conditions imposes unnecessary challenges on Tribal health systems and the Indian Health Service (IHS). For example, a 2012 study indicated that the 10.9% of AI/ANs with diabetes accounted for 37.0% of all adult treatment costs for IHS.[1] Investing

[1] Joan M. O'Connell, Charlton Wilson, Spero M. Manson, Kelly J. Acton

in Tribal public health improves the potential for healthy AI/AN communities and reduces the prevalence of chronic health conditions, which results in significant cost savings. Federal investments in Tribal public health also furthers the federal government's fulfillment of its trust responsibility to Tribes.

Establishing Tribal-specific funding streams, scaled for impact, will allow Tribes to secure needed funding and design and implement public health programs that meet the specific needs of their Tribal citizens. In cases where federal funding is restricted to states, those federal funding agencies should require states to report out their efforts to meaningfully engage with Tribes before and after funding is awarded, to ensure that the intended benefits reach Tribal populations. Therefore, NIHB requests that, in FY 2018, ***Congress create base funding for Tribal communities through the PHHS grant program by allocating at least 5 percent to Indian Tribes directly, annually.*** This will enable public health systems in Indian Country to access consistent, sustainable, public health infrastructure dollars so that Tribal communities can begin to catch up to other Americans when it comes to public health.

Public Health Emergency Preparedness: The Public Health Emergency Preparedness (PHEP) Cooperative Agreements at CDC provide base funding to states, territories and major cities to upgrade their ability to respond to a public health crises. But again, Tribal communities do not receive this funding directly, and few, if any, see any support from their state programs. Many Tribal reservations reach across state boundaries, and some occupy land areas larger than many states. Without federally-supported infrastructure support for prevention and response to natural disasters or pandemics in Indian Country, the impacts on American Indians and Alaska Natives (and others) could be enormous. Furthermore, failure to fund Tribal communities and reservations could mean that large land areas of this country are not covered for emergency infrastructure support, causing a domino effect throughout the rest of the nation when it comes to pandemics or natural disasters. ***NIHB requests that Congress direct 5% of PHEP funds to Tribes so that they can develop comprehensive and achievable response plans for public health crises.***

Substance Abuse and Mental Health Services Administration

Nowhere is the issue of lack of solid infrastructure support more acute than when it comes to mental and behavioral health services. AI/AN children and 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, leading to contemporary trauma.[6] Where Tribal reclamation of these systems has been possible, it has led to effective service systems designed and implemented, by and for AI/AN people, to promote cultural strength and healing. These Tribal systems have already begun to resolve the trauma left behind by federal policies and systems. But access to behavioral health services is limited. In a study of 514 IHS and Tribal facilities, 82% report providing some type of mental health service such as psychiatric services, behavioral health services, substance abuse treatment, or traditional healing practices, and to improve access 17% (87) have implemented telemedicine for mental health services.[7] However, none provide inpatient

Am J Public Health. 2012 Feb; 102(2): 301–308. Published online 2012 Feb. doi: 10.2105/AJPH.2011.300332

[6] Braveheart, M. Y. A., & DeBruyn, I. M. (1998). The American Indian Holocaust: healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research, 8*(2).

[7] Urban Indian Health Institute. (2012). Addressing depression among American Indians and Alaska Natives: A literature review. Seattle, WA: Urban Indian Health Institute.

psychiatric services.[8] Without access to care, persons in psychiatric distress often end up at the hospital emergency room.[9]

Mental Health Service Block Grant: Access to behavioral health services for AI/ANs would be improved if Tribes had access to the Mental Health Service Block Grant. Without this critical funding, comprehensive mental health services are not reaching Tribal communities, though states are awarded these funds. IHS has limited mental health funding, but has always been underfunded to provide sustained mental health infrastructure. ***Congress should dedicate funding to Tribes directly for the Mental Health Services Block Grant.***

Tribal Behavioral Health Grants and Zero Suicide: At SAMHSA, several programs specifically target Tribal communities. NIHB was pleased to see that Tribal Behavioral Health Grants (TBHG) received a substantive increase in recent years. This critical program is designed to address the high incidence of substance use and suicide among AI/AN populations and it is a vital component of ensuring that behavioral health challenges are addressed across Indian Country. In FY 2018, NIHB requests ***funding of $50 million for the TBHG program***. We also request ***funds to be appropriated for specific issues*:** namely, suicide interventions, expansion of mental health counseling capacity and infrastructure, and surveillance of and mediation for increasing levels of domestic violence.

Circles of Care: The SAMHSA Circles of Care Program offers three-year infrastructure/planning grants and seeks to eliminate mental health disparities by providing AI/AN communities with tools and resources to design and sustain their own culturally competent system of care approach for children. ***In FY 2018, we recommend increasing Circles of Care funding to $8.5 million.***

Substance Abuse Block Grant: The purpose of the SAMHSA Substance Abuse Block Grant (SABG) is to implement activities to treat and prevent substance abuse throughout the country. Few places are more seriously in need than Indian Country when it comes to these issues. Many reservations have been profoundly impacted by drug and alcohol use and in some cases hope seems elusive. Access to overdose prevention medication such as Naloxone, and medication assisted treatments (MAT) such as buprenorphine and methadone is a huge challenge for Tribes. While IHS operates Youth Regional Treatment Centers in each service delivery region, there are few inpatient centers for adults and those in treatment are often taken far from their families where support is nonexistent. However, SABG is operated by state governments, which means that Tribal communities are often left out. We recommend that the Committee allocate specific funding for SABG directly to Tribal communities so that there can be continuous, sustained funding to help address long-term substance abuse issues in Tribal communities. At the very least, Congress should require that SAMHSA require all SABG state grantees to consult directly with Tribes within their borders as a condition of participation, and prove that they are allocating funds to Tribal communities.

[8] Indian Health Service. (2011). *Inpatient mental health assessment*. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/FINAL_IHCIA_InpatientMH_Assessment_Final.pdf

[9] *Ibid*

More generally, NIHB requests that Congress provide direction to SAMHSA that would include Tribal consultation during the development of grants to ensure deliverables are culturally competent and trauma-informed. In addition, traditional healing practices should be considered fundable activities for programs administered by the agency. Traditional healing practices for behavioral health issues are critical in ensuring long-term change for AI/ANs.

Centers for Medicare and Medicaid Services

Medicaid Services for AI/ANs: While most of the appropriations for CMS move through mandatory funding, as Congress debates potential changes to the Medicaid system, it is critical that AI/ANs are protected. Over 40 years ago, Congress amended the Social Security Act to authorize Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated facilities to supplement inadequate IHS funding and as part of the federal trust responsibility to provide healthcare to American Indians and Alaska Natives. At the same time, Congress acted to ensure that States would be reimbursed at a 100 percent federal medical assistance percentage (FMAP) for Medicaid services provided to American Indians and Alaska Natives that are received through the Indian health system and that Medicaid payments to the Indian health care system are not subject to a block grant or per capita cap.

Congress must also preserve AI/AN protections, including freedom from premiums and cost sharing, prohibition of classifying trust lands and cultural and religious items as resources for eligibility purposes, and other protections. Congress must also ensure that States do not create any barriers to access to Medicaid for American Indians and Alaska Natives, such as work requirements, time limits, co-pays or usage caps. These barriers to care do not help reduce program costs, but only force AI/ANs to rely on the already underfunded IHS system meaning that they will have less access to both primary and preventative care. Furthermore, we request that the Committee provide oversight on CMS to ensure that any Medicaid waiver applications submitted are developed with significant Tribal consultation and have the full consent and approval of the Tribes in that state.

Expansion of Self-Governance at HHS

For over a decade, Tribes have been advocating for expanding self-governance authority to programs in the Department of Health and Human Services (HHS). Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. This proposal was deemed feasible by a Tribal/federal HHS workgroup in 2011. Therefore, we request that the Appropriations Committee direct HHS to enter into pilot projects for self-governance at the agency in FY 2018.

Conclusion:

Thank you again for the opportunity to offer to participate in the Public Witness Hearing for FY 2018. As noted above, the federal trust responsibility for health extends beyond the IHS to all agencies of the federal government. We thank the committee for the efforts it has put forward to prioritize this issues at the Department of Health and Human Services. While Tribes have made important gains in recent years in terms of funding, consultation and increased awareness throughout all of HHS, there is still a long way to go before health systems in Indian Country are on par with those enjoyed by other Americans. Please do not hesitate to contact our offices directly if you have any questions or if you require additional information.