Northwest Portland Area Indian Health Board
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2020 Legislative and Policy Requests

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization established under the Indian Self-Determination and Education Assistance Act (ISDEAA) that advocates on behalf of the 43 federally-recognized Tribes in Idaho, Oregon and Washington on specific health care issues. NPAIHB's delegates, appointed by each tribe, ensure that NPAIHB's mission, vision and values guide the work of the organization.

NPAIHB's mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives (AI/ANs) by supporting member tribes in the delivery of culturally appropriate, high quality health care. NPAIHB's vision is "wellness for the seventh generation." In order to achieve this vision, NPAIHB delegates respectfully ask that lawmakers and policy makers consider the following values in all legislative and policy initiatives.

Tribal Sovereignty. The government-to-government relationship and treaty and trust obligations require meaningful tribal consultation on all initiatives impacting tribes and AI/AN people. Meaningful tribal consultation involves an open exchange of information, discussion and decision-making by tribes and the federal government.

***Traditional Knowledge*.** In AI/AN communities, health and wellness involves multiple facets of life including the environment, space, and health of the earth. Conceptual framework for treating health among AI/AN people should include the dimensions of caring, traditions, respect, connection, holism, trust, and spirituality. Overall and holistic health promotion and disease prevention are core to the health and well-being of the AI/AN seventh generation and must be included in all initiatives.

Culture as Health Promotion. Cultural and traditional interventions must be incorporated alongside existing health care promotion efforts to ensure a culturally tailored and culturally relevant approach to health promotion, prevention and health care delivery for AI/AN people. Inclusion of all community members from our children to our elders will promote wellness and healing across all generations.

With these values in mind, NPAIHB makes the following legislative and policy requests:

Indian Health Service Funding

Fully Fund the Indian Health Service (IHS). IHS is significantly underfunded compared to other federal health agencies. Funding for IHS is in fulfillment of the federal government's treaty and trust obligations to tribes and promise to provide health care to AI/AN people in exchange for peace and land, among other agreements. FY 2020 IHS appropriations included only a 4% increase above FY 2019 enacted level. These small increases year-to-year are not getting IHS closer to full funding.

Recommendations:

- For FY 2021, pursuant to recommendation of National Tribal Budget Formulation Workgroup, fund IHS at $9.1 billion to get IHS up to full funding of $37.6 billion.[1]
- Ensure that annual appropriations include population growth and medical inflation rate increases to maintain current services. For FY 2021, at least $200 million should be appropriated for population growth and medical inflation above 2020.

[1] National Tribal Budget Formulation Workgroup Recommendation, *FY 2021 Summary Recommendations*, https://www.nihb.org/legislative/budget_formulation.php (last visited Jan. 15, 2020).

- Make tribes whole as to 2013 sequestration and restore the $175.7 million that was lost in IHS appropriations.

ISDEAA Section 105(l) Lease Agreements. ISDEAA section 105(l) lease agreements are a growing expense requiring IHS, upon tribal request, to enter into a lease for a facility owned or leased by a tribe or tribal organization. IHS is legally bound to enter into and pay the negotiated full lease compensation under section 105(l). IHS has no separate appropriation or funding source for 105(l) leases. For FY 2018 and FY 2019 IHS has reprogrammed services appropriations to pay for the leases. This results in lost program increases for IHS and tribal facilities that will impact their ability to maintain current services. It is anticipated that IHS will continue to reprogram program increases every year until a separate indefinite appropriation is authorized by Congress.

Recommendation:

- Establish a separate and indefinite discretionary appropriation for ISDEAA Section 105(l) lease funding.

Provide Mandatory Funding for IHS. IHS funding should not be discretionary and should be changed to "entitlement" or "mandatory spending." This would be in alignment with the federal trust and treaty obligations for health care to AI/ANs.

Recommendation:

- Congress must make IHS funding mandatory, no longer subject to the constraints of the annual discretionary appropriations process. (NPAIHB/CRIHB Joint Res 17-04-08).

Amend IHCIA to Authorize Advance Appropriations for IHS. Government shutdowns and continuing resolutions are harmful to our people and the IHS system. Continuing resolutions (CRs) have occurred every year since FY 1998 except for one year (FY 2006). CRs result in administrative challenges to IHS/tribal facilities which impact patients' access to care and the quality of care. However, the worst scenario for tribes is a government shutdown. The 35-day partial government shutdown last year reduced AI/AN access to care and caused financial harm to IHS employees. This must be prevented in the future through advance appropriations.

Recommendation:

- Congress must enact legislation that would provide advance appropriations to the Bureau of Indian Affairs and Bureau of Indian Education of the Department of the Interior and the Indian Health Service of the Department of Health and Human Services; or legislation that would provide advance appropriations to the Indian Health Service. (NPAIHB Res. No. 19-04-02)

Move the IHS Budget to the Jurisdiction of Labor, Health and Human Services, Education (LHE) and Related Agencies Subcommittee. The LHE Subcommittee handles health care related bills, and understands the complexities of health care delivery, such as medical inflationary rates. The IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, CHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The LHE Subcommittee has almost always been allocated appropriation increases that match or exceed medical inflation indexes. While the Interior Appropriations Subcommittee allocations reflect natural resource program inflation rates, which generally fall below medical inflation.

Recommendation:

- Congress should move the IHS budget from the Interior, Environment, and Related Agencies Appropriations Subcommittee to the Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee.

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Special Diabetes Program for Indians

Congress recently extended the Special Diabetes Program for Indians (SDPI) through May 22, 2020 at the current level of $150 million. Since 2004, SDPI has been funded at $150 million with no annual medical inflation increases. It is estimated that SDPI should be funded at over $234.5 million.[2] NPAIHB passed a resolution requesting permanent reauthorization of SDPI at $200 million per year with medical inflation thereafter (# 19-04-12).

In the Portland Area, 40 grantees receive funding under SDPI for diabetes treatment and prevention. These services have resulted in short-term, intermediate, and long-term positive outcomes for AI/AN in the Northwest. In addition, most Northwest Tribes have the expertise and capacity to directly manage SDPI funds and have been requesting an option to receive funds in ISDEAA Title I and Title V compacts and contracts.

Recommendations:

- Congress must permanently reauthorize SDPI at $200 million per year with medical inflation rate increases annually (NPAIHB Res. No.19-04-12); or reauthorize at $200 million for five years with medical inflation rate increases after year one.
- IHS must:
    - Provide an annual full and detailed accounting of IHS funding to headquarters and areas on SDPI funding.
    - Create the option for tribes to receive SDPI funds through Title I or Title V compacts or contracts. (NPAIHB Res. No. 19-04-12).
    - Allow areas to reallocate data infrastructure funds to Tribal Epidemiology Centers to assist tribes in managing their SDPI data.

Health Care Facility Funding

IHS Health Care Facility Construction Priority List. The 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current IHS Health Care Facilities Construction Priority List (Priority List) will not be complete until 2041. At the current rate of appropriations for construction and the replacement timeline, a new 2016 facility would not be replaced for 400 years. Many tribes and tribal organizations in the Portland Area have had to assume substantial debt to build or renovate clinics for AI/AN people to receive IHS-funded health care. In addition, Portland Area Tribes are a decade or two from receiving any funds under the Priority List. Until this funding mechanism is changed, NPAIHB does not support appropriations for IHS Health Care Facilities Construction.

Recommendations:

- Congress must fund the Indian Health Facilities account in the IHS budget to provide construction, repair and improvement, equipment, and environmental health and facilities support for all IHS Areas equitably, and for tribal governments through self-determination contracts and self-governance compacts. (NPAIHB/CRIHB Joint Res No. 17-04-12)

Regional Referral Specialty Care Centers. The Portland Area Facilities Advisory Committee (PAFAC) completed a pilot study in 2009 to evaluate the feasibility of regional referral centers in the IHS system. PAFAC recommends that the first specialty referral center be constructed as a demonstration project under Section 143 in the IHCIA.

[2] According to the U.S. Bureau of Labor Statistics average prices for medical care increased by 56.3% from 2004-2018 due to medical inflation

The facility would provide services such as medical and surgical specialty care, specialty dental care, audiology, physical and occupational therapy as well as advanced imaging, and outpatient surgery. It is anticipated that this facility could provide services for approximately 50,000 users within the regional service area as well as an additional 20,000 in telemedicine consults.

Recommendation:

- Congress must appropriate funding to demonstration projects under Section 143 so that Portland Area Tribes can move towards establishing a Regional Referral Specialty Care Center.

Small Ambulatory Grants Program and Joint Venture Funding. The Small Ambulatory Grants Program (SAP), IHCIA Section 305, provides funding for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. In the Portland Area, this could mean replacing old, worn out trailers that serve as the health clinics in tribal communities with a small modern clinic facility. However, funding under SAP does not include staffing packages.

Joint venture, under ICHIA Section 818, authorizes IHS to partner with tribes or tribal organizations on health care facility construction projects. Through this program, tribes or tribal organizations are able acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years. Tribes must use tribal, private or other available (non-IHS) funds to design and construct the facility. IHS then submits requests to Congress for funding for the staffing, operations, and maintenance of a facility pursuant to joint venture agreement requirements.

Recommendations:

- Congress must increase funding for Small Ambulatory Program Grants to support new facilities construction and include funding for staffing packages.
- Congress must increase funding for joint venture projects.

Patient Protection and Affordable Care Act / Indian Health Care Improvement Act

The Patient Protection and Affordable Care Act (ACA) has provided an incredible opportunity for increased access to health insurance for tribal members in our area. Increased access has improved the health outcomes of many AI/AN, while the increase of third-party revenue to IHS and tribal facilities (I/T) has expanded programs and services at I/Ts. There are also several important Indian-specific provisions in the ACA that are critical to the Indian health system. Section 2901(b) ensures that IHS, tribal and urban Indian programs (I/T/Us) are the payers of last resort; Section 2901(c) simplifies eligibility determinations for AI/AN enrolling in CHIP when seeking services from Indian providers; Section 2902 authorizes I/T/Us reimbursement for Medicare Part B services; and Title IX, Section 9021 ensures that health benefits provided by a tribe to tribal members are not counted as taxable income.

Threats to the ACA are concerning to tribes because of the permanent authorization of the Indian Health Care Improvement Act (ICHIA) with the ACA. IHCIA has improved workforce development and recruitment of health professionals, provided new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs, and created opportunities to improve access and financing of health care services for AI/ANs. Two areas with significant need, authorized under IHCIA but not funded or fully funded, are long term care and behavioral health, respectively.

Recommendations:

- Congress must protect the ACA and IHCIA to ensure tribes and tribal members continue to obtain the benefits of these laws.

- Congress must fully fund ICHIA, including long term care, recruitment and retention, and behavioral health.
- Fund Tribal Epidemiology Centers to fulfill their role as a Public Health Authority, as outlined in the IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.

Elders and Long Term Care

AI/ANs are living longer, with more functional disabilities, suggesting a growth for the population needing long-term care. In the Northwest, 1 – 2.9% of all AI/AN people are aged 65 and older, and the elder population is growing. AI/ANs older than aged 65 report their health as fair or poor more often than the overall population aged 65 and older. Our tribes want to keep elders in their homes and communities but they need funding opportunities that support hospice care, assisted living, long-term care ,and home-and-community based services. While IHCIA authorized the Secretary of HHS to fund these services, no funding has not been appropriated for these services.

In addition, American Indians are more likely to have poor eyesight from biological factors, such as a higher rate of refractive error and astigmatism, both easily corrected with eyeglasses. While some IHS/tribal facilities may provide eyeglasses, some do not have funding to do this.

Recommendations:

- Congress must fund long term care services, assisted living services, hospice care, and home-and-community-based services, authorized under IHCIA, for AI/AN people.
- HHS/CMS/IHS must create an encounter rate or enhanced rate for tribal nursing homes to overcome the significant payment-to-cost gap and provide hospice care.
- Congress must increase funding to IHS or ACL to ensure that elders have access to eyeglasses at no cost.

Behavioral Health (Mental Health & Substance Use)

NPAIHB is particularly concerned about our AI/AN adolescents and young adults. Suicide is the second leading cause of death for AI/AN adolescents and young adults. AI/AN suicide mortality in this age group (10-29) is 2-3 greater than that for non-Hispanic whites. While there are two Youth Regional Treatment Facilities in the Portland Area, the Healing Lodge of the Seven Nations in Spokane and NARA Northwest in Portland, more are needed with expanded services to address youth mental health needs and/or substance use.

The increased HHS opioid funding has provided an opportunity to address opioids and co-occurring substance use in AI/AN communities. For example, the Substance Abuse Mental Health Services Administration's (SAMHSA) Tribal Opioid Response (TOR) funding has provided 42 of the 43 tribes in the Portland Area with funding to begin to address the opioid epidemic in their communities; 28 of the 43 tribes applied through an NPAIHB consortium. While this funding has been supportive, it is mainly focused on Medication Assisted Treatment (MAT) which cannot comprehensively address the needs of AI/ANs related to opioid use, so broader funding opportunities with a broader array of services must be considered by SAMHSA.

Recommendations:

- Congress must:
    - Fund SAMHSA and IHS for AI/AN youth-focused prevention, treatment, recovery services.

- Increase SAMHSA and IHS funding for AI/AN Youth Regional Treatment Centers (YRTC) that provide aftercare and transitional living for both substance use and/or mental health; and support initiatives that increase the number of AI/AN YRTCs.
- Fully fund the IHS Behavioral Health Program for Indians at $150 million with option for tribal shares (ISDEAA Title I and Title V contracts and compacts) and non-competitive funding for direct service tribes, with inclusion of prevention services, and cultural and traditional healing practices as evidence-based practices; and fund the provision of technical assistance by Area Health Boards/Tribal Epidemiology Centers to Tribes for data collection and evaluation. (NPAIHB Res. No.19-04-09).
- Enact legislation change that would allow all IHS behavioral health initiatives to be funded through tribal shares (ISDEAA Title I and Title V contracts and compacts).
- Continue SAMHSA TOR non-competitive funding for tribes, directly to tribes and in parity with states, for longer terms with the flexibility to address co-occurring mental health issues with funding for prevention, cultural and traditional healing practices as evidence-based practices; and fund technical assistance for TOR grantees at regional level through Area Health Boards/Tribal Epidemiology Centers.
- Fully fund implementation of the SAMHSA National Tribal Behavioral Health Agenda to improve the behavioral health of AI/AN with specific emphasis on AI/AN youth.
- Fully Fund IHCIA behavioral health initiatives, including sections 702, 704, 705, 709, 710, 711,712, 714, 715, 723 & 724 so IHS/tribal facilities can provide inpatient treatment, training for mental health techs, expansion of tele-mental health as well as demonstration grants.
- Enact and fund legislation that supports an AI/AN mentorship and training program for master's level programs (MPH, MSW, Indian/Tribal Law) with a focus on cultivating AI/AN professionals who are proficient on indigenous knowledge, tribal best practices, harm reduction, chemical dependency.
- Increase housing opportunities (increase funding and housing communities such as tiny homes and/or change housing restrictions) for AI/AN to access housing when they are in recovery.

- SAMSHA must:
  - Provide more funding for prevention, training for mid-level SUD providers, data waiver trainings for SUD providers, and training and development of peer counselors.
  - Address 42 CFR part 2 restrictions and align it with HIPAA to allow for integrated care for AI/ANs with Substance Use Disorder (SUD).
  - Support a compendium of tribal best practices (e.g., Oregon has done this through statute) that can be funded through grant initiatives.

Medicaid/CHIP

Medicaid Funding/Preserve 100% FMAP. The Medicaid program provides critical health coverage for AI/AN people and has also become a very important source of financing for health care for Indian health programs in our area and across Indian country. Because the IHS budget has not received adequate increases to maintain current services, Medicaid has provided additional revenue for Indian health providers. The increased coverage and revenue associated with Medicaid Expansion has had a very positive impact on IHS/tribal health programs. The

100% Federal Medical Assistance Percentage (FMAP) to IHS/tribal facilities for services received through IHS and tribal facilities is a critical component to the Medicaid system and honors the federal trust responsibility.

Recommendation:

- Congress must continue to honor the federal trust responsibility for Indian health care by protecting 100% FMAP for services received through the Indian health system (NPAIHB/CRIHB Joint Res No. 17-04-04).

Medicaid Initiatives. Section 1115 of the Social Security Act (SSA) allows a state to apply to the Centers for Medicare and Medicaid Services (CMS) for a waiver of Medicaid requirements of the SSA for experimental, pilot, or demonstration projects. States can use section 1115 waivers to test health care services that promote the objectives of Medicaid and Children's Health Insurance Program (CHIP). In addition, states can also apply for a Section 1915(b) waiver to provide services through managed care delivery systems or otherwise limit choice of providers; or apply for a Section 1915(c) home and community-based services waiver to provide long-term care services in home and community settings rather than institutional settings. These waivers influence policy-making and alter the delivery of health care services provided to AI/ANs nationwide. For example, Medicaid work and community engagement requirements under 1115 waivers should not be left to the states to decide, but rather, HHS/CMS should provide an AI/AN exemption.

Most recently, Northwest Tribes are also concerned about recent guidance issued by CMS to states that support block granting. On January 30, 2020, CMS released a State Medicaid Director (SMD) Letter announcing the Healthy Adult Opportunity (HAO) initiative. The initiative invites states to submit 1115 waivers that set caps on Medicaid spending in exchange for increased program flexibility. Tribes are concerned about the impact to AI/AN beneficiaries in states that chose to implement this option.

Recommendations:

- HHS, CMS and states must:
    - Honor the government-to-government relationship with tribes and conduct meaningful consultation with tribes prior to issuing policies that have an impact on AI/AN people such as block granting and demonstration projects.
    - Protect fee-for-service structure because tribes and AI/AN should have an option to receive care at I/T and not be subject to managed care.
- Tribes are behind legislation(NPAIHB Res. No. 19-01-02). that support Medicaid program initiatives that meet the unique circumstances of the Indian health care system and Indian country. Congress must enact legislation that:
    - Creates the authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level;
    - Authorizes Indian Health Care Providers in all states to receive Medicaid reimbursement for health care services delivered to AI/ANs under IHCIA;
    - Extends full federal funding through 100% FMAP to states for Medicaid services furnished by urban Indian providers;
    - Excludes Indian-specific Medicaid provisions in federal law from state waiver authority; and
    - Removes the limitation on billing by Indian Health Care Providers for services provided outside the four walls of a tribal clinic

Community Health Aide Program Nationalization
& Dental Health Aide Therapists

NPAIHB has made great progress on establishing the framework in the Portland Area for Community Health Aide Program Expansion. The Portland Area has 12 Dental Health Aide Therapists working within Northwest Tribes and one more graduating from the Alaska program in June. There are also two Northwest tribal members in the Alaska Behavioral Health Aide education program and six more students starting in August. NPAIHB is also working on a establishing a Dental Health Aide Therapist education program in Washington state with the first cohort of students in FY 2021, and developing a Behavioral Health Aide education program with tribes in both Oregon and Washington.

Recommendations:

- Congress must:
  - Fund national expansion of CHAP in the lower 48 at $20 million for FY 2021 and ensure IHS direct service facilities are included in the expansion.
  - Support $5m of $20m for CHAP expansion in FY 2021 for Portland Area CHAP demonstration project.
- IHS must:
  - Support Portland Area CHAP demonstration project.
  - Finalize the IHS interim CHAP policy and support the development of regional certification boards with federal baseline standards that at a minimum meet Alaska CHAP standards for consistency of services provided by any CHAP program.
  - Create a permanent series and classification of position descriptions for all CHAP providers to be utilized in federally operated facilities
- In states of OR and WA:
  - Pass legislation that authorizes statewide practice of DHATs.

IHS IT Modernization

RPMS is now a legacy system and is inconsistent with emerging architectural electronic health record (EHR) standards. NPAIHB recognizes that the Veterans Administration's (VA) decision to move to a new Health Information Technology solution will create a gap for the parts of RPMS that are dependent on core coding from the VA. RPMS cannot meet these evolving needs without substantial investment in IT infrastructure and software.

Portland Area Tribes were disappointed that the IHS IT Modernization research project conducted in FY 2019 did not include any site visits to Portland Area IHS/Tribal facilities so the report issued does not reflect the IT profile of IHS/tribal facilities in our area. As IHS implements the first phases of the IT Modernization project, it must continue to conduct tribal consultation to ensure all areas needs are represented.

Recommendations:

- For FY 2021, NPAIHB recommends funding at $25 million for planning and phased-in maintenance of RPMS with ongoing tribal consultation and funding for support and technical assistance, with consideration of tribes that have purchased commercial off the shelf systems.
- In any modernization or phased-in replacement of RPMS, IHS must:
  - Conduct tribal consultation in each IHS area in its efforts to modernize or initiate a phased-in replacement of RPMS.

- Provide ample transition period, training, and technical assistance to IHS and tribal facilities once a decision is made.
- Consider the various EHR systems that tribal facilities use and ensure the system is streamlined and aligned with other systems to ensure coordinated care with no gaps in patient care.
- Consider that many tribal facilities have purchased commercial off the shelf systems and are using tribal resources for upgrades, technical support and maintenance. IHS must take into consideration the main barriers of an EHR system for our tribes on a COTS system include costs, reporting, various ways of tracking, purchased and referred care (PRC) and integration.

Veterans

AI/ANs serve in the U.S. Armed Forces at higher rates per capita, are younger as a cohort and have a higher concentration of female servicemembers compared to all other servicemembers, yet they are underrepresented among veterans who access the services and benefits they have earned. In FY 2016, the National Center for Veterans Analysis and Statistics counted approximately 11,028 AI/AN veterans in the Northwest. AI/AN veterans are more likely to lack health insurance and to have a disability, service-connected or otherwise, than veterans of other races. In addition, Indian country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining coordinated health care services from IHS and the VA. For these reasons, the VA must work with IHS and tribes to address the health care needs of AI/AN veterans and fulfill the federal trust responsibility.

Currently, the VA has 16 reimbursement agreements with tribal health programs in the Northwest (1 in ID, 6 in OR, and 9 in WA) and the program is growing. While the VA reimbursement agreements have improved relations between the VA and tribal health programs and the VA and AI/AN veterans, there is still need for improvement. Moreover, tribal health programs use purchased referred care (PRC) dollars to pay for third party specialty care of AI/AN veterans, but do not get reimbursed from the VA for the specialty care. In addition, current regulatory barriers for AI/AN veterans' access to care include: restrictions on specialty care, assessment of co-pays, duplicative processes, overly-burdensome administrative requirements, lack of care coordination, and delayed access to care. With the VA transition to the Cerner EHR system there is a concern that further coordination of care issues could arise. Lastly, when AI/AN veterans leave the military, they are in need of culturally responsive transition services to integrate back into their communities. Establishing a VA Tribal Advisory Committee (TAC) through legislation would allow for many of these AI/AN veterans' care issues to be addressed.

Recommendations:

- As to reimbursement agreements:
  - Congress must pass legislation to preserve and strengthen VA reimbursement agreements, ensure reimbursement at the OMB encounter rate, and allow VA reimbursement of Purchased and Referred Care (PRC) dollars for specialist care to AI/AN veterans.
  - VA must streamline and improve the process for establishing reimbursement agreements between the VA and tribal health programs, and must ensure that smaller tribes are included in opportunities to enter into agreements.
- As to AI/AN veterans' care coordination and needs:
  - VA must reduce barriers that further exacerbate AI/ANs ability to access care, and focus on improved care coordination for AI/AN veterans.
  - VA must enhance coordination of VA efforts regionally between VA facilities, states, Veterans Integrated Service Networks (VISNs), and tribes.
  - VA must conduct a tribal-specific needs assessment of AI/AN veterans in the twelve IHS Areas.

  - VA must work with the Department of Defense (DOD), IHS and tribes to create and expand culturally responsive transition services for AI/AN soldiers leaving the military and transitioning into civilian life following discharge, separation, or retirement.
- VA must engage IHS and tribes prior to the phased-in implementation of the Cerner EHR system to ensure there are no gaps in care coordination for our veterans.
- Congress must pass legislation creating a VA Tribal Advisory Committee (TAC) (NPAIHB Res No 19-04-01).

HCV and HIV Treatment and Funding

Hepatitis C (HCV) Treatment at IHS. The NPAIHB seeks to carry out the NPAIHB/CRIHB joint resolution #17-04-11 to eliminate Hepatitis C (HCV) among AI/AN people by "providing access to HCV treatment without restrictions" which was also enacted by the Affiliated Tribes of Northwest Indians (ATNI) and the National Congress of American Indians (NCAI). AI/ANs are disproportionately affected by HCV and have both the highest rate of acute HCV infection and the highest HCV-related mortality rate of any US racial/ethnic group. The AI/AN HCV-related mortality rate in Idaho, Oregon and Washington is over three times that of non-Hispanic whites and this disparity has persisted over time, demonstrating the need for enhanced and expanded access to HCV curative therapies. Lack of drug access to costly new medications (that reduce liver-related deaths, prevalence of hepatocellular carcinoma and decompensated cirrhosis and liver transplants) is the single most important barrier to a scale-up of HCV treatment and liver disease prevention. These HCV drugs are on the IHS formulary, but no funding has been appropriated to IHS for these drugs, so clinicians must spend considerable time mounting often unsuccessful attempts to get third-party payers such as private insurers, Medicaid, and patient-assistance programs to pay for them.

Recommendations:

- Congress and IHS must ensure that all AI/AN patients with HCV at I/T/U facilities have access to treatment to fulfill obligations to tribes and AI/AN people.
- Congress must appropriate at least $120 million to IHS to provide HCV treatment to AI/AN patients.

Minority AIDS Initiative (MAI). MAI was established to respond to the growing concern about impact of HIV/AIDS on racial and ethnic minorities and address social disparities for communities of color. Congress appropriates annual MAI funding in the Labor, Health and Human Services, Education and Related Agencies (LHE) appropriations bill. The vast majority of MAI funds is directed to Department of Health and Human Service (HHS) agencies that serve racial and ethnic minority groups. Currently, the MAI allocates resources to CDC, HRSA, NIH, SAMHSA, and OMH. IHS does not have the eligibility to receive MAI dollars. It is not clear why this exclusion persists. Without direct appropriations to IHS of MAI dollars, IHS will have far reaching and harmful impacts on Indian Country's ability to maintain ongoing HIV/AIDS and HCV prevention, treatment, and outreach efforts.

Recommendation:

- Congress must enact legislation that authorizes IHS to receive MAI dollars.

Minority HIV/AIDS Fund (MHAF). Congress appropriates an average of $50 million to the Office of the HHS Secretary for General Department Management (GDM) to MHAF. The HHS Secretary delegates these funds to other agencies to be used for MAI-related activities, which support programs that distinctly target communities of color. In FY 2019, $7.9 million of MHAF dollars were allocated to IHS for HIV/AIDS and HCV prevention, treatment, outreach and education – out of the total $53.9 millions of SMAIF dollars. MHAF has created long-lasting and impactful programs in Indian Country, such as WERNATIVE.org, Indian Country ECHO and HealthyNativeYouth.org. Continued appropriation to MHAF and inclusion of Indian Country in allocation of these dollars is necessary to maintain staffing, capacity, and organizational infrastructure to address health disparities for not only our

Northwest Tribes, but also Tribes across Indian Country. Any elimination of MHAF funding for IHS will dissolve almost all current HIV and HCV efforts and programs in Indian Country.

Recommendation:

- Congress must fund MHAF for FY 2021 at $60 million for FY 2021 with at least $10 million targeted for the IHS.

Ending the HIV Epidemic: A Plan for America. On February 5, 2019, the President in his State of the Union announced his Administration's goal to end the HIV epidemic in the United States within 10 years. In order for tribes and AI/AN people to be included in the *Ending the HIV Epidemic: A Plan for America* funding must be allocated to IHS, Tribal and Urban Indian Programs to develop infrastructure and systems to diagnose, treat, prevent and respond to the HIV Epidemic. In FY 2020, $25 million was proposed in the President's IHS budget but final appropriations for IHS did not include this funding. We are deeply concerned that lack of funding for *Ending the HIV Epidemic* in Indian Country will likely lead to continued HIV health disparities and health outcomes for AI/AN people.

Recommendations:

- Congress must fund IHS at $25 million dollars in FY 2021 to support *Ending the HIV Epidemic* in Indian Country.
- HHS must ensure that the Administration's national plan *Ending the HIV Epidemic* is inclusive of tribes and AI/AN people as to eligibility, geography, as well as culturally specific education, prevention programs, and linkage to appropriate medical care.

Public Health

Support Tribal Public Health Infrastructure. While many tribal health programs have some public health and medical care infrastructure; it is often underfunded and may lack the capacity to respond effectively to health, natural, and manmade disasters. Too often population density is often a primary consideration in the allocation of emergency preparedness resources, it is important to recognize that public health emergencies and disasters can and do occur on Indian reservations and in rural areas in proximity to tribes, and the impact of these emergencies can be felt on everyone regardless of geography. Far reaching impacts of natural disasters, agricultural blight, and infectious diseases are just a few examples of the interconnectedness of our reservation, rural and urban citizens.

Recommendations:

- Congress must appropriate funding directly to tribes for tribal public health infrastructure.
- HHS, CDC, IHS, and states must develop Tribal Public Health capacity, including equitable access to services and gradual capacity improvement.
- Congress must authorize a Public Health Emergency Fund established through the Secretary of Health and Human Services that tribes can access for tribally-declared public health emergencies (analogous to tribal disaster declarations to access FEMA funding).
- Fund Tribal Epidemiology Centers to fulfill their role as a Public Health Authority, as outlined in the IHCIA for activities such as technical assistance, capacity building, evaluation, public health surveillance, etc.
- State legislators must continue to provide funding at the state level for Washington Foundational Public Health Services and Oregon Public Health Modernization, including specific support to and involvement of tribes and tribal organizations.

Environment & Health Effects. In the Northwest, AI/AN people have rates of asthma nearly double that of the general population. They are more likely to report having asthma symptoms everyday as well as health status in the "fair" or "poor" category. AI/AN people are also exposed to many other contaminants within their communities (uranium, lead, etc.) and some within their homes (methamphetamine exposure). In addition, many tribes are located within areas that have been designated as Super Fund sites by EPA or experienced contamination from pesticides or other commercial activities which have contaminated surface and ground water in many tribal communities.

Recommendation:

- Congress must provide targeted funding to CDC and IHS for tribes to increase asthma treatment programs including education and remediation of the environmental triggers associated with asthma control, and for housing-related environmental hazards.

Workforce Development

Both IHS and tribally operated facilities have difficulty with recruitment and retention of qualified medical providers. Due to lack of funding, many recruiter positions have been abolished and those responsibilities have transferred to full time staff, making it difficult to devote meaningful time to these activities. In addition, not enough funding is provided for the IHS Scholarship Program and the Loan Repayment Program to assist with recruitment. It has been estimated that $33 million is needed for Indian Health Professions to fully fund the IHS Scholarship Program and Loan Repayment Program for all eligible applicants.

Recommendations:

- Congress must:
    - Expand Title 38 authorities for market pay for all provider positions including physician assistants to ensure that IHS and tribal facilities can be competitive in the current job market.
    - Fund IHCIA sections 112, 132 as well as 134, which would also provide additional resources to address recruitment as well as training programs to increase American Indian representation in provider positions.
    - Increase funding in FY 2021 for IHS Indian Health Professions in the amount of $10 million to fund scholarships for qualified applicants to IHS Scholarship Program and to support the Loan Repayment Program to fund physicians, nurse practitioners, physician's assistants, nurses and other direct care practitioners (NPAIHB Res. No.18-03-07).
    - Fund opportunities for leadership development and workforce development programs for AI/AN youth/adolescents.
- HHS agencies must partner with IHS and tribes to create funding opportunities specifically for the design and implementation of CHAP, BHA, DHAT education programs in partnership with tribes and education institutions.
- HRSA must be a key partner in working with tribes and IHS to support recruitment and retention efforts for tribal clinics and create set-asides for tribes. Funding opportunities must be streamlined and flexible as to HRSA grant application process for tribes with enhanced technical assistance.

Youth

Good health can provide adolescents with a strong foundation for adult health. Some adolescents' unsafe choices or vulnerable situations can have serious life-threating consequences. Alternatively, when young people are supported in making positive choices, the benefits to the individual and community are significant, because many

life-long patterns are established during adolescence. For these reasons, we believe that addressing the health and wellbeing of Native young people is imperative.

Recommendations:

- Congress and the Administration must:
  - Fund initiatives that provide safe environments for AI/AN adolescents, including safe schools, wellness centers, clinics, homes, and other social service programs, so that AI/AN adolescents have secure places to live, learn, and play.
  - Fund initiatives for AI/AN adolescents and young adults to take an active role in their own health and wellbeing specific to leadership training, career coaching, Youth Delegates and Youth Councils, mentorship and internship opportunities, community service, and other positive extracurricular activities.
  - Fund IHS Tribal Epi Centers to improve tribal capacity to support adolescent health.

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