Northwest Portland Area Indian Health Board

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2018 Legislative and Policy Issues

The Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents 43 federally-recognized Tribes in Idaho, Oregon and Washington on health care issues.

Indian Health Service

Fully Fund the Indian Health Service / Exempt IHS From Sequestration

Indian Health Service (IHS) is significantly underfunded compared to other federal health agencies. For example, in 2015, IHS expended only $3,136 per AI/AN patient, while the national average spending per user was $8,517 -- an astonishing 63 percent difference. IHS funding is in fulfillment of the federal government's trust responsibility assumed through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 U.S.C. § 13) legislatively affirmed this trust responsibility. For AI/ANs, the federal budget is not just a fiscal document, but also a moral and ethical commitment that reflects the extent to which the United States honors its promises of justice, health, and prosperity to AI/AN people. Health funding for Indian Country has been hurt by sequestration and government shutdown in the past. In FY 2013, sequestration cuts devastated Tribal communities throughout the United States. In a health care delivery system that has been chronically underfunded for decades, this was disastrous for clinics across Indian Country.

Recommendations:

- Congress must fully fund the IHS at $32 billion annually as fulfillment of the federal trust responsibility. (NPAIHB/CRIHB Joint Res No. 17-04-08)
- Congress must permanently, fully exempt the IHS from sequestration. (NPAIHB/CRIHB Joint Res No. 17-04-08)
- Congress must require the IHS to provide a detailed breakdown of how spending is allocated at the national and Area level to Congress and Tribes each year. (NPAIHB/CRIHB Joint Res. 17-04-08)
- 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)

Advance Appropriations for IHS

Since FY 1998 there has been only one year (FY 2006) when IHS appropriations have been provided at the beginning of the fiscal year. Late funding results in administrative challenges related to budgeting, recruitment, retention, provision of services, facility maintenance and construction efforts. This affects access to care and the quality of health care provided. Providing sufficient, timely, and predictable funding is needed to ensure the federal government meets its obligation to provide health care for AI/AN people. Healthcare services directly administered by the federal government, such as the Department of Veterans Affairs, are funded by advance appropriations to minimize the impact of late and, at times, inadequate budgets. The decision of Congress to enact advance appropriations for the VA medical program provides a compelling argument for the effectiveness of advance funding a federally-administered health program; which could easily be applied to the IHS. Beyond the efficiency inherent

to advance appropriations, providing timely and predictable funding helps to ensure the federal government's trust responsibility is carried out.

Recommendation: Provide advance appropriations for the Indian Health Service.

Permanently Reauthorize the Special Diabetes Program for Indians

Congress established the Special Diabetes Program for Indians (SDPI) in the Balanced Budget Act of 1997 to provide for the prevention and treatment services to address the growing problem of diabetes in Indian Country. Congress recently extended the Act through September 30, 2017; however they should permanently extend the Act. The SDPI provides a comprehensive source of funding to address diabetes issues in Tribal communities that successfully provide diabetes prevention and treatment services for AI/ANs and have resulted in short-term, intermediate, and long-term positive outcomes.

Recommendation: Congress must reauthorize SDPI at $200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at $150 million per year in 2018 with medical inflation rate increases annually thereafter. (NPAIHB Res No 17-03-08)

Equity in Health Care Facility Funding

The IHCIA requires the Health and Human Services (HHS) Secretary to submit a report to Congress that describes the comprehensive, national, ranked list of all health care facilities' needs for the Indian Health Service (IHS), Indian Tribes, and Tribal Organizations carrying out health programs under the IHCIA, initially by March 23, 2011, and thereafter update the report every five years.[1] The IHCIA also requires the IHS to maintain a health care facility priority system which is to be developed in consultation with Indian Tribes and Tribal Organizations and serve as the basis for the HHS Secretary to submit the above referenced report to Congress.[2] The initial report submitted to Congress estimated facilities needs and costs based on unfunded projects in the existing Health Care Facilities Construction Priority List (Priority List), in addition to those projects identified in Area Health Services and Facilities Master Plans (Masters Plans) developed in FY 2005 with their costs estimated by using the health care facility priority system. CRIHB, NPAIHB, and many other Tribes and Tribal Organizations do not feel that the report submitted to Congress was adequate to identify a national comprehensive list of facilities needs in light of the fact that the Priority List has been locked since approximately 1991 and Tribes and Tribal Organizations have not had an equitable opportunity to compete for funding in order to be placed on the list. The 2005 Area Master Planning process included inconsistent planning criteria (and the necessary resources to complete thorough and comparable master plans) across the entire IHS system, and neither of these two processes incorporated new authorities for health services or facility types authorized in the 2010 amendments to the IHCIA. The 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current Priority List will not be complete until 2041 and at the current rate of construction appropriations and the replacement timeline, a new 2016 facility would not be replaced for 400 years. Many Tribes and Tribal Organizations have had to assume substantial debt to build or renovate clinics for Indian people to receive IHS-funded health care.

Recommendations:

- Instruct the Government Accountability Office to review and issue a report on the IHS Facilities Construction Priority System, including historical and current funding distribution inequities. (NPAIHB/CRIHB Joint Res No. 17-04-12)

[1] 25 USC § 1631(c)(2)(A)(ii)(I).
[2] See "Report to Congress on Estimated Need For Tribal and Indian Health Service Health Care Facilities," submitted by the Indian Health Service, circa March 2011.

- 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)

Fund Regional Referral Specialty Care Centers

Portland Area Tribes have been very innovative in developing alternatives for facilities construction. The Portland Area Tribes completed a Pilot Study to evaluate the feasibility of regional referral centers in the IHS system. The Pilot Study concluded that the demand for Regional Specialty Referral Centers, when strategically placed, to offer specialty care, diagnostics, and ambulatory surgery care are economically feasible. The Study further recommends that a demonstration project be completed in the IHS. The current IHS Health Care Facility Priority system does not provide a mechanism for funding specialty referral centers. The Portland Area Facilities Advisory Committee recommends that the first specialty referral center be constructed as a demonstration project under the authorities in the Indian Health Care Improvement Act. The facility is anticipated to 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: Congressional appropriations committees must include $3.4 million for planning and design of a Regional Referral Specialty Care Center demonstration project in the Portland Area.

Fund Small Ambulatory Care Facilities

Portland Area Tribes annually request that small ambulatory facilities have a source of funds to support the new facility construction needs of smaller tribes who cannot compete in the current new facilities construction priority system. The current priority list was developed in 1991 and tribes are locked out of accessing badly needed construction dollars unless their facility is one of the facilities on the current list. The Portland Area Tribes continue to oppose any new facilities construction projects until the IHS completes its revision of the Health Facilities Construction Priority System.

Portland Area Tribes have long encouraged alternative methods to acquire new facilities. These alternative methods of acquiring health facilities must be supported in an effort to meet the demand for primary care. There is such an enormous need that depending exclusively upon IHS appropriations for all health facility requirements is not realistic. The IHS and Tribes have developed strategies (Joint Venture and Small Ambulatory Funding) that will greatly increase the number of new ambulatory health facilities constructed, but some IHS funding is required for this strategy of leveraging financing to work. In addition, staffing packages should be available to any new facility, regardless of how construction was funded.

The Indian Health Care Improvement Act (Section 305) authorized a grant program for the construction, expansion, and modernization of small ambulatory care facilities. This program assists tribes to secure quality health care in isolated rural areas. In the Northwest this could mean replacing old, worn out trailers that serve as the health clinics in Tribal communities. Small modern clinic facilities assist tribes to attract health care professionals, provide a health focus for the community, and, where tribes are agreeable and resources available, provide health care services to underserved non-Indian individuals in the community. This program has an excellent record of achievement that should be rewarded with increased appropriations.

Recommendation: Congress must continue to provide annual funding for small ambulatory facilities to support new facilities construction.

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. Tribes are concerned that the expansion of Medicaid and Medicare, as well as, new funding authorities for Veterans Administration, has created more competition for the same amount of providers.

Recommendations:

- Expand Title 38 authorities for market pay for all provider positions including physician assistants to ensure that Indian Health Service and tribal facilities can be competitive in the current job market.
- Congress must 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 AI representation in provider positions.

Dental Health Aide Therapist Program and Community Health Aide Program Nationalization

The dental care workforce can be expanded safely, effectively and quickly to address these deplorable oral health disparities through dental health aide therapists (DHATs). DHATs are part of a dentist-led team. They educate patients about oral health and prevention, perform dental evaluations, give fluoride treatments, place sealants, clean teeth, place fillings, and perform simple extractions. Like nurse practitioners and physician assistants in the field of medicine, dental therapists expand the reach of dentists and free them to perform advanced treatments. DHATs who come from and return to their communities bring immeasurable strengths. They have excellent technical skills and the cultural understanding, and personal connections to their communities. DHATs will help provide access and quality oral health care to AI/AN people who need it badly.

Our organization has a DHAT initiative program that has been instrumental in paving the way for DHATs in the lower 48. The Swinomish Tribe, a tribe in our area, had the first tribally operated DHAT program in the lower 48 and more are being planned in Washington since the state legislature passed a law allowing DHATs to practice on tribal land. And in Oregon, pilot project legislation has authorized two tribal DHAT sites and one urban site.

Relatedly, our area has been a strong voice for nationalization of the Community Health Aid Program (CHAP). We expect the next IHS Director to have a strong voice in advocating for nationalization of CHAP and to actively support DHATs in the lower 48.

Recommendations:

- Amend IHCIA to remove state authorization requirement for DHATs.
- Expand the Dental Health Aide Therapists (DHAT) program to allow sites to provide more preventative and routine care by allowing DHATs to perform exams and basic services.
- Support the Training and Utilization of DHATs in Tribal communities. (NPAIHB/CRIHB Joint Res No .17-04-10)
- Expand CHAP in the Portland and California IHS Areas and support the development of regional certification boards with federal baseline standards for consistency of services provided by any CHAP program. (NPAIHB/CRIHB Joint Res No. 17-04-09)
- Increase funding for Community Health Aide Programs (CHAPs) in order to expand and implement the program nationally under IHCIA section 111. (Portland Area Tribes Budget Recommendation)
- Provide more resources for behavioral health and dental aides, in order to leverage individuals who already live in a community that can build trust between providers and patients, while also

ensuring that services are available and delivered as close to the patient as possible. (Portland Area Tribes Budget Recommendation)

- Recognize tribal sovereignty and allow tribes to authorize/license/certify CHAP providers that at a minimum meet Alaska CHAP standards.

Information Technology & Electronic Health Record Replacement

Since 1984, the IHS has relied on RPMS as the health information solution. The RPMS is a government-developed health information system comprised of over 80 integrated software applications. The RPMS hardware, software, network, and database allows both large and small health facilities to work independently as well as within the larger network of the Indian Health system. The Veterans Administration's (VA) will move to a new health record system, which will leave the Indian Health Service's current Registration and Patient Management System (RPMS) without system support. RPMS has a similar infrastructure and clinical applications to VistA. The VA has selected to single source contract with Cerner as to be on the same platform as Department of Defense (DOD). Portland Area Tribes recognize there will be a need for substantial investment in IT infrastructure and software in order to transition to an alternate system.

Recommendations:

- IHS must provide tribal consultation in each IHS Area throughout process in efforts to modernize or replace RPMS.
- IHS must provide ample transition period, training, and technical assistance to tribes once IHS makes a decision on whether to improve RPMS or contract with a new EHR system.
- The RPMS improvements or the new EHR system must focus on the benefits to patient care that improve the involvement and utilization of providers in the health IT system.
- IHS must take into consideration the various EHR systems that tribes utilize instead of RPMS.
- IHS must provide additional training and technical support, especially for smaller tribal health clinics.
- IHS must provide a more user-friendly format for health care providers to highlight certain patient information and reporting for data collection purposes.
- IHS must make operability more of a focus in the modernization of the RPMS or a new EHR system, so that the system is more streamlined and aligned with other EHR systems.

Support transfer of IHS Appropriations from jurisdiction of Interior, Environment & Related Appropriations to Labor, Health and Human Services, Education and Related Appropriations

Move the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee. The LHE Committee handles health care related bills, and therefore understands the problems associated with health care delivery, such as medical inflationary rates. The Interior Appropriations Subcommittee is responsible for national parks, reclamation projects, mining activities, fish and wildlife, and other natural resource programs. It is reasoned that the IHS appropriation would benefit by being in the same pool of health expenditures that programs like Medicare, Medicaid, SCHIP, and other health programs appropriated out of the LHE Appropriations Subcommittee. The Labor-HHS-Education subcommittees have almost always been allocated appropriation increases that match or exceed health inflation indexes. While the Interior Appropriation Subcommittee allocations reflect natural resource program inflation rates, which generally fall below health inflation.

Recommendation: Move the IHS budget from the Interior Appropriations Sub-Committee to the Labor, Health and Human Services, and Education (LHE) Appropriations Sub-Committee.

IHCIA

Fully Fund IHCIA

The Affordable Care Act (ACA) included amendments to, and a permanent reauthorization of, the Indian Health Care Improvement Act (IHCIA). Both the ACA and IHCIA include many authorities that are beneficial for IHS, Tribal, and Urban (I/T/U) Indian health programs. Two areas with significant need are long term care and behavioral health:

Fund Long Term Care (LTC) and Assess LTC Needs

The IHS does not fund long-term care, which is why there are few long-term care services in Indian communities. There are only 15 known tribal nursing homes in the nation. Northwest Tribes support the study of the long-term care needs of AI/AN people. Tribes need more case management funding and funding to allow Tribes to provide advice on long-term care needs to their elders. Medicare and Medicaid programs could become important sources of funding for long term and home and community based care for elders with support from CMS. The IHS should receive a line-item appropriation to study long-term care programs in Tribal communities. Elder issues and Long Term Care (LTC) are a growing concern for Tribes across the country.

Recommendation: Fund long term care services, authorized under IHCIA, for AI/AN people and provide a line-item appropriation to IHS to study long-term care needs and programs for AI/AN people.

Increase Funding for Behavioral Health & Substance Abuse

AI/AN people have many socioeconomic factors that contribute to poor behavioral health outcomes such as high rates of poverty, unemployment and lower rates of education. They are 1.7 times more likely to die of suicide than all U.S. races. Suicide is also the second leading cause of death for AI/AN teens and young adults. According to national data on drug and alcohol use, AI/AN have the highest rates of substance dependence or abuse of all ethnic groups at 14.9% compared to 8.4% for whites.

Recommendations:

- Increase funding to implement National Tribal Behavioral Health Agenda to improve the behavioral health of American Indians and Alaska Natives.
- Fully IHCIA sections 702, 704, 705, 709, 710, 711,712, 714, 715, 723 & 724 for increases to Behavioral health funding to provide inpatient treatment, training for mental health Techs, expansion of tele-mental health as well as demonstration grants.

Preserve the Indian Health Care Improvement Act and Indian-Specific Provisions in the Patient Protection and Affordable Care Act

Any proposed future legislation repealing the Patient Protection and Affordable Care Act (ACA) must preserve the Indian Health Care Improvement Act (IHCIA). IHCIA, permanently reauthorized under the ACA, has improved the Indian health care system in several ways. It improved workforce development and recruitment of health professionals, it provided new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs, and has created opportunities to improve access and financing of health care services for American Indian and Alaska

Natives (AI/ANs). For example, the law has allowed the Indian Health Service (IHS) to carry out long term-care related services and be reimbursed for services such as home and community based services. IHCIA has also helped modernize the delivery of health services provided by IHS.

The ACA has provided an incredible opportunity for increased health coverage for the tribal citizens in our area through Marketplace plans and many tribes have implemented premium sponsorship programs for their tribal citizens. The increased access for AI/AN people to health care services through the Marketplaces and increased revenue at our IHS/tribal facilities has been significant and tribes cannot afford to lose these services for their tribal citizens or revenue to their clinics.

In addition, there are several Indian-specific provisions in the ACA that are critical to the Indian health system that are in jeopardy with an ACA repeal. 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.

Recommendations: Urge Congress to ensure that the IHCIA and Indian-specific provisions in any health care reform legislation are preserved so the Indian health system can continue to operate under a framework appropriate for 21st century healthcare delivery that honors the United States' trust responsibility to provide healthcare to AI/ANs. (NPAIHB Res No. 17-03-01)

Medicaid/CHIP

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). These waivers can influence policy-making and alter the delivery of health care services provided to AI/ANs. 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; or get certain ACA Marketplace provisions waived under a 1332 waivers. Oregon and Washington have 1115 waivers in place, while Washington has structured this waiver to completely transform its Medicaid system. Idaho is currently working on a combined 1115 and 1332 waiver application which will partially expand Medicaid for a very limited segment of the population.

As part of these initiatives, all three of our states are moving towards value based payment (VBP) models. VBP models are part of CMS's quality strategy to reform how health care is delivered and paid for. These models reward health care providers with incentive payments for the quality of care they provide to patients rather than the quantity of care to patients. These models are meant to replace, or move away from, fee-for service. Tribes and urban Indian health programs (UIHPs) are concerned about these models and have requested that states retain the fee-for-service system. These models also require collection of common performance measures for health outcomes that IHS/tribal EHR systems may not have the capacity to collect; or that could be met with GPRA data.

Another ongoing concern in our area is that Medicaid regulations prohibit funding from being expended at I/T/U health facilities classified as Institutions for Mental Diseases (IMD) for patients between 21-65 years old. Current law also excludes Medicaid payments to facilities exceeding 16 beds and limits the

access to care for many. Given the severe underfunding of I/T/U programs, the IMD limitations are too restrictive and have prevented AI/AN patients from accessing greatly needed behavioral health services.

Recommendations:

- CMS must monitor and enforce state tribal consultation requirements on Medicaid Transformation initiatives, waivers, SPAs and other policy changes.
- IHS needs to be involved in discussions with tribes, HHS/CMS, and state when waivers are being considered that will impact the Indian health system or that transform the Medicaid system.
- IHS/tribes need more information on VBP models, including metrics, expected outcomes, incentives, penalties, and what data will be collected and how it will be used, and if there will be adequate funding for the programs that are interested in participating in these models.
- Allow tribes an exemption from value-based payment structures and preserve fee for service payment structure within states.

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. Most of the IHS budget increases are directed toward staffing new facilities and minimally finance inflation and population growth for the Indian health programs. The increased coverage and revenue associated with Medicaid expansion has had a very positive effect on Northwest Tribal health programs. Northwest tribes have advocated that AI/AN who have been part of the expanded population continue to be covered in any health reform efforts.

It is essential in any health care reform efforts that the federal trust responsibility for Indian health care be honored, and 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS and tribal facility is preserved. Many of the health care proposals that have been discussed in the past are designed to stop or reduce federal spending on the Medicaid program, yet still recognize that certain limited and unique federal funding streams will have to be maintained. The tribes in our area are opposed to block grants, but if they were to move forward in legislation then we have requested a carve out for AI/AN to hold the federal government to its trust responsibility. The 100 percent FMAP provision for services received through an IHS or tribal facility must be preserved.

Recommendations:

- In any Medicaid reform efforts, honor the federal trust responsibility for Indian health care and preserve 100% FMAP for services received through the Indian health system (NPAIHB/CRIHB Joint Res No. 17-04-04).
- Any plan to change the manner in which State Medicaid costs are reimbursed by the federal government must include a carve out for services provided to AI/ANs so that the federal government's trust responsibility is not shifted to the States (NPAIHB/CRIHB Joint Res No. 17-04-04).
- Ensure state implementation of 100% FMAP to the benefit of tribes.

Veterans

Continue VA Reimbursement Agreements

Indian Country has long recognized the growing concerns and frustrations of AI/AN veterans in obtaining health services from the IHS and Veterans Administration (VA). Currently, the VA has 16

reimbursement agreements in the Northwest (1 in ID, 6 in OR, and 9 in WA) with Tribal health programs (THPs) and the program is growing so there is a need to improve the relationship between the VA and THPs as well as the experience of the veteran. Not all tribes have equal capability to get their veteran tribal members access to VA health benefits. The VA held a tribal consultation in Washington D.C. in September 2016; a roundtable in Phoenix, AZ. In July 2017; and is rescheduling a roundtable in Alaska (was scheduled for August 2017).

The VA is seeking tribal input on a new payment structure. VA has suggested a value-based rate structure instead of the all-inclusive rate payment methodology, which could decrease payments reimbursed to Tribes for health care services rendered to AI/AN veterans. The OMB all-inclusive rate is recent, established annually and based on cost reports from Tribal hospitals and IHS. It was set when Tribal facilities received authorization to bill Medicare and Medicaid services.

Recommendations:

- Legislation must preserve VA reimbursement agreements, reimbursement at OMB encounter rate, and allow an exemption for tribes from a value-based payment structure and ensure tribal consultation.
- VA leadership must conduct Area tribal roundtables this year with tribal leaders, tribal health directors, and tribal clinic directors on the VA reimbursement agreements prior to the end of the existing renewal agreements.
- VA must improve care coordination for AI/AN Veterans. It is a barrier to constantly refer AI/AN Veteran patients back to the VA because it is time consuming and, ultimately delays services.
- VA should reimburse tribal PRC dollars for specialist care to AI/AN veterans. The current process often leads to the tribe utilizing PRC dollars to pay for the specialist care of the AI/AN veteran. However, tribes do not get reimbursed for care coordination because of the restriction of reimbursement to direct care.
- VA must improve eligibility and service eligibility determinations. There is a need to streamline training so that eligibility requirements and benefits can be made quickly available.
- VA must expand direct care services for care provided to all veterans regardless if they are eligible for IHS funding or not. Tribes in the Northwest serve a significant number of non-native patients. There needs to be improvements in how to identify the veterans and make them eligible. When you a have a veteran in a rural community they are going to go to the facility that they know they will receive care and that they won't have to spend time and money, the VA system can be a barrier to this process.

Cross-Agency

HCV Funding

The NPAIHB seeks to carry out the NPAIHB/CRIHB joint resolution #17-04-11 to eliminate Hepatitis C among AI/AN people by "providing access to HCV treatment without restrictions" which was also enacted by ATNI and NCAI. AI/ANs are disproportionately affected by Hepatitis C virus and have both the highest rate of acute HCV (Hepatitis C) 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 not on the IHS formulary, 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.

CMS issued a Medicaid Drug Rebate Program Notice for State Technical Contacts, Release No. 172, dated November 5, 2015, which states that "limitations should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments for beneficiaries with chronic HCV infections. States should, therefore, examine their drug benefits to ensure that limitations do not unreasonably restrict coverage of effective treatment using the new HCV drugs. Clinical guidelines for testing, managing, and treating HCV put forth by the American Association for the Study of Liver Diseases (AASLD), the Infectious Diseases Society of America (IDSA), and the International Antiviral Society-USA (IAS-USA) can be found at http://www.hcvguidelines.org/full-report-view. These guidelines state that treatment is recommended for all patients with chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy. Idaho and Oregon continue to impose discriminatory restrictions which contradict CMS and clinical guidance.

Recommendations:

- Congress must appropriate funding for HHS Secretary's Minority AIDS Initiative Fund (SMAIF) of $54 million or include appropriation of $3.6 million for the Indian Health Service for HIV/HCV prevention, treatment, outreach and education.
- Congress must appropriate funding to the Indian Health Service to Assure Access to Hepatitis C Medications for all AI/AN people with HCV as part of the initiative to Eliminate HCV among AI/ANs in parity with the U.S. Department of Veterans Affairs. (NPAIHB Res No. 18-02-02)
- Department of Health and Human Services, and its agencies, including but not limited to the Centers for Medicare and Medicaid Services (CMS) and Indian Health Service (IHS), must make HCV treatment a clinical priority and ensure access to medications to all persons with medical need as determined per AASLD, IDSA or IAS-USA guidelines. (NPAIHB Res No. 18-02-02)
- State Medicaid Agencies must make HCV treatment a clinical priority and ensure access to medications to all persons with medical need as determined per American Association for the Study of Liver Diseases (AASLD) guidelines. (NPAIHB Res No. 18-02-03)

Support Tribal Public Health Infrastructure

While Tribal health programs have 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 that the impact of these emergencies can be felt on all Americans regardless of geography. One need only consider the far reaching impacts of natural disasters, agricultural blight, and infectious diseases to realize the interconnectedness of our reservation, rural and urban citizens.

Recommendations:

- Congress must provide funding and resources directly to tribes for tribal public health infrastructure.
- Portland Area Tribes request the authorization of a Public Health Emergency Fund established through the Secretary of Health and Human Services.

Environment & Health Effects

In 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.

Recommendations:

- Targeted funding to increase asthma treatment programs including education and remediation of the environmental triggers associated with poor asthma control.
- More funding needs to be devoted to training and remediation for those tribes that are dealing with housing contamination.
- Increased funding in the Sanitation Facilities program will also address training as well as provide evaluation and maintenance of current water systems to help mitigate or treat contamination from heavy metals such as lead and other harmful substances.

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