



2021 Legislative and Policy Agenda for Indian Health

January 2021 *(updated 2/26/2021)*

Established by Tribal leaders almost fifty years ago to advocate as the united voice of federally recognized American Indian and Alaska Native (AI/AN) Tribes, the National Indian Health Board (NIHB) seeks to support Tribal sovereignty, ensure fulfillment of the federal government's trust responsibility to Tribes, and to strengthen the government- to- government relationship between the federal government and Tribes across Indian Country. We focus our work in the space of health care and public health, and we work to identify Tribal priorities, to raise awareness of those needs, to secure resources, and to support Tribal efforts to build health system capacity. To advance the organization's mission, the NIHB Board of Directors sets forth the following priorities that the NIHB will pursue through its legislative and policy work during 2021.

Introduction:

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's relationship with the Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations. From this canon of law and policy, the federal government has committed to honoring and advancing Tribal sovereignty; fulfilling treaty promises and upholding the trust responsibility to Tribes; and ensuring that it works transparently, respectfully, and consistently on a government- to- government basis with Tribes across Indian Country.

Over the last several decades Tribes have seen some improvements in the government's efforts to support Tribal sovereignty and honor the trust responsibility for health, however the Indian health system remains critically underfunded and AI/ANs experience some of the poorest health outcomes compared to all other groups, in many areas of health status. While we continue to grapple with these long-standing barriers, we now face many new challenges including a once-in-a-century pandemic and the significant economic downturn that resulted from the public health emergency.

The COVID-19 pandemic brought with it a disproportionate impact on AI/AN people and illuminated many of the disparities Tribes experience, which have led to worse COVID-19 outcomes. These disparities include poorer health status and higher incidence of chronic conditions, lower access to health care, lower access to modern water and sanitation systems, and overcrowding, among other inequities. It has never been more important to increase the resources flowing to Indian Country. It has also never been more important to adjust the legal and policy landscape to better support Tribal sovereignty and Tribal health.

In 2021, NIHB will continue to advocate for the fulfillment of the federal trust responsibility and for the preservation and strengthening of the political relationship between the United States and Tribes. We will work with both the Legislative and Executive branches of government to press for quality healthcare for AI/ANs and the systems-level change that will improve the AI/AN health status across Indian Country.

The following provides an outline of national consensus requests on a range of topics and includes both legislative and administrative requests.

Improving the Response to the COVID-19 Pandemic/ Standing Up Recovery Efforts

At the time of this writing, COVID-19 transmission remains dangerously high, more contagious strains are being found within the U.S., and thousands of Americans continue to die each day. Despite alarming gaps in population-specific COVID-19 health disparities data, available information clearly demonstrates that Tribal communities face a disproportionate burden from this public health crisis. An analysis by Hatcher et. al. demonstrated AI/AN cumulative incidence of laboratory-confirmed COVID-19 cases to be 3.5 times that of whites¹. Additionally, several of the regional Tribal Epidemiology Centers (TECs) participated in a study, along with many State Health Departments, that examined COVID-19 mortality rates among AI/ANs across 14 states. This study yielded an age-adjusted COVID-19 mortality rate among AI/ANs that was 1.8 (95% CI = 1.7-2.0) times higher than the white population.

This disparity is not equally distributed across all age groups. In particular, AI/AN persons aged 20-29 years, 30-39 years, and 40-49 years experience COVID-19 mortality rates (respectively) at 10.5, 11.6, and 8.2 times that of their white counterparts.² AI/ANs continue to face significant chronic health disparities, especially for conditions like diabetes and respiratory illnesses, which increase the risk of a poor COVID-19 health outcome, including death. Without a bold and substantive Indian Health Service (IHS) budget to equip the Indian health system with the tools to address these disparities, they will continue to go unaddressed, leaving Indian Country more vulnerable to COVID-19 outbreaks.

Unfortunately, because of high rates of misclassification and under-sampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the impact of COVID-19 in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID-19, however, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities.

Multiple states with large AI/AN populations including but not limited to Minnesota, Michigan, New York and California continue to report thousands of COVID-19 cases without any information on patient ethnicity or categorizing cases as “other” on demographic forms. In California, for instance, the state noted they lack race/ethnicity data for nearly 30% of reported cases. Multiple studies demonstrate that surveillance systems frequently misclassify AI/ANs or omit them from surveillance systems entirely. These issues continue exacerbate health disparities including those from COVID-19.

The adverse impacts of COVID-19 in Indian Country extend beyond health status. In a hearing before the House Interior Appropriations Committee on June 11, 2020, IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted to 30-80% below last year’s collections levels, and that it would likely take years to recover those losses.³ These funding shortfalls have forced Tribes across the lower 48 states and Alaska to furlough hundreds of workers, curtail available healthcare services, or close clinics entirely.

Limited intensive care unit (ICU) capacity to address a surge of COVID-19 cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that contribute to rationing of critical health care services. When compared to other federal programs, IHS remains chronically underfunded. In FY 2018, IHS spending equaled \$3,779 compared to \$9,574 in Veterans Health Administration spending per capita and \$13,257 per capita spending under Medicare. This disparity undercuts IHS’s ability to respond to COVID-19.

¹ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm>

² <https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm>

³ <https://appropriations.house.gov/events/hearings/indian-health-service-covid-19-response>

LEGISLATIVE REQUESTS

- Congress must create substantial, dedicated and/or set aside funding for Tribes in all funding streams for COVID-19 response and recovery.
- Congress should explicitly allow health/public health related funding to be routed through IHS, which has a pre-existing mechanism for quickly distributing funds through the Indian/Tribal/Urban (I/T/U) system.
- Tribes are in the best position to know what their needs and priorities are. Congress must acknowledge Tribal sovereignty and allow for maximum flexibility for activities in funding streams to Tribes.
- Because of historic chronic underfunding, it may take Tribes longer to stand up response efforts. New funding for Tribes should take this into consideration and allow for longer timelines to spend down funding. Congress should extend timelines to spend down existing COVID-19 funding allocated to Tribes during 2020.
- Like many other under-resourced health systems, Tribal systems would benefit from streamlined reporting requirements so as not to overburden limited staffing resources. Congress should keep reporting requirements minimal in any new COVID-19 funding to Tribal Nations.
- Congress must provide funds to the Indian health system to support culturally appropriate outreach to Tribal citizens to improve public health activities to combat COVID 19, including those to reduce vaccine hesitancy.

ADMINISTRATIVE REQUESTS

- Wherever not prohibited by law, the Administration should work toward the outcomes outlined in the above mentioned (legislative) requests.
- The Centers for Disease Control and Prevention (CDC) must work with states, IHS, and other stakeholders to ensure that complete and accurate data is being captured and shared with Tribes so they can effectively respond and recover from COVID-19, and other similar public health emergencies.
- Ensure adequate supplies of personal protective equipment, COVID-19 tests and related supplies, and other material resources needed by health care providers and communities to address the public health emergency.
- Use all available authority to extend and make permanent telemedicine and other health care delivery efforts that mitigate COVID-19 spread and increase access to care.
- Improve capacity of the Indian health system to handle COVID-19 surges and mass vaccination events, especially with regards to increased staffing needs. One way to address this need would be to require that U.S. Public Health Service Commissioned Corps (Corps) deploy additional officers to Indian Country during this public health emergency. Providing support for cross training non-health staff to assist in vaccination (under supervision of providers) is another potential solution to address staffing needs. Tribes may design other solutions that allow them to respond to COVID-19, and we request that federal agencies support these Tribally-driven solutions, both in terms of funding and in terms of policy flexibilities.
- Increase the volume of vaccines going to Tribes and the IHS. Indian Country has a higher percentage of people at higher risk for adverse outcomes from COVID-19, and allocations of the vaccine should reflect and address this higher risk. Tribes must also have maximum flexibility to obtain vaccines through IHS, their state, or directly from the federal government, depending on what the Tribe determines will work best for their Nation.

- Provide support for the vaccine rollout and related activities. Support may include funding, policy flexibilities, and/or technical assistance.

Increase Telehealth Capacity in Indian Country

The expansion of telehealth during the COVID-19 pandemic represents a paradigm shift in the delivery of health care. It has gone from a relatively underutilized method of health care delivery to one that has been widely adopted and utilized; and we believe that it will broadly lead to greater access to health care. The adoption of telehealth will bridge distance gaps between provider and patient, which is particularly important in sparsely populated Tribal communities where transportation can sometimes be a major barrier to accessing health care. Expanding audio-only telehealth would allow patients to take advantage of two-way real time audio, as well as video communication. Conversely, if the federal government does not allow audio-only telehealth a significant portion of Indian Country will not be able to access telehealth.

Telehealth holds the potential to greatly improve access to care for Indian Country, but a lot of work will be required to ensure that Tribes can take advantage of changing paradigms. The Indian health system lacks the resources to build out the needed telehealth infrastructure, nor does it possess systems across Indian Country that prioritize resources in accordance with identified need, establish and promote best practices, and formally evaluate and report on successes and barriers for telehealth. In communities where it is available, however, telemedicine has allowed Tribal Nations to dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary medivacs and expand local treatment options, and reduce Medicaid costs.

LEGISLATIVE REQUESTS

- Expand access to telehealth and communications technology based services in the Indian health system through increased funding and technical fixes to law and policy.
- Permanently extend the existing waiver authority for use of telehealth under Medicare.
- Expand the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian Health system.
- Retire telehealth restrictions to allow for continuation of telehealth beyond the national emergency context.
- Eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization.
- Reimburse the IHS All-Inclusive Rate for telehealth services under Medicare.

ADMINISTRATIVE REQUESTS

- Expand Medicare reimbursement of audio-only telehealth and communications technology based services, including an expansion of the ability to provide direct supervision via audio only means.
- Recommend that the Federal Communications Commission (FCC) enter into a Memorandum of Understanding with IHS to coordinate Health IT and telehealth efforts to best utilize all government resources.
- Urge Center for Medicare and Medicaid Services (CMS) to use allowable authority to add additional services to the Medicare telehealth benefit on a permanent basis and in consultation with Tribes.
- Recommend CMS offer technical assistance (TA) to Congress where it may be needed in order to update the Medicare statute to remove restrictions on telehealth and communications technology based services.

- Maintain current telehealth waivers throughout the public health emergency to ensure the telehealth delivery system remains a viable option for delivery of essential medical, mental, and behavioral health services in Indian Country.

Full Funding and Mandatory Appropriations for the Indian Health Service

Year after year, the federal government has failed AI/ANs by drastically underfunding the IHS far below the figures outlined by the IHS National Tribal Budget Formulation Workgroup (TBFWG). For example, in 2018, IHS spending for medical care per user was only \$3,779, while the national health care spending per capita was \$9,409 - an astonishing 60% difference. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Tribal communities. While the average life expectancy is 5.5 years less for all AI/ANs than it is for other Americans, some Tribal communities have a life expectancy of up to 20 years less than the average American.

Without full funding, Tribes face an impossible task in efforts to eliminate disparities. Tribal treaties are not discretionary. The IHS budget should not be discretionary either. The Administration must work with Congress to provide an appropriately scaled and sustainable investment targeted toward primary and preventative health, including public health services, for Tribes to begin reversing the trend of rising premature death rates and early onset of chronic illnesses.

Congress will never achieve full funding of IHS through the discretionary appropriations process given the restrictive spending caps of the Interior, Environment and Related Agencies Appropriations account. The Interior account has one of the smallest spending caps at only \$36 billion in FY 2020, making it extremely difficult to achieve meaningful increases to the IHS budget. While the IHS budget increased by roughly 50% between FY 2010 and FY 2020, those increases largely only kept pace with population growth, staffing funding for new or existing facilities, and rightful full funding of contractual obligations such as Contract Support Costs (CSC) and 105(l) lease agreements. While these are critical needs, the fact is that the United States must fully fund the entire IHS budget, not just segments of it. The slight year-to-year increases have not even kept full pace with annual medical and non-medical inflationary increases, translating into stagnant healthcare services, dilapidated healthcare facilities, severe deficiencies in water and sanitation infrastructure, and significant workforce shortages.

Tribes call on the next Administration to take decisive steps to accelerate health gains in AI/AN communities, while preserving the investments and health improvements achieved over these past several years. To do this, the department must propose a budget for IHS that is bold, effective, and which contains important policy reforms to ensure that AI/ANs experience the highest standard of care possible. Funding IHS at \$12.759 billion in FY 2022, as recommended by the TBFWG, will instill trust among Tribal leaders that the Administration is truly committed to working directly with Tribes to fulfill treaty obligations for healthcare and build a more equitable and quality-driven Indian health system.

LEGISLATIVE REQUESTS

- Phase in full funding of the Indian Health Service.
- Enact a Fiscal Year 2022 IHS Budget in the amount of \$12.759 billion, as recommended by the IHS Tribal Budget Formulation Workgroup as the first step toward full funding.
- Fund a Tribally-driven feasibility study in order to determine the best path forward to achieve mandatory appropriations for IHS.
- Enact mandatory appropriations for the Indian Health Service annual operating budget.

- Enact indefinite, mandatory appropriations for the 105 (l) lease line item and Contract Support Costs (CSC) outside of the IHS budget.

ADMINISTRATIVE REQUEST

- Support a Tribal workgroup that can identify what full funding for IHS is.
- Work with Tribes and provide needed data as part of a Tribally-driven feasibility study in order to determine the best path forward to achieve mandatory appropriations for IHS.

Advance Appropriations for IHS

Advance appropriations would provide better continuity of care, resulting in better health outcomes for AI/ANs. It would allow for more efficient use of appropriated dollars by removing budgetary restrictions that force IHS to neglect long-term planning and focus limited resources on the most urgent health needs. In addition, it would ensure parity between IHS and the Veterans Health Administration (VHA) – both of which have the federal charge to provide direct care services. Funding disruptions create significant administrative costs for health programs. Moreover, advance appropriations would result in decreased costs to health programs by allowing long-term contracts with outside vendors and suppliers without the threat of funding disruptions or lapses caused by shutdowns and continuing resolutions (CRs). It

it would also allow for greater ability to plan programmatic activity over several years, thereby facilitating stronger strategic planning in program development and implementation.

IHS was the only federally funded healthcare entity subject to full sequestration during the 2013 government shutdown, as Congress had already protected entities such as the VHA when it authorized VHA to receive advanced appropriations in 2009. Should Congress seek to enact a similar law that reestablishes budget sequesters in the future, it must exempt IHS and all federal Indian programs and budget lines. During the most recent 35-day government shutdown at the start of FY 2019 –IHS was the only federal healthcare entity to be shut down.

LEGISLATIVE REQUEST

- Enact advance appropriations for the entire IHS budget to ensure long-term funding stability and insulate IHS from the effects of budget sequestration, shutdowns, and stopgap measures.

Tribal Water and Sanitation Infrastructure as a Public Health Priority

Human health depends on safe water, sanitation, and hygienic conditions. COVID-19 has highlighted the importance of these basic needs and illustrated the devastating consequences of gaps in these systems, including the spread of infectious diseases. Unfortunately, according to the 2018 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities, over 31 percent of homes on Tribal lands need sanitation facility improvements, while nearly 7 percent of all AI/AN homes do not have adequate sanitation facilities. Even more troubling, roughly 2 percent of AI/ANs do not even have access to safe drinking water. Many AI/AN communities simply cannot follow CDC’s COVID-19 sanitation and hygiene recommendations because they lack water and sanitation infrastructure. The lack of access to safe drinking water and basic sanitation in Indian Country negative impacts the public health of AI/AN communities.

LEGISLATIVE REQUESTS

- Increase funding for infrastructure development that can address deficiencies in water and sanitation in Indian Country, including for the IHS’s Sanitations Facilities Construction.
- Increase Tribal set-asides for the safe and Clean Drinking Water State Revolving Funds.

ADMINISTRATIVE REQUEST

- In accordance with the 2016 Water Resources Development Act reauthorization, an eligible use of funds should continue to include water operator training and certification. Successful Tribal Clean Water Act (CWA) implementation requires at least 20 percent of the national CWA Section 106 allocation to keep pace with the expansion of Tribal programs.

Permanency and Self-Governance of the Special Diabetes Program for Indians (SDPI)

Congress established the Special Diabetes Program for Indians (SDPI) in 1997 to address the disproportionate impact of type II diabetes in AI/AN communities. This program has grown and become our nation’s most strategic and effective federal initiative to combat diabetes in Indian Country. SDPI has effectively reduced incidence and prevalence of diabetes among AI/ANs and is responsible for a 54% reduction in rates of End Stage Renal Disease and a 50% reduction in diabetic eye disease among AI/AN adults.⁴ A 2019 federal report found SDPI to be largely responsible for \$52 million in savings in Medicare expenditures per year.⁵ As a direct result of SDPI, a recent study found that the prevalence of diabetes in AI/AN adults decreased from 15.4% in 2013 to 14.6% in 2017.⁶

After 15 months of short-term extensions (six in total), Congress has finally reached an agreement on long-term reauthorization of the SDPI. Congress was able to secure the cost savings to pay for a three-year extension of SDPI through the end of FY 2023. Unfortunately, the reauthorization does not include an increase in funding for SDPI. Instead, it maintains SDPI funding at \$150 million annually - the same level since 2004. The SDPI reauthorization did not include a critical legislative amendment to permit Tribes and Tribal organizations to receive SDPI awards pursuant to Title I contracting or Title V compacting agreements under the Indian Self-Determination and Education Assistance Act (ISDEAA). This technical change would prevent any administrative delays in implementation of the 638 provision, and further clarify the purpose of the new authority. Moreover, by specifically citing certain sections of P.L. 93-638, the technical change would ensure that IHS awards SDPI funds as part of the “Secretarial Amount” to those Tribes and Tribal organizations that elect to receive SDPI funds through the 638 mechanism. This would guarantee that Tribes and Tribal organizations receive all administrative and operational resources entitled to them under the 638 mechanism, including access to Contract Support Costs (CSC). The NIHB Board of Directors passed Resolution 21-04 to support the permanent reauthorization of SDPI.⁷

LEGISLATIVE REQUESTS

- Permanently reauthorize SDPI at a minimum of \$250 million with automatic annual funding increases tied to the rate of medical inflation.
- Authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts.

⁴ https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

⁵ https://aspe.hhs.gov/system/files/pdf/261741/SDPI_Paper_Final.pdf

⁶ <https://www.ihs.gov/newsroom/ihs-blog/april-2020-blogs/new-study-shows-decrease-in-diabetes-prevalence-for-american-indian-and-alaska-native-adults/>

⁷ https://www.nihb.org/docs/03012021/21-04_NIHB%20Resolution%20on%20SDPI.pdf

- Increase baseline funding to address stagnant funding and expand reach of the program to additional Tribes.

Create More Funding and Support for Behavioral Health

AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before the COVID-19 public health emergency began, and many of these challenges have gotten worse under the pandemic, especially for Native youth. A 2018 study found that AI/AN youth in 8th, 10th, and 12th grades were significantly more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days.⁸ According to the CDC, suicide rates for AI/ANs across 18 states were reported at 21.5 per 100,000 – 3.5 times higher than demographics with the lowest rates.⁹ Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma, alongside contemporary trauma.

Several years ago, a cohort of NIHB’s Native Youth Fellows presented the concept of a special behavioral health program for Indians (BHPI) modeled on SDPI to address chronic and pervasive behavioral health challenges in Indian Country. In May 2017, the NIHB Board of Directors passed a resolution formally requesting the federal government allocate the required funds to establish the BHPI, a program that would support substance abuse prevention and intervention programs for AI/ANs and promote resilience through cultural enrichment.¹⁰

LEGISLATIVE REQUESTS

- Enact the Native Behavioral Health Access Act. Although SDPI is a model, this legislation should advance additional Tribal priorities, including ensuring that funding will reach every Tribe in a Tribally designed and approved formula (rather than competitive grant), requiring minimal reporting, and allowing Tribes to receive the funding through self-determination contracting or self-governance compacting mechanisms.
- In coordination with Tribes, establish trauma-informed interventions to reduce the burden of substance use disorders including those involving opioids.
- In coordination with Tribes, incorporate behavioral health assessments such as Adverse Childhood Experience (ACE) into IHS and provide funding for Tribal health programs to do the same.
- Authorize reimbursement for traditional healing services through Medicare and Medicaid and reduce additional barriers in the Medicaid program for the treatment of substance use disorder.
- Authorize reimbursement for additional provider types that render behavioral health services through Medicare and Medicaid. These additional providers include Licensed Professional Counselor, Licensed Marriage and Family Therapist, and similar types of providers currently excluded.

ADMINISTRATIVE REQUESTS

⁸ Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open*. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

⁹ 2 Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. *MMWR Morb Mortal Wkly Rep* 2018;67:237–242. DOI: <http://dx.doi.org/10.15585/mmwr.mm6708a1>

¹⁰ https://www.nihb.org/docs/05172017/NIHB%20Resolution%202017-08%20NIHB%20%20Resolution_Substance%20Abuse%20Prevention%20and%20BH.PDF

- Create set aside, non-competitive funding for Tribes in all general funding streams to support behavioral and mental health initiatives.
- Wherever permissible, create direct funding to Tribes and avoid grant mechanisms which cause Tribes to compete against other Tribes or against well-resourced states, cities, and counties.
- Streamline reporting requirements to reduce burdens on Tribal nations receiving funding.

Medicare and Medicaid: Providing Health Care Access and Financial Support for I/T/U Facilities

Medicare and Medicaid play an integral role in ensuring access to health services for AI/AN people and provide critically important funding support for the Indian health system overall. In fact, in many places across Indian Country, these Centers for Medicare and Medicaid Services (CMS) programs allow for Indian health system sites to address medical needs that previously went unmet as a result of underfunding of the Indian health system. The role of these CMS programs in Indian Country goes beyond advancing general program goals and meeting the needs of individual healthcare consumers. As an operating division of the United States Department of Health and Human Services (HHS), CMS owes a trust responsibility to the Tribes, as that solemn duty runs from the entire federal government to all federally recognized Tribes.

In addition to the benefits these programs provide to enrollees, Medicare and Medicaid also supports the I/T/U system by enabling facilities to collect third party revenue. Third party revenue significantly contributes to the financial stability of Indian health system clinics and hospitals. According to a 2019 report by the Government Accountability Office¹¹, between Fiscal Year 2013 and Fiscal Year 2018, third party collections at IHS and Tribal facilities increased by \$360 million, with 65% coming from Medicaid, a substantial portion by any measure. Moreover, data show that the number of AI/ANs with Medicaid increased from 1,458,746 in 2012 to 1,793,339 in 2018. The 334,593 increase in Medicaid coverage is a 22.94% increase over 2012. In 2018, 33.55% of all AI/ANs had Medicaid compared to 29.55% in 2012. During that same period, Medicare collections grew 47% from \$496 million in FY 2013 to \$729 million in FY 2018. To ensure financial health, Indian Country must protect and strengthen access to third party revenue within the Indian health system.

Medicaid Priorities

LEGISLATIVE REQUESTS

- Authorize Medicaid reimbursements across all states to allow Indian health system providers to receive Medicaid reimbursement for all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the Indian Health Care Improvement Act (IHCA)—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible AI/ANs.
- Create an optional eligibility category under federal Medicaid law providing authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138% of the federal poverty level (FPL).
- Authorize a legislative fix that would exempt the Indian health system from changes to the formula for calculating Medicaid Disproportionate Share Hospital (DSH) payments.¹²
- Extend full federal funding through a 100% Federal Medical Assistance Percentage (FMAP) rate for Medicaid services furnished by Urban Indian Organizations (UIO) to AI/ANs.

¹¹ See <https://www.gao.gov/assets/710/701133.pdf>

¹² CMS is attempting to institute a new formula, which will reduce our funding for uncompensated care payments.

- Clarify that AI/AN exemptions from mandatory managed care applying to plans enacted through state plan amendments (SPA) also apply to all waiver authorities.
- Amend Section 105(a)(9) of the Social Security Act in order to clarify the definition of “Clinic Services” and ensure that services provided through an Indian health care program are eligible for reimbursement at the OMB/IHS all-inclusive rate, no matter where the service is provided.

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- Encourage states to increase Medicaid telehealth reimbursement for Indian Health Care Providers (IHCPs).
- Ensure that AI/ANs are exempt from any additional restrictions, such as work requirements, that may be placed on Medicaid access.
- Exempt IHCPs from any measures, such as limiting retroactive eligibility, that may be designed as a cost-saving measure for the state.

Medicare Priorities

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- Ensure parity in Medicare reimbursement for IHCPs. Since Indian health care providers are unable to bill their patients, they generally only receive 80% reimbursement for the services that they provide. Legislation is needed to address this and ensure that the Indian health care system receives 100% reimbursement for services provided through Medicare.
- Include pharmacists, Licensed Marriage and Family Therapists (LMFTs), licensed professional counselors, and other providers as eligible provider types under Medicare for reimbursement to I/T/U systems.
- Expand telehealth capacity and access in Indian Country by permanently extending waivers under Medicare for the use of telehealth.
- Exempt AI/ANs from *all* Medicare penalties or cost-shares. AI/ANs are already exempt from these items through the Medicaid program and were exempt from the Shared Responsibility Payment under the Affordable Care Act. Providing these exemptions would put the Medicare program in line with other federal health care authorities.

ADMINISTRATIVE REQUESTS

- Standardize payment rates for the Indian health care system under Medicare by ensuring that all Indian health care providers are able to be reimbursed at the IHS-OMB rates.
- Allow direct sponsorship of Part B premiums by Indian health programs. Currently, to cover premiums for citizens, Tribes must reimburse the beneficiary for the payment of their premium. For a person who cannot afford the premium, having to pay it and wait for a reimbursement results in undue financial hardship. Employers and unions can sponsor premiums and by extending the same opportunity to Tribes would both recognize Tribal sovereignty and streamline the payment process for the Tribe and beneficiary.
- Simplify and streamline reimbursement for Medicare Part D by ensuring that claims from IHS and Tribal facilities are reimbursed at the highest possible rate—not a discounted rate—by Pharmacy Benefit Managers (PBMs).
- CMS should require all Medicare Advantage plans to automatically deem Indian Health Care Providers (IHCP) as in-network even if they do not enroll in a provider agreement and to reimburse IHCP’s at the

OMB encounter rate (This automatic deeming and rate setting should not supersede rates that an IHCP has negotiated and prefers over the OMB rate.)

- Exempt IHS hospitals from the Hospital Star Rating System. The current rating system results in artificially low ratings for IHS hospitals, which results from the fact that they serve a vulnerable population and are often so small in volume that one adverse outcome has an outsized impact on their rating. In addition, the Indian health system as a whole is chronically underfunded, and these types of rating systems punish the fact of underfunding rather than providing additional, needed support.

Expand and Strengthen the Government-to-Government Relationship with the Federal Government and the Tribes/Expand Self Governance

The Indian Health Service (IHS) is the only agency within HHS that retains the authority to establish self-determination contracting or self-governance compacting (as those terms are defined under the Indian Self-Determination and Education Assistance Act) agreements with Tribal Nations and Tribal organizations. However, not all IHS programs are subject to ISDEAA agreements. For example, Tribes are barred from receiving IHS behavioral health grants (i.e., Methamphetamine and Suicide Prevention Initiative/Domestic Violence Prevention Initiative) under ISDEAA agreements. The Administration should commit to working with Tribes to ensure all IHS programs and funds can be allocated to Tribes under ISDEAA agreements.

Tribes also call on the federal government to expand self-determination and self-governance authority across all of HHS. In the interim, the Administration should work with Congressional appropriators to authorize interagency transfer of funds from other HHS operating divisions to IHS, given that IHS is currently the only agency with ISDEAA authority.

As background, in 2000, P.L. 106-260, included a provision directing HHS to conduct a study to determine the feasibility of a demonstration project extending Tribal self-governance to HHS agencies other than the IHS. The HHS study, submitted to Congress in 2003, determined that a demonstration project was feasible. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696 - Department of Health and Human Services Tribal Self-Governance Amendments Act - that would have allowed these demonstration projects. A second study was completed in 2011 by the U.S. Department of Health and Human Services Self-Governance Tribal Federal Workgroup that noted additional legislation would be needed for the expansion. Despite these findings supporting expansion of Tribal self-determination and self-governance, Congress has yet to act legislatively.

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. Self-governance represents efficiency, accountability, and best practices in managing and operating Tribal programs and administering federal funds at the local level. Expanding self-governance translates to greater flexibility for Tribes to provide critical social services within agencies such as the Administration on Aging, the Administration on Children and Families (ACF), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Administration (SAMHSA), and Health Resources and Services Administration (HRSA).

Allowing Tribes to enter into self-governance compacts with HHS and its operating divisions would mean that federal dollars are used more efficiently because resources in Tribal communities, which are often small, could be more easily pooled and would allow Tribes to organize wrap-around services to better serve those who have the greatest need. Self-governance allows Tribes to extend services to larger populations of eligible American Indians and Alaska Natives, leveraging other opportunities more efficiently than the federal government. It also leads to better outcomes because program administrators are in close contact with the people they serve, making

the programs more responsive and effective.

LEGISLATIVE REQUESTS

- Enact a permanent expansion of Tribal self-determination and self-governance across all agencies within the Department of Health and Human Services (HHS) and affirm that all programs at the Indian Health Service (IHS) are eligible to be contracted and compacted.
- Expand and codify all Tribal Advisory Committees (TAC) to ensure Tribes have a voice within all operating divisions that provide funding to Tribal governments and communities. Clarify that the TACs are exempt from the Federal Advisory Committee Act (FACA), and that Tribes have full exercise of sovereignty and are allowed to choose how they wish to be represented at TAC meetings, including utilizing their subject matter experts.

ADMINISTRATIVE REQUESTS

- Utilize all current legal and administrative authorities to expand Tribal self-determination and self-governance across all grant programs under Indian Health Service (IHS).
- Support expansion of self-determination contracting and self-governance compacting throughout HHS operating divisions.
- Strengthen the partnership between federal and Tribal governments through ongoing, meaningful Tribal consultation. Consultations must be conducted prior to decisions impacting Tribal Nations and must be widely publicized so Tribal leaders can prepare for and join the discussion.
- Tribes must determine how they choose to participate at such meetings and how they wish to be represented. The federal government has a trust responsibility to Tribes and therefore should support Tribal participation in such meetings, which includes financial support for travel and technical assistance support of the Tribe's choosing.
- Ensure that all HHS operating divisions have updated Tribal consultation policies, informed by Tribal input and approved by Tribes across Indian Country.
- Ensure that each agency has a TAC and that they are staffed and meet on a regular schedule according to Tribal leaders stated preferences. Meeting agendas must reflect Tribal input and respond to Tribal needs.

Interagency Agreements between HHS Operating Divisions and IHS

The COVID-19 pandemic has exposed the importance of ensuring that the different HHS operating divisions have a mechanism for distributing funding to Tribes in an equitable and expedient manner. Early in the pandemic, the lack of a pre-existing mechanism for distributing funds caused major delays in funding distribution, or in some cases, prevented Indian health providers from accessing those funds allocated for COVID-19 relief. Interagency agreements between IHS and other HHS operating divisions could have prevented these problems and allowed for swift distribution of needed funds. NIHB expects to see similar outcomes during future public health emergencies without action now. Interagency agreements must be created in order to ensure the expedient transfer of allocated funds during future pandemics or other similar emergencies.

LEGISLATIVE REQUEST

- In order to ensure the durability of the interagency agreements, they should be mandated by statute with fixed timelines for renegotiation.

ADMINISTRATIVE REQUESTS

- Facilitate interagency agreements between IHS and HHS operating divisions.
- Devise a mechanism to ensure that funding is transferred to IHS in a timely manner. Confirm that all funding transferred can be delivered via IDEAA contracts and compacts.
- Establish measurable benchmarks to ensure that the agencies are transferring funds and providing any applicable technical assistance in a timely manner.

Seat Tribal Representatives in All HHS Operating Divisions and in Other Posts within the Executive Branch

President Biden called for his administration to be more representative of the people they serve. We believe that fulfillment of the trust responsibility requires that the decisions of each agency be informed by Indian Country. Tribal Nations have frequently encountered difficulty when interacting with the various HHS operating divisions and it has often created delays in the delivery of services. This could be addressed by ensuring that the different operating divisions were aware of the uniqueness of the Indian health system and the importance of the trust responsibility.

ADMINISTRATION REQUESTS

- Seat Tribal representatives in all the HHS operating divisions.
- Appoint a Tribal representative in the HHS immediate Office of the Secretary.
- Seat a Federal Indian law expert in the HHS Office of General Counsel.

Create Set Aside Funding for Tribes in all HHS Operating Divisions

Tribes interact with the various HHS operating divisions on a regular basis and there should be funding dedicated to ensuring that the agencies can meet Tribal needs. In fact, honoring the trust responsibility requires the federal government to meet the needs of Tribal communities. However, the status quo often prevents this from happening. For example, Health Resources and Services Administration (HRSA) frequently gives out grants and conducts programming aimed at rural providers. Unfortunately, the existing framework forces Tribes to compete for these funds, and as a result, Tribes regularly lose out on funding when the system pits them against better resourced states or counties.

The work of the various agencies can be improved if Congress allocated base funding directly for the Tribes.

LEGISLATIVE REQUEST

- Create set aside funding for Tribes in the annual appropriation for each HHS operating division.
- Ensure funding can flow to Tribes through self-determination contracting and self-governance compacting, and that Tribes have maximum flexibility and minimum administrative burden. Ensure funding can be allocated through a formula to all Tribes, and not as competitive grants.

ADMINISTRATIVE REQUESTS

- Wherever possible, each agency should use administrative authorities to create set aside funding for Tribes.
- Each agency should devise a formula, through Tribal consultation, to ensure it allocates funding in an equitable manner.

- Each agency should conduct Tribal consultation on a yearly basis, at a minimum, so the agency can include Tribal requests and recommendations in the agency's budget request to Congress.

Establish a 21st Century Health Information Technology (HIT) System at IHS

The Indian Health Service (IHS) provides the technology infrastructure for a nationwide healthcare system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission-critical healthcare operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than 100 applications.

A properly resourced IHS HIT program directly supports better ways to: 1) care for patients; 2) pay providers; 3) coordinate referral services; 4) recover costs; and 5) support clinical decision-making and reporting, all of which results in better care, efficient spending, and healthier communities. The Resource and Patient Management System (RPMS) – used by IHS and many Tribal health programs—depends on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types.

In recent years, many Tribes and several urban Indian organizations have elected to purchase their own commercial-off-the-shelf (COTS) systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and allow for smoother navigation and use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system. When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), Tribes ramped up their efforts to re-evaluate the IHS HIT system and explore how Veterans Health Administration (VHA) and I/T/U EHR interoperability could continue. Tribes have significant concerns about Tribal COTS interoperability with RPMS, and the overall viability of continuing to use RPMS.

LEGISLATIVE REQUESTS

- Provide funding needed to establish a fully functional and comprehensive health IT system for the Indian health system. Health IT at IHS must be fully interoperable with Tribal, urban, private sector, and Department of Veterans Affairs (VA) HIT systems. Funding must also be provided to Tribes to offset the costs they have already expended to modernize their system in the absence of federal action. Funding for maintaining the system is also needed.
- Provide additional time for Indian health system providers to comply with CERT 2015. (Current legislative language only allows for five years of exemptions. It will take more time for IHS get the RPMS system CERT 2015.)

ADMINISTRATIVE REQUESTS

- The VA-IHS MOU mentions a goal of interoperability between the IT systems used by both agencies. An advisory group composed of Tribal leaders, Tribal technical assistants, subject matter experts, and federal representatives should be established to ensure continued progress to this goal.
- Follow up with the Health IT modernization work conducted by HHS and IHS, to identify and quantify funding needs and other support for the work of modernization.
- Utilize the CARES Act funding (~\$65 million) that is available to improve IHS and Tribes' data capacity for public health activities related to surveillance, reporting, data flow, and protection of sensitive Tribal,

patient, and employee data. CDC should provide technical assistance if its VAMS portal is utilized until IHS public health data capacity can be improved.

Creating a Sustainable Tribal Health Workforce

The Indian Health Service (IHS) and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: physician 34%; pharmacist 16%; nurse 24%; dentist 26%; physician's assistant 32%, and advanced practice nurse 35%. Current vacancy rates make it nearly impossible to operate a quality health care program. With competition for primary care physicians and other practitioners at an all-time high, the situation is unlikely to improve soon. The IHS cannot meet workforce needs with the current strategy. In order to strengthen the healthcare workforce, IHS and Tribal programs need investment from the federal government – to educate, to recruit, and to expand their pool of qualified medical professionals.

LEGISLATIVE REQUESTS

- Make the IHS Scholarship and Loan Repayment Programs tax-exempt.
- Increase funding for IHS scholarship opportunities with a focus on providing aid to students from Tribal communities so they can return to them. Expand the program so that it includes additional provider types eligible for the funding, including, but not limited to health administration professionals.
- Create new and additional set aside funding for Tribal medical residency programs.
- Provide full Title 38 personnel authorities to IHS, Tribal, and urban Indian (I/T/U) systems.
- Fund expansion of the Community Health Aide Program (CHAP) across Tribes in states outside Alaska.
- Remove all statutory restrictions on expansion of Tribal Dental Health Aide Therapists (DHAT).
- Require a Tribal set aside within the annual Medicare funding of \$16 billion in Graduate Medical Education (GME) and require service to Tribal communities. Remove administrative impediments to participation in GME funding by Indian operated hospitals.
- Provide funding for better incentives for medical professionals who want to work at IHS and Tribal sites, including support for spouses and families, and better housing options.

ADMINISTRATIVE REQUESTS

- Improve the recruitment and retention of health care providers throughout Indian Country through collaboration with the Biden Administration, IHS, and the Tribes.
- HRSA must include IHS and the staffing of the Indian health system as part of any rural health workforce agenda.
- Create opportunities for medical students to work in Tribal communities by conditioning receipt of Graduate Medical Education funds on placement in Tribal communities, including payment to the Indian health system for residency programs.
- Improve the medical workforce at IHS and Tribal health facilities by supporting mid-level providers through the Community Health Aide Program and other initiatives.
- Make eligible project funding under Joint Venture and Small Ambulatory Programs for a full staffing package. This requires increased recurring funding.
- Fund educational programs to middle and high school age students in Tribal communities so they can explore STEM education at a younger age and learn about what opportunities are available at the post-secondary level.

Support and Expand the Community Health Aide Program and the Dental Health Therapy Aide Program as a Means to Improve Oral Health Outcomes

As part of the Indian Health Care Improvement Act (IHCIA), Congress gave the Indian Health Service the legislative authority to expand the Community Health Aide Program (CHAP) to Tribes outside Alaska. Since the 1960s, CHAP has empowered frontline medical, behavioral, and dental providers to serve Alaska Native communities, successfully expanding access in these communities to urgently needed health services. Based on the IHCIA and on CHAP's success in Alaska, IHS developed CHAP expansion policies from 2016-2020. However, IHCIA includes a provision (25 U.S.C. § 1616l (d)) that requires Tribes wanting to utilize Dental Health Aide Therapists (DHATs) under CHAP in states that license dental therapists. This language raises a barrier between Tribes and oral health care services and inappropriately delegates aspects of the federal trust responsibility to the states. However, many Tribes have opted to not wait for a remedy from Congress and are actively engaging with states to ensure Tribes can employ dental therapists and have their services reimbursed by state Medicaid programs.

LEGISLATIVE REQUESTS

- Amend the IHCIA (25 U.S.C. § 1616l (d)) to remove the state approval requirement for Tribal DHATs under CHAP.
- Clarify that CHAP expansion includes IHS, Tribally operated health facilities, and Urban Indian Health Organizations.
- Provide annual dedicated funding for IHS to support CHAP expansion and CHAP education and certification programs, such as the Alaska Dental Therapy Education Program. At the same time, Congress must preserve and protect the CHR program, which many Tribes rely upon and which complements, not duplicates, the CHAP program.
- Expand the authority and funding of the IHS Scholarship and Loan Forgiveness Programs to include CHAP providers as eligible for benefits.
- Establish standardized oral healthcare benefits for AI/ANs under state Medicaid programs.
- Create a dental benefit under Medicare that does not require enrollment in managed care which is often unavailable in rural areas.

ADMINISTRATIVE REQUESTS

- Establish CHAP infrastructure, including certification boards and Academic Review Committees, at the national and Area level.
- Prioritize Tribal educational institutions in establishing regional CHAP education and certification programs.
- Revise, update, and reissue the agency's guidance issued in January 2014 that stated Tribes could only employ DHATs with the permission of the state legislature. Federal statute requires this only under the CHAP expansion.
- Include dental therapist positions within Annual Funding Agreements for Tribes located in states that have dental therapy licensing laws.
- Publish a comprehensive report on the impact of DHATs under CHAP, including patient safety, patient satisfaction, provider retention, and community level health outcomes as considerations of note.
- Direct the Office of Personnel Management (OPM) to publish a federal position description for Dental Therapists that is not specific to CHAP.

Promote and Sustain Environmental Health Improvements in Indian Country

The health of the environment directly impacts public health in Indian Country. Contaminated drinking water, harmful air pollutants, destruction of natural habitats, climate change, extreme weather, and exposure to toxic heavy metals are issues that Tribal communities struggle to prevent, often with little or no support from the federal government. Twenty-five percent of the nation's 1300 EPA designated Superfund sites are located in or near Indian Country, even though Indian Country is only approximately 2% of the national land area. Decreased environmental health impacts physical and mental health as well as emotional and spiritual wellness for AI/AN communities and individuals. Lower population counts of species that Tribes use for sustenance and ceremonial practices harm the overall wellness of Tribal members. Many Tribes also rely on traditional foods in areas where there are few affordable, healthy foods for purchase. Improving environmental health aids in the prevention of illness, disease and general well-being.

LEGISLATIVE REQUESTS

- Provide needed resources to Tribes most vulnerable to the effects of climate change, including for long-term planning, mitigation, and adaptation activities.
- Establish dedicated funding for Tribes for environmental health improvement efforts.
- Protect Tribal lands, minerals, air, and waterways from non-Tribal exploitation and abuse.
- Provide oversight to agencies such as Housing and Urban Development (HUD) to ensure federal lead removal programs provide resources, training, and screening tools directly to Tribes.
- Provide funding to Tribes that are beginning to transition to sustainable energy sources.
- Support emergency response to emerging/worsening environmental issues resulting from climate change, such as wildfires, heatwaves and flooding.
- Give Tribes adequate tools to preserve sacred spaces throughout their environment in a way that incorporates Tribal traditions and respects sovereignty.

ADMINISTRATIVE REQUESTS

- Dedicate staff at the White House Council on Native American Affairs and other federal agency coordinating bodies to examine climate change impacts in Tribal communities.
- Seat Tribal representatives on all advisory boards formed to work on climate change/environment.
- Dedicate standing time at the annual White House Tribal National Conference to discuss environmental health challenges in Indian Country and updates on how the Administration is supporting Tribal sovereignty in the climate change and environmental health space. Involve Tribal Nations as full partners in federal planning and mitigation activities.
- Dedicate time and resources to developing a body of Tribally-led research into current and pervasive challenges related to environmental health and climate change adaptation.
- Prioritize Tribal sanitation, clean water infrastructure, and electrical utilities.
- Create Tribal Relations Offices at all federal agencies overseeing land, water, or air.

Social Determinants of Health

The most advanced research on social and economic factors related to health by the Robert Wood Johnson Foundation (RWJ, 2018, 2019, 2020) clearly demonstrates the large, negative impact poverty, poor housing (and water and sanitation), food insecurity, and education have on the health of AI/ANs. An NIHB analysis of the prevalence of negative outcomes in counties with large Indian populations affirms the findings of the RWJF research. When combined with workforce shortages, these socio-economic factors result in adverse outcomes

such as shortened life spans for AI/ANs compared with the all-races US population morbidity rates.

LEGISLATIVE REQUEST

- Support legislation that would authorize the Director of the CDC to carry out a Social Determinants of Health Program – and ensure Tribes and Tribal organizations are prioritized.

ADMINISTRATIVE REQUESTS

- The Biden Administration must consider social and economic determinants of health when addressing disparities in the Indian health system.
- Work with Tribes to create Congressional budget requests to study and address social determinants of health in Indian Country.

Broadband Access

According to a 2019 Federal Communications Commission (FCC) Report, only 46.6% of homes on rural Tribal lands had access to a fixed terrestrial broadband at standard speeds, an astounding 27 points lower than non-Tribal lands. This is an unacceptable disparity and contributes to the difficulties that Tribes have had in addressing the COVID-19 pandemic. The lack of broadband access presents multiple barriers for Tribes. It inhibits their ability to fully realize the benefits of telehealth. The expansion of telehealth during the COVID-19 pandemic and its lasting effects have increased the importance of broadband as a public health issue. In addition to its public health implications, the lack of broadband access also presents a barrier to economic development, especially in an era where remote work is becoming adopted more widely.

LEGISLATIVE REQUESTS

- Fund a study of Tribal lands to determine where gaps in access to broadband exist and the best technologies to address them.
- Fund the expansion of broadband in Tribal lands in order to help address the disparities between rural Tribal and non-Tribal lands.
- Allocate funding directly to Tribes to provide for the expansion of telehealth. Tribes should be free to decide the best methods for expanding their broadband infrastructure. Funding support must acknowledge Tribal sovereignty and give Tribes the best ability to tailor expansion in ways that will not damage cultural resources.

ADMINISTRATIVE REQUESTS

- Establish a relationship with the FCC Office of Native Affairs and Policy (ONAP).
- ONAP should provide a regular update to Indian Country on the deployment of broadband.

Prioritize Indian Country in HIV Funding

The rate of HIV infection among AI/ANs in 2016 was 10.2 per 100,000 – the fourth highest among other racial/ethnic groups. Furthermore, the number of diagnoses of HIV infection among AI/AN persons continues to rise. The current national plan does not address the unique prevention and care realities of Indian Country. There must be specific language to discuss AI/ANs as a population that is statistically at higher risk for acquiring or passing away from HIV or viral hepatitis. It is imperative that HHS examine how to best design a framework, topic areas, and objectives that meet the health needs of Tribes and advance the federal government's trust

responsibility for health. HHS should also engage with Tribes through formal consultation to incorporate Tribes in all of the federal government's HIV response activities, including how best to capture AI/AN data in an accurate and respectful manner.

Linkage to care has been proven to be one of the most effective and simple interventions that can be undertaken with a person newly diagnosed with HIV or a person that has fallen out of care. However, only a handful of providers across the entire Indian/Tribal/Urban healthcare system are trained to provide HIV specialty care for AI/ANs. These providers are geographically scattered across the country. Therefore, many AI/ANs are required to rely upon referral care to providers outside the Indian health system, and outside of their own communities – often traveling hours for appointments. These providers, while technically knowledgeable, may not have experience or the cultural knowledge to be able to provide comprehensive, competent care to AI/AN people living with HIV. The lack of local providers, distance to HIV specialists, and lack of culturally competent care serve as deterrents for many AI/AN to seek ongoing care and monitoring.

Funding allocated and directed by the federal and state governments rarely make it to Tribal programs, and programs that do exist and are supported by the federal government have not been enough. HHS should, as integral components of its national HIV response, direct funding to support Tribal-specific training, technical and capacity building assistance, and materials dissemination.

LEGISLATIVE REQUEST

- Allocate funding directly to Tribes, Tribal organizations, and IHS for expansion of HIV programming.

Greater Support for Health Care Facilities Construction

The Indian health system is beset by antiquated and largely deficient health care facilities that are largely unequipped to respond to the COVID-19 pandemic. The average age of an IHS hospital is 37.5 years, compared to 10 years for mainstream hospitals. IHS facilities are only able to accommodate about 52% of need based on AI/AN population sizes. Especially in small villages and remote Tribal locations, there is no ability to place a patient in isolation especially while waiting for a care referral. While most medical equipment has an average useful lifespan of six years, medical and laboratory equipment in most IHS facilities are more than twice as old as that. This poses a serious public health risk for entire Tribal communities. IHS and Tribal hospitals have a severe shortage of beds in intensive care units (ICUs), or lack of inpatient facilities altogether. Going further, many of the hospital and clinic facilities lack the space to provide mandatory reoccurring services such as dialysis treatment. There is an urgent need to not only fund those facilities on the Health Care Facilities Construction Priority List (Priority List), but to help fund the construction costs for the Joint Venture Construction Program (JVCP) and for the Small Ambulatory Program (SAP).

There is significant concern that without an influx of funding many JVCP projects will be delayed or lose resources for construction projects. There is a need to fund the construction costs of all the JVCP projects for all Tribes and Tribal organizations that satisfied eligibility for the past and current JVCP competition. SAP funds are particularly important for Tribes that are not on the Priority List or participating in JVCP to address COVID-19 health care facility construction needs. The SAP is especially critical for those Areas that have no IHS or Tribally operated hospitals. There is significant concern that without immediate funding relief for health facilities in Indian Country, the Indian health system will buckle under this emergency. IHS and Tribes need equitable and flexible funding not only to increase hospital and clinic capacity and the shortage of hospital beds, but also to acquire and construct shelters of opportunity – such as by renovating Tribal gymnasiums or other suitable facilities to serve as triage units along with other priorities.

Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The M&I program funding is distributed through a formula allocation methodology based on health facility industry standards. Current funding levels for M&I are below about 78% of the total needed for all eligible facilities. The backlog of essential maintenance and repair is estimated to be \$767 million to fully fund all M&I needs. Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy health accreditation standards.

LEGISLATIVE REQUESTS

- Equitably fund construction of health care facility needs across all twelve IHS Service Areas.
- Infuse new funding to the Joint Venture Construction Program (JVCP) to prevent delay in new construction projects due to lost resources because of COVID-19.
- Ensure regular cycles of JVCP, with selection of new projects no less than every two years.
- Increase funding to the Small Ambulatory Program to assist Tribes with urgent, short-term facilities' needs.
- Provide adequate funding to address the backlog of M&I projects for IHS funded programs.

Educate Members of the Administration on Tribal Sovereignty and the Trust Responsibility

Many federal officials do not understand that Indians are not racial entities but political entities - sovereign nations- with their own laws, cultures, and citizens. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-governance and providing for the health and well-being of Indian peoples. Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the United States has “moral obligations of the highest responsibility and trust.”

ADMINISTRATIVE REQUESTS

- Educate Members of the Administration on Indian Country, the trust responsibility, and Tribal sovereignty.
- Educate the Administration that the trust responsibility runs from the entire Federal Government to the Tribes; it is not confined to Indian Health Service (IHS) or even the Department of Health and Human Services (HHS). Federal Agencies must work collaboratively to address the health needs of AI/ANs.
- Educate the Administration on the importance of traditional medicine and its role in our communities.

Remove Barriers that Inhibit Adoption of Traditional Practices

Recognizing Tribal sovereignty means recognizing the sovereign right of Tribal nations to utilize traditional practices to provide for the health of their people. Traditional medicine is central to many Tribal cultures and has been shown to be effective at treating many of the chronic health issues faced by AI/AN people. Despite its effectiveness, Tribal nations experience many barriers when seeking to implement or incorporate traditional and cultural practices and activities as grant activities even though these activities have been supporting Tribal health and wellness for time immemorial.

LEGISLATIVE REQUESTS

- Amend any applicable Medicare statutes to allow for reimbursement for the provision of traditional medicine.
- Amend Section 1905 of the Social Security Act to make traditional medicine a “mandatory benefit,” that states must cover through their Medicaid program.

ADMINISTRATIVE REQUESTS

- Agencies should include language in their Funding Opportunity Announcements that recognizes the value and applicability of cultural and traditional practices as viable grantee activities.
- Respect Tribal decisions to keep sacred knowledge private (some Tribes may wish cultural knowledge and wisdom to remain with the knowledge keepers such as elders, traditional healers, storytellers, and AI/AN people).
- Support Tribal models of health and healing interventions that may not fit typical or standard Western approaches.
- Modify funding requirements to fit the relevant traditional Tribal paradigms.
- Work with Tribes to design innovative and culturally tailored models of health promotion programs, provide additional funding to support unique AI/AN health promotion efforts.
- Work with states to help them file Section 1115 waivers in order to provide reimbursement for traditional practices through the Medicaid program.
- Encourage private insurers to cover traditional medicine.

Elevate the Indian Health Service Director

The Indian Health Service is the primary vehicle through which the federal government fulfills their promise to provide health care to AI/AN people, an essential element of the trust responsibility. The federal government has often struggled to fulfill this responsibility, not just through the chronic underfunding of the Indian Health Service, but also through the lack of support provided to our populations through the other operating divisions of HHS. The existing paradigm within HHS must change and a key component of that is ensuring that the concerns of Indian Country are heard by HHS leadership. In September 2019, the NIHB Board of Directors passed a resolution to support the elevation of the Indian Health Service Director.¹³

LEGISLATIVE REQUEST

- Elevate the Director of Indian Health Service to Assistant Secretary of Health and Human Services.

ADMINISTRATIVE REQUEST

- The Department of Health and Human Services should support this change in structure which is in keeping with the Agency’s duty to the Tribes and honors the federal trust responsibility.

Support and Expand the Role of the White House Council on Native American Affairs

The United States has a unique trust responsibility to Tribal nations, which was forged through treaties and other promises made to Tribal leaders in exchange for land and other resources that were crucial in the building of the United States of America. The United States has often failed to live up to their promises and many of the

¹³ <https://www.nihb.org/docs/09162019/19-07%20NIHB%20Resolution%20Elevating%20IHS%20Director%20Position%20to%20Assistant%20Secretary%20of%20HHS.pdf>

issues facing Indian Country are the result of years of neglecting this responsibility. Addressing these issues and fulfilling the trust responsibility will involve interagency cooperation across the Executive Branch. President Barack Obama recognized this when he established the White House Council on Native American Affairs in 2013. The Council was created to facilitate interagency cooperation and create opportunities for Indian Country to have their voices heard by the Administration. After the end of President Obama's term however, the Council went dormant and was not revived until 2020 when President Donald Trump revived it in response to the COVID-19 pandemic. This lack of continuity is unacceptable.

ADMINISTRATIVE REQUESTS

- The Council should be holding regular meetings with Tribal leaders in order to make sure that their work is informed by Tribal concerns, and Tribal leaders should be seated as full members of the council.
- The Council's role should be expanded, and a point of contact should be designated to hear concerns that Tribal leaders have with the various government agencies. This will prevent these concerns from being lost in the bureaucracies of the various agencies and allow Tribal leaders a direct forum to have them heard by higher-ups in the agencies, who presently serve on the Council.
- Expand the required number of meetings of the Council. The 2013 charter provided for three mandatory meetings. We believe that this is insufficient. The Council should be meeting at least six times a year.
- The Council should be required to issue regular reports on their work and their progress towards coordinating federal resources and improving the government-to-government relationship between Tribes and the federal government.
- The Council should convene a yearly White House Tribal Nations Conference, reviving a yearly event that was last held in 2016 and provided a forum for Tribal leaders to engage directly with the Administration.