

Testimony of the National Indian Health Board
HEARING
House Natural Resources Committee
Subcommittee for Indigenous Peoples of the United States
March 23, 2021

Chairwoman Leger Fernandez, Ranking Member Young, and members of the Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally-recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, thank you for the opportunity to submit testimony. The recommendations outlined in this testimony encompass critical policy needs to help protect and prepare AI/AN communities in response to the current COVID-19 pandemic. These are necessary for the Indian health system to be fully functional to address the pandemic and other related critical health care priorities. **NIHB has identified several policy priorities for Indian Country within the jurisdiction of the Committee that we urge you to address:**

1. **Provide Full Funding and Mandatory Appropriations for the Indian Health Service**
2. **Prioritize Tribal Water and Sanitation Infrastructure**
3. **Increase Support for Tribal Mental and Behavioral Health**
4. **Provide Greater Health Care Access and Financial Support for I/T/U Facilities**
5. **Create a Sustainable Tribal Health Workforce**
6. **Increase Telehealth Capacity in Indian Country while Expanding Broadband Access**
7. **Establish a 21st Century Health Information Technology (HIT) System at IHS**
8. **Expand and Strengthen the Government-to-Government Relationship with the Federal Government and the Tribes & Expand Self Governance**

The Reality of Broken Treaties

We continue to bear witness and experience the alarming obstacles to our everyday lives resulting from this unprecedented crisis. In a matter of weeks, COVID-19 reshaped the very fabric of our economy, our society, the way we conduct business, relationships and our personal livelihoods – in some ways, permanently. The past year has been a profoundly uncertain and challenging time; and also times of profound opportunity to achieve redress of hundreds of years of injustices, which are the children of colonization.

Today, our nation is confronted by the COVID-19 pandemic that continues to disproportionately ravage the most marginalized among us, and Indian Country has been right at the center of the pandemic. In order to understand how to address and overcome these challenges and realize the opportunity for transformation before us, we must first insist on an honest reckoning of our history. The challenges we face today - most recently evidenced through the impacts of COVID-19 on Tribal communities - are the fruits of colonization. This system of exploitation, violence and opportunism is the foundation on which this Nation was constructed. Despite the poor social

determinants of health most frequently found in the Indigenous and other communities of color - circumstances that proceed from hundreds of years of colonization - we are often blamed for our poor circumstances. What our communities are experiencing during this COVID-19 pandemic is simply the expected outcome of this historical truth.

Centuries of genocide, oppression, and simultaneously ignoring our appeals while persecuting Our People and our ways of life persist - now manifest in the vast health and socioeconomic inequities we face during COVID-19. The historical and intergenerational trauma our families endure, all rooted in colonization, are the underpinnings of our vulnerability to COVID-19. Indeed, we tell our stories of treaties, Trust responsibility and sovereignty – over and over – and it often appears the listeners are numb to our historic and current truths. But the truth does not change: that is the ground we stand on. We hear baseless stories about how “dirty Indians” are causing the outbreaks, or how private hospitals are refusing to accept referrals to treat Our People. These same sentiments echoed across all previous disease outbreaks that plagued Our People from Smallpox to HIV to H1N1. This begs the painful question: what has changed?

The underpinnings of colonization may finally be loosening as a consequence of the exposed neglect, abuse, bad faith and inequities AI/AN People have experienced during this pandemic. But it did not start with COVID-19. This pandemic and the way it is ravaging our Peoples is exposing the consequences of hundreds of years of US policy predicated on broken promises with the Indigenous Peoples of this land.

Health Inequities Create Additional Risks from COVID-19

The solemn legacy of colonization is epitomized by the severe health inequities facing Tribal Nations and AI/AN Peoples. When you compound the impact of destructive federal policies towards AI/ANs over time, including through acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and the outlawing of traditional ways of life, religion and language, the inevitable results are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country.

Chronic and pervasive health staffing shortages –from physicians to nurses to behavioral health practitioners – stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 GAO report found an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas (GAO 18-580). Lack of providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective and culturally indifferent, at best – inept at worst. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that – at 37 years. In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care.

Tribal Nations are also severely underfunded for public health and were largely left behind during the nation's development of its public health infrastructure. As a result, large swaths of Tribal lands lack basic emergency preparedness and response protocols, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response. And even though Tribal governments and **all twelve Tribal Epidemiology Centers (TECs)** are designated as public health authorities in statute, they **continue to encounter severe barriers in exercising these authorities due to lack of enforcement and education.**

When you compound the impact of broken treaty promises, chronic underfunding, and endless use of continuing resolutions, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do. Indeed, AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.¹

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.² In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)³; higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

CDC reported that the presence of underlying health conditions such as type II diabetes, obesity, cardiovascular disease, and chronic kidney disease significantly increase one's risk for a severe COVID-19 illness. AI/AN populations are disproportionately impacted by each of these chronic health conditions. For instance, type II diabetes incidence and death rates are three times and 2.5 times higher, respectively, for AI/ANs than for non-Hispanic Whites. Despite significant improvements in rates of End Stage Renal Disease (ESRD) as the result of the highly successful Special Diabetes Program for Indians (SDPI), AI/AN communities continue to experience the highest incidence and prevalence of ESRD.

Increased physical distancing and isolation under the COVID-19 pandemic have led to recent and alarming spikes in drug overdose deaths, suicides, and other mental and behavioral health

¹ South Dakota Department of Health. Mortality Overview. Retrieved from <https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf>

² Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.

³ Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

challenges. Population-specific data on increased drug overdose and suicide deaths during the pandemic are currently unavailable; yet if trends prior to the rise of COVID-19 are any indicator of risk, it is safe to assume that AI/AN People are experiencing serious challenges. One of the major drivers of increased mortality rates among AI/ANs overall has been significantly higher rates of drug overdose and suicide deaths than the general population.

So, into this neglected and stunted health system on which American Indians and Alaska Native rely - into this system which is, collectively, the living expression of how seriously the federal government takes Treaty obligations and the Trust responsibility that requires the provision of full and quality health care for American Indians and Alaska Natives - into all of this theatre of failure comes COVID-19.

Impact of COVID-19 and Vaccine Efforts in Indian Country

As of March 16, 2021, IHS has reported 188,783 positive COVID-19 cases, with a cumulative percent positive rate of 9.5% across all twelve IHS Areas.⁴ However, IHS numbers are highly likely to be underrepresented because case reporting by Tribally-operated health programs, which constitute roughly two-thirds of the Indian health system, are voluntary. According to data analysis by APM Research Lab, AI/ANs are experiencing the second highest aggregated COVID-19 death rate at 51.3 deaths per 100,000. The CDC reported on March 12, 2021, A/ANs were 3.7 times more likely than non-Hispanic white people to be hospitalized and 2.4 times more likely to die from COVID-19 infection. Reporting by state health departments has further highlighted disparities among AI/ANs.

- According to the Centers for Disease Control and Prevention (CDC), AI/AN People are 1.7 times (70%) more likely to be diagnosed with COVID-19 when compared to non-Hispanic white people
- According to the CDC, **AI/ANs are 3.7 times (370%) more likely to require hospitalization when compared to non-Hispanic white people**
- According to the CDC, **AI/ANs are 2.4 times (240%) more likely to die from COVID-19-related infection when compared to non-Hispanic white people.**
- There have been 5,981 AI/AN deaths related to COVID-19 complications since the pandemic was declared. **Nearly 60% of these deaths are from New Mexico, Arizona, and Oklahoma⁵**
- **In Alaska, 37% of the total state's deaths are reported to be AI/ANs⁶**
- The disparity in COVID-19-related death rates is not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the largest disparities. Among AI/ANs aged 20-

⁴ Indian Health Service. COVID-19 Cases by IHS Area. <https://www.ihs.gov/coronavirus/>

⁵ National Indian Health Board. March 17, 2021 CDC Provisional Death Count of AI/ANs, 5,981 US, with State Deaths, % of State Deaths and % of US Deaths. <https://public.tableau.com/profile/nihb.edward.fox#!/vizhome/CDCMarch1720215981AIANDeathsfromCOVID19/March172021CDCProvisionalDeathCountofAIANs5981USwithStateDeathsofStateDeathsandofUSDeaths>

⁶ National Indian Health Board. March 17, 2021 CDC Provisional Death Count of AI/ANs, 5,981 US, with State Deaths, % of State Deaths and % of US Deaths. <https://public.tableau.com/profile/nihb.edward.fox#!/vizhome/CDCMarch1720215981AIANDeathsfromCOVID19/March172021CDCProvisionalDeathCountofAIANs5981USwithStateDeathsofStateDeathsandofUSDeaths>

29 years, 30-39 years, and 40-49 years, the COVID-19-related **mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts**⁷

- Across 23 states, the cumulative incidence rate of laboratory-confirmed COVID-19 infections was **3.5 times (350%) higher among AI/ANs persons than that of non-Hispanic white persons**⁸

Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS⁹, Tribal governments have innovatively found ways of maximizing third party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third party collections can constitute up to 60% of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third party reimbursement shortfalls ranging from \$800,000 to \$5 million per Tribe, per month. In a hearing before House Interior Appropriations on June 11, 2020, former IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30-80% below last year's collections levels, and that it would likely take years to recoup these losses.

The COVID-19 pandemic has highlighted the weaknesses and gaps in public health infrastructure in Indian Country, and vaccine distribution has shown similar results. Tribal governments were forced to rely upon the vaccine dissemination channels created by the federal government. Tribal governments were forced to choose between receiving any one of the available vaccines through either the state in which they reside or through IHS, rather than providing the vaccine directly to the Tribes themselves. This sidestepping of the government-to-government relationship can and should be avoided in the future.

H.R. 1319, The American Rescue Plan, provides \$600 million specifically for vaccine activities in Indian Country. As of March 16, 2021, there have been 1.243 million vaccines distributed through IHS, and 761,646 doses have been administered. The latest number from IHS regarding the number of vaccines administered by the tribes who received the vaccine through states is 178,000 doses. NIHB is optimistic how this funding will impact this continued effort in eradicating the disease.

For some states in the country, vaccine administration, or “shots in arms,” have been less than ideal. However, Tribal government vaccine rollouts have been far outpacing their state counterparts. Regardless of how a Tribe obtained the vaccines, once they had them in hand, Tribes were able to get the doses in the arms of their citizens faster and more efficient than most of their surrounding communities and states. For instance, the state of Alaska had vaccinated 91,000

⁷ Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1853–1856. DOI: [http://dx.doi.org/10.15585/mmwr.mm6949a3external icon](http://dx.doi.org/10.15585/mmwr.mm6949a3external%20icon)

⁸ Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1166–1169. DOI: <http://dx.doi.org/10.15585/mmwr.mm6934e1>

⁹ Per capita spending at IHS in FY 2018 equaled \$3,779 compared to \$9,409 in national health spending per capita; \$9,574 in Veterans Health Administration spending per capita; and \$13,257 per capita spending under Medicare.

people at the end of January 2021 and 10,000 of those shots were administered to Tribal patients. The Chickasaw Nation of Oklahoma has done so well in vaccinating their citizens, they have recently opened their vaccine efforts to the community, regardless of if they are IHS eligible or not. Anyone in Oklahoma can now receive the vaccine through the tribe. For the Rosebud Sioux Tribe, they have been vaccinating those in their community nearly double the rate of South Dakota.¹⁰ In an analysis by the AP, federal data showed Native Americans were getting vaccinated at a higher rate than all but five states by the end of February 2021.¹¹

Systemic Barriers in COVID-19 Response

At the core of the federal trust responsibility to Tribal Nations is the fact that the federal government is supposed to ensure the health and welfare of Native peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold their end of the bargain in a way that is perhaps unparalleled in modern American history. However, Tribes are increasingly running into systemic barriers that impede their ability to actually receive help from the federal government and this is slowing or even outright denying access to aid.

One reason is because in all but the latest COVID-19 relief packages, the federal government decided to use competitive grant making as a means of distributing funds to Tribes. To apply for competitive grants, you need staff to put together an application. Tribes that were lower resourced found themselves having to use a skeleton staff to put together applications in order to have access to funds that they needed in order to provide care for their people. If Tribes could not pull together these resources, they were excluded from being able to apply for these pots of money.

Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. **The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the quality of a grant application – yet that is the construct that the federal government has forced Tribes to operate under.** That is unacceptable.

Instead, a more effective way to distribute aid to Tribes would be through a fixed funding formula that ensures sufficient, recurring, sustainable funding reaches all Tribal Nations. Doing so would allow Tribes to know that the funding was coming to them, how much they were getting, and be able to plan to utilize that money to help their citizens. It would have also alleviated the burden on Tribes to use their staff to apply for grant funding and allowed them to use their limited resources to treat the issue at hand. We were pleased, for the first time, Congress provided a dedicated, standalone section to Indian health in the American Rescue Plan. This type of mechanism in the law is precisely what Indian Country has been asking for and avoids competitive grants altogether.

¹⁰ NPR. Why Native Americans Are Getting COVID-19 Vaccines Faster. <https://www.npr.org/2021/02/19/969046248/why-native-americans-are-getting-the-covid-19-vaccines-faster>

¹¹ AP. Native Americans embrace vaccine, virus containment measures. <https://apnews.com/article/native-americans-coronavirus-vaccine-9b3101d306442fbc5198333017b4737d>

Another issue was the insufficient notice of funding opportunities. Many Tribes were not told what opportunities were available or how they would be able to access the funding. Given the Trust Responsibility, we would expect HHS to take special care to ensure that Tribes know of these opportunities and are able to submit any required documentation within a timely manner. Tribes were also forced to deal with agencies with whom they had little experience or knowledge. For example, in the initial funding allocations, aid to Tribes was distributed through the CDC and not IHS. This, in turn, created a delay in receiving funding as the CDC had to create a mechanism to either distribute the funding themselves or transfer the money to IHS. However, in the American Rescue Plan, funds were directed to flow through IHS, who already has an existing relationship with tribes to release these funds more efficiently and effectively.

We have felt deeply troubled by the systemic barriers that historically impeded the federal government's response to this crisis. As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were largely left behind during the nation's development of its public health infrastructure, and Tribal health systems continue to be chronically underfunded. As a result, many Tribal public health systems remain far behind that of most state, territorial, and even city and county health entities in terms of their capacity, including for disease surveillance and reporting; emergency preparedness and response; public health law and policy development; and public health service delivery. However, the American Rescue Plan provided unprecedented investments to Indian Country, especially regarding Indian health. With over \$6 billion being injected into the I/T/U systems, we are encouraged to witness the effects of this funding and the improvements that will be made to care, facilities, and AI/AN Peoples' lives. But we must ask ourselves, what has led us up to this point? Additionally, CDC must continue its trajectory of making meaningful and sustainable direct investments into Tribal communities for public health – thus further closing the gap in the disparities of lower health status, and lower life expectancy of AI/AN Peoples compared to the general population. We are thankful for the Members of this subcommittee and the continued support they have given Indian Country through this pandemic and all the support you have provided to our communities to end this pandemic.

Recommendations

The U.S. must continue to honor its trust and treaty obligations in its response to COVID-19. Thus far, the IHS has secured billions in emergency aid from Congress and through inter-agency transfers from HHS. These investments were necessary, but nowhere near sufficient, to stem the tide of the pandemic. NIHB is delighted to see more than \$6 billion secured in the American Rescue Package for Indian health with maximum flexibility and no expenditure deadline. This funding nearly doubles the annual discretionary budget of IHS and will go so far in the continued response to the pandemic, as well as rebuilding our communities. NIHB is pleased to see Indian health prioritized in so many areas often overlooked, such as lost third party billing, IHS facilities improvements, additional Purchased/Referred Care (PRC) dollars, dedicated funding to information technology and telehealth access, and potable water delivery. In swift fashion, the administration has already conducted Tribal consultation and urban Indian confer. This came less than a week after the legislation became law and they begin to disseminate this supplemental funding. **While the American Rescue Plan provides much needed to support to**

Indian Country's ongoing requests, the pandemic is far from over and there is work still left to be done:

1. Provide Full Funding and Mandatory Appropriations for the Indian Health Service

The Indian Health Service (IHS) is the only federal healthcare system created as the result of treaty obligations. It is also the most chronically underfunded federal healthcare system, and **the only federal healthcare system not exempt from government shutdowns or continuing resolutions.** Compared to the three other federal health care entities – Medicare, Medicaid, and the Veterans Health Administration – IHS is by far the most lacking in necessary support. In 2018 the Government Accountability Office (GAO-19-74R) reported that from 2013 to 2017, IHS annual spending increased by roughly 18% overall, and roughly 12% per capita. In comparison, annual spending at the Veterans Health Administration (VHA), which has a similar charge to IHS, increased by 32% overall, with a 25% per capita increase during the same time period. Similarly, spending under Medicare and Medicaid increased by 22% and 31% respectively. In fact, even though **the VHA service population is only three times that of IHS, their annual appropriations are roughly thirteen times higher.**

Tribal treaties are not discretionary. The IHS budget should not be discretionary either. **Congress must work 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, including the comorbidities that increase the risk of death due to the novel coronavirus.**

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. 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 117th Congress 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, Congress must enact a budget for IHS that is bold, effective, and 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.

- Phase in full funding of the Indian Health Service and 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 and advanced 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*.
- Insulate IHS from the effects of budget sequestration, shutdowns, and stopgap measures through advance appropriations.
- Permanently reauthorize the Special Diabetes Program for Indians (SDPI) at a minimum of \$250 million with automatic annual funding increases tied to the rate of medical inflation.

2. Prioritize Tribal Water and Sanitation Infrastructure

Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide. In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of “honey buckets” that are disposed in environmentally hazardous sewage lagoons. Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households roughly 71 times higher than the cost of water in urban areas with municipal water access. **When asked to wash their hands to keep them safe from COVID-19, some tribal members are unable to do so from the lack of clean, running water.**

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. The lack of access to safe drinking water and basic sanitation in Indian Country negative impacts the public health of AI/AN communities.

- 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.

3. Increase Support for Tribal Mental and 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.¹² 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.¹³ 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.

- Enact the Native Behavioral Health Access Act, ensuring funding will reach every Tribe in a Tribally designed and approved formula, rather than competitive grant, 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 additional provider types that render behavioral health services through Medicare and Medicaid, including Professional Counselor, Licensed Marriage and Family Therapist, and similar types of providers that are currently excluded.
- Create set aside, non-competitive funding for Tribes in all general funding streams to support behavioral and mental health initiatives.

4. Provide Greater 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 Office¹⁴, between Fiscal Year 2013 and Fiscal Year 2018, third party collections at IHS and Tribal facilities increased by \$360 million,

¹² 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

¹³ 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>

¹⁴ See <https://www.gao.gov/assets/710/701133.pdf>

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.

- 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 (IHCIA)—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).
- Extend full federal funding through a 100% Federal Medical Assistance Percentage (FMAP) rate for Medicaid services furnished by Urban Indian Organizations (UIOs) to AI/ANs.
- 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 service is provided.
- Exempt AI/ANs 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 are designed as a cost-saving measure for the state

5. Create 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.

- Make the IHS Scholarship and Loan Repayment Program tax-exempt.
- Focus on providing aid to students from Tribal communities so they can return to them and expand the program so that it includes additional provider types eligible for the funding.

- Create new and additional set aside funding for Tribal medical residency programs; and require a Tribal set aside within the annual Medicare funding of Graduate Medical Education (GME) for require service to Tribal communities.
- 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.

6. Increase Telehealth Capacity in Indian Country while Expanding 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 COVID19 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.

Tribes have been unable to take full advantage of recent federal regulatory flexibilities in use of telehealth under Medicare. Because the new flexibilities would sunset at the conclusion of the public health emergency, it is economically and financially unfeasible for many Tribes to make costly investments into telehealth infrastructure and equipment for a short-term authority. While mainstream hospital systems have largely made a seamless transition to telehealth, Tribes once again remain behind due to lack of historical investment.

- Fund a study of Tribal lands to determine where broadband access gaps exist and the best technologies to address them.
- Fund the broadband expansion 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.
- Permanently extend the existing waiver authority for use of telehealth under Medicare.
- Retire telehealth restrictions to allow for continuation of telehealth beyond the national emergency context.

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

HHS 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 UIOs 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.

- Provide funding needed to establish a fully functional and comprehensive health IT system for the Indian health system that is fully interoperable with Tribal, urban, private sector, and Department of Veterans Affairs (VA) HIT systems.
- Offset costs for Tribes that have already expended to modernize their system in the absence of federal action.
- 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.

8. 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 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. **All IHS programs and funds should 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. Additionally, authorizing interagency transfer of funds from other HHS operating divisions to HIS is the best interim step, 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.

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 programs more responsive and effective.

The most prominent example where the maximum self-governance is needed is the Special Diabetes Program for Indians (SDPI). Established by Congress in 1997, SDPI addresses the disproportionate impact of type II diabetes in AI/AN communities. It is the 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.¹⁵ A 2019 federal report found SDPI to be largely responsible for \$52 million in savings in Medicare expenditures per year.¹⁶ 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 2017.¹⁷

Congress was able to secure the cost savings to pay for a three-year extension of SDPI through the end of FY 2023. 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 ISDEAA. This technical change would prevent any administrative delays in implementation of the 638 provision, and further clarify the purpose of the new authority. By specifically citing certain sections of P.L. 93-638, the technical change would ensure that IHS awards SDPI funds 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).

- Enact a permanent expansion of Tribal self-determination and self-governance across all agencies within HHS and affirm that all programs at 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.

¹⁵https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

¹⁶https://aspe.hhs.gov/system/files/pdf/261741/SDPI_Paper_Final.pdf

¹⁷<https://www.ihs.gov/newsroom/ihs-blog/april-2020-blogs/new-study-shows-decrease-in-diabetes-prevalence-for-american-indianand-alaska-native-adults/>

- Authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts.
- 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.

Conclusion

Our treaties stand the test of time. They are the Supreme Law of this land. If a nation's honor and exceptionalism is a measure of its integrity to its own laws and creed, then one must look no further than the United States' continued abrogation of its own treaties to recognize that its honor is in short supply. Every square inch of this nation is Our People's land. As the sole national organization committed to advocating for the fulfilment of the federal government's trust and treaty obligations for health, we will always be dedicated to bringing into fruition the day where Our People can state with dignity that the United States held true to its solemn word. Ideally, fulfillment of trust and treaty obligations should be without debate and the U.S. should honor its promises. These lands and natural resources, most often acquired from us shamefully, are the bedrock of U.S. wealth and power today.

In closing, we thank the Committee for the continued commitment to Indian Country and urge you to further prioritize Indian Country as you continue to provide relief regarding the COVID-19 pandemic. We patiently remind you that federal treaty obligations to the Tribes and AI/AN People exist in perpetuity and must not be forgotten during this pandemic. We thank you that American Indians and Alaska Natives will continue to be prioritized to receive the vaccine, have sufficient funds to build and maintain a public health infrastructure, and the full faith and confidence of the United States Government will further be committed to this nation's first citizens to eradicate this disease. As always, we stand ready to work with you in a bipartisan fashion to advance health in Indian Country.