

**CHALLENGES AND OPPORTUNITIES FOR
IMPROVING HEALTHCARE DELIVERY IN
TRIBAL COMMUNITIES**

OVERSIGHT HEARING

BEFORE THE

SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

Wednesday, March 29, 2023

Serial No. 118-14

Printed for the use of the Committee on Natural Resources



Available via the World Wide Web: <http://www.govinfo.gov>

or

Committee address: <http://naturalresources.house.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

51-763 PDF

WASHINGTON : 2023

COMMITTEE ON NATURAL RESOURCES

BRUCE WESTERMAN, AR, *Chairman*
DOUG LAMBORN, CO, *Vice Chairman*
RAÚL M. GRIJALVA, AZ, *Ranking Member*

Doug Lamborn, CO	Grace F. Napolitano, CA
Robert J. Wittman, VA	Gregorio Kilili Camacho Sablan, CNMI
Tom McClintock, CA	Jared Huffman, CA
Paul Gosar, AZ	Ruben Gallego, AZ
Garret Graves, LA	Joe Neguse, CO
Aumua Amata C. Radewagen, AS	Mike Levin, CA
Doug LaMalfa, CA	Katie Porter, CA
Daniel Webster, FL	Teresa Leger Fernández, NM
Jennifer González-Colón, PR	Melanie A. Stansbury, NM
Russ Fulcher, ID	Mary Sattler Peltola, AK
Pete Stauber, MN	Alexandria Ocasio-Cortez, NY
John R. Curtis, UT	Kevin Mullin, CA
Tom Tiffany, WI	Val T. Hoyle, OR
Jerry Carl, AL	Sydney Kamlager-Dove, CA
Matt Rosendale, MT	Seth Magaziner, RI
Lauren Boebert, CO	Nydia M. Velázquez, NY
Cliff Bentz, OR	Ed Case, HI
Jen Kiggans, VA	Debbie Dingell, MI
Jim Moylan, GU	Susie Lee, NV
Wesley P. Hunt, TX	
Mike Collins, GA	
Anna Paulina Luna, FL	
John Duarte, CA	
Harriet M. Hageman, WY	

Vivian Moeglein, *Staff Director*
Tom Connally, *Chief Counsel*
Lora Snyder, *Democratic Staff Director*
<http://naturalresources.house.gov>

SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS

HARRIET M. HAGEMAN, WY, *Chair*
JENNIFER GONZÁLEZ-COLON, PR, *Vice Chair*
TERESA LEGER FERNÁNDEZ, NM, *Ranking Member*

Aumua Amata C. Radewagen, AS	Gregorio Kilili Camacho Sablan, CNMI
Doug LaMalfa, CA	Ruben Gallego, AZ
Jennifer González-Colón, PR	Nydia M. Velázquez, NY
Jerry Carl, AL	Ed Case, HI
Jim Moylan, GU	Raúl M. Grijalva, AZ, <i>ex officio</i>
Bruce Westerman, AR, <i>ex officio</i>	

CONTENTS

	Page
Hearing held on Wednesday, March 29, 2023	1
Statement of Members:	
Hageman, Hon. Harriet M., a Representative in Congress from the State of Wyoming	1
Leger Fernández, Hon. Teresa, a Representative in Congress from the State of New Mexico	3
Statement of Witnesses:	
Alkire, Janet, Great Plains Area Representative, National Indian Health Board, Washington, DC	5
Prepared statement of	7
Questions submitted for the record	13
Church, Jerilyn LeBeau, Chief Executive, Great Plains Tribal Leaders Health Board, Rapid City, South Dakota	16
Prepared statement of	17
Questions submitted for the record	24
Platero, Laura, Executive Director, Northwest Portland Area Indian Health Board, Portland, Oregon	31
Prepared statement of	33
Questions submitted for the record	39
Rosette, Maureen, Chief Operations Officer, the NATIVE Project; Board Member, National Council of Urban Indian Health, Washington, DC	44
Prepared statement of	45
Questions submitted for the record	48
Additional Materials Submitted for the Record:	
Submissions for the Record by Representative Westerman	
Oglala Sioux Tribe, Statement for the Record	63
Salt River Pima-Maricopa Indian Community, Letter to Chairwoman Hageman dated April 10, 2023	75
Submission for the Record by Representative Grijalva	
United South and Eastern Tribes (USET) Sovereignty Protection Fund, Statement for the Record	77

OVERSIGHT HEARING ON “CHALLENGES AND OPPORTUNITIES FOR IMPROVING HEALTH-CARE DELIVERY IN TRIBAL COMMUNITIES”

Wednesday, March 29, 2023
U.S. House of Representatives
Subcommittee on Indian and Insular Affairs
Committee on Natural Resources
Washington, DC

The Subcommittee met, pursuant to notice, at 10:04 a.m., in Room 1324, Longworth House Office Building, Hon. Harriet M. Hageman [Chairwoman of the Subcommittee] presiding.

Present: Representatives Hageman, Radewagen, LaMalfa, González-Colón; Leger Fernández, and Sablan.

Ms. HAGEMAN. Good morning. The Subcommittee on Indian and Insular Affairs will come to order.

Without objection, the Chair is authorized to declare a recess of the Subcommittee at any time. The Subcommittee is meeting today to hear testimony on “Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities”.

Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman and the Ranking Minority Member. I therefore ask unanimous consent that all other Member’s opening statements be made part of the hearing record if they are submitted in accordance with Committee Rule 3(o).

Without objection, it is so ordered.

I will now recognize myself for an opening statement.

STATEMENT OF THE HON. HARRIET M. HAGEMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Ms. HAGEMAN. Through treaties and Federal statutes, the Federal Government has assumed the responsibility of providing healthcare for American Indians and Alaska Natives. The Indian Health Service, or IHS, is the primary agency charged with providing health services to Native people and tribal communities throughout the United States.

IHS provides an array of medical services to Native people including in-patient, ambulatory, emergency, dental, public health nursing, and preventative healthcare.

The agency provides for healthcare in two ways, by direct service and through self-determination compacts and contracts. Direct service healthcare is care provided by Federal employees—doctors, nurses, and healthcare professionals directly to American Indians and Alaska Natives.

Beginning in the late 1970s, Congress granted authority to tribes for self-determination compacts and contracts of IHS services through the Indian Self-Determination and Education Assistance

Acts or ISDEAA, meaning that a tribe could independently operate their own tribal healthcare facilities. However, ISDEAA does not remove the responsibility that the Federal Government has taken upon itself to provide for the care of American Indians and Alaska Natives.

American Indians and Alaska Natives have much lower health outcomes than the average American, including lower life expectancy, and higher levels of disease, including diabetes and heart disease.

Currently, a Native person's life expectancy is 5½ years less than the average American. The IHS mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

To meet this mission, there is a lot of work to do and IHS must do better. IHS has long been plagued with issues of sub-standard medical care, various personnel issues, poor staff performance, aged facilities and equipment, unqualified staff, backlogs in billing and claims collections, and others.

Many of these issues first came to national attention in 2010, when a Senate report was issued on the utter failings of the IHS facilities in the Great Plains Area.

For over a decade, the Health and Human Services Inspector General and the Government Accountability Office have indicated that inadequate oversight of healthcare continues to hinder the ability of IHS to provide an adequate quality of care despite continued increases in the agency's budget.

In 2017, the GAO placed IHS on their high-risk list as one of the government programs and operations vulnerable to waste, fraud, and abuse. While IHS has made some progress on key recommendations, more work remains.

In the GAO's 2021 update, it indicated that IHS still had seven open recommendations at the end of 2020, one of which was from 2017, and it had still not yet been completed.

This includes recommendations on developing processes to ensure effective delivery of care, to prevent provider misconduct and substandard performances, and to collect information to inform agency decisions on resource allocation and staffing.

In 2023, IHS began developing and implementing an agency workplan to make an immediate impact on the Indian Health System and align processes with the IHS mission and strategic plan developed in 2019.

These are good starting steps, but that is just what they are, starting steps. It would have been helpful to hear from the Director of IHS today and how they are implementing the plan and what steps remain, however, despite ample notice of the hearing date and the importance of the subject matter of today's hearing, the IHS declined to be with us today.

I am deeply troubled with the Department of Health and Human Services and the IHS in their lacked capacity to prepare for this hearing.

I want to thank the witnesses that are here, and I look forward to their testimony.

The Chair now recognizes the Ranking Minority Member for her statements.

STATEMENT OF THE HON. TERESA LEGER FERNÁNDEZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. LEGER FERNÁNDEZ. Thank you so much, Madam Chair. I think this is a very important and welcome hearing because of the importance of making sure that we do meet our trust obligations and that we continue to seek the healthiest of outcomes for our Native Americans.

The Indian Health Service has been the topic of numerous hearings before this Committee, including, I think, we looked at that as a very first hearing in the 117th Congress because we were dealing with the aftermath and what did we need to do moving forward in dealing with the pandemic.

But as the Chair noted, IHS provides critically, culturally, competent health services to American Indians and Alaska Natives across the United States through its own facilities and, importantly, through tribally operated facilities and Indian organizations, which we have with us today, which is I think some of the brightest points with regards to the provision of healthcare in this nation for Native Americans.

But, unfortunately, as tribal leaders, organizations, and studies like the U.S. Broken Promises Report have noted, Congress has grossly underfunded IHS compared to its need. The agency's per capita expenditure per person was only \$4,078 in Fiscal Year 2019, compared to the average U.S. national health expenditure of \$9,726. We are talking about half what is needed.

American Indians and Alaska Natives face steep health inequities compared to these other population groups in the United States, which makes that figure even more alarming. As noted, a tribal citizens-maintained life expectancy is around 5.5 years less than U.S. citizens. They experience higher death rates in many categories, including chronic liver disease and cirrhosis, diabetes, suicide, and chronic lower respiratory diseases.

Decades of Federal underfunding stymied IHS's ability to provide healthcare services to Indian Country. I am also concerned that IHS 1993 healthcare facilities construction priority list, which originally contained over 40 facilities identified as high need, remains incomplete.

We know that IHS hospitals have an average of 40 years, which is almost four times greater than other U.S. hospitals. In my own district, Navajo Nation citizens have been on the agency's sanitation facility construction list for years.

They still lack access to crucial water lines in the interim. This is outrageous and unacceptable, and we should raise our voices against it regularly and often. Too many tribal patients simply experience inadequate access to healthcare.

Let's be clear, we all know this in this panel today, that the Federal Government has not fully delivered on its trust and treaty promises to Indian Country, especially in this arena.

Last Congress, we began to address that. We passed the Bipartisan Infrastructure Law to deliver \$3.5 billion for IHS sanitation facilities. We also approved advanced appropriations. I know many of you are going to speak to that and I am adamant that we

need to make sure that we keep at least advanced appropriations going forward.

And it was because of the bipartisan work with leaders like the late Congressman Don Young. This has always been a bipartisan effort to make sure that IHS is funded, if not mandatory, then definitely advanced appropriations.

Because we now know that those advance appropriations are not permanent and that is something that I look forward to working with the Republican colleagues to see if we can get that done, since we got it for 2 years last cycle, and let's see if we can make it mandatory.

According to the Tribal Budget Formulation Workgroups Fiscal Year 2024 request, the total need for IHS in the upcoming year is \$50 billion. For too long, tribal health providers have faced uncertainty in the annual budget process and it is high time we fixed that.

While we certainly have broader budget discussions on this Committee in the coming months, I want to note today that the enacted budget and the budget request for recent years come nowhere near that estimate of need.

That is why I am concerned about the recent Republican budget proposal which will revert this year's budget back to Fiscal Year 2022 enacted levels. For IHS, that would amount to just \$6.6 billion. We know that is not enough.

For example, that would mean IHS would have to reduce outpatient services by nearly 1.6 million visits, 1.6 million visits would go away. Dental visits would be reduced by 120,000, mental health visits by nearly 90,000, and the outpatient services by 4,000.

If we saw a 22 percent reduction in funding levels, the numbers would be even worse. So, today, I look forward to learning from our expert panel about what you believe Congress and this Subcommittee must do to improve healthcare services.

And once again, I am a big fan of subcontracting and compacting. I worked on several of those efforts, and the Health Boards delivering services in Jemez Pueblo at Santo Domingo Pueblo are exemplary and I look forward to hearing from your testimony today.

Ms. HAGEMAN. Thank you very much.

Now, I will introduce our witnesses. Ms. Janet Alkire, Board Member for the National Indian Health Board, Washington, DC; Ms. Jerilyn Church, Executive Director of the Great Plains Tribal Leaders Health Board, Rapid City, South Dakota; Ms. Laura Platero, Executive Director of the Northwest Portland Area Health Board, Portland, Oregon; and Ms. Maureen Rosette, Board Member for the National Council of Urban Indian Health, Washington, DC.

Welcome. Thank you for coming. I know several of you traveled quite a long distance and we appreciate your willingness to come and discuss these incredibly important issues with us.

Let me remind the witnesses that under Committee Rules, they must limit their oral statements to 5 minutes, but their entire statement will appear in the hearing record.

To begin your testimony, please press the talk button on the microphone. We use timing lights. When you begin, the light will turn green. When you have 1 minute left, the light will turn yellow,

and at the end of the 5 minutes the light will turn red, and I will ask you to please complete your statement.

I will also allow all witnesses on the panel to testify before Member questioning.

The Chair now recognizes Ms. Janet Alkire for 5 minutes.

STATEMENT OF JANET ALKIRE, GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, WASHINGTON, DC

Ms. ALKIRE. Chairwoman, Ranking Member, and members of the Subcommittee, thank you for the opportunity to testify on behalf of the National Indian Health Board.

In our language [Speaking Native language] means I greet you with a good heart. My name is Janet Alkire. I am the Chairwoman of the Standing Rock Sioux Tribe. I am also the Great Plains Representative for the National Indian Health Board. I am here today with a heavy heart.

I prayed this morning this hearing doesn't bring me to tears. As I think about my people back home, I think about all the health problems that go untreated. Even preventable diseases become life threatening. I think about my people living in pain and spending way too much time fighting to get the smallest amount of healthcare and there is no other option.

How many hearings do we have to have here before Congress does something? Before this Subcommittee does something? The health of Indian people is getting worse, not better.

We have the lowest life expectancy, and Madam Chair you just described it also. Since 2019, our life expectancy fell—65 is 2 years before the Social Security retirement age. We are dying before we can even get a full Social Security check.

Most Americans are planning for years of retirement, grandkids, grandchildren. Indian people are surviving day to day. We live in the richest country in the world, a country that was built on our lands and resources.

We signed treaties, agreements. We reserved our homelands and agreed to give up vast lands and resources in exchange for programs and services from the United States. We exchanged our lands for healthcare.

I am here to say the United States and Congress is breaking these treaties. I am talking about all of us sitting here together in this room, we all need to talk to other Members of Congress to take action together.

Tribal Nations fought and negotiated to reserve our lands. We did not take these agreements lightly. It is time for the United States to live up to its end of the bargain. This is not a hard problem to solve.

We need a surge in funding, as you mentioned, to bring IHS to modern healthcare standards, and then Congress must increase annual IHS funding three times just the same as everyone in the United States.

We need basic facilities and services. We need hospitals, clinics and you described many—we need surgical care, maternity wards, ambulances, dialysis, CT scans. The same equipment and healthcare that everyone else receives.

The IHS hospital at Standing Rock is more than 60 years old. It is falling apart and lacks space for life-saving equipment. We recently purchased a CT scan with our own limited funds. There was no room and we had to build it in a back entry to the building, but we do what we have to do, right?

Our babies cannot be born on our reservations. Mothers have to leave their support network, their families, sometimes the dads, definitely the grandmothers behind and travel over 75 miles to deliver a baby.

I have a story I wish I could share to you, but I know time is limited, but if we get time, I would love to share a cultural story relating to this.

On our reservation, they don't fill cavities, they pull teeth. Our members line up at 6 a.m. in the freezing winter hoping they will get one of four dental appointments at 7 o'clock, covered in blankets so they can stand in line. If you don't get those four, you are out. You don't get it.

We expect to lose our teeth, not get them fixed. We finally have four dentists, which I learned yesterday, but no dental assistants.

I know we have made some small progress in recent years. In 2010, as you mentioned, the Indian Health Care Improvement Act, Special Diabetes Program for Indians, but we need to continue to work on these things.

Congress must provide mandatory funding for IHS. Our treaties are the law of the land. The United States' commitment to Indian healthcare is the same as the commitment to veterans, which I am proudly a United States Air Force veteran.

Second, Congress must permanently reauthorize the Special Diabetes Program for Indians before it expires in September of this year. The program should be funded, at a minimum of \$250 million annually.

Third, contract support costs and 105 leasing funds must be mandatory and paid in full. We cannot run health facilities and health programs on uncertain budgets. Finally, IHS must recruit and retain professional healthcare.

These are all important, but what is really needed is right in front of us. Congress must live up to its treaty commitments, bring IHS facilities to modern standards, and increase the funding.

After this hearing, I will return home to our financially starved Indian Health Service Hospital covered in snow and running on boiler heat in below freezing temperatures. I will give all my time and energy to help my people in need, working my vision for a new medical facility, as you mentioned, that list is very old.

And I will be waiting. I will be waiting for this Subcommittee and Congress to finally take action. Congress must pay its overdue debts and provide American Indians and Alaska Natives the healthcare that we deserve and the healthcare we were promised.

[Speaking Native language.] Thank you.

[The prepared statement of Ms. Alkire follows:]

PREPARED STATEMENT OF JANET ALKIRE, GREAT PLAINS AREA REPRESENTATIVE,
NATIONAL INDIAN HEALTH BOARD

Chairwoman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board and the 574 sovereign federally recognized American Indian and Alaska Native Tribal nations we serve, thank you for this opportunity to provide testimony on challenges and opportunities for improving healthcare delivery in Tribal communities. My name is Janet Alkire. I serve as Tribal Council Chairwoman for the Standing Rock Sioux Tribe and Great Plains Area Representative for the National Indian Health Board (NIHB).

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for Indian people.¹ Its success is essential to our success as an organization, and to meeting this Nation's stated policy goal of ensuring the highest possible health status for Indians.² The NIHB therefore appreciates this Subcommittee's focus on Indian healthcare and stands ready to work with the Subcommittee toward achieving this national goal. We have a long way to go.

The NIHB Board of Directors sets forth an annual Legislative and Policy Agenda to advance the organization's mission and vision. Our objectives are to educate policymakers about Tribal priorities, advocate for and secure resources, build Tribal health and public health capacity, and support Tribally led efforts to strengthen Tribal health and public health systems. Today's testimony includes a subset of recommendations from this Agenda.

Summary Recommendations

1. **Reauthorize the Special Diabetes Program for Indians (SDPI) before September 30, 2023.**
2. **Authorize full mandatory funding for all IHS programs. Until then:**
 - a. **Authorize mandatory funds for Contract Support Costs and 105(l) Lease Payments.**
 - b. **Authorize discretionary advance appropriations.**
 - c. **Protect the IHS budget from "sequestration" cuts**
 - d. **Authorize Medicaid reimbursements for Qualified Indian Provider Services**
 - e. **Authorize federally-operated health facilities and IHS headquarters offices to reprogram funds at the local level in consultation with Tribes**
3. **Oversee federal agency data sharing policies to ensure compliance with existing law**
4. **Improve Health Professional Staffing in the Indian Health System**
5. **Support Tribal self-governance expansion at the Dept. of Health and Human Services**

The Trust Obligation

Tribal nations have a unique legal and political relationship with the United States. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.³ In fulfillment of this tribal trust relationship, the Supreme Court declared in 1832 that the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal nations.⁴ In 1976, Congress reaffirmed its duty to provide for Indian health care when it enacted the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1602), declaring that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy.

Current Health Status

Today, 47 years after the enactment of IHCIA, American Indians and Alaska Natives (AI/ANs) collectively still face the lowest health status of any group of

¹ <https://www.ihs.gov/aboutihs/>

² 25 U.S.C. 1602(i)

³ *Worcester v. Georgia*, 31 U.S. 515 (1832).

⁴ *Seminole Nation v. United States*, 316 U.S. 286, 296–97 (1942).

Americans. The Centers for Disease Control and Prevention (CDC) reported last year that life expectancy for AI/ANs has declined by nearly 7 years, and that our average life expectancy has *declined* to 65 years—10.9 years less than the national average and equivalent to the nationwide average in 1944.^{5,6} Native Americans die at higher rates than those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.⁷ Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.⁸ The CDC also found that, between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.⁹ Native Americans are also more likely than people in other U.S. demographics to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.¹⁰ According to a 2020 study by the Substance Abuse and Mental Health Services Administration, AI/ANs experience the highest rates of suicide,¹¹ with a recent, February 2023 CDC report finding that teen girls are experiencing record high levels of violence, sadness, and suicide risk.¹²

Historical—and Ongoing—Trauma

Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups which have been attributed, in part, to the ongoing impacts of historical trauma.^{13,14} AI/ANs have suffered physical, mental, emotional and spiritual harms resulting from historical and intergenerational trauma that began with colonization and the Doctrine of Discovery, whereby Tribal lands were seized and claimed by governments under the auspices that Tribal lands were “undiscovered” prior to colonization. Colonization further includes a history of genocide against AI/AN people, which spread with westward expansion and forced removal and relocation of numerous Tribes in the 1830s.

Cultural genocide followed. In 1869, the U.S. Government, as a part of efforts to assimilate AI/ANs into non-Native culture, adopted the Indian Boarding School Policy to eradicate AI/AN language, culture, and identity through forced separation and removal of AI/AN children from their families and Tribal communities. Between 1869 and the 1960s, more than 100,000 AI/AN children were removed from their family homes and placed in over 350 schools operated by the Federal Government and churches. Children were punished for speaking their Native languages, banned from expressing traditional or cultural practices, stripped of traditional clothing and hair, and experienced physical, mental, emotional, and spiritual abuse, including malnourishment, sexual assault, and medical experimentation. Many AI/AN children died at boarding schools while separated from their families and Tribal communities, the true number of which is currently unknown due in part to suppression and inaccessibility of both government and church records.

⁵ U.S. Department of Health and Human Services, *Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021* (hereinafter, “*Provisional Life Expectancy Estimates*”), Report No. 23, August 2022, available at: <https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf>, accessed on: March 20, 2023 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).

⁶ *Id.*

⁷ See, U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter “*Broken Promises*”), 65, available at: <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>, accessed on: March 20, 2023.

⁸ *Broken Promises* at 65.

⁹ *Broken Promises* at 65.

¹⁰ *Broken Promises* at 79–84.

¹¹ Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States, Results from the 2020 National Survey on Drug Use and Health*, available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFPRPDFWHTMLfiles2020/2020NSDUHFPRPDFW102121.pdf>, accessed on: March 22, 2023.

¹² Centers for Disease Control and Prevention, *PRESS RELEASE: U.S. Teen Girls Experiencing Increased Sadness and Violence*, available at: <https://www.cdc.gov/media/releases/2023/p0213-yrbs.html>, accessed on: March 22, 2023.

¹³ Walls, et al., *Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest*, *COMMUNITY MENTAL HEALTH J.*, Vol. 42, No. 6 (2006) at 522, <https://link.springer.com/content/pdf/10.1007%2Fs10597-006-9054-7.pdf>, accessed on: March 20, 2023.

¹⁴ Kathleen Brown-Rice, *Examining the Theory of Historical Trauma Among Native Americans*, *PROFL COUNS*, available at: <http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/>, accessed on: March 20, 2023.

Over 100 years of cultural genocide at Indian Boarding Schools is not relegated to distant memory but exists in the living memory of many Tribal members today, and the legacy of unresolved historical and intergenerational trauma caused by the schools has created health inequities and disparities, detrimental physical and behavioral health outcomes, and lack of meaningful connection to Native identity for many Tribal members. Research links AI/AN historical and intergenerational trauma to increased rates of depression, suicidal ideation, substance use disorders, domestic violence and sexual assault, and a lower life expectancy than any other group in the United States. That is why addressing the harm of historical and intergenerational trauma and the efficacy of Tribally led and culturally appropriate healing is an essential component of improving holistic health outcomes for AI/AN people.

Chronic Underfunding

In December 2018, the U.S. Commission on Civil Rights' Broken Promises report found that Tribal nations face an ongoing health crisis that is a direct result of the United States' chronic underfunding of Indian health care for decades, which contributes to vast health disparities between Native Americans and other U.S. population groups.¹⁵

According to IHS data from April 2022, actual IHS spending per user remains less than half of Medicaid spending per enrollee, less than half of Veterans medical spending per patient, and less than one-third of Medicare spending per beneficiary—even after including 3rd party revenue received by IHS.¹⁶ The Federal Disparity Index Benchmark, which assumes IHS users are provided services similar to those available to the U.S. population, recommends more than twice the investment per user than IHS receives¹⁷—an estimate that excludes approximately two-thirds of the population that could be served by an appropriately funded IHS.¹⁸

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.

Recommendations

1. Reauthorize the Special Diabetes Program for Indians (SDPI) before September 20, 2023.

Congress established the Special Diabetes Program for Indians (SDPI) in 1997 to address the disproportionate impact of type 2 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

¹⁵ *Broken Promises* at 65.

¹⁶ Indian Health Service, *email correspondence to the National Tribal Budget Formulation Workgroup*, attachment "2021 IHS Expenditures Per Capital and other Federal Care Expenditures Per Capita—4-27-2022," dated February 14, 2023.

¹⁷ *Id.*

¹⁸ The Indian Health Service estimates the population served as of January 2020 at 2.56 million; The U.S. Census Bureau estimates the AI/AN population as of July 2021 at 7.2 million.

disease among AI/AN adults.¹⁹ A 2019 federal report found SDPI to be largely responsible for \$52 million in savings in Medicare expenditures per year.²⁰

Still, diabetes and its complications remain major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (14.5 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.4 percent).²¹ In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.²²

The NIHB strongly supports the permanent reauthorization of the SDPI at a minimum of \$250 million annually, with automatic annual funding increases matched to the rate of medical inflation. SDPI has been flat funded since FY 2004. It is also important to note that last year, the Department of Health and Human Services (HHS) expanded the pool of potential grantees beyond current grantees to all eligible grantees. Practically, in 2022, this meant that there were additional, new grantees in the SDPI program, with the same level of funding. Additionally, the NIHB supports amending the SDPI's authorizing statute, the Public Health Service Act, to permit Tribes and Tribal organizations to receive SDPI funds through self-determination and self-governance contracts and compacts. This change will establish SDPI as an essential health service and remove the barriers of competitive grants—which do not honor the Trust and treaty obligation to tribal nations. Self-governance also removes unnecessary administrative burdens which leaves more funding available for services. Self-governance Supports Tribal sovereignty by transferring control of the program directly to Tribal governments.

2. Authorize full mandatory funding for all IHS programs.

Through its coerced acquisition of land and resources and genocide destruction of cultures and peoples the United States formed a fiduciary relationship with Tribal nations whereby it has created a trust relationship to safeguard Tribal rights, lands, and resources. As part of this coerced exchange, Congress has continuously reaffirmed its duty to provide for Indian health care. Unfortunately, Tribal nations face an ongoing health crisis directly resulting from the United States' chronic underfunding of Indian health care for decades. This contributes to ongoing health and persistent inequities and disparities. Mandatory appropriations for the IHS are consistent with the trust responsibility and treaty obligations reaffirmed by the United States in IHCA. Even today, 13 years after IHCA was permanently enacted, many provisions of IHCA remain unfunded and without implementation. Full and mandatory funding must include the full implementation of all authorized IHCA provisions.

Until Congress passes full mandatory funding for all IHS programs, the NIHB urges Congress to pass the following incremental funding measures:

a. Authorize mandatory funds for Contract Support Costs and 105(I) Lease Payments.

As the Appropriations Committee has reported for years, certain IHS account payments, such as Contract Support Costs and Payments for Tribal Leases, fulfill obligations that are typically addressed through mandatory spending. Inclusion of accounts that are mandatory in nature under discretionary spending caps has resulted in a net reduction on the amount of funding provided for Tribal programs and, by extension, the ability of the federal government to fulfill its promises to Tribal nations.

b. Authorize discretionary advance appropriations.

Advance appropriations for the IHS marks a historic paradigm shift in the nation-to-nation relationship between Tribal nations and the United States. With advance appropriations, AI/ANs will no longer be uniquely at risk of death or serious harm caused by delays in the annual appropriations process. However, the inclusion of

¹⁹ Indian Health Service, *Special Diabetes Program for Indians 2020 Report to Congress*, available at <https://www.ihs.gov/sdpi/reports-to-congress/>, accessed on: March 20, 2023.

²⁰ Department of Health and Human Service, *The Special Diabetes Program for Indians: Estimates of Medicare Savings*, ASPE Issue Brief, May 10, 2019, available at https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf, accessed on: March 20, 2023.

²¹ Centers for Disease Control and Prevention. National Diabetes Statistics Report website. <https://www.cdc.gov/diabetes/data/statistics-report/index.html>. Accessed March 20, 2023.

²² Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45–74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599–610.

advance appropriations each year is not guaranteed, and the solution in the FY 2023 Omnibus is far from perfect. NIHB urges Congress to pass a bill authorizing annual advance appropriations for all areas of the IHS budget and providing for increases from year to year that adjust for inflation, population growth, and necessary program increases. NIHB supports advance appropriations until full, mandatory appropriations are enacted.

c. Protect the IHS budget from “sequestration” cuts.

The IHS budget remains so small in comparison to the national budget that spending cuts or budget control measures would not result in any meaningful savings in the national debt, but it would devastate Tribal nations and their citizens. As Congress considers funding reductions in FY 2024, IHS must be held harmless. As we saw in FY 2013 poor legislative drafting subjected our tiny, life-sustaining, IHS budget to a significant loss of base resources. Congress must ensure that any budget cuts—automatic or explicit—hold IHS and our people harmless.

d. Authorize federally-operated health facilities and IHS headquarters offices to reprogram funds at the local level in consultation with Tribes

The Indian Self-Determination and Education Assistance Act (ISDEAA) authorized Tribal nations to take greater control over their own affairs and resources by contracting or compacting with the federal government to administer programs that were previously managed by federal agencies. This includes the ability to develop and implement their own policies, procedures, and regulations for the delivery of these services. Tribal nations may also receive direct services from the IHS. Unfortunately, some of the flexibility that makes ISDEAA so cost effective at delivering services is not available at the local level when direct services are provided by the IHS. Fundamentally, the ability to direct resources is one of Tribal sovereignty and self-determination. Just because a Tribe chooses to receive direct services from IHS does not mean it forfeits these rights. IHS must have greater budget flexibility, especially at the local service unit level to reprogram funds to meet health service delivery priorities, as directed by the Tribes who receive services from that share of the IHS funding.

e. Authorize Medicaid reimbursements for Qualified Indian Provider Services

In 1976, Congress gave the Indian health system access to the Medicaid program in order to help address dramatic health and resources inequities and to implement its trust and treaty responsibilities to provide health care to AI/ANs and today, Medicaid remains one of the most critical funding sources for the Indian health system. In order to ensure that States not bear the increased costs associated with allowing Indian health care providers access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for services received through Indian health care providers (100 percent FMAP). While Congress provided equal access to the Medicaid program to all Indian health care providers, in practice access has not been equal. Because States have the option of selecting some or none of the optional Medicaid services, the amount and type of services that can be billed to Medicaid varies greatly state by state. So, while the United States's trust and treaty obligations apply equally to all tribes, it is not fulfilling those obligations equally through the Medicaid program. To further the federal government's trust responsibility, and as a step toward achieving greater health equity and improved health status for AI/AN people, we request that Congress authorize Indian health care providers across all states to receive Medicaid reimbursement for a new set of Qualified Indian Provider Services. These would include all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the IHCA when delivered to Medicaid-eligible AI/ANs. This would allow all Indian health care providers to bill Medicaid for the same set of services regardless of the state they are located in. States could continue to claim 100 percent FMAP for those services so there would be no increased costs for the states for services received through IHS and tribal providers.

3. Oversee federal agency data sharing policies to ensure compliance with existing law.

As sovereign nations, AI/AN Tribes maintain inherent public health authority to promote and protect the health and welfare of their citizens, using the methods most relevant to their communities. Respecting and upholding Tribal sovereignty is core to any Tribal data policy. Tribal governments must always control how their data is accessed, used, and released.

Section 214 of the IHCA designated Tribal Epidemiology Centers (TECs) as public health authorities. The designation of TECs as public health authorities is derived from the inherent position of Tribal nations as public health authorities. As sovereign nations, Tribes have the right of self-determination. They can carry out their public health functions or delegate that authority to another entity, such as their area TEC.

We support the ability of TECs to access data in the same way state, and local health departments do, but none of these entities should have access to Tribal data without the informed consent of Tribes. HHS is responsible for developing a data policy that both ensures Tribal sovereignty is respected and ensures Tribes and TECs have unfettered access to data to be able to carry out their duties as public health authorities.

The NIHB urges this Subcommittee to conduct oversight on this issue to ensure that federal agencies follow the letter and spirit of the law upholding our right to access public health data.

4. Improve Health Professional Staffing in the Indian Health System

The IHS and Tribal health care providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. To strengthen the health care workforce, IHS and Tribal programs need investment from the federal government to educate, recruit, and expand the pool of qualified medical professionals. IHS currently provides scholarship opportunities to AI/AN students to enter the health professions. IHS also provides loan repayment opportunities for those who work in the Indian health system. However, both of these programs are severely underfunded. Congress should increase appropriations for both IHS scholarship and loan repayment programs. NIHB also supports legislation to move IHS loan repayment program to a tax-exempt status to increase the dollars available for the program, which is similar treatment to the National Health Service Corps loan repayment program. IHS should also provide loan repayment opportunities to those in health support positions such as Administrators, coders, and billers. Like other health professionals, these staff are desperately needed to keep Tribal health systems operating efficiently.

NIHB also encourages Congress to enact legislation that would make it easier for IHS to recruit and retain medical staff. For example, Congress should provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities, similar to authorities enjoyed by the Veterans' Health Administration (VHA). This would make IHS a more attractive employer for paid time off and scheduling options.

a. Reimburse for traditional healing services.

Integrating traditional health services with medical, dental, and behavioral health services allows for holistic care to tend to the mind, body, and spirit of AI/AN individuals. Tribal Nations know that health care programs are more effective at improving health for AI/AN people when they incorporate traditional medicine. Tribal nations, Tribal organizations, and UIOs have developed processes and policies for credentialing traditional practitioners in parity with western clinical privileges. They have also developed several traditional health models that the Centers for Medicare and Medicaid Services (CMS) can reimburse. Medicare and Medicaid reimbursement for traditional health services would support access to culturally appropriate services, which will improve health outcomes for AI/ANs and advance health equity. Designing the paths to credentialing and billing for traditional healing services must be Tribally led and approached with sensitivity and cultural humility, since traditional healing often includes protected, sacred practices.

b. Support and Expand the Community Health Aide Program (CHAP) and the Dental Health Aide (DHAT) Program

Since the 1960s, the Community Health Aide Program (CHAP) has empowered frontline medical, behavioral, and dental providers to serve Alaska Native communities, successfully expanding access in these communities to urgently needed health and dental services. CHAP is now a crucial pathway for AI/AN peoples to become health care providers. The IHCA authorized the IHS to expand the CHAP to Tribes outside Alaska. Based on the IHCA and the CHAP's success in Alaska, IHS developed CHAP expansion policies from 2016 to 2020. However, IHS' implementation of the nationalization of CHAP has been slow, and years after it was initiated, Tribes outside of Alaska are still waiting for IHS' to implement this highly successful program. IHS must work to swiftly operationalize the use of Dental Health Aides, Dental Health Aide Therapists, and Behavioral Health Aides. As Tribes

confront health care provider shortages and chronically poor health outcomes, they urgently need the pathways and resources CHAP provides. IHS must finish the expansion work expeditiously so Tribes outside Alaska can benefit from the program.

5. Support Tribal self-governance expansion at the Dept. of Health and Human Services.

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. A self-governance program model promotes efficiency, accountability, and best practices in managing Tribal programs and administering federal funds at the Tribal level. Because Tribes can tailor programs according to the communities' needs, self-governance results in more responsive and effective programs. The Indian Self-Determination and Education Assistance Act (ISDEAA) provides the mechanisms to achieve this. However, ISDEAA is not applied to all IHS programs or applicable throughout the HHS. Legislation and administrative action are needed to expand and strengthen Tribal self-determination and self-governance in healthcare-related programs throughout HHS. NIHB supports the introduction of legislation establishing a demonstration project to implement Title VI of the Indian Self-Determination and Education Assistance Act across HHS.

Conclusion

For the last 47 years, the United States has had a policy of ensuring the highest possible health status for Indians and to provide all resources necessary to effect that policy. Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis. Clearly, the status quo isn't working.

Time will tell if today's hearing on the challenges and opportunities for improving healthcare delivery in Tribal communities marked the beginning of significant change, or the continuation of the status quo. The challenges are many, but most are equally matched by the opportunities and solutions already identified by Tribal leaders, Congresses, and Administrations past and present.

There is a way forward if Congress can overcome perhaps the greatest remaining challenge: political will. The NIHB recognizes that the recommendations offered in this testimony will require coordination with other committees of jurisdiction, and we stand ready to help with that effort. But the heavy lifting must be borne by this Subcommittee. No other subcommittee in the House is as focused on Indian affairs as this one. For the sake of our People, we hope this Subcommittee in the 118th Congress is up to the challenge.

QUESTIONS SUBMITTED FOR THE RECORD TO JANET ALKIRE, GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Questions Submitted by Representative Westerman

Question 1. Does the current structure of the Indian Health Service (IHS) of being divided into 12 regions best serve the needs of tribal communities?

Answer. The IHS area system helps keep local Tribal communities closer to the administrative functions of IHS. It also means that Tribal leaders have access to decision makers at the local level when there are concerns with IHS care. Each area, just like each tribe, is unique. The needs in the Great Plains are different than those in the Navajo or Nashville areas. For this reasons, the area system still serves a purpose.

Unfortunately, the area offices have varying cooperative relationships with the Tribal Nations in their region. While some work collaboratively and in partnership, others area offices are reported to withhold information—both financial and epidemiological—from Tribes. We are encouraged recent IHS actions to help standardize practices and management across the 12 areas. We hope that this results in improved care throughout the system and greater accountability for the IHS area offices to the Tribal Nations that they serve.

1a) Would you suggest any changes to the IHS operating structure that you believe would improve healthcare service to tribal communities?

Answer. Changes in the operating structure of IHS should be done with full consultation and consent with Tribal Nations. NIHB acknowledges that there are still challenges with the IHS area system. Funding and resources across 12 areas could be more equitable. For example, some service areas have no IHS funded

hospital facilities at all, making them more dependent on scarce Purchased/ referred care dollars. Areas also vary widely in terms of patient population and number of Tribal Nations. The Indian Health Care Improvement Act, for example, has made the provision for a Nevada Area Office, but that aspect of law has never been implemented.

Question 2. Please further expand on your testimony about the expansion of tribal self-governance program: Which programs specifically do you think should have this authority?

Answer. Tribal advocates have identified 23 programs specifically at HHS to be part of a Self-Governance Demonstration program. These selected programs are federal programs that Tribal Nations are already operating under competitive or formula-based grants. We feel that these programs are all basic lifeline services that would allow Tribal health programs to effectively and seamlessly provide care to their people.

In addition, incorporating these programs into a Self-Governance agreement allows Tribes to provide much needed wrap-around services to their citizens with its programs operating in collaboration rather than in silos created by federal agencies. HHS has identified most these programs in previous reports—dating back to 2003—as being feasible for self-governance. Other programs have been newly created by Congress since the initial Self-governance report was issued in 2003.

Most importantly, self-governance would allow Tribal Nations to implement programming in our Tribal Nations that is culturally appropriate and tailored to local needs. For example, the proposal includes several programs under the Centers for Disease Control and Prevention (CDC). As you know, Indian Country was impacted by the COVID-19 pandemic in greater numbers than other communities. If we had robust, culturally appropriate public health services, we would have been able to quickly spring into action to improve information going to community members and disseminate available resources. Allowing self-governance programs puts local communities in the driver's seat to respond to local needs. States and localities are already receiving this support from CDC. It is time that Tribal Nations receive this support as well.

Self-governance also allows small tribal communities to more effectively pool limited resources so that they can get the most impact for the small dollar amounts. This also includes spending less time on bureaucracy which includes applying for and reporting on federal grants. Since 2013, Tribes and Tribal Organizations have continued to make the expansion of Self Governance at HHS a top priority in their communications to Congress and with the Department. Expanding Self-Governance at HHS is the logical next step for the Federal government to promote Tribal sovereignty and Self-Determination and improve services to American Indians and Alaska Natives and will help people get the services they need.

2a) Have you heard from the Department of Health and Human Services about any concerns they have about including the programs you think should be included within the tribal self-governance program?

Answer. In recent months, HHS has not been engaged in a substantive way on this topic with Tribal Nations. While the Secretary and other political leadership have noted an overall desire to support Tribal Self-governance expansion, we have seen little effort to engage in a collaborative process to work through how self-governance would be implemented. They have noted implementation concerns related to providing equitable funding, statutory barriers, and the ability to consolidate eligible programs as concerns. From the perspective of Tribal Nations, these concerns exemplify some of the great benefits of Tribal Self-governance. It would allow Tribes to implement programs efficiently and effectively, without unnecessary government bureaucracy. It would also shift away from the competitive grants process which creates unstable or inaccessible funding sources for Tribal governments. Too often, competitive grants only reward communities with high levels of institutional resources and capacity, not necessarily where needs are greatest.

Question 3. In your testimony, you mentioned that allowing IHS facilities to make reprogramming decisions with tribal consultation at a local level could help meet health service deliver priorities. Could you further expand on that idea for the Subcommittee, and also provide any examples of where local reprogramming authority would have been beneficial?

Answer. Yes, being able to make funding decisions for real time health issues would be very helpful. For example, if there was an urgent need to provide behavioral health funding due to a recent surge in overdose deaths, the local IHS could quickly reevaluate resources and target them to an area that was needed in the

community. Because direct service tribes have to go through so many burdensome approval processes, it often takes too much time and we don't have time to waste when there is a serious, targeted health challenge going on, like substance abuse.

Health care crises are often quick and in real time. There may be a need to get resources deployed to increase disease surveillance from one area to another. Having local funding flexibility will ensure that health systems can be more nimble, instead of depending solely on a budget created many months ahead of time. It is critical that any budgetary changes of this nature be done in consultation with local tribal communities. The ability to respond in real time to local needs honors Tribal sovereignty and self-determination. This principle still applies if the Tribe choose to allow IHS to provide their health services.

Questions Submitted by Representative Leger Fernández

Question 1. Could you share more on the anticipated impacts and loss of services that would occur if the FY24 enacted congressional budget reflects FY22 enacted levels for the Indian Health Service (IHS)?

Answer. If the FY 2024 enacted congressional budget reflects FY 2022 enacted levels for the IHS, it is likely that the IHS will face a reduction in purchasing power greater than or equal to the impacts of sequestration on the IHS budget in FY 2013, which devastated Indian health system hospitals and health clinics. We need only look back a decade to see quite clearly what this would do to Tribal healthcare.

During the FY 2013 funding sequestration, the IHS faced a roughly five percent cut in funding, which had devastating impacts on Tribes' and IHS's ability to provide healthcare services. The reductions in funding, staffing, and services had significant impacts on healthcare outcomes for Tribal communities.

The reductions in staffing levels meant that there were fewer healthcare professionals available to provide care to Tribal communities. This led to longer wait times for appointments and reduced access to critical healthcare services. The reductions in funding and staffing levels also led to reductions in preventive healthcare services, such as immunizations and cancer screenings. Some healthcare facilities had to reduce operating hours or even close temporarily due to the funding cuts.

With longer wait times for appointments and reduced access to primary care, many Tribal members had no choice but to seek care in emergency rooms. This led to increased utilization of emergency room services, which can be more expensive and less effective for managing chronic conditions.

The reductions in funding and staffing levels made it more difficult for the IHS to recruit and retain healthcare professionals. This is a challenge that the IHS already faces, and the funding cuts during the FY 2013 sequestration made it even more difficult to attract and retain qualified healthcare professionals to serve in Tribal communities.

The funding cuts during the FY 2013 sequestration also led to delays or cancellations of critical construction projects, which resulted in deteriorating healthcare infrastructure and reduced access to healthcare services. The delays or cancellations of critical construction projects meant that healthcare facilities in Tribal communities continued to deteriorate, creating safety concerns for patients and workers. This had a negative impact on access to healthcare services and healthcare outcomes for Tribal communities.

The increase from FY 2022 to FY 2023 was roughly 5 percent—the same amount sequestered in FY 2013. When taking into consideration fixed costs like pay costs, contract support costs, and payments for tribal leases, as well as medical and non-medical inflation and the population growth, it is very easy to predict the harmful impacts of funding the IHS at FY 2022 levels. Unfortunately, I can guarantee it will devastate our already starved annual budget.

This is evidenced in the significantly worse health outcomes for American Indians and Alaska Natives (AI/ANs), as detailed in the National Indian Health Board's written statement. One impact of lower budgets has meant a lack of quality medical providers due to lower pay scales, remote locations and lack of housing for professionals. AI/ANs experience some of the greatest disparities when it comes to maternal health and behavioral health, for example. With even fewer resources available to recruit and retain OB/GYNs or behavioral health teams, these challenges will get even worse if funding is reduced.

As Congress considers reducing funding levels, it is critical to understand that these services are not "nice to have" programs that the federal government provides each appropriations cycle. The IHS budget is the fulfillment of the United States' sacred promise to Tribal Nations. Failure to fund the IHS decade upon decade has already resulted in significant loss of life for AI/ANs. Funding reductions to the IHS

budget will not make much of a dent in the fiscal challenges of the United States, but it will do irreparable harm to those citizens of this nation that depend on IHS for life or limb services.

Ms. HAGEMAN. Thank you.

I thank the witness for your testimony and the Chair now recognizes Ms. Jerilyn Church for 5 minutes.

STATEMENT OF JERILYN LEBEAU CHURCH, CHIEF EXECUTIVE, GREAT PLAINS TRIBAL LEADERS HEALTH BOARD, RAPID CITY, SOUTH DAKOTA

Ms. CHURCH. [Speaking Native language.] Chairwoman Hageman, Ranking Member Fernández, and distinguished members of the Subcommittee, on behalf of the Great Plains Tribal Leaders Health Board, which serves 17 federally recognized tribes in South Dakota, North Dakota, Nebraska, and Iowa, thank you for this opportunity.

[Speaking Native language.] My name is Jerilyn Church, and I am a citizen of the Cheyenne River Sioux Tribe and serve as the president and CEO of the Great Plains Tribal Leaders Health Board.

Indian Health Service is the primary source of healthcare for nearly 150,000 citizens in the Great Plains. Historically, the Great Plains has been an example of failures that accompany chronic under resourcing, provider shortages, outdated facilities, obsolete equipment, and egregious health inequities are the norm in the Great Plains area.

The first opportunity for changing that reality is for Congress to authorize mandatory funding for all IHS programs, ensure discretionary advanced appropriations to protect the already deficient IHS budget from sequestration.

Second, Indian Health Service must increase its workforce to actively ensure that competent physician-led healthcare is provided as called for in the 2021 8th Circuit opinion *Rosebud Sioux Tribe v. United States*.

Tribes who exercise their sovereignty through Public Law 93-638 and run their own programs outperform direct service units on every level. So, IHS needs to ensure its administrative capacity to adequately support them.

For example, since the Great Plains Tribal Leaders Health Board assumed management of the Rapid City Service Unit 4 years ago, the Oyate Health Center has seen a 400 percent increase in third-party billing.

It has added 10,000 users and has lowered the rate of uninsured users from 56 percent in October 2019, to 49 percent in March 2023.

When IHS is funded, they successfully change health outcomes. For 25 years, the Special Diabetes Program for Indians has effectively reduced end-stage renal disease and diabetic eye disease.

Victor is a tribal elder who uses the SDPI Program in Rapid City. He consistently works with his dietician and lifestyle coach to

meet all his diabetes standards of care. He reduced his weight by 20 pounds and his A1C dropped from 7.8 to 6.3.

We have seen successes, yet diabetes is still more than twice the rate of the non-Hispanic White population. For Victor and thousands of other diabetics, we implore you to reauthorize SDPI.

A fourth and immediate opportunity to improve healthcare is for IHS and CDC to respect that tribes and Tribal Epidemiology Centers are statutorily mandated as public health authorities and to share public health data for the purposes of addressing public health threats.

From the start of the pandemic, the Great Plains Tribal Epi Center requested data on COVID-19 infections in tribal communities. Instead of sharing that data, as IHS routinely does with state public health authorities, IHS required the Epi Center to enter a data sharing agreement then refused to sign it until 2022, 3 years after it was negotiated.

The tribes never did receive the data that was needed when it was needed most. A current example, Native babies in the Great Plains are dying of congenital syphilis, a preventable disease at epidemic levels.

Tribes and TECS can help stop the spread of syphilis and protect Native families, but we need public health data.

Fifth, we urge the Committee to work with CMS to ensure the process of unwinding Medicaid does not result in the loss of basic services for many thousands of our tribal citizens as continuous enrollment ends. CMS should urge state Medicaid programs to work collaboratively with tribes who want to assist with outreach and recertification of those individuals before they lose benefits.

Finally, we urge IHS to support integrating culturally traditional healing practices into clinical services. A recent tribal survey indicated that American Indian patients who see both a physician and traditional healer, 61 percent trust the advice of their traditional healer over their physician. And they may limit disclosure of their medical history due to medical distrust and poor coordination of care.

Just as it is widely accepted that prayer improves health outcomes in clinical settings, that is also true for culturally traditional practices in our tribal communities.

[Speaking Native language] for allowing me to share these recommendations on improving healthcare delivery in tribal communities.

[The prepared statement for Ms. Church follows:]

PREPARED STATEMENT OF JERILYN LEBEAU CHURCH,
GREAT PLAINS TRIBAL LEADERS HEALTH BOARD

Introduction

Thank you for this opportunity to present testimony on current challenges and opportunities for improving healthcare delivery, and ultimately health care outcomes, for Indian people in our communities.

The Indian Health Service (IHS) is the primary source of health care for nearly 150,000 American Indians/Alaska Natives in the Great Plains Area. Of the six hospitals in the Great Plains, five are managed directly by IHS. Of the thirteen ambulatory health clinics in the Great Plains Area, seven are managed entirely by a tribe or a tribal organization under a Title I Self-Determination contract, five are managed directly by IHS, and one is tribally managed through a Title V Self

Governance compact. In addition, the Indian Health Service is responsible for two substance abuse treatment centers and supports three urban health care programs.

As requested by the Committee, this testimony will review seven timely and meaningful challenges and opportunities for improving healthcare delivery in Tribal communities in the Great Plains Area:

1. Enacting full mandatory funding of the Indian Health Service,
2. Building IHS capacity through workforce development,
3. Expanding self-determination contracting and self-governance compacting into additional HHS programs,
4. Permanently reauthorizing the Special Diabetes Program for Indians (SDPI),
5. Enforcing existing law that mandates data sharing with Tribal public health authorities,
6. Ensuring that state and federal agencies cooperate with Tribes to continue Medicaid benefits to all eligible AI/AN beneficiaries, and
7. Integrating and supporting traditional Native American healing practices throughout the Indian Health system.

Seven Areas of Opportunity

1. Funding: strategies for full and mandatory funding of the Indian Health Service.

In January 2023, Indian Country celebrated the passage of the Fiscal Year 2023 omnibus spending package, which for the first time included advanced appropriations of just over \$5 billion for the Indian Health Service. This historic achievement was clouded by the fact that \$5 billion is only part of IHS's \$7 billion budget, and by the fact that that \$7 billion budget is less than half of what patients need.

Therefore, this Committee can use the momentum of this historic opportunity to:

a. *Continue increasing the Indian Health Service's overall budget to fulfill its Treaty and trust responsibility for Indian healthcare.* In July 2022, a report of the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, HP-2022-21, found that IHS's 2022 budget funded less than half of patient need. A similar 2022 report from the advisory body the Tribal Budget Formulation Workgroup calculated that IHS would need a \$51.4 billion budget to meet the federal obligation to provide adequate health services in Native American communities (Office of the Assistant Secretary for Planning and Evaluation, 2022). According to a 2018 GAO report, GAO-19-74R, per capita spending on IHS patient health care was less than a third of Medicare per patient spending and less than a half of Medicaid per patient spending (Government Accountability Office, 2018). The Veteran's Administration, another non-entitlement program, spent 2.6 times more per patient than the Indian Health Service. Any equitable increase to the IHS budget would at least double the current amount, but with the current state of underfunding, any increase is meaningful.

b. *Authorize mandatory funds for the remainder of the IHS budget, while prioritizing mandatory funding for all nondiscretionary items such as Contract Support Costs and 105(l) Lease Payments.* While securing advanced appropriations for IHS is an historic success, extending advanced appropriations to the full IHS budget would be a better realization of the federal government's trust responsibility toward Indian Country, and would better protect the delivery of necessary and basic health services from any gaps in the annual funding cycle. In the alternative, funding at least any remaining nondiscretionary budget items, in particular contract support costs and 105(l) leases, through advanced appropriations would be a meaningful step forward.

c. *Protect the IHS budget from any further "sequestration" cuts.* Any budget control measures implemented on the IHS budget are catastrophic in their effects on health programs and services to Indian people. At the same time, the cuts do not have any significant benefit with regard to actual control of the federal budget. While we are sure that many small budget programs would like to request exemption from any future sequestration, budget cuts to Indian Health programs have an immediate effect on lives and health outcomes in our communities. Therefore, we urge the Committee to protect the IHS budget from further sequestration or other budget control measures.

2. Staffing: workforce development will increase the Indian Health Service's capacity to deliver healthcare services and enable the agency to fulfill its mission to provide those services to Native communities.

Like most other IHS areas, hospitals and clinics in the Great Plains service area face enormous challenges with staff recruitment and retention, sometimes resulting in inability offer services, particularly specialty services, and always resulting in overdependence on expensive temporary contractors. As of March 27, 2023, there were over 250 open positions advertised in the Great Plains Area on the IHS website. This is very clearly a case where an ounce of prevention is worth a pound of cure. Front end investment in workforce development, in recruitment and retention of medical officers and staff will lead directly to savings by not having to use temporary contractors to fill those positions, and not having to use limited purchased and referred care dollars (PRC) to refer patients out for specialty care. Those savings can be reinvested in the workforce, both to attract and retain staff and to stabilize and expand services.

Attached to this testimony is support from the Rosebud Sioux Tribe underscoring the federal government's established legal obligation to staff its facilities in the Great Plains Area. See Attachment 1, Comments from Rosebud Sioux Tribe Health Director Skyla Fast Horse, March 24, 2023. In 2021, the 8th Circuit Court of Appeals reaffirmed that the Indian Health Service did have a duty to provide "competent physician-led health care" at the Rosebud IHS Hospital. *Rosebud Sioux Tribe v. United States*, 8th Cir. 2021 (No. 20-2062). While it is heartbreaking that the Rosebud Sioux Tribe had to file suit in order to force IHS to staff its hospital, the court's conclusion lays bare the need both for additional funding for IHS and for geographically remote facilities in the Great Plains Area, and specifically for workforce development.

3. Self-Determination Legislation: the Tribes of the Great Plains Area support and request legislation establishing a demonstration project to implement Title VI of the Indian Self Determination and Education Assistance Act (ISDEAA).

In 2000, Congress enacted Title VI of the Indian Self Determination and Education Assistance Act (ISDEAA). The purpose of the self-determination sections of the ISDEAA was to allow Tribes to assume management of IHS and Bureau of Indian Affairs (BIA) programs created for the benefit of Indian people, with the assumption that Tribes with their close knowledge of local culture, people, and resources, would be better suited to manage those programs. The vehicle for assumption of those federal programs was a contract under Title I, and later a compact under Title V. Because of the runaway success of both contracting and compacting, Congress imagined expanding Self-Governance under the ISDEAA to include grant programs for Indians administered by other agencies within HHS. HHS conducted a feasibility study on this possibility and concluded in 2003 that such expansion was feasible. HHS identified eleven programs that could be integrated into Self-Governance under Title VI of the ISDEAA. That was twenty years ago. It is time, now, to promote Tribal sovereignty by taking this next step to improve health care delivery in our communities. Through this testimony and through the attached resolution of its Board of Directors, the GPTLHB respectfully requests that this Committee introduce legislation establishing a demonstration project to implement Title VI of the ISDEAA as described in the 2003 HHS recommendations. See, Attachment 2, GPTLHB Res. 2022-06, March 10, 2022.

4. Diabetes Prevention: permanent reauthorization of the Special Diabetes Program for Indians (SDPI) before September 30, 2023.

The Special Diabetes Program for Indians (SDPI) is recognized as one of the most impactful and successful IHS programs.

In its 2020 report to Congress, *Special Diabetes Program for Indians*, IHS found that besides reducing the incidence of Type 2 Diabetes overall, SDPI has reduced End Stage Renal Disease by an astonishing 54% and diabetic retinopathy by an equally staggering 50% (Indian Health Service, 2020). In 2019 HHS' report *The Special Diabetes Program for Indians: Estimates of Medicare Savings* determined that SDPI had resulted in an estimated \$52 million in Medicare savings annually. SDPI's impact through patient and community education and prevention activities ripples through Indian Country and beyond. (Dept. of Health and Human Services, 2019).

Therefore, the GPTLHB urges the Committee to propose and to advocate for the permanent reauthorization of the SDPI before September 30, 2023. Further, the GPTLHB joins in the National Indian Health Board's request that SDPI be

reauthorized at a minimum of \$250 million annually, with automatic annual funding increases matched to the rate of medical inflation, and that the Public Health Service Act be amended to permit Tribes and Tribal organizations to contract and compact under the ISDEAA for administration of SDPI funds.

5. Data Sharing: enforce existing law and policy which recognizes Tribes and Tribal Epidemiology Centers (TECs) as public health authorities which authorizes HHS agencies, including IHS and CDC, provide complete and transparent sharing of public health data with Tribes and TECs at the same level that those agencies share public health data with states.

The COVID-19 pandemic was particularly devastating to Native communities. One CDC report found a decline in life expectancy of 6.6 years in AI/AN communities over the course of the pandemic—the largest decrease of any racial or ethnic group in the United States. A Native baby born in 2021 had a life expectancy of only 65.2 years (Arias et al., 2022)—the same of that to a baby born in the 1940s (Bastian et al., 2020). During the pandemic, tribal governments and TECs were unable to receive information from IHS about COVID-19 cases and vaccinations that were provided to state and federal agencies. Tribal governments and TECs were not regularly provided life-saving information from IHS, other HHS Agencies, or state health departments, contributing to the significant loss of life from COVID-19 in Native communities.

Tribes and TECs are routinely denied access to information from IHS and non-tribal health departments in all areas of health—not just COVID-19. Nationally, there is currently a rise in sexually transmitted infections and we are seeing this increase in the GPA. Native babies are dying of congenital syphilis, a completely preventable disease. Tribes and TECs have the ability to address this outbreak and protect the health of Native people, if only we could access current data regarding cases in our Area. Yet despite a resolution from every tribal leader in our Area in support of IHS releasing data on STIs to the TEC, IHS has not provided the requested information as is required by federal law. Inaction by IHS is hindering the response to the outbreak and contributing to the spread of disease.

A 2022 GAO report documented the challenges TECs have in accessing public health data from HHS Agencies (Government Accountability Office, 2022). Despite the report's acknowledgement that HHS not only can, but is required to provide health information to TECs, a year later HHS has not provided any new health information to TECs. The Congress can improve the health of Native people nationwide by ensuring HHS, including IHS, comply with current federal law and provide Tribes and TECs access to protected health information that is shared daily with local and state public health authorities. No new legislation needs to be enacted. All HHS agencies should immediately stop defying Congress and release public health data to Tribes and TECs as has been repeatedly requested. We urge the Committee to confirm that HHS provides requested data to Tribes and TECs in compliance with the Indian Health Care Improvement Act and ask the Committee to work quickly—before one more baby is lost to a preventable disease.

6. Medicaid unwinding: direct CMS to work with states to share data with Tribes and Tribal organizations regarding American Indian/Alaska Native (AI/AN) beneficiaries and if possible to delay termination of benefits for AI/AN beneficiaries to allow Tribal/state coordination of redetermination efforts for those individuals.

Another area of concern is the hot-button issue of Medicaid “unwinding” and the transition out of the Public Health Emergency. The end of the continuous enrollment requirement has the potential to cause confusion and loss of services for AI/AN Medicaid beneficiaries, as well as direct fiscal impact to Tribal health programs. The Medicaid program is a federal-state partnership, with wide variation in services and program rules according to the various state plans. That local variability has resulted in inconsistent and conflicting implementation of unwinding guidance from state to state in a manner that protects eligible Tribal members in some states, while quickly severing access to benefits in others.

For example, Oklahoma takes an “eligible until you fail to prove otherwise” approach by sending four letters to people at risk of ineligibility with instructions on reasons for possible ineligibility, instructions for recertification, and access to a helpline. South Dakota, by contrast, has the opposite policy. Individuals who are high risk of ineligibility are sent one letter informing them their Medicaid has been terminated, and giving them the number for the Health Insurance Marketplace. The GPTLHB is currently working with South Dakota Medicaid to get contact information for AI/AN enrollees at risk of ineligibility, so we can assist and coordinate with

recertification efforts, but to date have only received incomplete data on Tribal member beneficiaries from the state.

We urge the Committee to exercise its oversight role to work with States, Tribes, and CMS to make sure that unwinding is accomplished cooperatively and without terminating services to eligible individuals. For example, we urge the Committee to (a) work to make sure that states share data on AI/AN enrollment throughout the unwinding process in order to help our health programs to assist with outreach efforts by identifying AI/AN Medicaid enrollees, and (b) work with CMS to provide financing mechanisms to assist in covering the costs that Tribes incur when working with the state on the unwinding process.

7. Traditional medicine: integrating Native American healing practices into IHS services.

Traditional Native American healing practices have never been part of the Indian Health Service. It is a delicate balance to achieve, to bridge two very different systems of medicine in a respectful, effective, and patient-centered way. However, research has indicated that when recommendations on how to integrate traditional Native healing systems into the IHS system have been led by traditional healers in our communities, it is possible for one system to enhance the other, with great benefit to our patients. These integrative methods have been shown to be both medically effective and cost effective at treating chronic physical illness, when used in conjunction with allopathic medicine (Mehl-Madrona, 1999). We strongly encourage you to direct IHS to work with Tribes at the Service Unit level to respectfully incorporate traditional cultural practices and cultural healing into the Indian Health treatment system.

Conclusion

Thank you again for allowing us to present this testimony on the most important and immediate opportunities for improving healthcare delivery in the Great Plains Area. While the last few years were painful and full of loss, at this moment in the Great Plains Area there is a great deal of forward motion in Indian Health care. Further, only the first of these seven opportunities requires significant new appropriations; the rest require mainly shifts in policy, enforcement, intergovernmental cooperation, and focus. Sometimes what it takes to improve healthcare delivery is money, but sometimes it is deep listening to the people most affected by the problem, and changing how we do things. I encourage you to listen and take action on all of these priorities and opportunities, so that we can continue moving forward together.

References

- Arias E., Tejada-Vera, B., Kochanek, K.D., Ahamd, F.B. (2022). Provisional life expectancy estimates for 2021. *Vital Stat Rap Rel*, 23, 1–16. DOI: <https://dx.doi.org/10.15620/cdc:118999>.
- Bastian, B., Tejada-Vera, B., Arias, E., et al. Mortality trends in the United States, 1900–2018. *National Center for Health Statistics*. 2020.
- Dept. of Health and Human Services. (2019). The special diabetes program for Indians: Estimates of Medicare savings. ASPE Issue Brief. Retrieved from: https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf
- Government Accountability Office. (2018). Indian Health Service: Spending levels and characteristics of IHS and three other federal health care programs. (GAO Publication No. 19-74R). Washington, DC.: U.S. Government Printing Office. Retrieved from: <https://www.gao.gov/assets/gao-19-74r.pdf>
- Government Accountability Office. (2022). Tribal Epidemiology Centers: HHS actions needed to enhance data access. (GAO Publication No. 22-104698). Washington, DC.: U.S. Government Printing Office. Retrieved from: <https://www.gao.gov/assets/gao-22-104698.pdf>
- Indian Health Service. (2020). Special diabetes program for Indians 2020 report to Congress. U.S. Department of Health and Human Services. Retrieved from: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI_2020Report_to_Congress.pdf
- Mehl-Madrona, L.E. (1999). Native American medicine in the treatment of chronic illness: developing an integrated program and evaluating its effectiveness. *Altern Ther Health Med*, 5(1), 36–44.

Office of the Assistant Secretary for Planning and Evaluation. (2022). How increased funding can advance the mission of the Indian Health Service to improve health outcomes for American Indians and Alaska Natives. (Report No. HP-2022-21). U.S. Department of Health and Human Services. Retrieved from: <https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ih-s-funding-disparities-report.pdf>

ATTACHMENT 1



Rosebud Sioux Tribe
Health Administration
227 NORTH BIA 9 – SOLDIER CREEK ROAD
PO BOX 719
ROSEBUD, SD 57570-0719
W: (605) 747-5100
F: (605) 747-5412



Rosebud Sioux Tribe Health Administration Written Testimony Comments

In regards to upcoming testimony before the U.S. House Committee on Natural Resources on the performance of the Indian Health Service, The Rosebud Sioux Tribe Health Administration has the following comments:

- The Indian Health Service should actively work to support any ongoing efforts towards contracting or compacting by any tribes for the assumption of services from the Indian Health Service
- The Indian Health Service should actively work towards ensuring that “competent physician-led healthcare” is being provided to tribes, as called for in *Rosebud Sioux Tribe v United States*, 2021 (No.20-2062)
- The Indian Health Services needs to demonstrate significant improvement in collaborating with tribes on integrating cultural practices and cultural healing into the health system.
- There is a significant need for better date and information sharing policies that make it easier for tribes and tribal organizations to request and receive health information in a timely manner from the Indian Health Service
- A greater investment is needed in updating the health information technology of Indian Health Services facilities, including the Electronic Health Record and any modernization of telehealth or remote monitoring technology.


Skyla Fast Horse, Health Director



ATTACHMENT 2

**GREAT PLAINS TRIBAL LEADERS HEALTH BOARD
RESOLUTION 2022-06**

- PURPOSE:** To approve supporting the legislation expanding Tribal Self-Governance in the Department of Health and Human Services
- WHEREAS,** the Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes Tribes and Tribal organizations to be funded by the federal government to provide services that the Federal government would otherwise be obligated to provide due to the trust and treaty obligations of the United States; and
- WHEREAS,** self-determination and self-governance under the ISDEAA have led to a significant improvement in the daily lives of American Indians and Alaska Natives; and
- WHEREAS,** the success of the ISDEAA prompted Congress in 2000 to establish permanent Tribal Self-Governance in the Indian Health Service (IHS) in Title V of the ISDEAA; and
- WHEREAS,** Title V authorizes participating Tribes to redesign IHS programs, and redirect funds supporting those programs, in any manner that the Tribes determine is in the best interest of their communities; and
- WHEREAS,** in Title VI of the ISDEAA, enacted in 2000, Congress envisioned expanding Self-Governance to include grant programs administered by other agencies within the Department of Health and Human Services (HHS); and
- WHEREAS,** in 2003, HHS issued a study concluding such an expansion was feasible and identifying 11 HHS programs that could be integrated into Self-Governance; and
- WHEREAS,** in 2004, the Senate considered legislation to authorize a demonstration project implementing Title VI, but that legislation was not enacted; and
- WHEREAS,** expansion of Self-Governance within HHS is the next logical step to promote tribal sovereignty improve health care services and has remained a top legislative priority of Tribes; and
- WHEREAS,** Tribes have drafted legislation, modeled on the 2004 Senate bill, that would establish a demonstration project expanding Self-Governance to specified programs administered by non-IHS agencies within HHS;
- NOW, THEREFORE, BE IT RESOLVED** that Great Plains Tribal Leaders Health Board supports the introduction and enactment of legislation establishing a demonstration project to implement Title VI of the ISDEAA.

CERTIFICATION

This is to certify that this resolution was adopted by the Great Plains Tribal Leaders Health Board, (GPTLHB) Board of Directors through a duly convened meeting held at the March 10, 2022 Board of Director's Meeting held over Zoom by a vote of:

13 FOR o OPPOSED 5 NOT VOTING

MOTION CARRIED.



Roger Trudell
Chairman, GPTLHB
Chairman, Santee Sioux Tribe of NE

Date: 3/10/22



Victoria Kitcheyan
Chairwoman, GPTLHB
Chairwoman, Winnebago Tribe of NE

Date: 3/10/22

QUESTIONS SUBMITTED FOR THE RECORD TO JERILYN LEBEAU CHURCH, GREAT PLAINS TRIBAL LEADERS HEALTH BOARD

Questions Submitted by Representative Westerman

Question 1. How has telehealth improved access to care? Do you have any information on how that has been different between tribally run healthcare facilities and Indian Health Service (IHS) run facilities?

1a) What data can you share with the Committee on how telehealth may have improved access to care?

Answer.

- Telehealth is used heavily in tribal communities across the country, with telehealth visits making up 60 percent to 70 percent of their healthcare services.¹
- IHS provides specialty services at 19 facilities in the Great Plains Area including behavioral health, cardiology, maternal and child health, nephrology, pain management, pediatric behavioral health, rheumatology, wound care, ear, nose and throat care, as well as dermatology.² Many of these specialty care services are provided through telehealth.
- One study found that for every dollar spent in telehealth, \$11.50 was saved in travel and child-care expenses and without any decrease in quality. In order to receive specialty care (which is often unfunded in Indian Health Service (IHS) facilities), those living on reservations must travel great distances, as reservations are typically geographically isolated. One study examining access to cancer support groups noted that trips often require between 2 to 5 hours of travel each way, with travel costs alone ranging from \$50 to \$200.³
- A study conducted in Nome, for example, found that, prior to use of telemedicine for audiology and ear, nose, and throat (ENT) services, 47% of new patients would wait five months or longer for an in-person ENT appointment. After the introduction of telemedicine, this rate dropped to 8% of all patients in the first three years, and less than 3% of all patients in the next three years.⁴
- Attracting and retaining behavioral health professionals in rural or remote areas is a significant challenge. Behavioral health providers are typically in short supply in any community and have numerous employment opportunities in urban, higher-paying, and more desirable locations. The telehealth model allows behavioral health professionals to live where they like and still provide services equivalent to in-person care to high-need, remote communities.

¹ Bailey, 2021. *Tribal Communities See Benefits and Challenges in Using Telehealth*.

² Indian Health Service, 2016. *Great Plains Area Tribal Leaders Briefing Summary & Follow-up*.

³ Kruse, Clemens, et al, 2016. *Telemedicine Use in Rural Native American Communities in the Era of the ACA: a Systematic Literature Review*.

⁴ Hays, Carroll, et al, 2014. *The Success of Telehealth Care in the Indian Health Service*.

- According to the IHS Tele-Behavioral Health Center of Excellence (TBHCE) the clinical telebehavioral health program noted that patients are 2.5 times more likely to keep their telepsychiatry appointments than in-person psychiatry sessions.⁴
- The TBHCE also found that in fiscal year 2013 the telebehavioral health program allowed IHS patients to avoid more than 500,000 miles of travel, which translated into over \$305,000 in savings for them. Since the telebehavioral health program was available to patients in 2013, these patients saved more than 16,450 hours of work or school that would otherwise have been missed to travel for appointments.⁴

Question 2. Could you further expand on the challenges the Great Plains Area is facing regarding workforce shortages for both IHS and tribally operated facilities.

Answer. First, it is important to note that finding, hiring, training, credentialing, and retaining sufficient staff to meet the needs of clients and provide treatment services are all critical staffing issues.⁵ Without qualified staff and providers, we are prevented from fulfilling our statutory and ethical obligations to our patients.

Specific workforce challenges currently facing the Great Plains Area include:

- An aging workforce at Indian health facilities throughout the Great Plains Area.
- Out-migration of workforce members (people who leave the workforce and simply stop working) in large part due to a shift in attitudes regarding work and life brought on by the COVID-19 pandemic that has led to a decrease in the available labor pool
- Small local labor pool size. For example, the Oyate Health Center is located in Rapid City, a city of just over 76,000 people. The small populations in our region do not provide an adequate staffing pool, so facilities in the Great Plains Area are often forced to recruit from other markets.
- Housing shortages. Lack of availability of housing throughout the region but especially on Reservations, has made it difficult to recruit qualified individuals from other areas to the Great Plains Area.
- Cost of housing. Again, using the Oyate Health Center as an example, rising housing costs in the Rapid City region make it too expensive for younger potential workforce members to move to the Rapid City area and purchase homes.
- Inflation in the wider economy means workforce members have fewer resources available to move to the Great Plains Region for work.
- Finally, potential applicants have reported procedural issues such as difficulty understanding job postings, the posted salary not reflecting the actual wage, or difficulty contacting hiring officials to obtain an interview.

2a) What are the greatest challenges to maintain an effective workforce for tribal health programs?

Answer.

- Lack of a competitive salary structure. When Tribal health programs lag in their review of salary structures, and do not remain competitive, non-Indian facilities will jump at the opportunity to pry employees away.
- Lack of remote or modular work opportunities, which could be offered when appropriate.
- Lack of technology enhancements to increase services. Technology like telehealth, virtual reality, wearables, AI, personalized medicine, and smart clinic management, if done correctly, could lead to expanded services. The resulting revenue could then be used to employ the correct size workforce.
- Lack of Congressional appropriations sufficient to meet federal treaty and trust obligations to tribes. Because of persistent underfunding, Tribal health programs are left without the required capital to employ an appropriately sized workforce and enhance or modernize services. As noted in Jerilyn LeBeau's testimony, contract support costs and 105(l) lease payments, as well as all IHS funding, should be made mandatory with a priority for contract support costs and 105(l) lease payment funding.

⁵ Great Plains Tribal Leaders Health Board, 2020. *Tribal Treatment Services Needs Assessment Report*.

- The system for recruitment and retention, especially in IHS facilities, is archaic and does not keep pace with modern job flexibility, benefits, and salaries that are offered in private clinics or hospitals, thus making it extremely hard to compete.

2b) Are there any tribally led efforts on recruitment and retention that IHS can learn from or institute?

Answer.

- IHS could do a lot more with creating formalized and intentional training opportunities that create labor pool pipelines between universities, colleges, trade schools, tribal colleges, job corps, and other organizations whose mission is to educate and train young and older adults to enter or re-enter the workforce.
- IHS could establish adult vocational education training programs that occur on an annual, bi-annual or quarterly basis inviting people interested in healthcare opportunities to get introduced to health care professions in a hands-on learning methodology where participants would gain experience working at Tribally managed facilities.
- More IHS funding could be allocated to recruit new graduates to work in Indian health organizations, while creating agreements with Tribally managed facilities to create employment opportunities for new graduates. Then new providers, especially nurses, could receive training and grow to be skilled caregivers in a culturally appropriate environment. We rely too much on hiring experienced nurses; an understanding that new graduates can be developed in the first stages of their career at a Tribal organization. These post-graduate programs would take more investment in the form of time and training up-front; but investing in new graduates could result in more individuals deciding to commit to a career in Tribal communities.

Currently, recent graduates interested in working in Indian healthcare are too often turned away for lack of an effective preceptor program in Tribal health organizations.

Question 3. Can you further expand on your testimony about staffing at Great Plains IHS facilities, and what improvements in recruiting and retention will not only improve care, but eventually be cost effective.

Answer. As mentioned above, an updated wage structure with competitive pay is the first fundamental step to attracting qualified employees. While there are still altruistic individuals who want to work in Indian Country for less than they can earn in the for-profit world, reliance on such individuals is not a successful or sustainable recruitment strategy. Indian healthcare facilities need to offer competitive and rewarding job opportunities that mirror the for-profit healthcare world around us. Recruitment efforts should also include longevity strategies, including pensions, housing, flexible schedules, and training opportunities for licensing. IHS hiring procedures, including facility certification processes, need to be streamlined to get good candidates hired quickly, and creative, clear, and broad advertisement strategies would reach a larger candidate pool.

IHS recruitment and retention plans should reflect a sincere recognition that workforce needs and realities have changed, or we will see greater and greater challenges at filling our open positions.

3a) Would a stand up of the Community Health Aide Program (CHAP), that currently operates in Alaska and was mentioned in Ms. Platero's testimony be useful to meeting those staffing challenges?

Answer. Yes, provided it is implemented effectively. The most successful implementation of the CHAP program has occurred in Alaska; the program there has existed since the early 1970s. Implementing the CHAP program outside Alaska will require recognition that the nurse, mid-level practitioner, and physician approach to health care is not all encompassing and the CHAP's (paraprofessional level health care providers) can and should be allowed to practice a certain level of medicine, especially in smaller Tribal or remote communities.

It would also require establishing a multi-year training program based on the Alaska model, accompanied by the appropriate funding to support trainees through their training. Essentially, the plan requires paying CHAP candidates throughout the training period, with a pay-back provision once the new CHAPs are working in their home, rural and/or Tribal. As this is already a proven program in the Alaska Area, we can list the keys to a successful CHAP program:

- Tribal community support
- American Medical Association support
- Local, regional, and statewide legislative support
- Fiscal support

3b) What other creative possibilities exist that tribal organizations and IHS could implement?

Answer. No response provided.

Question 4. The Subcommittee has heard from many different tribes that the Purchased/Referred Care (PRC) program has several challenges:

4a) Can you describe some of the issues you have heard about within the Great Plains region and what challenges are your tribal members facing when dealing with the PRC program?

Answer.

PRC Eligibility Rules: Residency

- The PRC program eligibility rules and procedure are confusing to most patients. To be eligible for PRC, a patient needs to reside within the CHSDA (Contract Health Service Delivery Area) for that Service Unit. Acronyms such as CHSDA do not help matters, but the basic problem is that any eligible Indian can receive services at an IHS-funded facility, but only those who reside in a certain territory can be referred out for specialty care. Eligibility for Purchased and Referred Care is dependent on residency.
- The residency rule is inconsistent in that the CHSDA in some IHS Areas only covers certain counties, whereas in other IHS Areas, the CHSDA is the entire state. Oklahoma and Nevada are examples of state PRC coverage, whereas in South Dakota, only residents of Pennington County are eligible for PRC at the Oyate Health Center in Rapid City, while residents of neighboring counties can receive care at the Oyate Health Center, but cannot be referred out to a cardiologist, for example.
- Further, certain PRC programs only cover the enrolled members of that Tribe, and not other Tribes. For example, the Cheyenne River IHS Service Unit CHSDA includes the two reservation counties plus the adjacent Meade County. All members of federally recognized Tribes who reside on the two reservation counties are eligible for both services at the Cheyenne River IHS Hospital and the hospital's PRC program. But while all members of federally recognized Tribes who reside in adjacent Meade County may receive services at the Cheyenne River IHS Hospital, only Cheyenne River Sioux Tribal members in Meade County are eligible for the PRC program. An Oglala Sioux Tribal member residing in Meade County and receiving care at the Cheyenne River IHS Hospital would have to pay for their own specialty care or give up that care, unless they could prove a "close social and economic tie" to the Tribe. IHS and tribal PRC programs have wide discretion to interpret this phrase, and there is variation.
- Then again, some PRC programs choose to set a period of time the Tribal member has to reside within the CHSDA to establish eligibility for the PRC program, and those time periods, usually 30, 60, or 90 days, were inconsistent from facility to facility.

The rules for residency that establish eligibility for the PRC program are so complex that often staff at the Indian healthcare facility get it wrong. Along with the need for patient education on PRC, this puts an additional burden on ongoing staff training protocols, keeping employees up to date on an unnecessarily complex and contradictory set of rules.

Rather than attempting to educate every Tribal member and employee on this complex and limiting eligibility system, it would be much simpler, more consistent, and fair to simply expand PRC eligibility to any eligible Indian patient receiving services through that facility and to provide sufficient funding for such expanded care.

PRC Eligibility Rules: Notification

- 72 hour/30 day notification rule⁶

If a Tribal member receives emergency health services outside of an IHS or Tribal facility, they must notify their home facility within 72 hours, or for elderly or disabled patients, within 30 days. There are several problems with implementation of this rule.

First, facilities may not follow the 72-hour rule if that particular facility did not receive notice through the PRC program. While some IHS facilities consider notification to anyone in the IHS facility as notification of an Emergency Room (ER) visit, other facilities require that the patient notify “PRC and PRC only.” This is inconsistent and places an improper requirement on the language of 25 U.S.C. § 1646 and 42 CFR § 136.24.

There are also inconsistent implementation issues within single IHS facilities. For example, if a patient notifies the IHS facility of an unscheduled non-IHS ER visit, some nursing staff will log a ‘telephone encounter,’ while others will not. If this becomes the key issue on whether IHS allows or refuse to authorize PRC Program funds for that patient, the PRC system becomes unacceptably capricious.

PRC Procedure

- The effectiveness of the PRC Program can be hampered by a lack of specialty providers locally. For example, there is only one private health care facility in Rapid City offering Gastroenterology (GI) services. Limited availability for services like GI and Neurology leads to long wait times—measured in months—for scheduling appointments. Better availability of telehealth in specialty areas could help with this issue.
- Lack of notification to the patient and/or Tribal facility when PRC bills are paid. IHS has contracted with Blue Cross Blue Shield (BCBS) of New Mexico to pay PRC bills, but they often do not notify patients when their PRC bills are paid. Tribal PRC programs also experience difficulties with communications with this IHS vendor.
- Communication and appeals of PRC denials. The denial letter generated in the IHS Resource and Patient Management System (RPMS)/Contract Health Services Management System (CHS-MS) software package is not patient friendly. Patients cannot review and understand the denial letter, which creates a challenge for them to understand their rights to appeal the denial in a timely manner.
- PRC health service request deferrals. As you know, budgetary limitations on PRC dollars have led to IHS implementing a ranking system where PRC service requests are categorized into levels of descending priority 1–5, a system which many Tribal health facilities inherited and still implement. While PRC committees try to approve as many levels as possible, and while most Level 1 requests will be approved, PRC requests at levels 2–5 of urgency are often deferred, sometimes temporarily, and sometimes indefinitely. It is easy to forget that every request for PRC services is made by a provider, reviewed by a care team or doctor, and is medically necessary. If the PRC budget had adequate funding to cover all PRC service requests, the level system of deferrals and denials would not be necessary. Many if not all of the problems with the PRC program could be resolved by adequate program funding.

⁶25 U.S.C. §1646 Authorization for emergency contract health services, *Indian Health Care Improvement Act of 1996* (Pub. L. 94-437, title IV, § 406, as added Pub. L. 102-573, title IV, § 405, Oct. 29, 1992, 106 Stat. 4566) and 42 CFR § 136.24, Authorization for contract health services.

4b) And what suggestions or recommendations would you provide to the Committee to make that process better?

Answer.

- Staff and patient training on the PRC program should be done at each level of the IHS/Tribal/Urban facility. This includes the patient registration area, clinic rooms, urgent care, primary care, emergency room staff as well as all support staff. PRC eligibility and rules should be discussed and reviewed at staff meetings. Medical providers and nursing staff should have a thorough enough understanding of the PRC program to answer patient questions and guide them through the process with a solid understanding of the eligibility requirements.
- Staff and patients should be trained on residency eligibility specific to the CHSDA for that facility and any facility-specific rules regarding which patients are eligible for PRC and which are not.
- There should be national guidance regarding what constitutes adequate notification to the facility under the PRC 72-hour/30-day notification rule. This would reduce inconsistency both nationally and within individual IHS facilities.
- To address the availability of specialty providers for PRC services, Indian health facilities could contract with providers to conduct clinics onsite at the facility, reducing the need for PRC funding to be used for specialty care. This onsite direct care could include telehealth services.
- IHS PRC programs should be required to send written notice to patients when their PRC bill has been paid. Oyate Health Center (OHC) does this, but to the best of our knowledge, the federal sites do not.
- PRC programs should be required meet with each PRC service vendor in their service area and report on these meetings to their Tribe or Tribes. Vendors need to understand the PRC process, know the contact for that vendor in the PRC program staff, and know that they will receive payment in a timely manner.
- The IHS RPMS/CHS-MS automatically generated denial letter needs to be scrapped and rewritten in a way that each patient understands what the facility needs from them to approve their PRC referral, for example proof of residency, whether their referral was deferred or denied and for what reason, and their appeal rights. The status of their request, who to contact with any questions, and how to contact them should be crystal clear.

Question 5. Your testimony and the hearing discussed how the Department of Health and Human Services (HHS) is not sharing public health data with Tribal Epidemiology Centers.

5a) Is there any further information you believe the Subcommittee should have regarding this issue?

Answer. HHS is in violation of federal law regarding data sharing with Tribal Epidemiology Centers (TECs). We are not expecting that IHS will respond to the Government Accountability Office (GAO) report with expanded access to IHS data. Congress needs to hold HHS and HHS agencies accountable for the lack of data provided to TECs. In some sense, this is an easy fix. No law needs to be changed and no new law needs to be passed. HHS simply needs to follow existing federal law which clearly states that TECs are to be given access to any and all data that is held by the HHS Secretary. We refer the subcommittee to the work of the National Committee on Vital and Health Statistics which recently made five additional recommendations to the Secretary of Health and Human Services regarding sharing of data, primarily from the CDC and IHS, with Tribes and TECs.⁷ These recommendations are in addition to the recommendations made in the March 2022 GAO Report regarding data sharing with TECs,⁸ and the similarly-themed July 2022 Report by the HHS Office of the Inspector General.⁹¹

⁷ <https://ncvhs.hhs.gov/wp-content/uploads/2022/12/NCVHS-Tribal-Data-Recommendations-12-12-final-w-review-508.pdf>

⁸ <https://www.gao.gov/products/gao-22-104698>

⁹ <https://oig.hhs.gov/oei/reports/OEI-05-20-00540.asp>

5b) Are you aware of any changes that have happened or are in the works at IHS or HHS on their data sharing policies?

Answer. HHS, IHS, and Centers for Disease Control and Prevention (CDC) are developing their responses to the March 2022 GAO report regarding data sharing with TECs. CDC created a “Tribal Data” page, and their response has been marked as “Closed—Implemented” by the GAO. HHS and CDC have not yet fulfilled the recommendations of the GAO and they remain open. These responses are currently being developed and will be released at some point. Outside of the responses to the GAO report, we are unaware of any other changes that have been made or are in progress related to data sharing policies at HHS.

Question 6. Can you provide the Committee with information about facility construction in the Great Plains area, specifically how the lack of new IHS facilities has impacted delivery of healthcare for tribes in your area?

6a) Given the significant amount of federal funds that have been allocated to IHS’s priority list in the past two years, what recommendations do you have to Congress and IHS to approach facility construction needs in the future to ensure federal funds are pushed out expeditiously?

Answer. While we are appreciative of increased funding for facility construction, and the very real opportunities to improve both care and outcomes as a new facility opens, the following issues continue to stymie federal construction efforts for Indian healthcare facilities.

Funding-related construction delays.

Some Indian health facilities were built with funds allocated under the American Recovery and Reinvestment Act (ARRA). These buildings were “fully funded,” meaning the total construction dollars were released in one distribution, allowing the facility to be completed on a regular commercial timeline. Normally, IHS construction projects are not fully funded, they are “phase funded.” This means the project is divided into phases and funding is distributed one phase at a time. This often results in construction delays and complications, especially when the federal government’s annual budget is delayed and funded by a series of continuing resolutions. Fully funding IHS construction projects instead of phase funding them would help push those funds out in an expeditious manner.

Tribal control over the initial process and building design.

Another change which would both expedite construction and result in more patient centered and culturally appropriate buildings would be to ensure IHS gives Tribes the opportunity, consistent self-determination regulations, to assume the authority for the pre-planning, planning and design of construction projects, including through the use of their own architecture and engineering (A/E) firm. Construction projects which are fully funded and where the Tribe controls the design, such as the IHS Hospital in Eagle Butte which was completed in 2012, produce a better result than the traditional IHS construction process. IHS needs to ensure that it complies with its own regulations and provides tribes such opportunities with respect to all construction funding. A requirement that IHS document that it has provided an adequate opportunity for each Tribe impacted by the new construction funding to assuming the preplanning, planning, design and construction and that it has obtain an affirmative statement from the tribal governing body that it has declined the opportunity. This should involve an informational presentation at each stage of the project’s development to the proper tribal officials of the pros and cons of assuming the project responsibilities.

Other considerations in the construction process.

Even if Congress completely funded the existing IHS facilities need tomorrow, IHS’s construction and engineering programs do not have the capacity to construct that many facilities in a timely fashion. Enhancing capacity in those departments, or creating a scalable project management model in IHS’s construction management program, would help IHS respond to increased Congressional funding for these badly needed projects.

In summary, the following points could help Congressional funds allocated for new IHS facility construction be put to use more quickly and effectively:

- Full funding each IHS construction project, instead of phase funding
- Including sufficient money for staffing and operations, in particular adequate Maintenance and Improvement (M&I) funding for each new facility, in the staffing package for that building.
- Formalizing Tribal authority in the design and initial document process, including use of the Tribe's A/E firm.

Questions Submitted by Representative Leger Fernández

Question 1. Could you share more on the anticipated impacts and loss of services that would occur if the FY24 enacted congressional budget reflects FY22 enacted levels for the Indian Health Service (IHS)?

Answer. No response provided.

Ms. HAGEMAN. I thank the witness for their testimony.
The Chair now recognizes Ms. Laura Platero for 5 minutes.

**STATEMENT OF LAURA PLATERO, EXECUTIVE DIRECTOR,
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD,
PORTLAND, OREGON**

Ms. PLATERO. Good morning, Chair Hageman, Ranking Member Leger Fernández, and members of the Subcommittee. I appreciate this opportunity to testify today.

My name is Laura Platero, and I am a citizen of the Navajo Nation and serve as Executive Director of the Northwest Portland Area Indian Health Board.

The Northwest Portland Area Indian Health Board is a tribal organization under the Indian Self-Determination Education Assistance Act, also known as ISDEAA, serving the 43 federally recognized tribes of Idaho, Oregon, and Washington.

We also operate the Northwest Tribal Epidemiology Center, one of 12 across Indian Country, which are public health authorities under the Indian Healthcare Improvement Act.

Epi Centers collect and protect tribal data, evaluate health outcomes of programs, and assist with public health response, among many other core functions.

In the Northwest, American Indians and Alaska Native people face significant health disparities compared to other populations. Like all under resourced communities, they are vulnerable to chronic diseases, such as heart disease, diabetes, substance misuse and overdose, and experience higher numbers of unintentional injuries and violence.

Fentanyl overdoses are currently a serious concern in many Northwest tribal communities. This is why we are organizing a national tribal opioid summit later this year. These significant health disparities in large part are due to historical and ongoing funding shortfalls.

In this regard, this Committee inherits the legacy of the Federal Government not fulfilling trust and treaty obligations to Tribal Nations. Tribal Nations were promised healthcare for their people. It must be high quality and comprehensive care to ensure that our future generations are healthy and thriving.

More improvements today will also result in reduced disparities and costs down the road. Honoring the promises to Tribal Nations must be at the forefront of this Subcommittee.

Despite gaps in healthcare and limited funding, tribal communities have been innovative in addressing their community health needs. This would not be possible without ISDEAA contracts and compacts.

These contracts and compacts have upheld tribal sovereignty and given tribes the resources to control and develop innovative health programs that meet the needs of their community in a culturally responsive way.

These programs also maximize dollars by reducing IHS administrative costs to run the program at the local and area level, more dollars are allocated to tribal health programs. This allows programs to increase services and providers and increase access to care.

While American Indian and Alaskan Native people were disproportionately impacted by COVID-19, due to underlying health disparities and the lack of infrastructure in many communities, tribal innovation in response to COVID prevailed.

When tribes are given the resources and control of those resources, they know how to respond to meet the needs of their community. Many tribes received funds in their ISDEAA contracts and compacts and were able to quickly roll out COVID-19 vaccinations to not only their own community members, but their surrounding non-Native communities.

They also had the flexibility to rapidly stand up community testing sites, vaccination sites, conduct case investigations, and provide treatments for COVID-19.

COVID-19 clearly shows us that self-determination and self-governance works. We request that this Subcommittee support expansion of ISDEAA compacts and contracts across HHS and its agencies.

For ISDEAA, tribal health programs, contract support costs, and 105(l) leases are critical to support operation of these programs. Our Northwest tribes request that contract support costs and 105(l) lease funds be provided through mandatory appropriations.

We also ask this Subcommittee to swiftly enact H.R. 409, the IHS Contract Cost Support Cost Amendment Act to protect contract support cost payments.

Another important ask of Northwest tribes is related to workforce. Given the remote location of many tribal communities, IHS and tribal health programs find it hard to recruit and retain providers.

Fortunately, Tribal Health Programs, through their ISDEAA contracts and compacts, have found ways to address staffing needs, for example, to address behavioral health provider needs, programs have been able to contract with psychiatrists to provide tele-psychiatry services. Tele-health flexibilities have allowed tribal health providers to expand their services and reduce no-show rates.

We need tele-health to remain permanent. Another innovative way tribes are addressing staffing needs is through the Community Health Aid Program. This program is creating mid-level providers

across tribal health programs for dental, behavioral health, and medical services.

Northwest tribes have been very resourceful in standing up three education programs and a CHAP certification board with minimal IHS funds. We now need additional funding to maintain and grow this program in the Northwest.

We have also included a number of Medicaid and Medicare legislative initiatives that this Subcommittee should consider in our written testimony to expand health services and staffing in the Northwest.

I thank the Committee for this opportunity to testify. We invite you to attend our opioid summit in August, August 22 and 24 in Tulalip, Washington.

[The prepared statement of Ms. Platero follows:]

PREPARED STATEMENT OF LAURA PLATERO, THE NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD

Chair Hageman and Ranking Member Fernandez, and Members of the Subcommittee, I appreciate the opportunity to present this testimony on “Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities.”

My name is Laura Platero, and I serve as the Executive Director of the Northwest Portland Area Indian Health Board (NPAIHB or Board). NPAIHB was established in 1972 and is a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638. The Board advocates on specific health care issues in support of the 43 federally-recognized Indian tribes in Idaho, Oregon, and Washington (Northwest or Portland Area). The Board’s mission is to eliminate health disparities and improve the quality of life for American Indians and Alaska Natives (AI/AN) by supporting Northwest Tribes in the delivery of culturally-appropriate, high-quality health care. “Wellness for the seventh generation” is the Board’s vision. We thank the Subcommittee for their continued support in improving the delivery of healthcare services in Indian Country.

I provide the following testimony to address opportunities and challenges for improving healthcare delivery in the Northwest:

Northwest Tribes have been strong advocates in requesting that the federal government uphold trust and treaty obligations to Tribal Nations, including full funding for the Indian Health Service (IHS). They are also known for their long history in IDSEAA Self-Determination contracting and Self-Governance compacting. There are 13 ISDEAA Title I Contract Tribes, 25 ISDEAA Title V Compact Tribes, five federally operated IHS facilities and three urban Indian facilities. In the Portland Area, there are 200,000 AI/AN users¹ of the Indian health system. There are no IHS or tribally-operated hospitals in the Portland Area. The lack of an IHS or tribally-operated hospital limits AI/AN people’s access to the breadth of inpatient care and specialty services provided by hospitals. To fill this gap in services, tribal health programs purchase all in-patient and specialty care not provided in their outpatient clinics with IHS Purchased and Referred Care (PRC) dollars. In 2025, IHS, with the Portland Area Tribes Facilities Advisory Committee (PAFAC), will stand up the first Regional Specialty Referral Center (“Center”) in the Indian health system, a specialty outpatient care facility in Puyallup, Washington. Two more Centers in other parts of the Portland Area will ensure outpatient access to care across the region. No funding has been allocated for the two additional Centers yet.

Health Disparities, COVID-19, and Tribal Innovation in the Northwest

Like AI/AN people across Indian Country, AI/ANs in the Northwest experience significant health disparities when compared to other populations. They have a life expectancy that is about 7 years lower than that of non-Hispanic Whites (NHW). They also experience disparities at all stages of life and are particularly vulnerable to chronic diseases such as heart disease and diabetes, injuries, violence, substance misuse and overdoses. In the past year, there has been an alarming increase in

¹In the Portland Area Indian Health Service system, there are approximately 218,000 users registered, with 114,000 active users.

Fentanyl overdoses in Northwest Tribal communities. AI/AN people in the Northwest are also less likely to have health care coverage and access compared to their NHW counterparts which, in part, explains the low rates of preventative health care services accessed by AI/AN people. Chronic health disparities² and lack of access to care, resulted in COVID-19 disproportionately impacting AI/AN people. AI/AN people had significantly higher rates of COVID-19 cases (3.5x),³ hospitalizations (5.3x), and deaths (1.8x)⁴ than non-Hispanic Whites.

While COVID-19 was devastating to many Tribal communities, it also highlighted the resilience and innovation of Tribal communities to respond to the pandemic. When Tribes have adequate resources and control of those resources, Tribes know how to respond to public health emergencies and to address the healthcare needs of their community members. For example, Tribes were successful in quickly rolling out COVID-19 vaccinations in their communities. AI/AN people were the most vaccinated ethnic and racial group in the U.S. early in the pandemic. Many Northwest Tribes also provided vaccines to non-Natives in and around their communities.

Based on this experience, NPAIHB recommends that the Subcommittee:

Expand the use of ISDEAA Self-Determination contracts and Self-Governance compacts.

Northwest Tribes have had long-standing requests to the IHS and HHS to move away from grant funding and allow tribes the option to receive funds through their contracts and compacts. Self-determination and Self-governance contracts and compacts honor tribal sovereignty and the government-to-government relationship. IHS continues to provide funding through grant programs, such as the Special Diabetes Program for Indians and several IHS Behavioral Health grant initiatives. Grant programs result in IHS administrative costs to operate the grant program and reduce funds to tribes. This Subcommittee must support an option for tribally-operated facilities to receive grant funds through their ISDEAA contracts and compacts.

In addition, during the pandemic, HHS agencies allocated funding to IHS that was distributed to tribes through existing formulas and ISDEAA contracts and compacts (e.g., Centers for Disease Control and Prevention). This process successfully allowed tribes to receive funds quickly from CDC and to use those funds to best meet the needs in their communities. All HHS funding should be allocated to Tribes through this mechanism. This Subcommittee must support legislation expanding ISDEAA contracting and compacting to HHS and its agencies.

Maintain advance appropriations.

IHS was provided advanced appropriations for the first time in Fiscal Year 2024. This is essential to ensure that the IHS has stable funding year after year to shield our tribal health programs from potential government shutdowns and continuing resolutions. Tribal health programs cannot budget for future years and plan for expansion of services without stable funding year after year. We thank members for supporting advance appropriations that was included in the Consolidated Appropriations Act, 2023.

Support mandatory funding for Contract Support Costs and ISDEAA 105(l) Leases.

Mandatory appropriations is needed for contract support costs (CSC) and the ISDEAA 105(l) leasing program to ensure that discretionary appropriations for other IHS subaccounts are not impacted by the growing costs of these programs. If CSC and 105(l) programs do not receive mandatory appropriations, IHS program increases, medical inflation and population growth will continue to be underfunded and result in increased health disparities and increased chronic healthcare needs.

²Chronic health disparities among AI/AN people is the result of significant underfunding of the Indian Health Service. U.S. Comm'n On Civil Rights, Broken Promises: Continuing Federal Funding Shortfall For Native Americans At 19 (2018) available at <https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf>.

³Hatcher 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; 69:1166–9.

⁴Arrazola 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.mm6949a3>

Create workforce opportunities through the Community Health Aide Program.

The Community Health Aide Program (CHAP) is a program that was designed and implemented by the Alaska Native Health system over 60 years ago. In nationalizing it to the rest of the country, tribes everywhere have an important opportunity to tackle social determinants of health while improving healthcare workforce and retention. CHAP is unique because it not only increases access to care but creates access points to health education so that tribal citizens can become health care providers with professional wage jobs on reservations and in tribal health programs throughout the country; thus, addressing poverty and supporting economic viability in Tribal communities. The education programs associated with CHAP are the foundation of the program.

In the Northwest, we have established a Dental Therapy Education Program, two Behavioral Health Aide Education Program, and are in the process of developing the Community Health Aide Education programs. We have also worked with the Portland Area IHS Office to standup a CHAP Certification Board to certify our Portland Area CHAP providers. Approval of the certification process is in process. Portland Area Tribes and NPAIHB have been innovative and creative in securing funding for CHAP expansion despite only receiving one IHS grant of \$1 million (of the \$20 million appropriated to IHS for the expansion of CHAP in the lower 48). This Subcommittee must consider this crucial opportunity to address workforce shortages in Tribal communities.

Consider innovative approaches to address facility construction needs.

At the current rate of appropriations for construction and the facility replacement timeline, a new 2021 facility would not be replaced for 290 years. Many tribes and tribal organizations in the Northwest have assumed substantial debt to build or renovate clinics for AI/AN people to receive IHS-funded health care. This Subcommittee should consider opportunities to utilize the demonstration authority under the Indian Health Care Improvement Act to provide flexible funds to Tribes to address unmet construction needs for health facilities.

Reauthorize and increase funding for Special Diabetes Program for Indians (SDPI).

Diabetes impacts AI/AN people at significantly higher rates. Nationally, 8.2% of the population has diabetes (all populations, over 18 years old)⁵ compared to 14.7% of AI/AN people across the country with diabetes. This is significantly higher than any other national demographic, with Hispanic people the next highest at 12.5%. COVID-19 continues to be a threat to our diabetic patient populations. Recent data shows that there are higher rates of long COVID in people with diabetes and an increased risk of diabetes with individuals with long COVID.⁶

Congress reauthorized the SDPI program at \$150 million per fiscal year until Fiscal Year 2023.⁷ SDPI funding has remained stagnant at \$150 million and has not increased in pace with inflation and population growth. This program has been successful in creating positive health outcomes that reduce costly care for more chronic conditions and hospitalizations. We request that this Subcommittee reauthorize SDPI at \$250 million for FY 2024, exempting the program from mandatory sequestration, and increase the funding to \$260 million in FY 2025 and \$270 million in FY 2026 in order to expand our diabetes programs. Lastly, this Subcommittee should consider creating an option for tribes to receive SDPI funds through their ISDEAA contracts and compacts.

Provide Health IT Modernization funds to reimburse tribes.

The Resource and Patient Management System (RPMS) is now a legacy system and is inconsistent with emerging architectural electronic health record (EHR) standards. NPAIHB recognizes that the Veterans Administration's (VA) decision to move to a new Health Information Technology solution will create a gap for the parts of RPMS that are dependent on core coding from the VA. RPMS cannot meet these evolving needs without substantial investment in IT infrastructure and software. COVID-19 has really highlighted the challenges with RPMS and has required double entries of data for reporting purposes. Many Tribes have had to use their

⁵National Diabetes Statistics Report 2020, Estimates of Diabetes and its Burden in the United States. Centers for Disease Control and Prevention.

⁶See Raveendran AV, Misra A. Post COVID-19 Syndrome ("Long COVID") and Diabetes: Challenges in Diagnosis and Management. *Diabetes Metab Syndr.* 2021 September-October; 15(5): 102235. <https://doi.org/10.1016/j.dsx.2021.102235>

⁷See Consolidated Approps. Act 2021, Pub. L. No. 116-260, 134 stat. 2923 (2020).

own revenues and incur substantial debt to purchase electronic health record systems to interface with local hospital systems to improve patient care. However, since IHS has been appropriated hundreds of millions of dollars in recurring and one-time funding for EHR, Tribes have not received any funding to support Tribal health IT investments. This Subcommittee must support IT modernization efforts with priority for Tribes that have purchased commercial off the shelf systems.

Support Access to Care Factor in Purchased and Referred Care Allocations.

The PRC program makes up over one-third of the Portland Area budget because we have no IHS or tribally-operated hospital. Year after year, PRC receives nominal increases often less than 1% despite this being the second rated priority of the National Tribal Budget Formulation Workgroup every year. Areas with IHS hospitals can absorb these costs more easily because of their infrastructure and large staffing packages.

When there are increases to the PRC budget, the Portland Area Tribes receive additional funding to account for the lack of an IHS/Tribal hospital in the Area, often referred to as the access to care factor. However, Congress through the IHS budget has only ever funded this access to care factor three times in the past 12 years—in FY 2010, 2012, and 2014. Without year-to-year increases to PRC to fund the access to care factor, inpatient care for Portland Area Tribes goes severely underfunded. We request this Subcommittee support annual funding for the access to care factor.

H.R. 409—IHS Contract Support Cost (CSC) Amendment Act

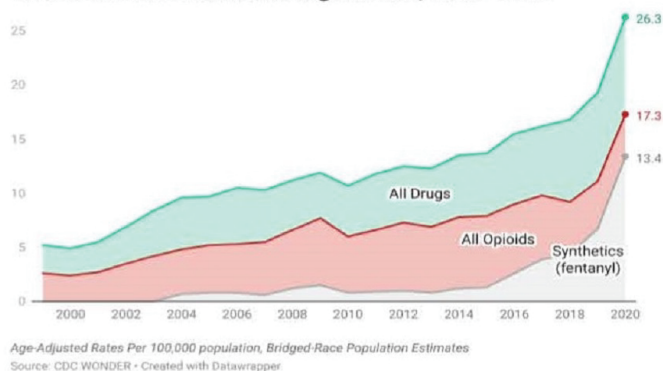
The federal appeals court decision in *Cook Inlet v. Dotomain* that decided tribal overhead costs are disqualified from being reimbursed if the IHS would “normally” incur that same cost in running the contracted programs undermines the long-standing understanding of the ISDEAA. The Northwest Tribes have been relentless advocates for Tribal Self-Determination and Self-Governance Title I and Title V contracts and compacts. However, the *Cook Inlet* decision can destabilize our tribal health program operations and threaten our Tribal Self-Determination and Self-Governance to provide health care to our people by significantly reducing our contract support cost recovery.

In *Fort Defiance Indian Health Board v. Becerra*, 604 F.Supp.3d 118 (D. NM 2022), IHS cut a tribal contractor’s Contract Support Cost (CSC) FY 2022 payments by 95% or nearly \$17 million arguing that historic overpayment has occurred relying on the *Cook Inlet* decision. Although *Fort Defiance* has been settled, there still remains an urgency to swiftly enact H.R. 409 to reverse the *Cook Inlet* decision. The Northwest Tribes are concerned that IHS will not fully reimburse tribes for their CSC payments and assert claims for past payments just as the agency has done in the *Fort Defiance* case. We urge the Subcommittee to swiftly enact H.R. 409 to reverse *Cook Inlet* and restore the long-standing interpretation of the Indian Self-Determination Act related to CSC payments.

Opioid Epidemic

The Northwest Tribes are facing an alarming opioid and Fentanyl epidemic that is disproportionately affecting Indian Country. The rate of illicit drug use for AI/AN’s use is nearly twice as high compared to the rate for non-Hispanic Whites in the U.S. Recently, from 2020 to 2021, AI/ANs experienced a 33.8% increase in all drug overdose deaths compared to a 14.5% increase among the total U.S. population for the same period.

U.S. Overdose Deaths Among AI/AN's, 1999-2020



The Northwest Tribes need increased funding to address the opioid epidemic through self-governance and self-determination compacts and contracts. The IHS Special Behavioral Health grants and SAMHSA Tribal Opioid Response grants are difficult to access with the many administrative requirements of applying for and receiving grant funding. Grants do not provide administrative flexibility to allow the Tribes to establish programs that meet the needs of their own communities. Many tribes do not have grant specialists and the grant programs make tribes compete with each other for limited resources. This Subcommittee should consider ways to provide funding for behavioral health and opioid response through their contracts and compacts to address this growing opioid crisis in Indian Country.

The Northwest Portland Area Indian Health Board will be hosting a National Tribal Opioid Summit at the Tulalip Tribes, Washington on August 22–24, 2023. We invite the Subcommittee Members to come together in partnership with tribes to have meaningful discussions across Federal, regional, and state decision-makers to address this epidemic.

Medicare and Medicaid

Medicaid and Medicare third party reimbursements are vital sources of revenue for the sustainability of tribal health programs. Tribal health programs continue to face barriers in recovering these third-party reimbursements to their full capacity despite federal law authorizing reimbursement. Some of these challenges include managed care plans inappropriately reimbursing tribal health programs, states that have not expanded Medicaid under the Affordable Care Act, lack of partnership between state and tribal health programs on eligibility. These challenges have resulted in high rates of uninsured AI/AN people. According to recent data, AI/AN adults had the highest rate of uninsured than any other race –25% of AI/AN non-elderly adults are uninsured.⁸

NPAIHB makes the following legislative requests related to Medicaid and Medicare:

Make permanent Medicare reimbursement for telehealth for tribal health programs.

The NPAIHB, Affiliated Tribes of Northwest Indians, and National Congress of American Indians have called upon the states and the Centers for Medicare and Medicaid Services (CMS) to make Medicaid and Medicare reimbursement permanent for telehealth, including the use of audio-only calls beyond the COVID-19 Public Health Emergency (PHE).⁹ The use of telehealth has expanded access to vital

⁸ Samantha Artiga, Kendal Orgera, & Anthony Damico, *Changes in Health Coverage by Race and Ethnicity since the ACA, 2010–2018*, Henry J. Kaiser Family Fund. (Mar. 5, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>

⁹ See Nw. Portland Area Indian Health Bd. Res. 2022-03-03, *Call on Ctrs. for Medicare and Medicaid Servs. and States to Permanently Expand Telehealth* (2022); Affiliated Tribes of Nw.

healthcare services to our AI/AN people. In order to maintain these services in tribal health programs, Northwest Tribes need to be able to continue to receive Medicaid and Medicare reimbursements at the OMB encounter rate. The Consolidated Appropriations Act of 2023 extended certain Medicare telehealth flexibilities through December 31, 2024. However, we ask this Subcommittee to enact legislation that permanently expands those Medicare telehealth flexibilities, including access to telehealth in patients' homes and through audio-only, and to remove any in-person requirements for mental health or substance use disorder treatment or any other services.

Expand Part B coverage to include pharmacists and community health providers.

Congress recently expanded Part B coverage for marriage and family therapists and mental health counselors in the Consolidated Appropriations Act of 2023. Although this was an important first step to expand behavioral health services for Medicare, we request that Part B is expanded to include Tribal pharmacists, certified community health aides and practitioners, behavioral health aides and practitioners, and dental health aide therapists.

Authorize Medicaid reimbursements for Qualified Indian Provider Services.

The Northwest Tribes request that the Subcommittee enact legislation that authorizes all Indian Health Care Providers to bill Medicaid for all Medicaid optional services as well as specified services authorized under the Indian Health Care Improvement Act regardless of whether the State authorizes those services in their Medicaid program for other providers. It's important that Congress honors their federal trust and treaty responsibility to provide healthcare to AI/AN people and that that responsibility and obligation should not be passed through states to provide healthcare.

Provide Medicaid reimbursements for services furnished by Indian Health Care Providers outside of an IHS or tribal facility (Four Walls Issue).

In 2016, CMS informed states that they have updated their payment policy for services received by AI/AN people through Indian Health Care Providers (IHS or tribal health programs). Through further guidance in 2017, CMS clarified that IHS or tribal clinics could not receive reimbursement for services furnished to AI/AN people outside the "four walls" of their clinic. CMS has provided a grace period (which ends nine months after the end of the COVID-19 public health emergency) to allow states and tribes to come into compliance with this updated policy and to implement revisions to state Medicaid programs to create a Tribal Federally Qualified Health Center (FQHC) workaroud. Many Tribal health programs provide health care services to their people in their community, such as community schools, community events, or in their homes. Providing healthcare services in community and not just in the brick and mortar clinic has become an essential part of healthcare delivery in tribal communities.

In order to fix this "four walls" issue, we request this Subcommittee enact legislation that amends the "clinic services" definition to ensure that reimbursements for services furnished by IHS and tribal clinic services providers will be available wherever the service is delivered.

Conclusion

Thank you for this opportunity to provide testimony on our challenges and opportunities to improve the delivery of healthcare in honor of trust and treaty obligations to Tribal Nations. As evidenced by our testimony, when tribes are given control of health care funding and grant funding, tribes are creative, innovative and can reduce health disparities in their communities.

I invite you to visit the Northwest to learn more about our health care needs in our Area. I look forward to working with the Subcommittee on our requests and we are happy to share proposed legislative language for our requests.

Indians Res. 2022-20, *Call on Ctrs. for Medicare and Medicaid Servs. and States to Permanently Expand Telehealth* (2022); Nat'l Cong. of Am. Indians Res. ANC-22-024, *Call on Ctrs. for Medicare and Medicaid Servs. and States to Permanently Expand Telehealth* (2022).

QUESTIONS SUBMITTED FOR THE RECORD TO LAURA PLATERO, EXECUTIVE DIRECTOR,
NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Questions Submitted by Representative Westerman

Question 1. How has telehealth improved access to care? Do you have any information on how that has been different between tribally run healthcare facilities and IHS run facilities?

Answer. Many tribes in the Northwest were already providing some form of telehealth prior to the COVID-19 public health emergency (PHE). With the declaration of the PHE, tribal health programs were provided numerous flexibilities to expand telehealth, including audio only calls without compromising any Medicaid and Medicare reimbursement. Additionally, these flexibilities ensured they were not violating any federal privacy laws. Tribal health programs quickly rolled out telehealth services in their programs to reduce face to face encounters in the height of the pandemic.

Through the expansion of telehealth, tribal health programs found that expansion of telehealth reduced no-shows, maintained continuity of care, and expanded the breadth of services in an ambulatory care clinic. American Indian and Alaska Native (AI/AN) patients were more likely to show up for their telehealth visit than a face to face encounter which continued care for many patients that would have otherwise gone unseen. Because many tribal health programs are in remote locations and cannot compete with larger healthcare systems, tribes face challenges recruiting and retaining specialty providers. For example, a number of Tribes have reported on successfully contracting with psychiatrists to provide services through telehealth. The upcoming end of the public health emergency and roll back of many flexibilities to provide telehealth, especially through audio-only threaten the ability of tribes to maintain telehealth services in their health programs.

Indian Health Service (IHS) and Tribal health programs are operated and managed very differently. Tribal health programs through their self-governance contracts and compacts are able to rapidly alter their services and operations to meet the needs of their communities compared to IHS-operated facilities. Some tribes noted that tribal health programs were more successful in implementing telehealth in their services and programs because of the limitations IHS-ran facilities have in making local decisions. One tribe explained that broadband is a significant limitation to one IHS operated facility to expand telehealth. Through the course of the public health emergency, this facility has not been able to procure and maintain a functioning and reliable Internet services throughout the facility. The direct service tribes often point to the inability for IHS-operated facilities to make decisions at their service units and having to seek permission through the Area office to make changes in their services, procure and purchase equipment, or even provide any specific staff training.

1a) What data you can share with the Committee on how telehealth may have improved access to care?

Answer. One tribe shared that with implementation of telehealth in their behavioral health program they were able to significantly reduce no-shows. The no show rate for this year was at 272 no-shows compared to 2,216 no shows in 2019 when telehealth was not offered.

Question 2. Could you further expand on the challenges the Portland area is facing regarding workforce shortages for both IHS and tribally operated facilities.

Answer. The Portland Area face chronic workforce shortages that has been heightened by the COVID-19 pandemic. These shortages are due to programs not able to compete with salaries and benefits of working within larger health care systems and tribes being in rural areas in the Northwest. Now, tribal health programs are grappling with retention of their workforce.

2a) What are the greatest challenges to maintain an effective workforce for tribal health programs?

Answer. Some of the greatest challenges is providers working for tribal health programs that are not from the tribal communities. This results in a revolving door of providers which makes it difficult to maintain steady workforce that the community grows to trust and build relationships. Additionally, housing and the remote locations of some tribal health programs make it difficult to recruit specialty providers.

2b) Are there any tribally led efforts on recruitment and retention that IHS can learn from or institute?

Answer. Through the course of the COVID-19 public health emergency, there were many flexibilities that made it easier for programs to implement telehealth. Many tribal health programs were quick to implement telehealth to expand services and minimize face to face exposure. As part of the expansion of telehealth across the U.S., tribal health programs used this as an opportunity to contract with providers to provide services through telehealth. For example, a number of tribes reported implementing telepsychiatry programs because psychiatrists are very difficult to recruit to tribal health programs. Requiring face to face visits to continue telepsychiatry services threaten tribal health programs from providing these critical services.

Another tribally-led effort to address recruitment and retention of providers in the Northwest is through the expansion of the Community Health Aide Program (CHAP). CHAP addresses chronic workforce shortages by training community members to become midlevel providers to return to and serve their communities. CHAP providers can be trained to provide dental services, behavioral health services, and medical services. The NPAIHB and the Northwest Tribes have developed education programs to train dental therapists and behavioral health aides, and are in the process of building out a community health aide education program. This Subcommittee should continue to support additional funding to further build out the CHAP workforce and education programs in the Northwest.

Question 3. Your statement mentioned the Community Health Aide Program and your work to develop a program for the Pacific Northwest.

3a) Can you further expand on how you are working to establish that program?

Answer. NPAIHB, through the Tribal Community Health Provider Program (TCHPP) has been working on CHAP implementation since 2015. In order to expand CHAP in the Northwest, we have worked in three areas: regulatory, education programs, and tribal/clinical integration.

Regulatory

For our regulatory work, NPAIHB has been working on the development of the Portland Area CHAP Certification Board, national infrastructure, and state infrastructure. The TCHPP staff work closely with tribal partners and Portland Area IHS Staff on the design and implementation of the Portland Area CHAP Certification Board (federal certification board necessary for certification of providers and education programs), Academic Review Committees, Area specific standards and procedures, and other infrastructure necessary to provide regulatory oversight to CHAP providers and education programs. This work is similar to national accreditation agencies and state licensing boards. Last week, the IHS Director has formally recognized the Portland Area CHAP Certification Board which will allow our Portland Area CHAP providers to become certified.

TCHPP staff work closely with Portland Area IHS and IHS Headquarters through the national CHAP Tribal Advisory Group to support the design, creation, and implementation of federal infrastructure necessary for CHAP implementation. TCHPP also provides technical support to other Areas interested in CHAP implementation and provides regular learning opportunities through a CHAP learning collaborative Echo, giving presentation at conferences and meetings, and 1:1 with other Area partners.

TCHPP staff work closely with the Tribes and state Medicaid agencies on state infrastructure including state plan amendments, state legislation (when necessary), administrative rules, and other state specific activities to ensure CHAP providers are integrated into IHS and tribal health systems and reimbursed by third party payors.

CHAP Education Programs

In Alaska, there are education programs for all CHAP provider types available. TCHPP staff for the Portland Area work closely with curriculum experts, tribal partners, and education institutions to design, implement, and support CHAP education programs for all disciplines of CHAP specifically to meet the needs of the 43 Tribes in Washington, Oregon, and Idaho. In the Portland Area, there are education programs for Dental Health Aide Therapists (DHAT) at Skagit Valley College in partnership with the Swinomish Indian Tribal Community and Behavioral Health Aides (BHA) at the Northwest Indian College in partnership with the Lummi Nation and Heritage College in partnership with the Yakama Nation. We are in the process of developing a Community Health Aide (CHA) education program to further expand primary and emergency care clinicians in tribal communities. These

education programs have not received funding from the IHS for year to year operations. All of our education programs would benefit from federal funding to support their operations.

TCHPP staff are working closely with curriculum experts to design curricula for the remaining levels of Dental Health Aides (DHA) and BHAs and Practitioners and all levels of Community Health Aides. TCHPP staff are also working closely with tribal partners and education institutions to design and implement education programs around these curricula.

The TCHPP team and the Northwest tribes recruit students into the programs and support the students once they have entered the programs through funding (stipends and scholarships), mentorship programs such as with Elders, knowledge holders, and culture keepers ECHO, and other direct support of students.

Because of the limited financial resources available for CHAP, TCHPP staff are constantly fundraising to support implementation, tribal partners, education partners, and students. We encourage the Subcommittee to come to the Northwest to visit our CHAP education programs to learn more on CHAP implementation in the lower 48. This is an opportunity to expand access to care across IHS and Tribal health systems.

Tribal/Clinical Integration

Lastly, TCHPP staff work closely with tribal health programs to provide clinical supervision for CHAP providers, train supervising providers, and work with all levels of staff to integrate CHAP providers into existing processes and structures. We host the CHAP ECHO Learning Collaborative every month to bridge the gap between traditional practices and modern standards of care through bringing together DHATs, BHAs, and CHAs.

3b) Would that program that works only with tribally run healthcare programs, or do you think it could work within IHS also? Would any structural changes need to happen at IHS to make the CHAP program work within IHS's system?

Answer. The CHAP program is designed to work both with tribally run health care programs and with IHS programs. IHS will need to do some work on their internal infrastructure in order to incorporate CHAP into their workforce, so IHS facility implementation might take a few years longer than implementation in tribally run health care programs. That infrastructure work has already begun at the IHS Headquarters level.

CHAP—done correctly CHAP is structural change—CHAP was designed to sit outside of state regulatory environments and provide tribes and tribal organizations the ability to regulate a health system where they could provide the necessary tools to break down current barriers to health provider education and care. Current implementation outside of Alaska is struggling to grasp the supportive (and not regulatory) role that the federal government is meant to take in successful CHAP implementation. The Alaska CHAP Program has been successful for over 60 years and has been tribally run and operated with support from the Alaska Area IHS office. This has allowed CHAP to develop organically in Alaska Native communities over that time and provides the backbone of primary care in Alaska Native communities.

In order for CHAP to be successful outside of Alaska to the same degree—tribes and tribal health organizations need the flexibility to build a CHAP that is responsive to their needs and does not necessarily look exactly like the existing IHS system which has been failing tribes for centuries. Tribes are in the best position to understand the unique structural barriers that affect their citizens' ability to enter health provider education programs and access primary care.

CHAP education programs are tailored to meet the unique needs of tribal communities and are also successful for non-tribal citizens interested in health provider careers. Doing things like embedding prerequisites into pre-sessions (prerequisites are often barriers to entry), providing extra academic support during the education program, “indigenizing” curriculum to make it more relevant to the communities served, and building competency-based education programs are some of the ways that CHAP education programs are tailored to meet the needs of tribal communities.

3c) What other creative possibilities exist that tribal organizations and IHS could implement?

Answer. Structural change is slow and hard won because the existing structures have so much support to keep them in place—if we could focus on CHAP implementation with an eye toward structural change, this could open up so many possibili-

ties for tribal health programs, IHS, and tribes to experiment with creative ways to meet the health care needs of their communities

Question 4. The Subcommittee has heard from many different tribes that the Purchased/Referred Care program has several challenges:

4a) Can you describe some of the issues you have heard about within the Portland Area, and what challenges are your tribal members facing when dealing with the PRC program?

Answer. The Purchased/Referred Care (PRC) program is a critical program for the Portland Area because there is no IHS or Tribal hospital. The PRC program makes up over one-third of the Portland Area budget. IHS and Tribal health programs have to purchase all inpatient and specialty care which results in very limited services available for these programs to cover. Tribally-operated PRC programs need additional funding to cover higher level of services. Without year-to-year increases to PRC to fund the access to care factor, inpatient care for Portland Area Tribes goes severely underfunded.

One tribe has reported challenges in demonstrating eligibility for and obtaining specialty care from their IHS-ran PRC program. Some of these challenges include onerous documentation requirements not required by the IHS handbook or any other IHS authority; length of time IHS takes to process authorizations for PRC referrals; private health providers considering refusing to accept PRC referrals because of the administrative barriers to receive timely payment. These challenges have resulted in AI/AN people not receiving the necessary care they need, being referred to collection agencies for unpaid bills, and even deaths. We are happy to provide your office with the name of the tribe for any additional follow-up on these PRC issues stemming from IHS-operated facilities.

4b) And what suggestions or recommendations would you provide to the Committee to make that process better?

Answer. We recommend that the Committee supports increased funding for PRC. PRC has not received a significant increase since 2014 which has resulted in less funding available to expand covered referred services. For any changes to IHS-ran PRC programs, the IHS facility and Area Office should consult with the tribes on the chronic challenges in obtaining eligibility for and accessing PRC services in an IHS-operated facility.

Question 5. In your testimony, you mentioned difficulties in accessing certain grants at IHS and SAMHSA. Could you further expand on those difficulties?

Answer. The Northwest Tribes have been advocates for the expansion of Indian Self-Determination Education Assistance Act (ISDEAA) contracts and compacts across the Department of Health and Human Services (HHS). Tribal self-governance and self-determination compacts and contracts provide tribes the administrative flexibility to develop programs and services that meets the needs of the tribal communities. Over the past years, more and more funding has been made available in agencies such as SAMHSA and CDC, but they have required tribes to submit competitive grants. Many tribes do not have the administrative capacity to track open grant opportunities, apply for those grants, and maintain in compliance with exhaustive granting requirements.

COVID-19 showed how successful the self-governance and self-determination programs. Many tribes faced challenges maintaining their grants when they had to alter their programs and services to limit face to face exposure. Many tribes were unable to spend down their grants during COVID-19, such as Special Diabetes Program for Indians (SDPI) and behavioral health grants. With contracts and compacts, Tribes are able to easily move around funds to address the most pressing health-related issues. This resulted in quick response to address the public health emergency that ultimately resulted in American Indians and Alaska Natives being of the most vaccinated racial and ethnic groups in the U.S.

5a) What are the specific challenges for tribes and tribal organizations?

Answer. The federal government has treaty and trust obligations to provide healthcare services to American Indian and Alaska Native people. Grants do not fulfill these treaty and trust obligations because they do not provide funding to all tribes and tribal organizations. Tribes do not always have the administrative staff or grants specialists to keep track of opened grant opportunities, apply for those grants, and maintain in compliance with specific reporting requirements.

One specific challenge with SAMHSA grants is the burdensome Government Performance and Results Act (GPRA) Data Reporting requirements. We have found that GPRA reporting requirements took more time to complete and submit than the

actual delivery of services provided by the funds. These reporting requirements use more administrative resources than the SAMHSA funding provided to Tribes and tribal organizations. Currently, SAMHSA grants are set with a 20% administrative funding cap, but grantees frequently find additional resources must be expended to complete the reporting requirements. In other cases, many Tribes and Tribal organizations lack the time, staff, and resources necessary to meet the GPRA grant reporting and because of this, they are unable to apply for those grants or may decide not to reapply.

5b) What do you think should be changed about the grant process to make them more accessible to tribes and tribal organizations?

Answer. First and foremost, we recommend that IHS and HHS moves away from grant funding and allow tribes the option to receive funds through their contracts and compacts. This Subcommittee must support legislation expanding ISDEAA contracting and compacting to HHS and its agencies. Until there is legislation in place, HHS agencies should allocate funds to IHS to distribute to Tribes through ISDEAA contracts and compacts using existing formulas. Moving forward, Tribes should be exempt from GPRA reporting requirements, so more resources can go directly to services instead of being redirected to data collection, data entry, and data reporting.

Questions Submitted by Representative Leger Fernández

Question 1. Could you share more on the anticipated impacts and loss of services that would occur if the FY24 enacted congressional budget reflects FY22 enacted levels for the Indian Health Service (IHS)?

Answer. In the Consolidated Appropriations Act of 2023, Congress appropriated \$7 billion for IHS which includes a \$327 million increase over FY 2022 enacted level.¹ Of this increase for the overall IHS budget, Hospitals and Health Clinics received \$100 million increase, Tribal Epidemiology Centers received additional \$10 million, dental services received \$12 million increase, Purchased/Referred Care received \$12 million increase, and Alcohol and Substance Abuse received \$8 million increase. These are all crucial line items to Portland Area IHS and Tribal health programs which has allowed providers to keep pace with population growth and medical inflation. Medical costs are significantly increased in the Northwest and our tribal health programs cannot compete with large healthcare systems in the urban areas.

Additionally, Purchased/Referred Care (PRC) received only a 1% increase over FY 2022 enacted levels. This does not even cover medical inflation and population growth. PRC has not received a significant increase since 2014. When there are increases to the PRC budget, the Portland Area Tribes receive additional funding to account for the lack of an IHS/Tribal hospital in the Area, often referred to as the access to care factor. Cutting PRC back to FY 2022 levels would put us even further behind to even address population growth and medical inflation let alone to fund the access to care factor. We request this Subcommittee ensures that PRC is prioritized for increased funding and that it is not further cut.

Lastly, the Northwest Portland Area Indian Health Board operates the Northwest Tribal Epidemiology Center (NWTEC) that provides health-related research, surveillance, training and technical assistance to improve the quality of life of AI/AN people in the Northwest. With the increased funding for TECs, we have been able to expand the NWTEC and employ eight (8) epidemiologists and biostatisticians to increase services to the Northwest Tribes. The NWTEC conducts critical data linkage work to improve data validity and accuracy as AI/AN are chronically misclassified in state and federal data sets. Without accurate data, this impacts our Tribes from understanding healthcare needs and funding priorities. Any proposed cuts to TECs would require us to scale back our epi-related work including reducing the number of epidemiologists and biostatisticians we have on staff.

Conclusion

Thank you for this opportunity to submit follow-up responses to the Indian and Insular Affairs Subcommittee. I invite the Subcommittee to come visit the Northwest Portland Area Indian Health Board and our Northwest tribes to learn more about our challenges and programs and services.

¹See Consolidated Approps Act 2023, Pub. L. No. 117-328.

Ms. HAGEMAN. I thank the witness for her testimony and the Chair now recognizes Ms. Maureen Rosette for 5 minutes.

STATEMENT OF MAUREEN ROSETTE, CHIEF OPERATIONS OFFICER, THE NATIVE PROJECT; BOARD MEMBER, NATIONAL COUNCIL OF URBAN INDIAN HEALTH, WASHINGTON, DC

Ms. ROSETTE. Good morning. My name is Maureen Rosette, and I am a citizen of the Chippewa Cree Tribe and also a Board Member of the National Council of Urban Indian Health, NCUIH.

NCUIH is the national advocate to ensure urban Indian organizations have the resources and policy support to help serve the over 70 percent of American Indians and Alaska Natives living off reservation.

I am also the Chief Operating Officer at the NATIVE Project, an UIO in Spokane, Washington, which has a service population of over 20,000 American Indians and Alaska Native people.

In our facility alone, we have served Natives from over 300 different tribes. Let me start by thanking Chairwoman Hageman, Ranking Member Leger Fernández, and members of the Subcommittee for inviting NCUIH to testify.

I wanted to remind the Committee of the importance of urban Indian organizations to the Indian Health System. Growing up, I lived and grew up on my reservation and I was a consumer of my own tribally-operated health program.

At the age of 28, I moved to Spokane to go to law school, had no health insurance. I had two little kids, a 3-year-old and a 5-year-old. We had no health insurance.

At the time, if the NATIVE Project had had medical services, we would have had some healthcare, at least access to healthcare, but we didn't at the time. I just hoped and prayed that none of us got sick.

Now, I have insurance and I can go anywhere I want, but our family has chosen to be consumers of the NATIVE Project because of the excellent healthcare we get there and it is culturally appropriate. That is what we want.

Today, there are 41 UIOs, which are a fundamental and necessary component of the Indian Health System, and we work hand-in-hand with IHS to help provide the resources necessary to provide healthcare to Native people.

As the Committee knows, IHS has been on the GAOs high-risk report since 2017. Although IHS has been making progress on the GAO recommendations, full and stable funding has continuously been a barrier to addressing these recommendations.

We are grateful that Congress finally passed advanced appropriations for IHS in last year's omnibus. For over 50 years, without advanced appropriations or mandatory funding, our providers have been operating without budget certainty.

Indian health providers had to operate knowing they will not be able to pay their doctors on time because of late payments due to politics in Congress. This instability created barriers for our providers, and we could not be the hubs for innovative solutions for our communities.

Advanced appropriations will now allow IHS to make long-term cost saving purchases and minimize the administrative burdens for the agency and UIOs. Advanced appropriations will also improve accountability and increase staff recruitment and retention at IHS.

When IHS distributes its funding on time, our UIOs can pair doctors and providers. This means that Native people can have access to the care and services they need to be thriving communities.

As such, we request the Committee work with the appropriators to ensure advanced appropriation is maintained in future years. Despite these historical challenges, urban Indian organizations have been great stewards of the funds we can access.

Increases in funding have been met with improvements in the care we provide to our community. For example, my organization, the NATIVE Project, has used our funding to build and create a new Children and Youth Services Center.

We broke ground on the center in May 2022 and are looking forward to the increased care we will be able to provide our community. This new building will provide substance use and mental health resources, such as therapy and wellness practices and provide space for traditional Indigenous practices.

We will now have a space for healing our children as they grow to become the future of our communities. The declaration of the National Indian Health Policy states, “It is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians to provide all resources necessary to affect that policy.”

The Indian Health Service System is essential to fulfilling this policy. As IHS works to address the key issues and recommendations provided by the GAO, they must not be hindered by lack of funding, funding stability, and budgetary cuts.

Full funding will ensure IHS operates to provide the best healthcare possible for our people. We urge Congress to take this obligation seriously and work with IHS to ensure they have the resources necessary to protect Native lives. Thank you.

[The prepared statement of Ms. Rosette follows:]

PREPARED STATEMENT OF MAUREEN ROSETTE, NATIONAL COUNCIL OF URBAN INDIAN HEALTH (NCUIH)

My name is Maureen Rosette, I am a citizen of the Chippewa Cree Nation and the Chief Operations Officer of the NATIVE Project, an urban Indian organization (UIO) in Spokane, Washington. I am also a Board member of the National Council of Urban Indian Health (NCUIH), the national advocate for health care for the over 70% of American Indians and Alaska Natives (AI/ANs) living off-reservation, and the 41 UIOs that help serve these populations. I would like to thank Chair Hageman, Ranking member Fernandez, and members of the Subcommittee for inviting NCUIH to testify at this hearing.

The Beginnings of Urban Indian Organizations

The Declaration on National Indian Health Policy in the Indian Health Care Improvement Act states that “Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy”. In fulfillment of the National Indian Health Policy, the Indian Health Service funds three health programs to provide health care to AI/ANs: IHS sites, tribally operated health programs, and Urban Indian Organizations (referred to as the I/T/U system).

As a preliminary issue, “urban Indian” refers to any American Indian or Alaska Native (AI/AN) person who is not living on a reservation, either permanently or temporarily. UIOs were created in the 1950s by American Indians and Alaska Natives living in urban areas, with the support of Tribal leaders, to address severe problems with health, education, employment, and housing caused by the federal government’s forced relocation policies.¹ Congress formally incorporated UIOs into the Indian Health System in 1976 with the passage of the Indian Health Care Improvement Act (IHCA). Today, UIOs continue to play a critical role in fulfilling the federal government’s responsibility to provide health care for AI/ANs and are an integral part of the Indian health system. UIOs serve as critical health care access points for and work to help provide high-quality, culturally competent care to the over 70% of AI/ANs living in urban settings.

Consistent and Full Funding Leads to Accountability and Solutions

In 2017, IHS was first added to the Government Accountability Office’s (GAO) High-Risk Series report, where several key recommendations were identified for IHS to undertake in order to remove the High-Risk designation. Since then, IHS has continuously worked to address the recommendations, closing out almost all of GAO’s initial recommendations.²

The GAO has cited a lack of consistent and full funding as a barrier for IHS. Up until the passage of the Consolidated Appropriations Act, 2023, IHS was the only federally funded health care provider that did not receive advance appropriations. This uncertainty and disruption drastically impacted the ability of IHS to make important, long-term and cost saving purchases, as stated by the Congressional Research Service.³ This new funding stability will also allow for IHS, and UIOs, to continue to serve their communities and patients regardless of the status of a funding package, which will decrease administrative burdens on both the agency and UIOs. For example, with each continuing resolution (CR), UIOs must negotiate and execute brand new contracts with IHS, specific to the timing of the package, sometimes delaying the distribution of funding until the end of the resolution. For a population that not only has significantly poorer health disparities and has seen a significant decrease in life expectancy,⁴ and delays in funding can be the difference between life and death.

Full, stable and reliable funding is the most critical piece to allow IHS to truly begin to address its outstanding issues and improve the care it provides to Indian Country. When IHS can issue payments to UIOs on time, UIOs are able to create long-term plans and better improve the care and resources they provide to their communities. It is for this reason that we request that the Committee work with appropriators to maintain advance appropriations for IHS and protect IHS from sequestration, including

UIOs Use of Critical Funds Positively Impacts Communities and Tribal Partners

It is important to note that UIOs are excellent stewards of the funding they receive and fill a critical role in fulfilling the trust responsibility. While UIOs are funded through a single line item in the IHS budget, they have been able to do as much as possible, and then some, for their patients and communities. Most UIOs have a service area with a Native population of tens of thousands, and that does not include patients who may drive hours to come to a UIO specifically for the culturally competent care it offers.

Since the last Congressional session, with the passage of the Infrastructure Investment and Jobs Act, UIOs are now allowed to use existing IHS contracts and funding to upgrade their facilities. Since then, six UIOs have opened new facilities in the past year and an additional 16 UIOs have plans to open new facilities over the next two years.

In fact, the NATIVE Project was able to break ground in May 2022 on a new wellness center focused on child and youth wellness.⁵ This new building will provide

¹Relocation, National Council for Urban Indian Health, 2018. 2018_0519_Relocation.pdf (Shared)-Adobe cloud storage

²High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas, US Government Accountability Office, 2019. <https://www.gao.gov/products/gao-19-157sp>

³Advance Appropriations for the Indian Health Service: Issues and Options for Congress, Congressional Research Services, 2022.

⁴*Provisional Life Expectancy Estimates for 2021*, Elizabeth Arias, Betzaida Tejada-Vera, Kenneth Kochanek, and Farida Ahmad, 2022. <https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf>

⁵*Watch and learn from our children: The Native Project breaks ground on new youth wellness center inspired by the kids it will serve*, Amber D. Dodd, The Spokesman-Review, 2022. <https://www.spokesman.com/stories/2022/may/20/watch-and-learn-from-our-children-the-native-proje/>

not only behavioral and mental health resources, such as therapy and wellness practices, but will also provide space for traditional Indigenous practices. During a ceremony held the day we broke ground, a Kalispel elder spoke about the significance of keeping children at the center of work like this and praised the NATIVE Project for our work. “It’s important for me to note that my life and the life of many of us are well, we are well in heart because of concepts (such as) the NATIVE Project” said Francis Cullooya, whose Indian name ‘Tsisulex’ translates to ‘standing on the ground’. The NATIVE Project is also honoring elder Cullooya by dedicating a room in the new building to him.

The work UIOs do is critical not only to their communities and their patients, but also to our Tribal neighbors. Many UIOs work in partnership with neighboring Tribes to provide overflow patient care when Tribal facilities are at capacity. Andrew Joseph Jr., a member of the Colville Tribe, the Health and Human Services Chair for the Colville Business Council and Co-Chair of the IHS Tribal Budget Formulation Workgroup, has repeatedly praised the NATIVE Project for taking care of his Tribal citizens. “The Colville Tribe has, I would say, over 2,000 tribal members that utilize the NATIVE Project, over 160 families that utilize the NATIVE Project, and the way IHS is funded, if the NATIVE Project wasn’t there, our people would come home to a depleted . . . low funded IHS facility, so the NATIVE Project actually does a lot of work in saving our people’s lives” said Chair Joseph in a video of support. Therefore, it is essential that IHS continues to receive the support it needs, through funding and prompt appointment of leadership. Without it, UIOs cannot continue to increase the care and resources we provide to our communities.

These funds are critical to UIOs, and yet, due to lack of full funding for IHS, it has taken over a year to receive funds due to the administrative burden it takes for IHS to receive these funds, create guidance, and distribute funds with the lack of resources, personnel, and funding to issue these funds in a timely manner.

Administrative and Leadership Turnover Impacts Communication and Transparency with UIOs

Another regular recommendation that GAO provides to IHS is the need for stable leadership and senior staff. Since 2015, IHS has routinely gone for extended periods of time without a permanent Director due to nomination delays.⁶ This can lead to concerns and questions over the legitimacy of the policy decisions that these acting directors make. Recently, IHS was functioning under the direction of an Acting Director, Elizabeth Fowler, for nearly two years, prior to President Biden’s nomination of Director Roselyn Tso. And again, it took the Senate over 6 months to confirm Director Tso to the position.⁷

The lack of an IHS Director has routinely prevented Tribes, Tribal organizations, and UIOs from addressing the health care needs of their Native American populations. For urban Indian organizations, we were unable to share our priorities for our communities with the IHS Director until mid-December 2022, nearly three years into this administration’s tenure. Additionally, the lack of consistent leadership and the constant turnover of acting leadership has led to lapses in communication, particularly with urban Indian organizations. On several occasions, UIOs have not received updates on a number of key policy changes, updates and collaborations. For example, UIOs experienced the lack of communication regarding the implementation of the VA-IHS Memorandum of Understanding (MOU). IHS did not facilitate conversations between VA and UIOs prior to the publication of the VA’s rule on identification for Native veterans. With the expansion of the VA Reimbursement Agreement Program (RAP) to include UIOs, through the MOU, there are currently less than one-tenth of UIOs enrolled to receive reimbursement from the VA for care to Native veterans. UIOs have requested additional guidance be provided from both VA and IHS to assist with increasing UIO enrollment in the Reimbursement Agreement Program to improve health outcomes for our Native veterans.

While awaiting confirmation of a director, IHS has been working to fill a number of key senior agency positions. Specifically, Dr. Rose Weahkee became Director of the Office of Urban Indian Health Programs in 2020 and it has been under her leadership that UIOs, and NCUIH, have experienced increased interaction with the agency. For example, because of the leadership that Dr. Weahkee provides, the Office of Urban Indian Health Programs has been involved in a collaborative process

⁶ Crisis at Indian Health Service, Indianz.com, 2019. <https://www.indianz.com/News/2019/02/06/ihs-leadership-crisis.asp>

⁷ Senate Confirms Roselyn Tso as Director of the Indian Health Service, National Council of Urban Indian Health, 2022. <https://ncuih.org/2022/09/21/senate-confirms-roselyn-tso-as-director-of-the-indian-health-service/#:text=Today%2C%20September%202021%2C%202022%2C,without%20a%20permanent%20IHS%20Director>

with UIOs for over a year now in the development of the OUIHP Strategic Plan. Throughout this process, the Office of Urban Indian Health Programs has held several Urban Confers with UIOs and NCUIH, as well as continuously incorporated the feedback and edits to the Strategic Plan, from UIOs and NCUIH, that have resulted from these confers.

Since her confirmation, Director Tso has greatly stepped up to fill the void from the continued lack of a permanent Director. In the first 5 months of her tenure, Director Tso has visited at least three different urban Indian organizations—one in California, one in Arizona and one in Nebraska. Director Tso has also made an effort to ensure that UIOs are being heard throughout the agency and that IHS is as transparent as possible with our organizations and NCUIH. As mentioned previously, the Director was able to attend the NCUIH Board of Directors quarterly meeting. During this meeting, we were able to highlight several of our concerns, including communication challenges. Despite challenges highlighted within the GAO report and the impact of the political process, IHS has consistently made efforts and worked to address the outstanding issues, making great strides in improving the agency's relationship, collaboration, and partnership with the UIOs.

Conclusion

Among the most important legal obligations within the federal trust responsibility is the duty to provide for Indian health care, and the I/T/U system is essential to executing this trust and treaty responsibility. As IHS works to address the key issues and recommendations provided by the GAO, they must not be hindered by a lack of full funding, funding stability, budgetary cuts, and administrative and leadership turnover. Full, stable funding and exemptions from budget cuts and shut-downs are the only way to truly invest in the oversight of IHS and support the optimal care that our people deserve. We urge Congress to take this obligation seriously and work with IHS to ensure they have the resources necessary to protect Native lives.

QUESTIONS SUBMITTED FOR THE RECORD TO MAUREEN ROSETTE, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Questions Submitted by Representative Leger Fernández

Question 1. Could you share more on the anticipated impacts and loss of services that would occur if the FY24 enacted congressional budget reflects FY22 enacted levels for the Indian Health Service (IHS)?

Answer. IHS is chronically underfunded, and reducing its budget to the FY22 enacted levels would have a significant impact in its ability to provide care to Native patients. For example, the \$220 million reduction in IHS' budget authority for FY 2013 resulted in an estimated reduction of 3,000 inpatient admissions and 804,000 outpatient visits for AI/ANs.¹ If Congress were to decrease the budget to FY22 enacted levels, the resulting reduction of \$360 million in IHS' budget authority would have an even greater impact on Native healthcare compared to the effects seen in 2013.

Returning to FY22 enacted levels would have a significant impact on urban Indian organizations (UIOs) as it would reflect a 19% decrease in the Urban Indian Health line item. UIOs are already underfunded, for example, in FY 2018 U.S. healthcare spending was \$11,172 per person, but UIOs received only \$672 per AI/AN patient from the IHS budget.³ This underfunding is due, in part, to the fact that UIOs receive direct funding only from the Urban Health line item and do not receive direct funds from other distinct IHS line items. As a result, UIOs rely on every penny in the Urban Health line item to provide culturally competent care to their patients.

As funding for UIOs has increased over the past few years, it has been met with expansions in services for our communities. For example, my clinic, the NATIVE Project, was able to break ground on a new wellness center focused on child and youth wellness. This new building will provide not only behavioral and mental health resources, such as therapy and wellness practices, but will also provide space

¹ Contract Support Costs and Sequestration: Fiscal Crisis in Indian Country: Hearings before the Senate Committee on Indian Affairs.(2013) (Testimony of The Honorable Yvette Roubideaux)

² Recent Trends in Third-Party Billing at Urban Indian Organizations. National Council of Urban Indian Health. 2018. Recent-Trends-in-Third-Party-Billing-at-Urban-Indian-Organizations-1.pdf (ncuih.org)

for traditional Indigenous practices. Across the country, we are seeing UIOs expand services such as maternal and neonatal health, youth support services, and traditional healing services. Any reduction in the IHS budget will halt the progress made to address the needs in our communities and further constrain our ability to expand services or address facilities-related costs.

In addition to regular budgetary concerns, reducing the budget will have a direct impact on UIOs' ability to recruit and retain staff and providers. Many of our clinics have expressed difficulty in providing competitive pay, particularly compared to private or larger healthcare provider organizations in their service areas. Without more funding, UIOs cannot compete with inflation, high cost of living, or pay higher raises and hazard pay like other facilities. In a survey of UIO leaders, one leader highlighted the impact of underfunding by saying, "due to inflation and market changes, salaries have grown exponentially. It is becoming exceedingly difficult to staff the organization with high-quality employees, especially medical providers, while IHS funding stays the same year after year."³ In the IHS Portland Area, where my UIO is located, underfunding has caused significant recruitment challenges, with 100% of Dentist positions being vacant in 2021.⁴ Without sufficient staffing levels, Native patients will go unserved and may compromise the critical care needed for their well-being and ability to thrive.

It is critical that our Native communities are appropriately cared for, in the present and in future generations. We urge Congress to take this obligation seriously and provide UIOs with all the resources necessary to protect the lives of the entirety of the Native population, regardless of where they live. The federal government must continue to work toward its trust and treaty obligation to maintain and improve the health of American Indians and Alaska Natives and ensure our budget is protected as budget-cutting measures are being considered.

Ms. HAGEMAN. I thank the witness for her testimony.

The Chair will now recognize Members for 5 minutes for questions, and I will begin.

Ms. Alkire, in your testimony, you stated that Congress should conduct oversight to ensure that tribes and tribal organizations, specifically Tribal Epidemiology Centers have access to public health information at the same level as state and local health departments.

Could you further expand on that and give examples of the barriers that exist for data sharing right now?

Ms. ALKIRE. Yes. Thank you. Prior to becoming the chairwoman, I actually worked where Ms. Church works right now, at the Great Plains Tribal Chairman's Health Board. I was the administrator for the Northern Plains Epidemiology Center at that time, and one of the things, way back in 2010, we were asking for data sharing then from the state. And here we are in 2023, we just went through a pandemic, we don't know if we are going to go through another one, and we are still asking that question. Why are we not sharing data?

And as a tribal chairwoman now, I can say this, it is not the only agency that we struggle with that. At the Bureau of Indian Affairs, it is the same thing. And I don't mean to throw that in there, but I mean, this is something that we need to get past.

We cannot adequately address all our needs at the tribe, even as decision makers and these ladies here at the Health Boards, in addressing our healthcare needs without collecting the data and

³The National Council of Urban Indian Health. 2022 Annual Policy Assessment. 2023. Policy-Assessment-22 NCUIH D284 V6.pdf

⁴Assistant Secretary for Planning and Evaluation, Indian Health Service. How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives. 2021. <https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihf-funding-disparities-report.pdf>

sharing the information so we can tell our story to you, and you can tell the story adequately also.

So, the epidemiology, the data is so important. We just need to get past that.

Ms. HAGEMAN. Ms. Church, you seem to have some experience with this same problem?

Ms. CHURCH. Recently, I shared what happened during COVID-19 and not having that information made it so that we couldn't prioritize which of our 17 reservations that we were going to support for emergency operations.

We operated a Regional Emergency Operation Center and I believe, because of that, people died unnecessarily. We could have done more if we were at the right place at the right time, and we didn't know where to be at the right place at the right time.

Right now, with the syphilis outbreak, we reached out to CDC, we reached out to IHS for information. We reached out to CDC for Epi-Aid. They are in the process now of responding to that request for Epi-Aid, but I still don't know where to tell them to go first.

And IHS has, I think, 10 days to respond with an answer. The acting area director in Aberdeen responded, when I followed up on Day 10 for information on the outbreak. His response was, we are still looking into the legality of sharing that information.

Ms. HAGEMAN. OK. All right. I would like to direct my next question to Laura Platero. Since Portland area has both tribally run and IHS run health facilities, can you discuss some of the differences you have seen between management styles, and do you think facilities are learning from each other about what are best practices and how to ensure culturally competent healthcare for your tribal members?

Ms. PLATERO. Thank you, Chair Hageman. In terms of management styles, I would say that tribally operated facilities have more decision-making authority, and this results in more timely decisions. For example, they are able to purchase equipment and supplies that they need without having to get approval at the area level.

Similarly, staff training. They can make those decisions locally, rather than have to go to the area to get approval for those. For hiring, it also can take months for a Federal facility to get someone hired. By the time the person gets through the process, they may not be available.

In terms of the tribal facilities, of course they have that flexibility to expedite hiring when there is a need. There are also funding flexibilities for tribally operated facilities, in terms of moving funding across sub-accounts.

So, if someone would like to direct some healthcare funds to their behavioral health program or their mental health program, they can move those funds. Federal facilities are unable to do this.

There is just a lack of flexibility overall. And we have heard from some of our communities, even with presence in the community, many individuals who work at the federally operated facilities may not necessarily be integrated into the community or be part of social events, and it does, I think, it does matter to have a presence, like, at events locally in the community. And I am sure that is not the case for all places, but I heard that from one tribe.

Also, PRC eligibility for federally operated facilities. We have heard there are a lot of delays. There are penalties to members who get billed for services. This has been extremely burdensome.

We heard of one incidence where it resulted in someone not getting care and they ended up passing. And that tribe did, I would rather not give their name, but I am happy to share that later with the Committee and connect you with the tribe. They did want to talk with you.

Ms. HAGEMAN. OK. Well, thank you for that.

I am now going to recognize the Ranking Member, Ms. Leger Fernández, for your questioning.

Ms. LEGER FERNÁNDEZ. Thank you so much, Chair. And I want to really thank the witnesses because what is really key is, I think one of you said it is, that making sure that the voices that you represent are heard by us so we can raise our voices in support of what you are doing.

And I really want to thank you, from the heartbreaking thought of babies dying because we don't get them the care they need, with regards to this congenital syphilis, to the idea that somebody, if you are a Native American, you might not make it to see the Social Security.

These are really impactful stories that paint the picture. And I want to touch a bit on the advanced appropriations, mandatory appropriations. And I know that you have each testified you would like to see both, but I really am pleased that we at least got to the advanced appropriations for IHS last year on a bipartisan basis.

So, once again, let me just hear, Ms. Rosette, would you support advanced appropriations for IHS on a permanent basis?

Ms. ROSETTE. Yes.

Ms. LEGER FERNÁNDEZ. Ms. Church?

Ms. CHURCH. Yes.

Ms. LEGER FERNÁNDEZ. Ms. Platero?

Ms. PLATERO. Yes.

Ms. LEGER FERNÁNDEZ. Ms. Alkire?

Ms. ALKIRE. Yes.

Ms. LEGER FERNÁNDEZ. And Ms. Alkire, I really hope we might have time for a second round of questions, because I do want to hear the story about cultural competency and I think the important piece that I have witnessed over the years is that the tribally run organizations, either compacted or contracted, are able to blend in cultural competency much better.

But you have also pointed out that some of the IHS facilities also have that, and the study about getting better when you have trust in your doctor.

Do you see that using traditional healing practices also helps in terms of following the Western prescriptions as well? Maybe Ms. Church, if you want to answer that?

Ms. CHURCH. Sure. Absolutely. When our relatives feel comfortable in a healthcare facility that speaks to who they are and their culture, they trust even the Western physicians even more because they see those physicians respecting their culture. They see them respecting their spirituality.

And the quality of the care provided by the physicians also changes because they are exposed to culture, and they are aware that this is an important piece of that relative's healing journey.

Ms. LEGER FERNÁNDEZ. Thank you. And I think that the other thing I have seen is that 638 compacted-contracting facilities also do a great job of recruiting Native American providers into them.

I wanted to follow up real quickly on the issue of, if each of you could give me one example of how having advanced appropriations has helped? Ms. Rosette?

Ms. ROSETTE. Well, before we were having problems, we couldn't plan ahead, is how it has helped. Like, with our new building. Before we couldn't plan for things like that because we were not sure if we were going to have the funding.

Now, we know, at least for a while, that we will have the funding there for us so we don't have to use what money we have saved for operations.

Ms. LEGER FERNÁNDEZ. Right. When there is uncertainty, everything costs more.

Ms. Platero, quickly?

Ms. PLATERO. Same thing. Certainty in funding. Being able to plan, security with providers knowing they will have continued employment.

Ms. LEGER FERNÁNDEZ. Ms. Church?

Ms. CHURCH. Being able to use those resources more effectively and with confidence.

Ms. LEGER FERNÁNDEZ. Yes. And Ms. Alkire? I am sorry if I said it wrong.

Ms. ALKIRE. Alkire.

Ms. LEGER FERNÁNDEZ. I am from New Mexico, so my apologies for the mispronunciation.

Ms. ALKIRE. That is OK, thank you. I think the ladies all stated very well. It does come down to planning. It does come down to not feeling the uncertainty of what is going to happen next.

I mean, our people we have a lot of issues in regards to trusting systems in the first place, and when we have these issues with IHS, whether they can pay for something or not pay for it or the funding ends, as we used to say early, the first 2nd quarter, they just can't help you.

That is devastating, actually.

Ms. LEGER FERNÁNDEZ. Right.

Ms. ALKIRE. It is just devastating for us.

Ms. LEGER FERNÁNDEZ. Thank you. And on two things, because I am coming near the end of my time. What I like to say is, here in Congress we are your WD-40, so when you run into those problems, with regards to data sharing, which is legally required, reach out to us.

We will push, to the extent we can. We can't guarantee anything, but we can get our big can of WD-40, I have a lifetime supply that comes in every week, because there are so many things we have to push, so remember to do that.

And I do intend to address the diabetes, because it is a big issue, so we will be addressing the reauthorization. I will take that up, and I just wanted to make sure you knew that.

Thank you so much, Madam Chair.

Ms. HAGEMAN. Thank you. The Chair now recognizes Member Radewagen for 5 minutes of questioning.

Mrs. RADEWAGEN. [Speaking Native language]. Thank you, Chairwoman Hageman and Ranking Member Leger Fernández for holding this hearing today and thank you to the panel for your testimony.

Indian Health Service direct service facilities have faced significant medical staffing challenges and currently there is a scarcity of people entering the medical profession leading to staffing shortages throughout the healthcare system.

So, in each of your opinions, what are the current workforce challenges unique to the IHS system and has IHS provided any recent initiatives to support the tribal healthcare systems' unique staffing needs?

Ms. Alkire?

Ms. ALKIRE. I love that question, actually, because I can answer it in two ways. Definitely, we need more healthcare professionals. I come from a community; it is rural. I think where we talk about additional funding for Indian Health Service, they have a hard time recruiting, I think because a lot of times we are asking these professionals to come to my community or our communities that are very rural.

We have one store, one gas station, and you want someone that probably is going to make a couple hundred thousand dollars out here to come to where we live. The housing that was built in our community, I told you our hospital is 60 years old, the housing is probably about that too.

So, you are asking them to come there. I think that is a big deterrent, in regards to funding. The other part is, I have a niece that went to school to be an occupational therapist. She took advantage of the IHS scholarship.

Unfortunately, when she graduated school and she wanted to come work for her people and work for us, the IHS told her she could either go to Alaska or Arizona, to pay it back. And she was willing to pay it back.

The problem, and this is probably comes down to that flexibility thing, she did go to Arizona, but eventually, because we are who we are and these ladies know, we go back home. So, she came back to North Dakota and now she is paying back her scholarship.

And, unfortunately, she is not an occupational therapist anymore because it is discouraging. And she has to get another job to pay that back. It is just a long story.

I think if IHS could work on that, that would help with recruitment, but I think it all comes down to additional funds and resources for the organization to help with that recruiting effort. To bring those people in, because I think it is going to be a tough ask to bring them into our communities.

Mrs. RADEWAGEN. Thank you. My time is almost out.

Ms. ALKIRE. I am sorry.

Mrs. RADEWAGEN. The thing is, I had hoped to hear briefly from Ms. Church, Ms. Platero, and Ms. Rosette, but Ms. Church?

Ms. CHURCH. Yes. The systems that IHS has in place for recruitment and onboarding are very slow. So, we have a young physician that works for us right now and I asked her about her experience

and what she said was, she couldn't even get people to answer the phone and follow up to her application.

So, she ended up going to the IHS facility, walking in, and asking for the status of her application. I don't know if it is because they are understaffed, but they need to improve their systems so that people don't have to knock on their doors to work for them.

Again, antiquated facilities, low pay, rural environments are not attractive to a lot of our providers.

Mrs. RADEWAGEN. Ms. Platero? I think Ms. Rosette's going to have to submit it for the record.

Ms. PLATERO. Thank you. Another issue, besides what Ms. Church stated, is also housing. There is a lack of housing. And also, many providers don't want to move to rural areas.

In addition, I think if a provider finds out that they may have a caseload of 900 patients. We have one facility that currently with their shortage in staffing, they have a caseload of 900 patients per provider.

And also, there is no, which is really important, there is no same-day care at many of the facilities, just because they don't have the capacity, given the limited number of providers that are available.

Mrs. RADEWAGEN. Thank you. Ms. Rosette?

Ms. ROSETTE. We don't really have the same problem in our facility at Spokane because we are in the city. So, as far as recruiting providers and employees, it has not been that big of an issue because we do, but on the other side of it, it seems like they are understaffed. So, it takes us longer to get our contracts and everything like that. So, that has been our side of it. It is not necessarily on our own physicians but on getting contracts from IHS.

Mrs. RADEWAGEN. Thank you very much. It is very important information, and I often visit Indian reservations when I am moving around in the states.

Thank you, Madam Chairwoman.

Ms. HAGEMAN. Thank you. Very important testimony. That is one of the reasons why I really wish that the Representative from IHS would have been here today. I think that that would have been important information for them to hear.

I come from a rural area in Wyoming, grew up outside of a town of about 300 people. Our closest city was about 4,000 people and it was 25 miles away. So, when there was an injury or something, I can relate to the fact of getting to healthcare and accessing healthcare.

And I appreciate your comments, and hopefully we can get the IHS to address some of these. With that, I will recognize Representative Sablan for his 5 minutes of questioning.

Mr. SABLAN. Thank you very much, Madam Chair.

Good morning to our witnesses. In about 3 years, IHS will be celebrating 50 years of its existence, I will say, and we still have some of the things you are bringing up today, problems maybe.

No, problems certainly, but each one of you seem to hint at the need for additional resources or funding or things for your communities for Native Americans.

Do you agree funding would help? Because while we do oversight here, the [inaudible] in another room somewhere, those are the people who need to hear this.

And, look, with all the best of intentions, no one can provide everything, but this thing didn't start 47 years ago, this inequity, it started at first contact with non-Native Americans a long time ago.

But we need to work and continue to get it better as much as we can, and I want to thank all of you for your testimony. At this time, I yield my time to Ms. Leger Fernández.

Ms. LEGER FERNÁNDEZ. Thank you so much, Mr. Sablan.

I do want to take a little moment of personal privilege and note that all of our witnesses, the Chair, and the Ranking Member are all women.

Not to mention anything, I know you are brilliant, Mr. Sablan and Mr. LaMalfa, but you know, that doesn't happen, it didn't used to happen, and now it happens with great frequency.

Mr. SABLAN. [Inaudible].

Ms. LEGER FERNÁNDEZ. We will fix everything. We can fix everything, right? We can get that done. So, one of the things that I wanted to touch on briefly is, thank you Mr. Sablan, it made me think about the budget issues, right? Because we are going to go into a budget.

I mentioned on a macro basis what would happen if we would cut back funding to 2022 levels for IHS. And as we look at the budget, like, where are those needs the greatest and where should we not cut back?

Can you tell me what would happen if there would be, let's a modest 15, you know, not a modest, that would be huge, but a 10 percent cut, a 10 to 20 percent cut on what your budgets would be? What would that look like at the local level?

I gave you the macro. And it would hit everybody, right? From urban to Lakota. So, can you share with us quickly, I have about a minute left on that. Let's start with—

Ms. CHURCH. [Inaudible] which in turn would then help PRC because we would have those services in house instead of sending them out. It would also impact our ability to provide some of the preventative work that we do.

We really take our public health seriously because that is the first step in making sure that chronic disease doesn't happen in the first place.

Ms. LEGER FERNÁNDEZ. Ms. Rosette?

Ms. ROSETTE. Yes. At our facility, the problem with a lot of the UIOs, we would probably end up having to reduce our staffing and that is, like was mentioned earlier, we spend half as much on our individuals as the national average, so taking 10 percent more would take us even down further and we need our providers.

In Spokane alone, we gained about 10,000 additional American Indian and Alaska Natives between 2010 and 2020. So, reducing that would just put a greater burden on the problem.

Ms. LEGER FERNÁNDEZ. Ms. Platero?

Ms. PLATERO. For our area, we don't have an IHS or tribally operated hospital. So, for us it would result in reduced purchasing

referred care, which would mean less specialty care and the ability or the lack thereof to be able to provide for higher levels of priority.

As it is, we are already feeling medical inflation and less funding and to have a cut of 10 percent would be drastic to the Northwest.

Ms. LEGER FERNÁNDEZ. OK. Ms. Alkire, I am sorry that I have run out of time, but I would welcome if you would like to submit, if anybody would like to submit, written testimony in response to what that would mean at your level? Because you painted some of the big broad strokes, what does that mean, in terms of the baby who won't get prenatal care, the mother who won't get preventative care so that she has a healthy baby, if you could just kind of describe what that would look like, I think that would be very powerful as we look at it. Thank you very much.

Ms. HAGEMAN. The Chair now recognizes Mr. LaMalfa for his 5 minutes of questioning.

Mr. LAMALFA. Thank you, Madam Chair. I also share your disappointment with the IHS not sending representation today as the interactions are extremely important here, but maybe another round.

So, thank you panelists for your time and for your travel to get here all the way to DC. A couple of questions. I wanted to follow up on facilities and I think Ms. Platero, you represent Northwest Portland, is that considered, for IHS purposes, urban?

Ms. PLATERO. No. We represent the 43 tribes of Washington, Oregon, and Idaho.

Mr. LAMALFA. Yes.

Ms. PLATERO. Our office is based in Portland.

Mr. LAMALFA. But none of your work is in urban area then?

Ms. PLATERO. No, it is not.

Mr. LAMALFA. All right. Thank for you clarifying that. My understanding is that there are difficulties sometimes within the way IHS administers the dollars for facilities to get the funding allocated.

I understand it is an urban problem, but for rural facilities as well, for facility maintenance, equipment, et cetera, they are not able to use that general IHS budget for that. Is that something that, I see you nodding your head too, but Ms. Platero and then we will come to Ms. Rosette too.

Ms. PLATERO. That is correct for the Portland area. For healthcare facilities construction, we haven't received, or our tribal facilities haven't received, funding in over 15 years for—

Mr. LAMALFA. And it is ineligible? Is it somehow ineligible according to IHS?

Ms. PLATERO. There is a great need for facility construction, so the wait list is very long. There is a priority system that currently exists so that our tribes basically have to pay for their own facilities with their own funds.

Mr. LAMALFA. But I guess more zeroing in on it, are some of those funds you are just flat ineligible because of the way IHS categorizes them or is more of just the back end?

Ms. PLATERO. There are just not enough funds.

Mr. LAMALFA. There is not enough? OK.

Ms. PLATERO. It is significantly underfunded for construction.

Mr. LAMALFA. OK. Thank you. Ms. Rosette, you are nodding too?

Ms. ROSETTE. Yes. Urban Indian organizations are only included within IHS's budget through an Urban Indian Line Item. We do not receive direct funds from most of the other distinct IHS line items, such as hospitals and clinics, Indian health professionals, or facilities.

So, yes, we only are eligible under the Urban Indian Health line item and do not have access and are not eligible for any kind of facilities funding.

Mr. LAMALFA. OK. Ms. Church, I was referring back to some information, going back to the Dorgan Report of 2010, and some of the issues they had brought up with IHS in that report are pretty shocking.

Some of the things listed are missing or stolen narcotics, as well as not strong pharmaceutical audits, backlogs in billings and claims, and discouraging the employees there from communicating with us as overseers in Congress, and personnel issues, et cetera, et cetera.

So, since 2010, when that report came out reviewing things pre-2010, what do you see has improved in that area with IHS's performance within?

Ms. CHURCH. Yes. Sure. In the beginning, Indian Health Service responded the best they could. They came in and they started to work with the facilities in the Great Plains and many of the direct service units are now accredited, but they have not been able to sustain that level of activity and quality assurance in order to keep it there.

So, without additional funding, I imagine that it won't be long until they are back to the same place they were before.

Mr. LAMALFA. So, a tick of improvement, but then quickly falling off, you think?

Ms. CHURCH. Yes. Because it takes a great deal of resources and it takes human capital to—

Mr. LAMALFA. And retention must be very difficult, as we are talking about rural, whether it is Indian healthcare or in general, rural healthcare, which I face in a very rural district with many tribes, and in small-town healthcare, it is very tough to get and retain people there.

So, the time has already eclipsed. Madam Chair, I will yield back and hope for a second round perhaps.

Ms. HAGEMAN. Why don't we go for a second round of questions. I have a couple of questions that I wanted to ask, specifically to Ms. Church. You mentioned in your statement, the lack of staffing at Great Plains IHS facilities and that you think improvements in recruiting and retention will not only improve care, but eventually be cost effective.

Could you further expand on that and what recruitment and retention initiatives you have found to be useful and effective?

Ms. CHURCH. What we believe at Oyate Health Center, I can speak from the tribal perspective, is that we have to grow our own. We run a health facility, but we also run, what I call a learning facility.

We create opportunities within every area of Oyate Health Center to foster additional training for our current employees and we want

to become a learning center for programs, whether it is phlebotomy, or our next goal is residency.

If you are fostering your own community and your own staff, they are more likely to stay and the commitment is there, not because they have an IHS payback, but because they believe in the mission.

Ms. HAGEMAN. OK. And I just wanted to ask Ms. Platero—actually, Ms. Rosette—do all of the urban areas in the United States have Indian Healthcare Services that they provide?

Ms. ROSETTE. There are some of them. I mean, there are some that provide alcohol treatment and some of them provide referrals for medical care. There is outreach and referral. There is limited ambulatory and then there is full ambulatory.

So, there are three different types of services they can provide, so in some form, yes.

Ms. HAGEMAN. OK. Thank you. I will then go ahead and turn to the Ranking Member Ms. Leger Fernández for her supplemental questions.

Ms. LEGER FERNÁNDEZ. Thank you. And I love the fact that many of my supplemental questions were asked by my colleagues on this panel, so we are clearly all on the same wavelength as wanting to make sure that things get better in Indian Country.

And that is why I love this Committee, because it is so bipartisan, recognizing that we have problems and recognizing that we will find solutions for them.

I wanted to quickly ask the panelists a bit about the data sharing. Give us a little context, and Ms. Church, I think you spoke the most about it, about the agency practices that need to be changed to be able to facilitate better communications, and Ms. Rosette, if you see that something isn't answered with regard to UIOs that would be great.

Ms. Church?

Ms. PLATERO. Sure. IHS needs to partner with us and see the Heath Boards and the Epi Centers as a resource for them. If we are partnering together, we are in the communities.

If the state goes to one of our reservations to address syphilis, the people there are not going to talk to them. They are not going to trust them. We will work with our own tribal leaders and our own tribal health directors to identify those folks that need to be brought to treatment.

By working together, IHS is going to be more successful as well. I don't understand the issue with not wanting to share data when it is so clearly stated in statute. I never understood and it has been a long, long battle.

Ms. LEGER FERNÁNDEZ. Thank you very much. And did you want to add anything to that, Ms. Rosette, regarding the Urban Indian Health organizations?

Ms. ROSETTE. Yes, just that a lot of us, several of us are not on the IHS's RPMS system. So, we have other off-the shelf EHR systems and our data, it is hard to get our data to them with the antiquated system that they have. And when we do send data to IHS, it is often recorded wrong or there is always a problem with our numbers.

I think if we had some formal system, EHR system, where we could talk to each other and share our data easily, that would be very helpful.

Ms. LEGER FERNÁNDEZ. Thank you. And I know former Chair and now Ranking Member Grijalva had a bill that dealt with part of encouraging more collaboration between the Urban Health Units and this is another piece of that that definitely—what the frustration is, it is already in statute, right?

But the need that came up last cycle that we discussed was the need to be seen as partners in this. Your statement is so accurate.

And Ms. Alkire, share with us the culturally relevant story you wanted.

Ms. ALKIRE. Thank you. I would love to. I talk about this story because it talks about identity. It talks about definitely about our culture. You talked about the facilities. I am trying to get us a new medical facility.

I know IHS is not going to pay for it. I know, as a tribal chairwoman, I am having to try to think innovatively to look at ways to get this hospital built for our people, but I am hoping and, as you said, the IHS is going to staff this for us.

So, I am very hopeful, no matter what, but the story I wanted to share with you all is the Grandma story and this is about, we call it [Speaking Native language]—I can't even say it now.

[Speaking Native language] and basically, what is it is to touch the Earth. My passion is to have our babies born on Standing Rock. In the Great Plains, there is only one unit, one hospital that delivers babies yet and that is the Pine Ridge Indian Reservation, the rest of them don't.

We all became clinics. Now our babies, like I said, are born in these places far away. What [Speaking Native language] basically means is that when our babies are born and when the mother, when her water breaks how our ancestors did it, that was the ground, that was the place that that baby would be tied to.

I feel, and I don't know where this come from, but I feel in my heart that this is also a big break in who we are as a people, that our people are born in these communities that they are not related to culturally and these ceremonies can't be done because now, I feel like, our babies would be lost again.

They start right at the beginning and the way we did it was we take the baby, and we touch them to the Earth of the ground where the water was broken so they are tied to the Earth.

And I say this, I have to use this example. We see now the geese flying North. That is because they are going back to where their babies are born. Turtles travel thousands of miles to go back to where they belong.

Us, as a people, I feel I want our babies born on Standing Rock, it is going to be hard already, I want them to feel like this is where they belong. They will never be lost.

Ms. LEGER FERNÁNDEZ. Thank you. That is a beautiful story, and my time has expired. I yield back.

Ms. HAGEMAN. Thank you. The Chair now recognizes Ms. Radewagen for additional questioning.

Mrs. RADEWAGEN. Thank you, Chairwoman Hageman.

Several testimonies mentioned traditional healing practices and that further integration of those practices would be useful for healthcare delivery to Native peoples.

So, I wanted to give each of you the opportunity to expand on that, particularly, how those practices have been beneficial to tribal members and how IHS could encourage use of them in both direct service and tribally run health programs.

Ms. Church?

Ms. CHURCH. Sure. How we are approaching integrating traditional healers, teachers at Oyate Health Center is we are developing a cultural advisory board. I have identified knowledge keepers across the region, and they guide us on how to do that appropriately.

It is very sensitive because in our tradition, our traditional healers don't ask for money. They don't say, this is my fee, right? So, we have to look at innovative ways to support them and to find ways to have those ceremonies appropriately, but still integrate them with the work that is being done in the clinical setting.

So, they tell us what is appropriate and what is not appropriate. Some of the ceremonies, they say, it is not appropriate to do it at the health center, but send them to this healer or to that healer.

A lot of our physicians and even some of our own tribal members may not have grown up with those traditions, so there is a longing for knowledge. And when we are advocating for people to take care of themselves, if we are incorporating those teachings that they may not have heard before or maybe their parents or grandparents, they come, they show up for their appointments, they show up for health education, and they show up for ceremony. And families are strengthened, and their spirits are strengthened.

Mrs. RADEWAGEN. Ms. Platero?

Ms. PLATERO. Thank you. Traditional healing practices are definitely part of the holistic approach to care. You can't have healing without addressing the spiritual aspect of a person.

Similar to what Ms. Church said, our people will show up to appointments, events that are focused on a cultural practice event, whether it is a healer or an activity. For our tribal clinics and tribes, they have been asking for traditional healing practices to be reimbursed under Medicaid and Medicare.

This is one way that would allow for continuity of these services, so that when there is some kind of cost involved, they are paying a healer, there is the ability to pay that person and keep the service going, thus improving holistic healthcare for people in our communities.

Mrs. RADEWAGEN. Ms. Alkire?

Ms. ALKIRE. I agree with the ladies, basically, I don't want to take up too much time. I feel like I ramble on, but I wanted to talk traditional. During COVID, we had a lot of our people who did not take the immunization, because they don't believe in it.

So, we have to rely on our traditional healers, and they do. I think it all comes down to communication. IHS needs to hear that and definitely allow these things to happen. I think we can all get there, though. Thank you.

Mrs. RADEWAGEN. Ms. Rosette?

Ms. ROSETTE. Yes, thank you. We are also supposed to [inaudible] healing within their own facilities. We have not yet implemented that into our UIO because we don't have the space for it right now. We don't have a job description for a traditional healer, so to hire somebody, it has to be somebody that is willing to do that work for you.

So, in our facility, that is what we want to find somebody that is known as a healer, but it is hard to find that type of person that wants to do that in a facility like ours.

Mrs. RADEWAGEN. Thank you, Madam Chairwoman. I yield back.

Ms. HAGEMAN. Thank you. And now for the last set of questions, the Chair recognizes Mr. LaMalfa.

Mr. LAMALFA. Thank you, Madam Chair.

Keeping it compact, I appreciate it. Let's see, I want to ask our panel here about mobile health clinics and, obviously, most tribes face the rural issues, the rural challenges.

So, mobile clinics could be a very, and probably are, and that is why I want to hear from you. How important are they to the far-flung rural tribes that have a chance to utilize those and what are the issues with them or with having more of them? And are there any regulations that you see that are standing in the way of their further expansion?

And I will stop there and maybe ask a second question on that.

Are they something that tribes wish to use more? Is there something stopping them from doing so? Ms. Alkire, I will start with you.

Ms. ALKIRE. I will be honest; I haven't seen very many of them lately. I used to see mobile units come for women's clinics and I don't know if IHS resources have gotten scarce, so I don't see them.

Mr. LAMALFA. You wish for more of them?

Ms. ALKIRE. Yes.

Mr. LAMALFA. OK. You are not seeing them—

Ms. ALKIRE. And that would be helpful because the reservation I come from is 2.3 million acres. It straddles both North and South Dakota and a lot of our communities are far apart from one another.

And our one medical facility is on the North Dakota side, and so it takes a long time for them to get to those appointments.

Mr. LAMALFA. OK. I want to get to the other panelists, but you don't see it enough? Are there any barriers by IHS stopping them from happening?

Ms. ALKIRE. I think the barriers are just lack of resources. They just don't have the money to have them.

Mr. LAMALFA. OK. Thank you. Let's keep moving. Ms. Church?

Ms. CHURCH. Yes. If you have a limited budget and you need to prioritize inpatient or ambulatory care and choose between a new program with mobile units, you are going to focus on your internal services.

Mr. LAMALFA. Your brick and mortar? Yes. So, you are not aware of IHS barriers or any regulation against having them? It is more funding, probably, again?

Ms. CHURCH. Exactly.

Mr. LAMALFA. OK. Ms. Platero, what do you think?

Ms. PLATERO. I am not aware of any barriers. I would say that a way to increase providers in rural areas is the community health aid program expansion. That is a way to grow your own and have more providers in rural areas.

Mr. LAMALFA. OK. Ms. Rosette, what do you think?

Ms. ROSETTE. I am in an urban area, so the mobile vans are not really an issue there, but transportation is. So, even though we have a bus system at IHS, there is no barrier though from IHS for us to have a mobile van.

Mr. LAMALFA. OK. So, funding probably? All right.

Ms. ROSETTE. Yes.

Mr. LAMALFA. Let me ask all the panelists, you have 2 minutes. How do you feel about the delivery of healthcare via an in-house IHS system versus a tribal operated, you know, the tribe runs itself instead of under IHS's umbrella?

How well is IHS delivering the product versus when the tribe has more self-control over it? Ms. Alkire?

Ms. ALKIRE. Do you want to take this?

Ms. CHURCH. Sure. Rapid City Service Unit was one of those facilities at CMS where they lost their accreditation or certification, and they were not able to provide the level of care that the community needed.

Since Oyate Health Center was established, we have so much more flexibility on every level. We hire people faster. Most importantly, we get to hold people accountable if they are not—

Mr. LAMALFA. And IHS isn't doing that when they are operating it, is that—

Ms. CHURCH. It is very hard for them to hold people accountable because of the Federal H.R. laws.

Mr. LAMALFA. Yes. Yes.

Ms. CHURCH. So, that is the biggest thing, we can foster people to grow professionally, and we can hold people accountable who are not doing their jobs.

Mr. LAMALFA. OK. Thank you. Ms. Platero?

Ms. PLATERO. Self-governance tribes or tribes that run their own health programs are able to make decisions as to funding, like moving funding through sub-accounts from clinical or healthcare to behavioral health. I mean, they can make those on-site decisions to improve healthcare.

Mr. LAMALFA. OK. Ms. Rosette?

Ms. ROSETTE. It is not applicable in the urban setting.

Mr. LAMALFA. OK. All right. Well, bottom line in here is you would like the funding challenges and more flexibility to come from within the tribe than from 2,000 miles away?

OK. Thank you. Well, my own experience is that one day I was in district, and all of a sudden had a tooth problem and was able to pop into a tribal clinic where I knew the folks and such and been working with them, and they fixed me up in no time. And it was really great, at least getting me to where I can get to my dentist to do the longer-term work. So, I like that experience.

Madam Chair, thank you. I yield back.

Ms. HAGEMAN. Thank you. I want to thank the witnesses for the valuable testimony that you have provided today, and again for

your willingness to travel to Washington, DC so that we could hear directly from you.

I also want to thank the Members for your questions and your willingness to engage on this incredibly important subject.

The members of the Committee may have some additional questions for the witnesses, and we will ask you to respond to those in writing. Under Committee Rule 3, members of the Committee must submit questions to the Committee Clerk by 5 p.m. on Monday, April 3, 2023.

The hearing record will be held open for 10 business days for these responses. And if there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 11:30 a.m., the Subcommittee was adjourned.]

[ADDITIONAL MATERIALS SUBMITTED FOR THE RECORD]

Submissions for the Record by Rep. Westerman

Statement for the Record

Frank Star Comes Out President of the Oglala Sioux Tribe

The Oglala Sioux Tribe appreciates the opportunity to submit testimony for the record for this important Subcommittee hearing. Improving the healthcare delivery to tribal communities, especially to our people on our Pine Ridge Indian Reservation, is one of our Tribe's highest priorities. It is past time for the Federal Government to take the bold actions required to finally ensure our people have the high quality of healthcare they deserve. Our Treaty requires it. For too long our people have suffered from inadequate healthcare delivery. We hope this testimony will help Congress finally fix this.

Introduction

The Oglala Sioux Tribe has approximately 54,000 members. It is a member of the Oceti Sakowin (Seven Council Fires, known as the Great Sioux Nation). The Tribe was a party to an 1825 Treaty (7 Stat. 252), which in Article 2, brought the Oglala Sioux Tribe under the protection of the United States and the Oglala Sioux Tribe has been a protectorate Nation of the United States ever since. This treaty established the legal relationship between the Oglala Sioux Tribe and the United States. The Oglala Sioux Tribe is also a signatory to the Fort Laramie Treaty of 1851 (11 Stat. 749) and the 1868 Sioux Nation Treaty (15 Stat. 635). The Fort Laramie Treaties of 1851 and 1868 cemented the United States' obligations to the Oglala Sioux Tribe. In Articles IV and XIII of the Fort Laramie Treaty of 1868 the United States specifically committed to providing healthcare to the Sioux people. In *Rosebud Sioux Tribe v. United States*, the Eighth Circuit affirmed that the U.S. Government has a judicially enforceable duty to provide competent physician-led healthcare to us as a signatory of the Fort Laramie Treaty of 1868, and because of the numerous promises and commitments the Federal Government has made to provide healthcare for Tribes.¹ Despite this, the chronic underfunding of the Indian Health Service (IHS) and Indian Country programs in general has taken an enormous toll on our Tribe and our citizens.

We look to you to fulfill the Federal Government's obligations, and we look forward to working with this Subcommittee to ensure the legal and policy authorities are in place along with fully-dedicated funding for the IHS programs that serve Tribal Nations and Native people so that our people get the high-quality healthcare they deserve. We emphasize that our Tribe is a *direct service tribe*: our healthcare is delivered directly from the IHS as a treaty obligation, with certain programs that we have contracted to carry out ourselves. Thus, we need Congress to dedicate full funding to the IHS to carry out its treaty obligation to deliver high-quality

¹See *Rosebud Sioux Tribe v. United States*, 9 F.4th 1018 (8th Cir. 2021); and see *Blue Legs v. U.S. Bureau of Indian Affairs*, 867 F.2d 1094 (8th Cir. 1989) (Snyder Act imposes affirmative obligations on Federal Government to provide healthcare to Tribes).

healthcare to our people and full funding to the specific programs we carry out via 638 contracts with the IHS.

Full funding of Indian Country healthcare programs is demanded of the Federal Government because of the Treaty and trust obligations owed to our people. Any cuts to such programs would be devastating given the historic and severe underfunding of such programs and the impact that has had on our people. All of the Indian healthcare programs need attention. Below, however, we focus on certain specific high priorities for our healthcare. We also lay out the overarching needs of our Reservation and the Great Plains Area overall, which warrant congressional action to address.

First, to focus the vast and desperate need to correct the healthcare delivery inadequacies on our Reservation and in the Great Plains Area, we remind you of former Chairman Byron Dorgan's 2010 Senate Committee on Indian Affairs Report, *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area* (commonly known as the "Dorgan Report.") The Dorgan report identified "deficiencies in management, employee accountability, financial integrity, and oversight of IHS' Aberdeen Area facilities" and reported that "these weaknesses have contributed to reduced access and quality of health care services available to patients."² The Pine Ridge Service Unit, which provides healthcare for the Oglala Sioux Tribe, had the second highest incidence of employee grievances in the Aberdeen Area.³ The Report chronicled "substantial" diversion of health care services due to a range of issues "including a shortage of providers, inadequate reimbursement from public and private insurers, and lack of bed availability."⁴ The Dorgan report also identified a linkage between the understaffing of pharmacist positions in IHS facilities with a substantial issue in the area of loss and theft of narcotics and controlled substances from these pharmacies.⁵ In addition, "[o]ther reasons for service diversions included: no available inpatient beds, nonworking equipment, water outages, and high humidity."⁶ We regret to report that, unfortunately, such severe problems have persisted almost thirteen years later.

More recently, the Government Accountability Office (GAO) testimony addressed the quality of healthcare provided by the IHS and concluded that the IHS provided limited and inconsistent oversight over the timeliness and quality of care provided in its facilities, and that those "inconsistencies in quality oversight were exacerbated by significant turnover in area leadership."⁷ In addition, the GAO testimony reported that incomplete funding of the Purchased/Referred Care program has resulted in gaps in services that delay diagnoses and treatments, which can exacerbate patient issues and necessitate more intensive treatment.⁸ We also point you to the 2018 Broken Promises Report, which conveys that the problems with the Federal Government's delivery of healthcare to Native people persist, stating "[O]ver the years, Native American health care has been chronically underfunded" and cites statistics showing that in 2017, IHS health care expenditures per person were \$3,332, compared to \$9,207 for federal health care spending nationwide.⁹ These reports provide a mere sketch of what healthcare looks like for our people.

We support the testimony provided to the Subcommittee by Jerilyn Church on behalf of the Great Plains Tribal Leaders Health Board. However, we note that there were no witnesses presenting at the hearing representing direct service tribes. As a direct service tribe, we implore you to take action to address the following issues.

² U.S. Senate Committee on Indian Affairs, *In Critical Condition: The Urgent [Need] to Reform the Indian Health Service's Aberdeen Area*, 4 (Dec. 28, 2010) ("Dorgan Report").

³ Dorgan Report, 14.

⁴ *Id.* at 19.

⁵ *Id.* at 15.

⁶ *Id.* at 20.

⁷ Government Accountability Office, *High Risk: Status of Prior Recommendations of Federal Management of Programs Serving Indian Tribes*, 2, GAO 17-790T (Sep. 13, 2017).

⁸ *Id.* at 19.

⁹ United States Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfalls for Native Americans* (December 2018) at 66-67; see all of Chapter 2 for discussion of Health Care; see also Government Accountability Office, *Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs*, GAO-19-74R (Dec. 10, 2018).

I. Protect & Strengthen the Indian Health System

Modernize the Funding Model: the President's FY 2024 Request

A. *Move the Entire Indian Health Service Account to Mandatory Spending and Fully Fund the Indian Health Service*

At present, Indian Country healthcare is frustratingly vulnerable to federal shutdowns and Indian Country healthcare is the *only* major federal healthcare system subject to this treatment. The healthcare provided by the Veterans Health Administration—the Federal Government's other non-entitlement health program—is not subject to federal shutdowns, and the same should be true for the Indian Health Service. *We, therefore, urge Congress to move the entire Indian Health Service (IHS) account over to mandatory spending.* Our Treaties call for this. These changes would ensure that our services are not interrupted by political machinations far outside of our control. Continuous funding will also ensure that Native people are no longer treated as second class citizens—entitled only to a lesser type of federal healthcare.

Barring the mandatory and full funding of all IHS accounts, Congress must do everything in its power to minimize service interruptions for the Indian Health Service. The Consolidated Appropriations Act of 2023 took the monumental first step toward sustainable funding of the IHS by providing advance appropriations for FY 2024. But Congress must maintain this momentum and provide advance appropriations once again. We urge you to provide advance appropriations for FY 2025 and beyond so that health care programs can actually undertake long-term planning and our patients can rest assured that their treatments will continue even in uncertain political times. Relatedly, we support the proposal to immunize IHS from the federal budget sequestration process.¹⁰ Healthcare cannot be something that is blindly cut as the collateral damage of a political impasse in Washington, D.C.

In addition to making the entire Indian Health Service Account mandatory spending, Congress must FULLY fund the IHS. The President's 2024 IHS budget includes a 10-year plan to close funding gaps, a move that we support because it would not only provide greater stability for the IHS but it would provide more money for healthcare programs. While we do support this request, the bottom-line is that Congress must fully support the IHS so it and the tribes that contract or compact its programs, services, functions and activities can do so at the level of need and without being extremely under-resourced, as they are now—especially in the Great Plains Region.

B. *Permanently reauthorize the Special Diabetes Program for Indians*

Congress must reauthorize the Special Diabetes Program for Indians and should do so before the program expires later this year. The Program has been a tremendous success story for public health and for Indian Country. From 2013 to 2017, diabetes in American Indian and Alaska Native adults decreased from 15.4% to 14.65%; and end-stage renal disease due to diabetes fell by 54% between 1999 and 2013.¹¹ What these numbers hide, however, is that the incidence of these health outcomes not only *did not rise*, but *fell* despite an increasingly unhealthy dietary and lifestyle environment of fast-food, processed and pre-packaged meals, and reduced mobility. In addition, the Office of the Assistant Secretary for Planning and Evaluation reported in 2019 that the 54% decrease in end-stage renal disease in American Indian and Alaska Native populations saved Medicare an estimated \$436 million to \$520 million over a 10-year period.¹² The Program is doing what Congress intended it to do, and it has returned measurable success. Permanent reauthorization and continued funding of this program will ensure that the hard work and resources that made the last twenty years of the program a success will not be lost and that we will keep making strides for the next generation. Accordingly, we support the President's budget request of \$250 million for the program for FY 2024, \$260 million for the Program for FY 2025, and \$270 million for the program for FY 2026,¹³ and we implore Congress to permanently reauthorize the Program.

¹⁰Department of Health and Human Services, *Fiscal Year 2024 Indian Health Service Justification of Estimates for Appropriations Committees*, (hereafter IHS Budget) CJ-248.

¹¹National Indian Health Board, SDPI Overview https://www.nihb.org/sdpi/sdpi_overview.php (accessed Mar. 30, 2023).

¹²Office of the Assistant Secretary for Planning and Evaluation, *The Special Diabetes Program for Indians: Estimates of Medicare Savings* (May 9, 2019) <https://aspe.hhs.gov/reports/special-diabetes-program-indians-estimates-medicare-savings>.

¹³IHS Budget, CJ-242.

C. Implement the North And South Dakota State-Wide Purchased/Referred Care Delivery Area

We support the President's proposal to appropriate \$12 million to actually implement the North and South Dakota State-wide Purchased/Referred Care Delivery Area (PRCDA).¹⁴ However, the budget must also include additional funding to pay for the additional Purchase Referred Care (PRC) services that will be needed as a result of expanding the PRCDA. As the President's request notes, a 2010 amendment to the Indian Healthcare Improvement Act directed the IHS to establish this Purchased/Referred Care Delivery Area, but the IHS has not done so. Establishing this Delivery Area will ensure that tribal members located anywhere within those states are able to access needed Purchased/Referred Care services. This is critically important as many of our members live in the State but outside the current PRCDA and therefore are not eligible for PRC services even though they desperately need them. IHS estimates that implementing this provision will provide services to 24,000 tribal members in the Dakotas.¹⁵ This provision of the Act must finally be implemented and adequate additional funding must accompany this authorization.

D. TRANSAM Program

The President's FY 2024 budget requests \$500,000 for the TRANSAM program so that IHS can purchase medical equipment and ambulances from the Department of Defense. While we wholeheartedly support the acquisition of needed equipment and vehicles for IHS and tribal facilities, we object to this manner of acquisition. First, the Department of Defense and the Indian Health Service are both arms of the Federal Government. Under this model, the Indian Health Service—one of the most historically and egregiously underfunded federal agencies—is required to draw funds from its budget to pay the Department of Defense—one of the wealthiest and most excessively funded federal agencies—to gain access to basic healthcare delivery necessities. Taxpayer dollars helped fund the Department of Defense's purchases of this equipment. There should not be another toll, especially one that will severely impact Native peoples via a reduction in IHS dollars. Congress must fix this facially inequitable policy and authorize the Defense Department to donate the equipment to the IHS.

Modernize the Funding Model: Other Proposals

Congress must fully fund and implement all provisions of the Indian Healthcare Improvement Act.¹⁶ Those heretofore unfunded authorities in that Act are expected to help with workforce development, behavioral healthcare, and substance use management, and are expected to improve access to healthcare generally, but for long-term and home-based care in particular.¹⁷ Fully funding these provisions will provide long-overdue resources for IHS and tribal facility construction and maintenance projects to ensure that our community has access to modern, state-of-the-art healthcare facilities.

We support the 2022 policy recommendations of the National Indian Health Board regarding Medicare reforms to improve access to and obtain financial support for Indian healthcare.¹⁸

The Federal Government should facilitate tribal governments' decisions to assume healthcare delivery, but it also must acknowledge and act on the fact that even when those assumptions occur the Federal Government cannot evade its Treaty and trust obligations. That said, we support the expansion of contracting and compacting under Titles I, V, and VI of the Indian Self-Determination Education and Assistance Act and the opportunity for to decide for themselves how best to ensure their citizens have the best healthcare services possible. The Federal Government must support tribally run programs, but also continue to uphold its Treaty and trust obligations whether a Tribe is direct service, operates entirely under a 638 contract, or some combination. We emphasize that our Tribe is a direct service tribe: our healthcare is delivered directly from the IHS as a treaty obligation, with certain programs that we have contracted to carry out ourselves.

¹⁴ IHS Budget, CJ-136.

¹⁵ *Id.* at CJ-137

¹⁶ National Indian Health Board, *2022 Legislative and Policy Agenda for Indian Health*, 14-15 <https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf>.

¹⁷ *Id.*

¹⁸ National Indian Health Board, *2022 Legislative and Policy Agenda for Indian Health*, 47-49 <https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf>.

Provide Adequate Supportive Infrastructure

We have significant infrastructure problems in the Great Plains region. In particular roads, bridges, and culverts are in terrible shape, despite our repeated pleas for federal assistance. These conditions delay emergency response times and at times our roads are impassable. If we are going to seriously address the challenges of healthcare delivery in the Great Plains Region, we need Congress to also take bold measures to build and maintain our roads so that they do not pose a hindrance to routine and emergency medical care. Congress must adequately fund the Bureau of Indian Affairs roads accounts and create a new roads maintenance account, not subject to the formula, that targets backlogged road and bridge projects by taking mile inventory, remoteness, and weather conditions into consideration.

Conduct an Audit of the IHS

Tribes have a right to know *exactly* where federal appropriations to the IHS go, especially direct service tribes like ours. We ask Congress to require the IHS to conduct a comprehensive audit at the Central, Regional and Service Unit levels, and make that audit available for Tribes to review and comment on in government-to-government consultation.

II. Build the Healthcare Workforce

We need Congress to employ a multi-faceted approach to improve the healthcare workforce. Most urgently, we need Congress to appropriate funds and legislate additional enticements for the recruitment and retention of healthcare workers for Indian Country and specifically on our Pine Ridge Reservation. These funds and enticements must cover not only physicians, dentists, and other specialists, but must support the employment of administrative professionals and other staff. At a minimum, these resources must support full staffing of our current facilities. Salaries must be competitive with other healthcare positions so that we are not losing professionals to wealthier areas of this country. Moreover, given the unique hardships on the Pine Ridge Reservation, we support the idea that healthcare workers in our area be entitled to higher and/or hazard pay to incentivize them to come and serve our community.

Because of the urgent need to fill positions in our area, we support the President's proposals regarding discretionary Title 38 hiring authorities for IHS, authority for IHS to conduct 60-day mission critical emergency hiring, application of Title 38 on-call pay to IHS, and authority for IHS to hire and pay experts and consultants to address particularized needs.¹⁹

It is important to not only recruit healthcare workers to our Reservation, but also to retain them. This is the only way our people can even begin to receive any continuity of care: through healthcare providers who get to know them, which, importantly, will lead to our people coming to trust them. As it stands now, our people have very little trust in the IHS's Pine Ridge Service Unit. This is a core problem that needs to be addressed. Retainment of healthcare professionals on our Reservation would be a good first step toward addressing this core problem.

We also need Congress to provide funding for our community to build the housing units necessary to support our healthcare workforce. As we have testified before to many different committees, we have a housing deficit of 4,000 homes on our Reservation. We cannot attract (or retain) healthcare professionals to our area if we have no place for them to live. Our reservation is approximately the size of the entire country of Cyprus; it is simply too vast for healthcare providers to commute long-distance. We need housing directly in the vicinity of our facilities.

We need Congress to get to work on growing the healthcare professional pipeline for Indian Country. We need additional funding and authorities that would better facilitate an educational and training pipeline for more Native people to join the ranks of healthcare professionals. Congress should also expand the availability of scholarships and loans for medical education in service of Indian Country and should expand loan forgiveness for similar service. The cost of graduate medical education has surpassed the value of the incentives Congress is currently providing. These programs must also provide flexibility for graduating students to choose to go home to serve their communities. As a small step toward addressing these issues, we support the President's proposals to provide federal income tax exemptions for scholarship and loan repayment funds and to permit scholarship and loan repayment on a half-time but double duration basis.²⁰

¹⁹ IHS Budget, CJ-287-88, CJ-295-96, CJ-298-99, CJ-296-97.

²⁰ IHS Budget CJ-291-92, CJ-289-290.

Our native community has brilliant, hard-working, and service-minded students who want to work for the benefit of our people. The Community Health Aide, Dental Health Aide, and Behavioral Health Aide Programs that debuted as pilot programs in Alaska work to train Native students to provide culturally informed community-based care. This is consistent with how we have healed our sick since time immemorial. Congress should fund these programs at scale across Indian Country as soon as possible.

Relatedly, we need resources to provide traditional healing to ensure that our healers can take care of themselves while they take care of others. It is often the case in our tradition that our healers do not ask for money or compensation in exchange for their services, as such a transactional concept is not native in origin. Nevertheless, we recognize that our healers need to be able to provide for themselves in a modern capitalist economy. Accordingly, we need for IHS and tribal facilities to have the flexibility to support our healers in various ways. First, reimbursement of traditional healing services through Medicare and Medicaid would help our facilities support our healers and our patients who request their services. Second, we need healthcare coverage for tribal healers to provide services outside of the physical clinic environment because some ceremonies are not appropriately conducted nor possible inside a health clinic. We need for our healers to be able to provide covered care in the manner they see fit, unrestrained by federal statute or regulation. We also need the Federal Government to respect us and our healers when we decline to provide details about sensitive traditional knowledge and ceremonial practices.

Finally, Congress should devote attention and funding to cultivating a pool of talented professionals able to competently teach our youth by focusing on culturally relevant professional development (in collaboration with Tribal colleges and universities). Science, technology, engineering, the arts, and mathematics (STEAM) training and education is especially important to building holistically trained healthcare professionals to serve our Tribe. With that in mind, our Tribe is working toward creating a Tribal Research and Training Center, which would encourage our citizens to pursue careers in STEAM fields. The Center would also serve as a data and research hub where we can research, collect, and analyze our own data for use in support of initiatives to benefit our citizens in a broad spectrum of areas from health to economic development. Facilities that house valuable professional development in the community improve health outcomes and are the backbone of a healthy economy. We ask for financial support as we pursue this project.

III. Learn from the Pandemic

The pandemic taught us many lessons, the importance of an emergency response plan chief among them. We struggled to navigate federal bureaucracy during the pandemic to access life-saving personal protective gear and other resources from our federal partners. Tribes sought access to the Strategic National Stockpile and other federal repositories but were met with long wait times and insufficient communication. Knowing what we know now, we need Congress to cut through red tape to ensure that tribes have a direct through line to the federal government (not through states) to access federal emergency resources.

We also need the Federal Government to improve data sharing with our tribal health providers so that we can implement agile responses to quickly evolving crises and for everyday use. This should not require the implementation of data sharing agreements since Tribes (and tribal epidemiology centers) are federally recognized public health authorities.²¹ Since there has been some confusion on this matter, we need Congress to legislate to clarify that data sharing agreements are not required for sharing public health data with Tribes. We also need the Federal Government to provide a national catalog of available resources.

We ask Congress to glean the best practices from the COVID-19 pandemic, which were developed in real-time during the pandemic and perfect them in consultation with Tribes for use in future public healthcare emergencies.

²¹ See 45 C.F.R. § 164.501 (defining “public health authority” to include a Tribe).

IV. Resources for Our Other Pandemics: Crises in Mental Health, Drug Addiction, and Crimes Against Our People

Mental Health

Between 2001 and 2020, suicide was the leading cause of death of American Indian and Alaska Native children in South Dakota aged 10 to 14 and the second leading cause of death for those aged 15 to 24 and 25 to 34.²² On our Reservation alone, the suicide rate is twice the national average for all ages and four times the national average for teenagers.²³ Our children and youth are in distress. Worse, this is a well-known problem which we have all failed to correct.²⁴

The United States has, for years, watched as the mental distress of American Indian and Alaska Native people has increased to the point where the despair of our people eclipses all others. Congress must act on this. These statistics prove that the United States has failed to honor its Treaty and Trust responsibilities to our people. Interpreting the same laws that affect our Tribe, the Eighth Circuit in *Rosebud Sioux Tribe v. United States* affirmed that the U.S. Government has a judicially enforceable duty to provide competent physician-led healthcare to the Rosebud Sioux Tribe. In coming to that conclusion, the court considered the promises the United States Government made to provide medical care in the Fort Laramie Treaty of 1868 (to which we are subject), to authorize appropriations for the “relief of distress and conservation of health” in the Snyder Act, and to raise the health status of Indians to the “highest possible level” in the Indian Healthcare Improvement Act.²⁵

Congress needs to address the epic mental health challenges we face through funding and bold legislative actions. We need resources for behavioral and mental health prevention and intervention for all of our people. We need services for those who are depressed, have suicidal ideation, and have attempted suicide in the past. We need services for the family members, friends, and colleagues who lost someone to suicide. We need to be flexible and innovative in the delivery of these services and to reduce barriers to access and stigma associated with these services. We need to provide our youth and families with life and socio-emotional learning skills so that they are able to navigate the everchanging world in which we live in now. We need resources to recruit, retain, and house mental health professionals on our Reservation, including trauma resource counselors for our schools. All of these professionals must be paid competitive salaries so they will come and stay and help us turn the tide of mental health on our Reservation.

One of our top funding priorities is the completion of a Youth Rehabilitation Center to address the youth opioid, suicide, and alcohol abuse epidemic on our Reservation. The 29,987 square foot facility would provide targeted residential treatment services for female and male patients coping with opioid addiction, alcoholism, and sexual trauma. Through this facility, Lakota youth will be able to receive comprehensive mental and behavioral health services in their home community. We envision that counselors, caseworkers, therapists, medical professionals, and family members will be involved in creating and sustaining a safe environment for our youth to heal and make progress toward their goals. We need funding for facilities, administration, security, support services, and to hire a Project Manager. Financing this position would allow project development to move forward for the betterment of the mental, physical, and spiritual welfare of our Lakota youth.

²² Centers for Disease Control and Prevention, *WISQARS Leading Causes of Death Visualization Tool*, <https://www.cdc.gov/injury/wisqars/fatal.html>. Nationwide, suicide is the second leading cause of death for AI/AN across the same time frame for all three groups. However, in 2020 suicide became the leading cause of death in the 10–14 age range nationwide.

²³ Patrick Strickland, *Life on the Pine Ridge Native American reservation*, Al Jazeera (Nov. 2, 2016) <https://www.aljazeera.com/features/2016/11/2/life-on-the-pine-ridge-native-american-reservation>.

²⁴ National Indian Council on Aging, Inc., *American Indian Suicide Rate Increases* (Sep. 9, 2019) <https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life-day/> (suicide rate up 139% for AI/AN women and 71% for AI/AN men between 1999 and 2019); Deborah Stone, Eva Trinh, et. al. *Suicides Among American Indian or Alaska Native Persons—National Violent Death Reporting System, United States, 2015–2020*, CDC Morbidity and Mortality Weekly Report (Sep. 16, 2022) <https://www.cdc.gov/mmwr/volumes/71/wr/mm7137a1.htm> (suicide rates among non-Hispanic AI/AN persons increased nearly 20% from 2015 to 2020).

²⁵ *Rosebud Sioux Tribe v. United States*, 9 F.4th 1018 (8th Cir. 2021).

Drug Addiction

Our Tribe is also fighting a tidal wave of substance use disorders. The problem escalated to the point that our Tribe declared a State of Emergency due to the increasing rates of homicide and methamphetamine use on our lands.²⁶ Such activities are antithetical to the Lakota way of life and the balance of our society. Despite the documented and increasing rates of these issues, we lack the facilities and trained personnel to mount a comprehensive response.

One of our most pressing needs is for on-reservation drug treatment facilities. We need detox facilities, and our existing residential and outpatient treatment facilities are in desperate need of renovations to accommodate additional patients. We would also like to offer skills-based transitional living facilities to assist patients with their long-term recovery goals, but we lack the necessary resources for their development and operation. We need funds for harm reduction services, medication-assisted treatment, diversion programs, and for peer recovery support systems.

We also desperately need funding to specifically address the law enforcement, public health, and mental health impacts of the opioid and methamphetamine epidemics on our Reservation. We need funding to purchase Naloxone and similar overdose kits for our public spaces, and to support training of law enforcement officers and other public officials on the use of such medicines. We need funding for education initiatives targeted at preventing drug use. We need funding to support families who have lost someone to this epidemic and for those who are dealing with the ongoing traumas of having a loved one struggling with this addiction. We need the Federal Government to focus on this crisis and develop and fund these initiatives and others to combat it. We also need support for us to provide culturally appropriate healing practices the way we see fit.

It should go without saying that our Native veterans deserve a proportional investment in mental health and substance use resources. American Indian and Alaska Natives serve in the United States Armed Forces at a rate five times the national average.²⁷ Like all veterans, our Native veterans face monumental struggles with depression, alcoholism, post-traumatic stress disorder, challenges adapting to civilian life and, devastatingly, suicide. We need resources and initiatives for them too.

Certain Crimes Against Our People

Concurrently with our mental health and substance abuse pandemics, Indian Country is facing a substantial domestic violence and human trafficking crisis that is finally starting to get the long overdue attention it needs.²⁸ More than four in five American Indian and Alaska Native men and women have experienced violence in their lifetime, including 56.1% of women who have experienced sexual violence.²⁹ American Indian and Alaska Native women die from homicide at a rate more than twice that of non-Hispanic white women.³⁰ Between the violence, the high rates of depression, suicide, and drug addiction, we have deeply traumatized communities. As noted above, we need resources for mental healthcare to address these issues head on. But, we also need health resources for support services for the families of our missing and murdered community members. They need access to counseling and

²⁶In 2016, we saw the number of homicides on the Pine Ridge Reservation nearly double in what was widely reported to be crime fueled by an increase in methamphetamine use. In early 2017, the FBI reported that the drugs were coming to the Reservation from outside areas, such as Denver. Tiffany Tan, *FBI: Murders down 80% on Pine Ridge following meth-fueled spike in 2016*, Rapid City Journal, (Mar. 4, 2018) <https://tinyurl.com/498cz7dk>; see also Associated Press, *Homicides on Pine Ridge reservation nearly doubled in 2016*, (Feb. 12, 2017) <https://apnews.com/article/6d7b7f5f215b47a299e65eca09466a16>. Last year, this theory was confirmed after six individuals were convicted in a meth conspiracy after trafficking meth into South Dakota from Colorado, primarily to the Pine Ridge Reservation. Hunter Dunteman, *Six convicted in Pine Ridge meth conspiracy after 'pounds' of drug entered South Dakota*, Mitchell Republic, (Mar. 17, 2022) <https://tinyurl.com/bdctbk9v>.

²⁷Danielle DeSimone, *A History of Military Service: Native Americans in the U.S. Military Yesterday and Today*, (Nov. 8, 2021) <https://www.uso.org/stories/2914-a-history-of-military-service-native-americans-in-the-u-s-military-yesterday-and-today#:?.text=Native%20Americans%20serve%20in%20the,the%20Armed%20Forces%20for%20centuries>.

²⁸President Joe Biden, A Proclamation on Missing or Murdered Indigenous Persons Awareness Day, 2022 (May 4, 2022) <https://www.whitehouse.gov/briefing-room/presidential-actions/2022/05/04/a-proclamation-on-missing-or-murdered-indigenous-persons-awareness-day-2022/>.

²⁹Bureau of Indian Affairs, *Missing and Murdered Indigenous People Crisis* <https://www.bia.gov/service/mmu/missing-and-murdered-indigenous-people-crisis> (accessed Mar. 29, 2023)

³⁰National Indian Health Board, *2022 Legislative and Policy Agenda for Indian Health*, 26 <https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf>

they need financial support for their households, especially when their major income-earner goes missing. We also need the United States Government to step up and provide the resources to make our Reservation safe again. Our citizens will not be healthy if they are not safe.

On a related note, we support the President's proposed legislative initiative to withhold annuity and retiree pay for federal employees convicted of crimes against children.³¹ The individual, Stanley Patrick Weber, whose case prompted the proposal, committed his crimes at our Pine Ridge IHS facility. This hideous issue demands protection of our children and retribution from their abusers.

V. Rural Cancer Care

We strongly support the President's request for funding to improve rural cancer care. The Pine Ridge Reservation is one of the largest reservations in the United States and also one of the most rural communities. There are no cancer treatment services available at the Pine Ridge Hospital. Instead, patients must travel 110 miles to Rapid City for access to chemotherapy, radiation therapy, surgery, and palliative care. Too many of our people live below the poverty line. They should not be faced with the decision of choosing to spend their scarce dollars on gas money to get to cancer treatments or putting food on the table for their families. We need cancer treatment services on our Reservation—for our patients, their families and our quality of life.

In addition to the challenges of cancer care that all rural communities face, our people also have unique health disparities that make circumstances even more dire for us. As of late 2016, the cervical cancer rate on our Reservation is five times higher than the nationwide average.³² Tribes of the Great Plains also have had significantly higher than average mortality rates for colorectal cancer (58%), lung cancer (62%), cervical cancer (79%) and prostate cancer (49%).³³

The Susan G. Komen for the Cure Foundation identified the three counties, Oglala Lakota, Jackson, and Bennett Counties, where the Pine Ridge Reservation is located as high risk for breast cancer disparities due to socioeconomic factors like high unemployment, low education, high uninsurance, and high poverty.³⁴ Other reported obstacles to our members' care include communication difficulties, lack of information about side effects, cost of treatment, difficulty obtaining and maintaining insurance, fear, language barriers, lack of education, perceived racial, economic, and gender bias, lack of cultural competence in healthcare professionals, and transportation challenges.³⁵ These problems are compounded because our people are diagnosed at later stages because they "never enter the continuum [of care] due to lack of accessible screening sites and lack of Native-specific education."³⁶ Likewise, even though our people have a high rate of tobacco use, we also have a high rate of late-stage lung cancer diagnoses.³⁷

Many of these disparities also relate to the health of our environment, though we are waiting for science to catch up and paint a clearer picture on that. Only three years ago we had to cap a community drinking water well after uranium in excess of the safe Drinking Water Standards was detected by our Department of Water

³¹ IHS Budget, CJ-294.

³² Patrick Strickland, *Life on the Pine Ridge Native American reservation*, Al Jazeera, (Nov. 2, 2016) <https://komengreatplains.org/wp-content/uploads/2013/03/Komen-South-Dakota-2015-Community-Profile-Report-updated-10.28.16.pdf>.

³³ Deborah Rogers & Daniel G. Petereit, *Cancer Disparities Research Partnership in Lakota Country: Clinical Trials, Patient Services, and Community Education for the Oglala, Rosebud, and Cheyenne River Sioux Tribes*, Am. J. Public Health 95(12): 212902132 (Dec. 2005) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449496/>.

³⁴ Susan G. Komen South Dakota, *Community Profile Report 2015*, at 6 <https://komengreatplains.org/wp-content/uploads/2013/03/Komen-South-Dakota-2015-Community-Profile-Report-updated-10.28.16.pdf>.

³⁵ Deborah Rogers & Daniel G. Petereit, *Cancer Disparities Research Partnership in Lakota Country: Clinical Trials, Patient Services, and Community Education for the Oglala, Rosebud, and Cheyenne River Sioux Tribes*, Am. J. Public Health 95(12): 212902132 (Dec. 2005) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449496/>.

³⁶ Susan G. Komen South Dakota, *Community Profile Report 2015*, at 7 <https://komengreatplains.org/wp-content/uploads/2013/03/Komen-South-Dakota-2015-Community-Profile-Report-updated-10.28.16.pdf>.

³⁷ Monica M. Bertagnoli, *Cancer Care in the Rural United States: A Visitor's Perspective from Appalachian Ohio; Pine Ridge, South Dakota; and Sidney, Montana*, JCO Oncology Practice 16, no. 7 (July 1, 2020) <https://ascopubs.org/doi/full/10.1200/OP.20.00244>.

Maintenance and Conservation.³⁸ Our springs have also returned elevated levels of arsenic, lead, and uranium, though some uranium may be naturally occurring.³⁹ As of late 2010, as many as 35% of private wells on the Reservation contained arsenic in excess of the EPA's maximum contaminant limit and as many as 6% contained uranium in excess of the maximum contaminant limit.⁴⁰ According to the Keepers of the Waters, there are 272 abandoned uranium mines in South Dakota which are also contaminating our land and water.⁴¹ These contaminants place us at a higher risk for cancer and other illnesses,⁴² so our Tribe needs resources for environmental remediation to prevent further disease and for cancer care to address the existing legacy of contamination. We also need the Federal Government to ensure our Mni Wiconi Project (clean drinking water project) is finally completed (see details below).

VI. Environmental Health

Essential to our Lakota conception of health is understanding that we are at our healthiest when we are in harmony and balance with the world around us. Unfortunately, as our cancer statistics partially demonstrate, our environment is in a state of disarray. The legacy of hard rock mining has poisoned our water tables and our open lagoons pose an obvious public health risk to our community. Further, the Federal Government continues to invest in the fossil fuels we know are warming our climate and ultimately making our world less livable.

We need Congress to invest in clean water infrastructure for our people. Water is life, but unclean water leads to disease and death. We want to work with you to finally complete the Mni Wiconi Project, which, as you probably know, is a Bureau of Reclamation-funded rural water project. It is a monumental clean drinking water project that serves Missouri River water to our Reservation as well as to the Rosebud Reservation, Lower Brule Reservation, and neighboring non-Indian water districts. The Project's Service Area is 12,500 square miles, its pipelines run 4,200 miles, and will serve approximately 52,000 people. The Mni Wiconi Project Act specifically states the United States' trust responsibility to ensure adequate and safe water supplies are available to meet the economic, environmental, water supply, and public health needs of the Reservations.

While the Project is a life-changing project for our Reservation, it is still not complete decades after its inception. We still need approximately \$25 million to upgrade 19 existing community water systems on Pine Ridge and transfer them into the Project as intended by the Act. Once transferred, these systems will be operated and maintained pursuant to authorized funding under the Mni Wiconi Project Act. The Project will not be complete until this work is done.

We also need increases in Operations, Maintenance, and Replacement (OM&R) funding for the Project so this significant federal investment and important project for our people's health and welfare does not fall into disrepair due to inadequate funding. Further, we need increased Funding for Tribal Water Maintenance Departments. We need to do water systems upgrades, pipe construction and repairs, well maintenance, and address water tank needs and associated equipment maintenance. We also need support for Low Income Water Assistance Programs (which includes water hook ups, pump repairs, and minor home repair for sanitation and safety).

³⁸Talli Nauman, *Native Sun News Today: Oglala tribal staff caps water well with uranium in it*, Indianz.com (Feb. 19, 2020) <https://www.indianz.com/News/2020/02/19/native-sun-news-today-ogla-tribal-staf.asp>.

³⁹Allen J. Heakin, *Water Quality of Selected Springs and Public-Supply Wells, Pine Ridge Indian Reservation, South Dakota, 1992-97*, U.S. Geological Survey Water-Resources Investigations Report 99-4063 (2000) <https://pubs.usgs.gov/wri/wri994063/>.

⁴⁰Charles J. Werth, et al., *Final Report: Use of Bone Char for the Removal of Arsenic and Uranium from Groundwater at the Pine Ridge Reservation*, EPA Grantee Research Project Results https://cfpub.epa.gov/ncer_abstracts/index.cfm/fuseaction/display.abstractDetail/abstract_id/9210/report/F.

⁴¹Keepers of the Waters, *Living Waters of the Cheyenne River*, <https://www.keepersofthewaters.org/projects/cheyenne-river#:?.text=There%20are%20currently%20about%2015%2C000,and%20people%20surrounding%20these%20waterways>.

⁴²See Maryalice Yakutchik, *Killer in the Water: Tracing arsenic's threats to health in the Badlands*, Johns Hopkins School of Public Health (2022) <https://magazine.jhsph.edu/2022/killer-water> (noting that arsenic in drinking water is "considered one of the prominent environmental causes of cancer death in the world" and that arsenic exposure is linked to cancer, diabetes, cognitive deficits, and cardiovascular disease); National Cancer Institute, *Arsenic*, <https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/arsenic#:?.text=Which%20cancers%20are%20associated%20with,skin%20cancer%20in%20epidemiological%20studies> (reporting that arsenic in drinking water is linked to bladder cancer and skin cancer, and general exposure to arsenic has been linked to "cancers of the lung, digestive tract, liver, kidney, and lymphatic and hematopoietic systems.")

Similarly, we need resources to address our aging and overstressed lagoon system because our lagoons are at and beyond their limits. We also need resources to investigate the health of our local water sources because preliminary data we have collected indicates that we have dangerous chemicals in our rivers and streams. We need to be able to test our water sources, track the source of this pollution, and treat our water so that our people, animals, and crops have access to clean, unpolluted water. We need Congress to continue to provide resources for tribes through the Clean Water Act funds. We also need Congress to ensure that the IHS Sanitation Facilities Construction account is funded at a level sufficient to support all of the clean water infrastructure projects across Indian Country. The Infrastructure Investment & Jobs Act made a crucial investment in these issues, but the amounts to be appropriated under that law still will not meet our needs. In addition, we echo the recommendations made by the National Congress of American Indians that Congress should appropriate \$100 million for the EPA Tribal General Assistance Program and \$30 million for the Tribal Air Quality Management Program.⁴³

Crucial to all environmental health is the very basic premise that poisons should not be spilled on our lands and in our waterways. We have opposed numerous federally approved mining, drilling, and pipeline projects over the years. Some have called us radicals, but the recent Keystone pipeline spill—the “largest U.S. crude oil spill in a decade”—underscores the importance of our fight and that it is reality-based.⁴⁴ That spill left a community in Kansas reeling from a spill of 14,000 barrels of oil onto livestock pasture and into a nearby creek. The spill is the third spill of several thousand barrels of oil since the Keystone pipeline opened in 2010. Yet local residents seem to acknowledge that pipeline breaks and oil spills are just a part of life and business.⁴⁵ This has been one of our major concerns all along—there is no such thing as a safe pipeline just as there is no such thing as a clean mining operation. These activities endanger the health of our environment and they are conducted on our Treaty lands and on our sacred sites (Dakota Access Pipeline and Jenny Gulch gold mining exploration in He Sapa). The Federal Government must stop these activities. They are done without our consent, they are bad for our local environment, and the oil and gas activities are bad for our global climate. Instead, the Federal Government should be proactively investing in sustainable energy projects and forest restoration initiatives (with tribal consent!)—investments which actually improve our health.

Like water, quality food is the key to good health. The Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR), and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) provide desperately needed meals and school lunches for our most vulnerable. Congress must protect and fully fund these programs in the upcoming Farm Bill. We also need for these programs to be expanded to incorporate more locally grown and raised foods. Locally sourced foods produce multi-pronged benefits for our people. First, inclusion of local crops and animal protein directly stimulates our tribal economies when these programs purchase from our tribal ranchers and farmers. Second, the inclusion of our local foodstuffs actualizes a return to traditional practices and provides a spiritual benefit to our people. Third, increasing variation of the foods provided by these programs maximizes health outcomes as we become empowered to turn away from the ultra-processed wheat flour and sugar-based meals that have defined the Indian Country culinary experience from the Federal Government. Finally, sourcing these foods locally reduces the greenhouse gas emissions needed to transport foods for these programs across the country. This helps the environment which in turn helps us, our crops, and our animals.

Similarly, we request that Congress invest more resources in developing meat processing facilities on tribal lands. We would like to be able to process animals, like the sacred buffalo, on our Reservation, in our traditional ways. Currently, a lack of funding is an obstacle, as are some U.S. Department of Agriculture laws, regulations, and policies requiring oversight by certain types of inspectors (ex. under

⁴³ National Congress of American Indians, *Written Testimony of President Fawn Sharp to U.S. Senate Committee on Indian Affairs*, 3 (Mar. 8, 2023) <https://www.indian.senate.gov/sites/default/files/Testimony%20NCAI%20-%20SCIA%20-%20Tribal%20Priorities%20-%202023-03-08.pdf>

⁴⁴ Erwin Seba and Nia Williams, *Kansas residents hold their noses as crews mop up massive U.S. oil spill*, Reuters (Dec. 11, 2022) <https://www.reuters.com/world/us/residents-hold-their-nose-crews-mop-up-huge-us-oil-spill-2022-12-10/>

⁴⁵ “Stuff breaks. Pipelines break, oil trains derail.” Washington, Kansas resident Dana Ceeclre, 56. “Hell, that’s life.” “We got to have the oil.” Carol Hollingsworth of Hollenberg, Kansas, 70. Erwin Seba and Nia Williams, *Kansas residents hold their noses as crews mop up massive U.S. oil spill*, Reuters (Dec. 11, 2022) <https://www.reuters.com/world/us/residents-hold-their-nose-crews-mop-up-huge-us-oil-spill-2022-12-10/>

the Federal Meat Inspection Act). We urge Congress to provide us funding to build and run these facilities and enact flexibility so that we are not hamstrung in our efforts by an overly fretful federal nanny state.

With respect to the food programs discussed above, Congress should expand 638 contracting and compacting abilities so that tribes cannot only administer these programs but can design them from the ground up.

VII. Conclusion

Thank you for your tireless work in service of Indian Country and for your consideration of these comments. As you can see from these comments: Mitakuye Oyasin, which means everything is connected. This is our philosophy and way of moving through the world. It is a fact and particularly evident when talking about healthcare. The health of our people relies not on only on having healthy bodies and dedicated professionals to treat us when we are sick or injured in body, but also having, among other things: (1) adequate behavioral and mental health prevention and intervention for healthy minds and spirit; (2) safe, clean, and modern healthcare facilities and safe and clean environs; and (3) fueling our bodies with clean and nutritious water and food. Our Tribe stands ready to work with this Subcommittee and Congress overall to make sure the Federal Government is living up to its Treaty and trust obligations and our people are getting the high-quality healthcare they deserve.

SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY
Scottsdale, Arizona

April 10, 2023

Hon. Harriet Hageman, Chairwoman
 House Natural Resources Committee
 Subcommittee on Indian and Insular Affairs
 1324 Longworth House Office Building
 Washington, DC 20515

Re: Oversight hearing on Improving Healthcare Delivery in Tribal Communities

Dear Chairwoman Hageman:

On behalf of the Salt River Pima-Maricopa Indian Community (“SRPMIC”) I am pleased to submit this letter to be made part of the hearing record of the Subcommittee on Indian and Insular Affairs (“the Committee”) for the oversight hearing conducted on March 29, 2023 on the topic of Improving Healthcare Delivery in Tribal Communities. As a Tribal nation located in the State of Arizona in the Phoenix metropolitan area we are making tremendous progress to improve the healthcare system and delivery for not only the membership of our Community but also for area urban Native Americans. The Community’s River People Health Center (“RPHC”) is central to this mission and is tribally operated by Self-Governance Compact with the Indian Health Service (“IHS”) under Title V of the Indian Self-Determination and Education Assistance Act (“ISDEAA”). Based in our newly constructed 200,000 square foot state of the art health center, RPHC is creating a Community of Care offering a robust health and services delivery model that addresses the 5 Determinants of Health: Social, Behavioral Health, Clinical, Environmental and Genetics. As such, I want to share with the Committee the SRPMIC views on how IHS funding decisions impact healthcare delivery in our Community paired with recommendations for how Congress can help IHS improve its service to Tribal Organization.

- **Continue Advance Appropriations for the Indian Health Service (“IHS”).** In the FY 2023 Consolidated Appropriations Act, Congress in a historic move, finally provided advance appropriations for the IHS for FY 2024. Going forward, we urge that all necessary steps be taken to continue advance appropriations for the IHS for FY 2025 and beyond, which would bring IHS in alignment with the U.S. Department of Veterans Affairs’ eligibility for advance appropriations.
- **Fully fund critical IT infrastructure investments.** In FY 2023 Electronic Health Record modernization was funded at \$217 million, which was an increase of \$72.5 million (50%) over FY 2022. We need the same kind of increase in this critical line item for FY 2024 to ensure that full implementation of interoperable Electronic Health Records (EHR) and tele-health occurs. For Tribes and Tribal health organizations who have committed their own resources to move away from RPMS and making their systems functional, IHS should take this into consideration with any new resources and ensure these programs are not only interoperable, but compensated accordingly.
- **Mandatory Funding for Contract Support Costs and 105(l) lease payments.** We appreciate the continuing commitment to ensure that Contract Support Costs (CSC) and 105(l) lease costs are fully funded by including an indefinite discretionary appropriation in recent years for both of these accounts. We strongly support the transition of these accounts to mandatory funding. This change would bring the appropriations process into line with the clear legal requirements of the authorizing statute. CSC and 105(l) lease funds are already an entitlement under substantive law that enables the ISDEAA to function as intended by Congress. It is legally contradictory and operationally problematic to appropriate funding for CSC on a discretionary basis. A simple amendment to a permanent appropriations statute could solve this challenge.
- **In some IHS Regions, CSC funding decisions take an adversarial position rather than advocate for Tribal Self-Determination and Self-Governance.** We remain concerned with recent actions of the IHS that effectively impede the efforts of the SRPMIC and other Tribes to expand and improve healthcare services. The IHS often bars access to the very CSC resources that this Committee seeks to provide Tribes. There have been no

substantive amendments to the ISDEAA in recent years, yet the new IHS administration has shifted its CSC award determinations and negotiation positions so dramatically they no longer align with longstanding IHS policy and practice over the last 20 years. These recent CSC determinations and positions also fail to align with the mission of IHS, or even its newly established commitments identified in the IHS 2023 Agency Work Plan. The SRPMIC would welcome the opportunity to talk with the Committee in further detail regarding our experiences assuming operation of the RPHC in the Scottsdale/Phoenix, AZ area.

- **Amend Indian Self-Determination and Education Assistance Act to Clarify CSC provisions.** We also request assistance to amend the ISDEAA to clarify that when agency funding paid to a tribe for program operations is insufficient for contract and compact administration, CSC will remain available to cover the difference. In the recent court decision *Cook Inlet Tribal Council, Inc. v. Dotomain*, a federal appeals court held that costs for activities normally carried out by IHS are ineligible for payment as CSC—even if IHS transfers insufficient, or even no, funding for these activities in the Secretarial amount. Under this new ruling, if facility costs are higher for a Tribe than for IHS, the Tribe is forced to cover the difference by diverting scarce program dollars. Recently, this serious misinterpretation of the ISDEAA was applied to one Tribal organization resulting in the threat of a 90% reduction of CSC reimbursement. A legislative fix is urgently needed to clarify the intent of Congress for this matter and ensure consistency with precedent.
- **Extend Self-Governance Funding Options to the Special Diabetes Program for Indians (SDPI) and increase funding to \$250 million/year.** We appreciate that Congress included a three-year reauthorization of SDPI in the Consolidated Appropriations Act, 2021 (P.L. 116-260). SDPI's success rests in the flexibility of its program structure that allows for the incorporation of culture and local needs into its services. SDPI needs to be reauthorized in a manner that ensures participants have the option of receiving their federal funds through either a grant (as currently used) or self-governance funding mechanisms under ISDEAA. Additionally, SDPI has not had an increase in funding since FY 2004. SDPI should be permanently reauthorized at a minimum of \$250 million per year with annual adjustments for inflationary increases.

In closing, I want to thank you for conducting the oversight hearing on Improving Healthcare Delivery in Tribal Communities. Your consideration of the SRPMIC recommendations is greatly appreciated. If you have any questions please contact Mr. Gary Bohnee, Office of Congressional and Legislative Affairs.

Sincerely,

MARTIN HARVIER,
President

Submission for the Record by Rep. Grijalva

Statement for the Record

United South and Eastern Tribes Sovereignty Protection Fund

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we write to provide the House Committee on Natural Resources Subcommittee on Indian and Insular Affairs with the following testimony for the record for its March 29, 2023 hearing entitled Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities. We share this testimony in pursuit of solutions to the systemic challenges facing the Indian Health Service (IHS) and Tribally-operated facilities. While USET SPF appreciates efforts to address problems within the Indian Health System and acknowledges that certain preventable issues persist within IHS, we maintain that the majority of these challenges are due to chronic federal underfunding. Until Congress fully funds the IHS, the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations. Congress must meet its trust responsibility to Tribal Nations by providing full, stable funding to the IHS. Further, while we support reforms that will improve the quality of services delivered by the IHS, we assert that any attempts to reform the IHS, through Congressional action or otherwise, must be accomplished through extensive Tribal consultation that results in the incorporation of Tribal guidance.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.¹ USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, and our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

IHS Reform Efforts

In prior Congresses, there have been various attempts to improve the IHS through legislative reforms. While USET SPF has always welcomed efforts to improve healthcare delivery in Indian Country, we have also maintained that one-size-fits all policy approaches are inappropriate for the Indian Health System.

Tribal Nations are not a monolith, and some IHS areas do not experience the same challenges and failures as others. Any attempts to reform the IHS should be done in close, meaningful consultation with Tribal Nations, as broad solutions risk harming relationships and best practices at the Area level. Despite the present challenges, there are many successes within the Indian Health Care System that stand to be harmed by overly broad IHS reform efforts. Legislative proposals aimed at priorities like increasing Tribal sovereignty and fulfillment of solemn trust and treaty obligations should be the focus of Congress (and the federal government as a whole) and will garner broad support from Tribal Nations compared to proposals to over-legislate the IHS.

¹USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe-Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mi'kmaq Nation (ME), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Monacan Indian Nation (VA), Nansemond Indian Nation (VA), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), Upper Mattaponi Indian Tribe (VA) and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Fulfill Trust and Treaty Obligations Through Full and Mandatory IHS Funding

The United States has trust and treaty obligations to Tribal Nations that have been reaffirmed time and again through treaties, statutes, regulations, judicial decisions, and Executive Orders. Congress itself reaffirmed the trust responsibility in 2010 when it permanently reauthorized the Indian Health Care Improvement Act, declaring that “it is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indian and urban Indians and to provide all resources necessary to effect that policy.” This necessitates a budget for the IHS that reflects both the resources necessary to operate a comprehensive health system and the priorities of Tribal Nations. For far too long, the chronic underfunding of the IHS has had disastrous effects on the health and wellbeing of Native peoples—effects that could have been largely preventable in a full and mandatory funding atmosphere. Until the IHS is fully funded through mandatory appropriations, the United States will continue to fall short of its obligation to provide for the health and wellness of Tribal Nations.

Through the Fiscal Year (FY) 2025 Budget Formulation Process, Tribal Nations and the IHS have built a budget request based on an estimated funding figure—\$54 billion—that approaches full funding. This figure is not fully representative of full funding, as it does not include activities such as necessary investments in public health. Full funding for the IHS would also need to be determined in close consultation with Tribal Nations. USET SPF is pleased that the IHS has convened the “FY 2025 Sub-Workgroup on Mandatory Appropriations for the IHS,” a collaborative effort with Tribal Nations to determine a full funding figure of the agency. We have long advocated for a joint Tribal-federal workgroup to ascertain a funding figure that accounts for the full scope of the IHS’s charge and circumstances in Indian Country, in addition to determining how to fund the agency on a mandatory basis. In September 2021, USET SPF sent comments to the Department of Health and Human Services (HHS) Secretary Xavier Becerra offering input on approaches for funding the IHS on a mandatory basis.

While USET SPF does not dispute that the IHS has challenges to overcome, we assert that they are largely due to the chronic underfunding of the agency and could be solved in a full funding atmosphere. For example, the memorandum issued for the hearing cited challenges in the Purchased/Referred Care (PRC) program, including problems with the formula and cost overruns. The PRC program, which provides for specialty health care services not available within the IHS, exists mainly because of the IHS’s lack of resources for specialty and intensive care. Many of the challenges associated with the PRC program currently could be avoided with proper investments in hospital and clinical services within Indian Country—investments that would be made in a full, mandatory funding atmosphere.

The Biden-Harris Administration’s FY 2024 Request continues to propose a shift in funding for IHS from the discretionary to the mandatory side of the federal budget, including a 10-year plan to close funding gaps and an exemption from sequestration, a move that would provide even greater stability for the agency and is more representative of perpetual trust and treaty obligations. This 10-year plan would shift the IHS to mandatory funding beginning in FY 2025 with funding increases each year to account for inflation, cost increases, staffing needs and current deficiencies within the system. By FY 2033, the total annual funding level for the IHS would reach \$44 billion, a figure that approaches the resources necessary to fund the agency more comprehensively. The plan includes a proposal to establish a new dedicated funding stream for innovative public health infrastructure investment in Indian Country and, importantly, the President’s proposed plan also includes a mandatory indefinite appropriation for Contract Support Costs (CSC) and Section 105(l) Lease agreements beginning immediately. USET SPF strongly supports immediately shifting CSC and 105(l) lease agreements to mandatory funding. Year after year, USET SPF has urged multiple Administrations and Congresses to request and enact budgets that honor the unique, Nation-to-Nation relationship between Tribal Nations and the U.S., including providing full and mandatory funding that accounts for all agency authorities, including currently unfunded Indian Health Care Improvement Act (IHCA) authorities. While we firmly believe all Indian Country funding should be fully funded today, including the IHS, we continue to strongly support this proposal, recognizing that additional detail and planning is necessary to provide a fully developed plan to fund IHS on a full and mandatory basis. USET SPF strongly urges Congress to take up this proposal, and we look forward to working with the Committee on potential legislative language.

Expand Self-Governance Compacting and Contracting

The U.S. Government bears a responsibility to uphold the trust obligation, and that obligation includes upholding Tribal sovereignty, self-determination, and self-governance. The Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes the federal government to enter into compacts and contracts with Tribal Nations to provide services that the federal government would otherwise be obligated to provide under the trust and treaty obligations. Although self-government by Tribal Nations existed far before the passage of ISDEAA, Tribal Nations have demonstrated through ISDEAA authorities since the bill's enactment that we are best positioned to deliver essential government services to our citizens, including through the assumption of federal program and services. Tribal Nations are directly accountable to and aware of the priorities and problems of our own communities, allowing us to respond immediately and effectively to challenges and changing circumstances.

The success of self-governance under the ISDEAA is reflected in the significant growth of Tribal self-governance programs since its passage. In the USET region, the majority of our Tribal Nations engage in self-governance compacting or contracting to provide essential health care services. Across Indian Country, nearly two-thirds of federally recognized Tribal Nations engage in self-governance, either directly through the IHS or through Tribal organizations and intertribal consortia. In Fiscal Year (FY) 2020, approximately 50% of the IHS budget was distributed to self-governance Tribal Nations. However, despite the success of Tribal Nations in exercising these authorities under ISDEAA, the goals and potential of self-governance have not yet been fully realized. Many opportunities still remain to improve and expand self-governance, particularly within HHS. USET SPF, along with Tribal Nations and other regional and national organizations, has consistently advocated for all federal programs and dollars to be eligible for inclusion in self-governance compacts and contracts.

Attempts to expand self-governance compacting and contracting administratively have encountered barriers due to the limiting language under current law, as well as the misperceptions of federal officials. In 2013, the Self-Governance Tribal Workgroup (SGTFW), established within the HHS, completed a study exploring the feasibility of expanding Tribal self-governance into HHS programs beyond those of IHS and concluded that the expansion of self-governance to non-IHS programs was feasible, but would require Congressional action. USET SPF maintains that if true expansion of self-governance is only possible through legislative action, Congress must prioritize this action. We strongly support legislative proposals that would create a demonstration project at HHS aimed at expanding ISDEAA authority to more programs within the Department. In addition, a major priority for Tribal Nations during the upcoming reauthorization of the Special Diabetes Program for Indians (SDPI), along with increased funding and permanency for the program, is ISDEAA authority. USET SPF looks forward to supporting legislation aimed at fulfilling these priorities during this Congress.

Improve Public Health Funding and Data Sharing

Many of the challenges and shortfalls plaguing the Indian Health Care System are the result of sustained, chronic underinvestment in prevention and public health measures paired with generations of historical trauma and structural discrimination. As the United States's public health infrastructure took shape and grew throughout the twentieth century, Tribal Nations were routinely left out of resource distribution. While Tribal Nations have always and continue to invest in the health and wellbeing of our citizens, our efforts continue to be hampered by lack of funding and inconsistently applied data sharing authorities. In order to more effectively respond to the challenges in our communities, including those posed by current and future public health crises, Tribal Nations need increased resources as well as the ability to efficiently and easily obtain necessary public health data.

In an already strained funding environment, there are often little resources left for public health prevention and surveillance activities in Tribal Nations. Although the IHS supports limited public health activities at federally operated facilities, the primary responsibility for the development and delivery of public health infrastructure and services often lies with Tribal Nations, particularly in regions with high concentrations of self-governance Tribal Nations. While many Tribal Nations and IHS regions have worked to incorporate some public health components in their governments, these entities often do not operate at the same capacity as state programs, and certainly lack much of the authority afforded to state entities. The Indian Health Care Improvement Act (IHCA) authorized the formation of Tribal Epidemiology Centers (TECs), and since 1996, the TECs have been working to im-

prove the capacity of Tribal health departments to deal with public health issues and priorities. TECs are charged with seven main functions, including data collection, evaluation of systems, and the provision of technical assistance to Tribal Nations. The USET TEC, which serves Tribal Nations in the Nashville IHS Area, provides both aggregate and Tribal Nation-specific public health and mortality data in addition to its other functions. However, despite the critical nature of this invaluable work and Congressional directives to share data, TECs struggle with accessing public health data not only on the federal and state levels, but the Tribal levels as well. Access to timely, accurate data is vital to the delivery of healthcare services in Indian Country, as it is difficult to direct resources appropriately without fully understanding the challenges facing our people.

Congress has the obligation to correct these challenges within Indian Country. In addition to providing full funding to the IHS, Congress must meaningfully invest in public health capacity building in Indian Country. Funding for expanding the Community Health Aide Program (CHAP) to the lower 48 is one example of necessary investments in public health and preventative care in Tribal Nations. To mitigate challenges in data access, the federal government should compel agencies like the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) to issue specific guidance to states and other public health entities directing them to comply with legislative directives to share usable data with Tribal Nations. USET SPF is appreciative of efforts within the Subcommittee to conduct oversight in these matters.

Conclusion

While the challenges in delivering healthcare in Indian Country are numerous, the opportunities for correcting them are simple and widely supported. The United States has a trust responsibility to provide for the “highest possible health status” of Tribal communities, and that necessitates funding the entities and organizations that provide that healthcare fully. It also requires an expanded recognition of Tribal sovereignty and self-determination in our health care. Tribal Nations are unequivocally best positioned to provide for the health and wellness of our communities, but we require the proper resources to which we are legally and morally entitled. USET SPF appreciates the work of the Subcommittee in calling additional attention to the challenges within the Indian Health System, and we look forward to working with the Subcommittee and its members to advance solutions to these challenges this Congress.

