National Indian Health Board

WRITTEN TESTIMONY OF COUNCILMAN LEE SPOONHUNTER
ROCKY MOUNTAIN AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD
BEFORE THE HOUSE NATURAL RESOURCES COMMITTEE
SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS
LEGISLATIVE HEARING ON H.R. __ "RESTORING ACCOUNTABILITY IN THE INDIAN HEALTH SERVICE ACT OF 2023"

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 the Restoring Accountability in the Indian Health Service Act of 2023. My name is Lee Spoonhunter. I serve as Tribal Councilmember for the Northern Arapaho Tribe and Rocky Mountain Area Representative for the National Indian Health Board (NIHB).

Formed in 1972, NIHB is recognized nationally and internationally for its expertise in Indian health policy. NIHB's membership consists of the eleven Area Indian Health Boards (AIHBs) and the Tribes of the Tucson Area directly. NIHB supports Tribal policy through collaborative partnerships with Tribal, Congressional, federal, state, and International governmental and non-governmental organizations, as well as through original research and development, public education, and outreach.

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for Indian people. 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. The NIHB, therefore, appreciates this Subcommittee's focus on Indian healthcare and stands ready to work with the Subcommittee towards 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.

IHS Accountability

> "*For decades and generations, IHS has had a notorious reputation in Indian Country but it is all we have to count on. We do not go there because they have superior health care; we go there because it is our treaty right, and we go there because many of us lack the resources to go elsewhere.*"
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> 2016 Statement of Victoria Kitcheyan, Treasurer, Winnebago Tribal Council, to the Senate Committee on Indian Affairs

The *Restoring Accountability in the Indian Health Service Act of 2023* arises from our conflicted past relations with the United States and from the chronic underfunding of the United States treaty and trust obligations to provide for the health of Tribal nations and their citizens.[1] The NIHB is supportive of the intent of this draft legislation to address policy concerns at the IHS. However, we believe there is more work to be done to improve this legislation before there are any amendments to the Indian Health Care Improvement Act (IHCIA). To that end, the bill should not supersede any consensus recommendations of the IHCIA National Steering Committee (NSC) and should seek to empower collaborative policy development on a government-to-government basis.

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 Government Accountability Office (GAO) report found an average of 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas (GAO 18-580). In May of this year, IHS Director Roselyn Tso testified before this Subcommittee that the agency currently has a 28% provider vacancy rate and a 40% mental health professional vacancy rate. This challenge is not getting better. Lack of providers also force 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 a lack of competitive salary options, many IHS facilities are in a serious state 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, these aging facilities impose an even greater strain on availability of direct care.

NIHB is glad to see that the draft legislation would focus on improving staffing at the IHS. We must continue to think creatively about how to recruit and retain the best medical professionals to the Indian health system. We hope that we can continue this conversation about how to attract the best providers to the agency. We are also glad to see language to help improve and standardize the IHS. However, the policies identified in this bill must be done with the necessary appropriations to back them up. NIHB also supports ensuring that the legislation would not impact Tribal health programs negatively, and that the true needs of IHS are adequately reflected.

IHCIA and the National Steering Committee

A number of the issues addressed in the *Restoring Accountability in the Indian Health Service Act of 2023* came up in the regional and national meetings on the reauthorization of the IHCIA. For years, when it came to renewing and modifying IHCIA, there was a National Steering Committee (NSC) that consisted of Tribal representatives from across the country. During this process there were multiple regional consultation meetings and a national consultation in Washington, DC. This process identified the needed objectives and policy changes for IHCIA. This allowed any

[1] *See*, U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter "*Broken Promises*"), available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf, accessed on: November 20, 2022.

amendments to IHCIA to be supported by Tribes and for Indian Country to speak with a unified voice. The NSC worked diligently to reach national consensus on many issues, some of which were contentious or controversial.

As we work with the Subcommittee to support and examine necessary reforms to IHS, we call upon Congress to support a nationally-focused NSC process again. This process would balance the perspectives and needs of the entire Tribal health system resulting in a consensus among Indian Country and stakeholders. The NIHB stands with its partners and allies that any federal policymaking should be respectful of the Tribal leaders' decisions and policy outcomes that came through such process.

For example, NIHB consistently hears that there is that the lack of transparency around activities and decision making at IHS, particularly when a Tribe receives its services directly through an IHS operated service unit. NIHB partners are concerned that one of the issues with IHS accountability is that there is not a clear and common understanding of the rules and procedures that give rise to these issues. When policy is enacted regarding IHS, the impact of that policy is often thrust upon Tribes receiving direct services from IHS to bear regardless of whether the driving force of the underlying policy or decision is explained. The IHS Restoring Accountability Act, to our knowledge, was not a product of an NSC process. A considerable amount of the policy in this bill has been developed and proposed without national Tribal consensus and is at risk of inadvertently harming Tribal nations and Tribal health systems.

Treaties, Trust, and the Duty Owed

Tribal nations have a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions, and administrative law. 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.[2] In fulfillment of this Tribal trust relationship, the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal nations.[3] This bargained for exchange means that Tribal nations paid, in full, for the duties owed by the United States and that the United States has to duty to uphold its end of the exchange, which it continues to generously benefit directly from.

The United States' long-standing and repetitive use of language regarding trust relationships and legal obligations is not by accident. In a trust relationship, a trustee owes certain fundamental duties to the beneficiaries, including a duty of loyalty to all beneficiaries, a duty to provide requisite resources, and a duty to act in good faith. The duty to provide requisite resources is not only one of quantity, but one of continuity and stability. Otherwise, the purpose of the trust relationship recognized by the United States for centuries is effectively meaningless.

Most recently, 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 urban Indians and to provide all

[2] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[3] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).

resources necessary to effect that policy." Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis.

Today, most Tribal lands are held in trust by the United States or have been completely taken from our Nations through the long history of U.S. war, removal, assimilation, reorganization, and termination. As a result, Tribes do not have the same asset base or tax base as other governments. Tribal nations rely on federal government funding and on economic development, but infringement on Tribal tax jurisdiction and drastically reduced land bases leave most Tribal nations in a position of unique reliance on annual appropriations for their healthcare infrastructure and delivery.

The Health Status of Indian Country

The Centers for Disease Control and Prevention (CDC) now reports that life expectancy for AI/ANs has declined by nearly 7 years, and that our average life expectancy is now only 65 years—equivalent to the nationwide average in 1944.[4] With a life expectancy *10.9 years less than the national average*,[5] Native Americans die at higher rates that 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.[6] Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.[7] Between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans[8] 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 to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.[10] AI/ANs experience the highest rates of suicide according to a 2020 SAMHSA study,[11] with a recent, February 2023 CDC report finding that teen girls are experiencing record high levels of violence, sadness, and suicide risk.[12] Additionally, Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups[13] which have been attributed, in significant part, to the ongoing impacts of historical trauma.[14]

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[4] 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: October 13, 2022 (*total for All races and origins minus non-Hispanic American Indian or Alaska Native*).
[5] *Id*.
[6] *Broken Promises* at 65.
[7] *Broken Promises* at 65.
[8] *Broken Promises* at 65.
[9] *Broken Promises* at 65.
[10] *Broken Promises* at 79-84.
[11] Substance use 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/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.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: November 20, 2022.
[14] Kathleen Brown-Rice, *Examining the Theory of Historical Trauma Among Native Americans*, PROF'L COUNS, available at: http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/, accessed on: November 22, 2022.

The Resources Provided to the Indian Health Service

Although annual appropriations for IHS have consistently increased since 2009, after adjusting for inflation and population growth, the IHS budget has remained static in recent decades. In December 2018, the U.S. Commission on Civil Rights' *Broken Promises* report found that Tribal nations face an ongoing funding 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. We saw this crisis manifest in the worst way possible during the COVID-19 pandemic, and now we see it in the latest data and reporting.

Supplemental appropriations enacted during the pandemic were historic investments for Indian Country. It cannot be lost to history that the United States' swift action saved lives, but it must also be clear that the IHS is so disproportionately underfunded by Congress that a historic investment in response to a global virus still provided less resources than the estimate of annual obligations for IHS services in a single year – an amount collaboratively developed by the IHS National Tribal Budget Formulation Workgroup (NTBFW). For comparison, the latest enacted regular appropriations for IHS totals about $7 billion, or roughly 7 times less than the need-based estimate from the Workgroup for FY 2023.

Imagine having only one day's worth of food for a week: for generations. Imagine if the federal government asked you why you are so hungry all the time when they 'already gave you food;' why you can't manage your groceries like someone with a full pantry when they took nearly all of your resources. This staggering comparison underscores the purposeful inequity that continues to result in American Indians and Alaska Natives (AI/ANs) having some of the worst health outcomes of any U.S. population. Surely, this cannot be the highest possible health status promised by the United States in the IHCIA.

We understand and appreciate the need for Congress to embrace fiscal restraint and balancing the national debt. However, our ancestors have already prepaid for health care. This is not a new or "nice to have" program. IHS is an essential program that is the fulfillment of sacred promises made to Tribal nations. It is time that the U.S. Congress finally live up to these obligations and provide his with adequate funding. We cannot expect the Indian health system to improve when it does not have the resources it needs.

Just Like our Life Expectancy – U.S. Spending Policy is Stuck in the Termination Era

Regardless of the Fund source or authorizing provision, the United States is making an annual budget policy decision much like the dark Termination Era policies that we pretend are behind us. Tribes and their citizens originally had a system of health care delivery imposed on them that was intentionally insufficient. Meanwhile, States and local governments violated Tribes' tax jurisdiction, effectively rendering Tribal nations without a way to fund basic infrastructure and governance in often isolated and drastically reduced or wholly taken lands.

As part of this imposed system, the resources provided to IHS have been chronically underfunded and measurably unequal compared to investments in other U.S. populations. We see this systematic isolation, sovereign infringement, forced dependence, assimilation, and termination in the annual

appropriations process each year. We feel it in our communities, and the outcomes and data have been placed before us. We cannot expect Tribal communities' health to improve when they are consistently starved for resources. Too often, Tribal nations are trapped in a federal funding structure operating on the assumption that only state governments are worthy of base funding, essentially, assuming that we do not exist as jurisdictional sovereigns.

IHS Restoring Accountability Act – Step in the Right Direction

The IHS Restoring Accountability Act is well intentioned, and we sincerely appreciate the work that the subcommittee has undertaken to elevate the quality of care challenges at IHS. The legislation does move the needle forward in some respects by expanding eligibility on student loan repayment and the types of providers required to complete Tribal culture and history training. Below, we offer some comments on specific areas of the draft legislation.

- **SEC. 104: Clarification regarding eligibility for Indian Health Service loan repayment program.** Loan repayment programs are smaller in scale, when considering their availability to individuals, than loan forgiveness programs. Expanding the eligibility requirements of the Indian Health Service Loan Repayment Program (IHSLRP) to include individuals willing to serve in half-time practice and individuals with master's degrees in health care programs who are also certified in business administration and health-related fields could result in an increase of applicants for employment. Additionally, this program addresses the broad employment need and ongoing shortage of employees by providing employment in exchange for assistance with student loans rather than outright forgiveness. To further address employment vacancies, payments made through the IHS loan repayment program should be tax exempt. Making this assistance tax exempt, as it is for other federally-operated health care loan repayment programs, would help address the workforce shortages at IHS and throughout Indian Country.

- **SEC. 105: Improvements in Hiring Practices.** We are glad to see language in the bill that would improve on IHS' ability to quickly hire medical professionals. Too often, we hear stories of critical staff being lost to IHS because the federal hiring process is too burdensome and bureaucratic. We also agree with the language in the bill to provide notice to Tribal nations on key personnel changes. NIHB looks forward to working with Tribal nations and the committee to think of creative ways to recruit and retain medical professionals in a timely and efficient manner.

- **SEC. 107. Tribal Culture and History**. The legislation accurately addresses the need to strengthen and expand the current training requirements for culture and history provided in IHCIA. While issues regarding the creation of training curriculum and consultation of Tribes on the curriculum is not discussed, requiring the training be mandatory and completed annually is a step in the right direction. Expanding the list of individuals required to complete the training to include employees, volunteers, and contractors allows for more culturally aware and educated employees providing care to every individual.

- **SEC 108. Staffing Demonstration Program**. In this section the bill would direct IHS to carry out a demonstration project in which IHS may provide federally managed Service units with staffing resources. Staffing is a key challenge for health care providers

everywhere. The creative demonstration project at these facilities could impact long-term staffing. However, we urge the Subcommittee to work with Tribal nations to examine how this provision could be more broadly expanded throughout the IHS and Tribal health system. We also would urge that critical resources are appropriated as part of this project.

- **SEC. 111. Enhancing Quality of Care in the Indian Health Service.** Section 111 requires HHS to consult with Indian tribes, governing boards, Area offices, Service units, and other stakeholders and establish best practices for governing boards and Area offices. The language contained in this section is thorough and will go a long way in standardizing care for IHS patients and improving the overall safety of the IHS. However, Congress must ensure that it is fully funded for it to have a significant impact.

Overarching impacts:

Self-Governance Impact
Certain provisions in the bill would require the IHS to adopt policies or practices that would impact compacting and contracting pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). For example, Section 111 of the draft bill requires the Secretary of HHS to establish best practices provisions for governing boards and for Area offices and ultimately "adopt" those best practices, but there is no apparent shield from the effects of that adoption for Tribes that enter into ISDEAA agreements. On its face, the language appears to intend to address best practices at IHS-operated Service units, but the definitions used for the purpose of this section would include tribal health programs operated by a Tribe or Tribal organization through an ISDEAA agreement. Policies such as draft Section 111 put forward without an exemption for Tribes or Tribal organizations that enter into ISDEAA agreements could result in policies that infringe on the notions of Tribal sovereignty and self-determination that were and are the fundamental policy underpinnings of ISDEAA. Further, it undermines the government efficiency aspects of ISDEAA compacts and contracts because it could add another compliance layer to operations that are a return to the United States telling Tribes how their treaty and trust rights should be structured.

With respect to the impacts of this draft bill on contracting and compacting under ISDEAA, it is important to note that draft section 111 is a single example of how well-intended policies may impact tribal sovereignty and self-determination in ways that were not intended or expected. NIHB is not an ISDEAA compact or contract negotiator for Tribal nations, and the potential for impacts on self-determination or '638' contacting and self-governance compacting expand beyond that of draft Section 111 in the bill. One solution may be to include a section in the bill that clarifies that none of the bill's provisions are intended to have an impact on tribally-operated programs, unless a tribe specifically agrees otherwise. NIHB continues to collaborate with its partners to identify these provisions and propose solutions, but the activity, again, underscores why outreach to Tribal nations from this Committee is absolutely necessary to identify these concerns and develop policy solutions on a government-to-government collaborative basis.

Unfunded mandates. This draft bill has twenty-four sections, seven of the sections specifically add additional reporting requirements for IHS and five others establish additional programs to be created and implemented by either HHS or IHS. Many sections, like section 111: Enhancing Quality of Care in the Indian Health Service, add more than one additional reporting requirement

for multiple different agencies including but not limited to The Department of Health and Human Services, IHS, the Centers for Medicare and Medicaid Services, and GAO. While many of the reporting requirements and programs outlined in the draft bill are well intentioned, and likely needed, Congress must provide appropriated funds for these actions to occur. Additional transparency from IHS is essential in improving care and ensuring that the scarce dollars appropriated to IHS are well spent. But time and time again, Congress enacts legislation that places yet another barrier on Indian Country receiving access to quality healthcare. Mandatory appropriations for the IHS are consistent with the trust responsibility and treaty obligations reaffirmed by the United States in IHCIA. It's time for Congress to provide essential appropriated funding, otherwise this legislation will be another set of unfunded challenges at IHS.

Additional Key Policy Recommendations:

In addition to the comments below, we would like to reiterate some policy recommendations to improve and enhance the Indian Health Service.

- **Expansion of Tribal Self Governance for the Special Diabetes Program for Indians (SDPI):** Tribes and Tribal organizations have repeatedly called for a change to the Special Diabetes Program for Indians (SDPI) program structure to allow recipients the option to receive funding through 638 contracts and compacts which would allow for self-determination and self-governance. This would establish SDPI as an essential health service, remove the culturally inappropriate competitive grant structure, prevent the unnecessary federal administrative burden, and support Tribal sovereignty by transferring control of the program directly to Tribal governments.

  Data sharing with IHS operated sites and TECs: CDC data from 2021 show that rates of syphilis are increasing exponentially for American Indians and Alaska Natives nationwide, far outpacing the national average. Despite these high rates, Tribal Epidemiology Centers have not been told the number of infant deaths from syphilis by any state or federal agency. Up to 40% of infants born to mothers with untreated syphilis can be stillborn or die. Great Plains Tribal Leaders' Health Board and its Tribal Epi Center along with Great Plains Area Tribes have asked, repeatedly, for more information around the syphilis outbreak to help better monitor and address the devastating syphilis rates in the region. But it has not be provided by IHS. Without this data, TECs and Tribes cannot target prevention and education activities; provide testing and treatment to those who need it most; or ensure that not one more Native baby is born with congenital syphilis.

  This is just one example of a serious issue. This happens time and again where our Tribes and TECs are not given access to data that they are entitled to receive by law. It is critical that leadership at the highest level take immediate action.

- **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 IHCIA. Even today, 13 years after IHCIA was permanently enacted, many provisions of IHCIA remain unfunded and without implementation. Full and mandatory funding must include the full implementation of all authorized IHCIA 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(*l*) 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. **Permanently 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. 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 IHCIA 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.

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 affect 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. 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. At the same time, as noted earlier, we encourage Congress to support an NSC process that would allow for Tribes to advocate for needed changes to IHCIA with one united voice. This process is critical to ensure that the changes only improve, and do not cause unintentional harm for the Indian health system. For the sake of our People, we hope this Subcommittee in the 118th Congress is up to the challenge.

Thank you again for the opportunity to offer testimony on this legislation today. We are happy to answer any questions you might have.