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Written Testimony of
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On Behalf of the TSGAC
Submitted to the Department of Health and Human Services
in response to its 23rd Annual Tribal Budget Consultation
Session on the FY 2023 Budget Request

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Introduction

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), the following is the formal written testimony on the top policy, budget and legislative priorities identified by Tribal Nations that administer healthcare programs under Self-Governance agreements. Self-Governance is a Tribally-driven, Congressional legislative option, whereby Tribal governments are authorized to negotiate annually to assume management and control of programs, services, functions and activities (PSFAs) that were previously managed by the Federal government. Self-Governance allows Tribal Nations to exercise their inherent, sovereign right to self-govern and to administer Federal program funds in a manner that best fits the needs of their citizens and communities. Despite TSGAC being comprised of Tribal Nations that elected to use Self-Governance for the delivery of Federal resources, it is important to note that the recommendations below protect all Indian Health Programs—Direct, Urban, Contracting and Self-Governance. Our goal is to ensure that all Indian Health Programs are considered a top priority regardless of the administrative arrangement or delivery system.

The growth and success of Tribal Self-Governance is best documented by the 375 Tribes that currently have a Self-Governance agreement with the Indian Health Service (IHS). In 1994, only 14 Tribal Nations signed agreements with IHS. Tribal governments administering healthcare programs through Self-Governance agreements manage over $2 billion in health care appropriations to IHS each year. In addition, Federal policy supporting Tribal Self-Determination and Self-Governance has significantly strengthened the Tribal-Federal relationship.

In each budget priority and each policy decision, it is of utmost importance that all the HHS Departments and Operating Divisions uphold the trust and treaty obligations of the United States.

HHS Priorities

Encourage the HHS Intra-Departmental Council for Native American Affairs (ICNAA) to break down barriers hindering intradepartmental coordination: The ICNAA serves as the focal point for coordination among the numerous agencies, departments, and offices within the Department of Health and Human Services (HHS) on health and human services issues affecting

Tribal Nations and their citizens. Coordination among the numerous HHS agencies and departments has the potential to improve service delivery.

The response to the COVID-19 pandemic provides examples of how the lack of a coordinated effort within HHS diminishes the effectiveness of Federal services. While Tribal governments are greatly appreciative of COVID-19 relief funds that have been available, Tribal Nations overwhelming requested that the Centers for Disease Control and Prevention (CDC) transfer funds authorized as part COVID-19 response legislation to IHS. Tribal Nations have an existing relationship with IHS and believe it was best suited for the streamlined, timely distribution of funds to Tribes. Unfortunately, interagency transfers of funds between CDC and IHS are prohibited by appropriations law. As such, CDC disbursed funds through a process that resulted in significant delays and the initial exclusion of numerous Tribal Nations.

Self-Governance Tribes continue to advocate that disbursement of any new funding to Tribal Nations utilize program formulas developed in consultation with Tribal governments rather than disbursement through grants. If funding were streamlined and provided through Self-Determination contracts and Self-Governance agreements, Tribal governments would be able to develop a long-term plan to meet the needs of their communities, rather than spend inordinate amounts of time and money applying for grants, administering grants and then reporting on them. Grants do not reflect the trust and treaty obligations of the United States to Tribal Nations, nor are funding decisions made that grant processes equitable.

> Recommend Action: Request that: (1) HHS request that Congress consider eliminating the legislative barriers hindering transfer of program funds to IHS; and, (2) HHS identify all sources of funding Tribal governments are eligible for in order to eliminate the many layers of bureaucracy and streamline the processes for distribution of funds to their intended recipient.

Expand Broadband and Telehealth Capacity: The expansion of telehealth in Indian Country has substantially changed how Tribal governments deliver healthcare services to their communities. For example, COVID-19 dramatically increased the need to connect Medicare patients to their providers through telehealth in order to reduce risk of infection. Further, telehealth expansion allowed Tribal governments to reach patients in an environment where they are most comfortable without them having to travel to a healthcare facility. We believe the telehealth model will play a more significant role as a mechanism for delivering healthcare well beyond the end of the COVID-19 pandemic.

To this end, the *Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act* provided the Secretary of HHS with the ability to waive telehealth restrictions during national emergencies. In doing so, it enacted Section 9 of the bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (H.R. 4932, S. 2741). The CONNECT for Health Act was most recently introduced in October 2019 and has the support of the American Medical Association and over 100 other organizations. Section 3 of the CONNECT to Health Act would provide HHS with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on provider types, technology, geographic area, and services.

As telehealth expands however, we are concerned that Indian Country may be left behind. We face multiple difficulties that hinder widespread adoption of telehealth, including a lack of broadband access, and difficulty navigating the various CMS requirements around telehealth reimbursement.

> Recommended Actions: Recommend that HHS: (1) support the expansion and adoption of telehealth across the different HHS operating divisions; (2) work with Tribal leaders and Congress to permanently extend the existing waiver authority for use of telehealth under Medicare; (3) enact certain sections of the CONNECT for Health Act; and, (4) dedicate additional funding to the infrastructure needed to expand broadband capacity in Tribal communities.

Provide for Greater Data Access and Transparency: The COVID-19 pandemic has exposed the critical importance of having access to data. Data is essential to properly plan and administer healthcare programs. However, Tribal governments are often not given access to even the most basic data. For example, many Tribal governments are unable to receive data on how many of their Tribal citizens have been vaccinated.

> Recommended Action: HHS must commit to greater data transparency with Tribal governments. HHS needs to work with its operating divisions to make data available to Tribal governments.

Establish a Self-Governance Demonstration Project that respects the tenets of the Indian Self-Determination and Education Assistance Act (ISDEAA): Title VI of ISDEAA required the Secretary of HHS to conduct a study to determine the feasibility of a Tribal Self-Governance demonstration project for appropriate HHS PSFAs in agencies other than IHS. HHS submitted the required report to Congress in March of 2003. The report concluded that the demonstration project was feasible. In 2013, HHS convened a Self-Governance Tribal Federal Workgroup (SGTFW) and issued a final report in September 2014 to guide implementation of the demonstration project. Expanding Self-Governance translates to greater flexibility for Tribes to redesign programs that provide critical social services within agencies such as the Administration on Aging, Administration on Children and Families, Substance Abuse and Mental Health Administration, and Health Resources and Services Administration. Self-Governance reduces levels of Federal bureaucracy and expands local decision making and Tribal control. Yet, nearly 20 years after HHS reported to the Congress that expanding Self-Governance to HHS programs in agencies other than the IHS is feasible, the effort has not advanced.

Under the Biden/Harris Administration, there are renewed opportunities to prioritize expansion of Self-Governance for HHS programs. The Biden-Harris Plan for Tribal Nations states "*He [President Biden] will ensure federal agencies provide support in ways that is most useful for tribes and* ***honors tribal Self-Determination***."

> Recommended Action: In collaboration with Tribal leaders, we strongly urge HHS to work with Tribal leaders to implement solutions to overcome the factors that hindered prior expansion efforts and to develop and adopt a plan that advances establishment of a demonstration project to expand Self-Governance in the agencies listed above.

Improve coordination of care between the Veterans Administration (VA) and HHS agencies*:* As VA, IHS, and Tribal Nations work to improve partnerships, we must address issues related to coordination of care, reimbursement methodologies and services between the VA and IHS. There are many similar services VA offers that Tribal governments already manage on behalf of IHS or through grants with HHS. Enhancing coordination would be very beneficial for Native veterans who often struggle to access resources.

Recommended Actions:

- Facilitate meetings between VA, HHS, and Tribal leadership to focus on health and social services available to Native veterans and to strengthen the implementation of the IHS-VA Memorandum of Understanding.
- Provide support to the soon to-be-established Tribal Advisory Committee in VA as determined under the recently enacted Department of Veterans Affairs Tribal Advisory Committee Act.

Support moving IHS funding to mandatory funding: Unlike other health programs such as Medicare and Medicaid, IHS is funded as a non-defense, discretionary line item, creating an inconsistent funding environment year-to-year and ignoring external factors that contribute to the recognized growing gap between IHS and other public health programs. The Federal government has a trust responsibility to provide American Indian and Alaska Native people with access to quality health care. Transferring the IHS budget to the mandatory side of the budget would assist the Federal government to fulfill its trust and treaty obligations to American Indian and Alaska Native people while also creating a consistent budget based on important factors such as population growth, inflation, and evolving technology. This would also eliminate the possibility of budget reductions due to sequestration and the uncertainty of funding due to continuing resolutions.

Recommended Action: Support Congressional legislation to move IHS from discretionary to mandatory funding to ensure consistent, efficient and effective funding for IHS programs and services by providing timely technical expert assistance to Congress.

IHS Priorities

Advocate for a plan to fully fund Indian Health Services within the next 12 years: To address the existing IHS funding shortfall, Tribal and Urban programs have worked together under the National Tribal Budget Formulation Workgroup to develop the first true Needs Based Budget (NBB) The initial amount proposed in FY2005 totaled $19.5 billion. This includes amounts for personal health services, wrap-around community health services and facility investments. In 2020, this amount is now $36 billion, based on the FY 2017 estimate of 2.9 million American Indian/Alaska Natives eligible to be served by IHS, Tribal and Urban health programs. Given the lack of adequate budget increases over the past 14 years, the amount of time to reasonably phase-in the NBB of $48 billion has been extended to 12 years.

Recommended Action: Establish a joint Tribal/Federal workgroup to update and develop a plan and timeframe to provide for full funding of IHS.

Advocate for an increase in funding to support current IHS services: Current services include mandatory cost increases necessary to maintain those services at current levels. These

"mandatories" are unavoidable and include medical and general inflation, pay costs, contract support costs, phasing in staff for recently constructed facilities, and population growth. If these mandatory requirements are not funded, Tribal governments have no choice but to reduce health services, which further erodes the access to and quality of health care services available to American Indian and Alaska Native peoples. Although the IHS budget has grown, the net increases were realized due to reduced purchasing power as a result of inflation and population growth.

Recommended Action: Request appropriations to fully fund the IHS Budget Formulation Workgroup recommendations to maintain current services.

Request an additional appropriation for sanitation and facilities to ensure 100% of all American Indian and Alaska Native homes have access to safe water and wastewater disposal: For some Tribal communities, access to safe drinking water and proper wastewater disposal remains non-existent. Third world conditions exist in many Tribal communities due to a lack of basic water and wastewater infrastructure.

According to the World Health Organization (WHO) and the CDC, the provision of safe water, sanitation, and hygienic conditions is essential to protecting human health in response to the COVID-19 outbreak. Unfortunately, according to the 2018 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities, over 31% of homes in Tribal lands are in need of sanitation facility improvements, while nearly 7% of all American Indian and Alaska Native people reside in homes that do not have adequate sanitation facilities. Even more troubling is that roughly 2% of American Indian and Alaska Native people do not even have access to safe drinking water. It is impossible for our Tribal communities to abide by CDC's sanitation and hygiene standards without the necessary water and sanitation infrastructure. As demonstrated during the COVID-19 pandemic, **this has resulted in needless deaths and severe illness in our communities that could have been prevented**.

In its FY2021 budget request, IHS reported that $2.57 billion is needed to raise all IHS and Tribal sanitation sites to a Deficiency Level 1 classification. However, in 2018, the U.S. Government Accountability Office found that weaknesses in the database IHS uses to track drinking water and sanitation deficiencies may not result in the most accurate estimate of the need for water and wastewater infrastructure in Indian Country.

Recommended Action: There is an urgent need for assistance to ensure American Indian and Alaska Native people have access to safe water and wastewater disposal. We urge IHS to enter into a contract with a reputable private entity to conduct an independent assessment of the water and wastewater needs in Indian Country and complete that assessment by the end of fiscal year 2022. Once the true needs are identified, IHS should include the full amount in their budget and develop a plan to implement the projects necessary to eliminate this need.

Provide Tribal Governments and UIO access to the Strategic National Stockpile: The World Health Organization reports that every suspected case of COVID-19 should be tested if we are going to be successful isolating this virus and preventing further spread within communities. For tests to be administered, health clinics must have access to numerous materials, including protective gear such as gloves, N-95 masks, and face shields; appropriate swabs and media for

taking a sample; vials for submitting swabs to labs for analysis; and sealed bags for transporting the vials. Many, if not all, of these items have become scarce or nonexistent across Indian Country, leaving IHS and Tribal health clinics struggling to get the supplies they need to protect patients and workers alike. Currently, IHS and Tribal health authorities' access to the Strategic National Stockpile (SNS) is extremely limited and is not guaranteed in the SNS statute. While mitigation efforts continue under the current COVID-19 pandemic, it is essential that we take lessons learned to better prepare for future pandemics.

Recommended Action: Establish a formal process for I/T/U access to the SNS.

Funds for Expanded Public Health Monitoring and Infrastructure: CDC provides guidance for public health officials working with a patient to help them recall everyone with whom they have had close contact during the timeframe while they may have been infectious. Given the magnitude of COVID-19 cases and plans to eventually relax mitigation efforts such as stay at home orders and social distancing, Tribal communities will need a large number of trained contact tracers. These contact tracers need to quickly locate and talk with the patients, assist in arranging for patients to isolate themselves, and work with patients to identify people with whom the patients have been in close contact so the contact tracer can locate them. Case investigation, contact tracing, and contact follow-up and monitoring will need to be linked with timely testing, clinical services, and agile data management systems to facilitate real-time electronic transmission of laboratory and case data for public health action.

The COVID-19 pandemic has wreaked havoc on Tribal communities—both large and small. Most importantly, it has exposed the dire need for investment in Tribal public health infrastructure. According to the latest data from the CDC, American Indian and Alaska Native people are 1.7 times (70%) more likely to be diagnosed with COVID-19, 3.7 times (370%) more likely to require hospitalization and 2.4 times (240%) more likely to die from COVID-19-related infection when compared to non-Hispanic white people.

As our Tribal economies attempt to recover from this crisis, we must also properly plan for any future pandemics. Public Health monitoring and infrastructure will play a key role in this process.

Recommended Action: Tribes request funding to assist in the area of on-going public health monitoring related to COVID-19 cases; and to prioritize Tribal public health infrastructure.

Ensure an adequate funding source for leases authorized under 25 U.S.C. § 5324(l), also known as "105(l)" leases: In *Maniilaq Association v. Burwell*, the court held that IHS is legally obligated, pursuant to ISDEAA § 105(l), to enter into a lease at the request of any Tribe or Tribal Organization providing a tribally leased or owned facility utilized to provide PSFAs under an ISDEAA contract or compact. It is imperative that budget needs for 105(*l*) leases be accurately captured.

Recommended Actions: Provide such sums as may be necessary through mandatory spending and continue to make this a separate line item.

Request an increase for the Special Diabetes Program for Indians (SDPI): Since 2002, SDPI has been level funded at $150 million a year. This translates to a significantly reduced spending power in 2021—a reduction of more than 32 percent. SDPI is a critically important program for many Self-Governance Tribes and supports more than 300 diabetes treatment and prevention programs. The results of this program are tangible and well documented with improved health outcomes. However, HHS support is need to ensure that Congress enacts legislation that will provide adequate funding for this successful program.

> Recommended Action: Request an increase for SDPI to $200 million annually and permanent authorization for the program and to permit Tribes and Tribal organizations to receive SDPI funds through Self-Determination and Self-Governance contracts and compacts.

Support Advance Appropriations for IHS: The ability of Tribal Nations and the IHS to address essential health care needs is hindered by the lack of full funding available at the beginning of the fiscal year. In recognition of a similar systemic issue, Congress passed legislation in 2010 to provide advance appropriations for health care accounts of the VA. Similar in operations, the VA and the IHS are the only agencies to provide direct, Federally-funded health care to specific populations and thus, should have the same access to advance appropriations.

For the first time, the President's FY2022 proposed budget includes an advance appropriation for IHS in 2023 to support Administration and Tribal priorities – an issue that has been at the forefront of Tribal government advocacy work for over a decade.

> Recommended Action: Support congressional legislation that authorizes advanced appropriations for IHS by providing technical support to Congress to develop a plan for the implementation of advanced appropriations.

Centers for Medicare and Medicaid Services (CMS) Priorities

Support Medicare and Medicaid Priorities developed by the CMS-TTAG and Fully Fund the CMS Tribal Technical Advisory Group (CMS-TTAG) Strategic Plan Activities*.* The CMS-TTAG serves an important role as the Advisory Committee to CMS. This long-standing partnership began in 2003 and was codified in statute in 2009. In December 2020, the CMS TTAG approved a new 5-year strategic plan with an annual budget request for $5.7 million to fully fund TTAG's goals and objectives. In March 2021, the CMS Division of Tribal Affairs (DTA) presented a TTAG budget that was only $3.5 million. The TTAG and CMS DTA work is critically important, and we recommend CMS work with the TTAG to understand the impact of these issues and provide an adequate budget to support the TTAG activities.

> Recommended Action: Urge CMS/HHS to fully fund the TTAG at $5.7 million or at least at the FY2019 budget level of $5.2 million to make it a priority to improve American Indian/Alaska Native access and participation in Medicare and Medicaid programs.

Support for Medicaid, CHIP, and Affordable Care Act (ACA) Outreach and Enrollment Funding. Medicaid reimbursement is a critical source of revenue for the I/T/U system. Medicaid

represents 67% of third-party revenue at the IHS, and 13% of overall IHS spending.[1] It is likely that together with Medicare over $1billion in CMS funding supports Indian Health Programs. The majority of insured American Indian and Alaska Native people have either an ACA Marketplace plan, Medicaid, or CHIP. Much of the funding for outreach and enrollment for ACA expired, but now more than ever, we need to ensure that American Indian and Alaska Native people have access to health care.

> Recommended Action: Dedicate funding to enrollment for ACA plans to increase their investment in funding Medicaid and CHIP outreach and enrollment.

Support for Equal Access to Medicaid for All American Indians and Alaska Natives: The Medicaid program is a critical component of the Indian health system. As noted above, Medicaid resources now account for nearly 13 percent of total funding for the IHS, and an even greater amount for Tribally-operated health programs. However, access to Medicaid has been uneven across Indian country. Tribal leaders are advancing a legislative proposal to provide greater access to and responsiveness of the Medicaid program for the Indian health system, while at the same time reducing regulatory burdens and costs on the states. It maintains and expands the rule that states are fully reimbursed for services received through Indian Health Care Providers to American Indians and Alaska Natives, thereby decreasing costs to the states. The proposal would make Medicaid's scope of services more consistent across states, and it creates an additional option for expanding Medicaid eligibility.

> Recommended Action: Support efforts to advance a legislative proposal to provide for equal access to Medicaid for all American Indians/Alaska Natives.

Utilize the Broken Promises Report to Develop Budget Priorities: On December 28, 2018, the United States Commission on Civil Rights ("the Commission") transmitted a report titled *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* to President Donald J. Trump. In the Report, the Commission states, "*The efforts of the Federal government have been insufficient to meet the promises of providing for the health and wellbeing of Tribal citizens, as a health disparity exists today between Native Americans and other population groups*."; and further, *"The United States expects all nations to live up to their treaty obligations; it should live up to its own."*

One of the key recommendations included in the U.S. Commission on Civil Rights Report states,

> "*the Federal government should invest in Native American communities because such investment strengthens America. Recognizing the Federal government's ongoing and historic failure to honor its trust obligations to protect and support Native Americans… the Federal government should provide steady, equitable, and non-discretionary funding directly to Tribal nations to support the public safety, health care, education, housing, and economic development of Native tribes and people.*

While Tribal Nations are disheartened by some of the findings and statistics included in the Report, we remain supportive of the recommendations and conclusions.

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[1] Samantha Artiga, Petry Ubri, and Julia Foutz, *Medicaid and American Indians and Alaska Natives* (Washington, DC: Kaiser Family Foundation, Sep. 7, 2017), Figure 4. https://www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/

Recommended Action: Be cognizant of the responsibility for fulfilling the trust and treaty obligations in all engagement and provision of services to Tribal Nations. Consider the report and the proposed recommendations in the development of the Presidential Budget Request for Fiscal Year 2023. Measure annual results against the report as a baseline.

Summary

The TSGAC truly appreciates the opportunity to provide these written recommendations and we look forward to working with the Department and others to advance Indian Country's top health and human services priorities. We hope to continue close collaboration in a government-to-government partnership in order to narrow, and hopefully close, the gap in health care and health status within the framework of Tribal Self-Governance and Self-Determination. Thank you.