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MAY 2021

Building Health Equity With Tribal Nations

The National Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2023 Budget

Executive Summary

THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2023 BUDGET

Tribal Sovereign Leaders on the National Tribal Budget Formulation Workgroup (TBFWG), representing all twelve Indian Health Service (IHS) Areas, met on February 11-13, 2021 to exercise their right to provide meaningful input into the Indian Health Service budget request for the FY 2023 budget year. Following a thorough discussion of the Area Tribal health care needs, the national Tribal FY 2023 budget priorities and recommendations were established, as highlighted below:

- Urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life safety issues at IHS and Tribal Health facilities by implementing a budget which fully funds IHS at $49.8 billion.

- Increase the Tribal Budget Formulation Workgroup Recommendations to a total of $49.8 billion for the IHS in FY 2023 by adding *at a minimum*:
  - +$197.1 million for full funding of current services
  - +$303.1 million for binding fiscal obligations[1]
  - +$36.57 billion for program increases for the most critical health issues (~287% above FY 2022 Budget Recommendations).

    Top priorities for program expansion include:
    1. Hospital & Clinics ..... +$8.65 Billion
    2. Purchased/Referred Care..... +$5.22 Billion
    3. Health Care Facilities Construction/Other Authorities.... +$3.59 Billion
    4. Mental Health..... +$3.23 Billion
    5. Alcohol and Substance Abuse.....+$2.31 Billion
    6. Indian Health Care Improvement Fund.....+$2.16 Billion
    7. Maintenance & Improvement .....+$2.27 Billion
    8. Dental Services ..... +$2.49 Billion
    9. Sanitation Facilities Construction..+$1.88 Billion
    10. Community Health Representatives .....+$1.17 Billion
    11. Equipment ..... +$726.8 Million
    12. Health Education .....+$646.0 Million
    13. Public Health Nursing.....+$627.5 Million
    14. Urban Indian Health ..... +$749.3 Million
    15. Electronic Health Record..... +$355.8 Million
    16. Community Health .....+$153.9 Million
    17. Indian Health Professions.....+$195.7 Million
    18. Tribal Management Grants.....+$23.7 Million
    19. Facilities & Environmental Support.....+$141.6 Million
    20. Self-Governance ..... +$43.9 Million
    21. Direct Operations.....+$19.6 Million
    22. Alaska Immunization ..... +$1 Thousand

- Support the Preservation of Medicaid, the Indian Health Care Improvement Act (IHCIA) and other Indian-specific provisions in the Patient Protection and Affordable Care Act (P.L. 111-148), or any subsequent replacement bill, and provide dedicated funding to begin implementing the new authorities and provisions of the IHCIA, which have not yet been implemented and funded (~$100 Million in FY 2023)

1 Includes placeholder estimates for Contract Support Costs (CSC), 105(l) leases, and staffing for new facilities and newly recognized Tribes

- Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
  - » Health IT for full implementation of interoperable EHR systems & tele-health capacity at ~$3 Billion over 10 years.
  - » Funds should be provided outside of the discretionary budget, sequestered from the operating budget of health services.
  - » Health Facilities Construction Funding & Equipment at ~$21 Billion over 10 years.

- Advocate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions

- Support Advance Appropriations for the Indian Health Service

- Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficient use of federal dollars at the local level

- Recommend the Department and the Office of Management and Budget (OMB) work with Congress to move and create a mandatory appropriation account for the status and legal obligation to pay CSC and 105(l) lease agreements. The funding for this legal/statutory obligation competes with discretionary funding that could be directed to other program increases.

- Oppose IHS action to unilaterally restrict ISDEAA authorities in the absence of Tribal consultation and devise a mechanism to ensure that funding is transferred to IHS in a timely manner.

- Recommend that the Special Diabetes Program for Indians (SDPI) be permanently reauthorized and increase funding to $250 million per year, plus annual inflationary increases, and authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts.

- Expand the model of IHS as a jurisdiction for COVID-19 vaccines to future activities, and providing Tribes the opportunity to become jurisdictions as well.

Federally Recognized Tribal Nations are uniquely distinct domestic sovereign governments and, like other governments are responsible for the health and well-being of their citizens. This status and distinction is recognized in the United States Constitution, several Supreme Court decisions, and numerous laws and treaties. The legal obligations to Tribes are well documented in legal doctrine of the United States which also acknowledge the sovereign government-to-government relationship between Tribes and the federal government. Tribes have been displaced throughout the lands which is now known as the United State of America, yet continue annually to press for a meaningful partnership with the federal government to uphold historic Treaty and Trust responsibilities. Unfortunately, this partnership has suffered from a history of broken promises and unfulfilled Treaty and Trust obligations.

In the Executive Summary of the *Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans* which was released in December 2018 by the U.S. Commission on Civil Rights, the Commission writes "Since our nation's founding, the United States and Native Americans have committed to and sustained a special trust relationship, which obligates the federal government to promote tribal self-government, support the general wellbeing of Native American tribes and villages, and to protect their lands and resources. In exchange for the surrender and reduction of tribal lands and removal and resettlement of approximately one-fifth of Native American tribes from their original lands, the United States signed 375 treaties, passed laws, and instituted policies that shape and define the special government-to-government relationship between federal and tribal governments. Yet the U.S. government forced many Native Americans to give up their culture and did not provide adequate assistance to support their interconnected infrastructure, self-governance, housing, education, health, and economic development needs."

As part of these historic agreements, millions of acres of Tribal lands and natural resources were ceded, often involuntarily, in exchange for the resulting federal Trust obligations and responsibilities that exist in perpetuity, including, but not limited to, health care for American Indians and Alaska Natives. These obligations and responsibilities do not exist as welfare, but as repayment on a nation-to-nation agreement. This special and unique relationship exists domestically only with American Indians and Alaskan Natives due to our sovereign government-to-sovereign government relationship with the United States. This duty to build health equity must start with a true partnership with

Tribal Nations to understand the needs in Tribal lands and must give credence to the recommendations made by Tribal leaders.

House Interior, Environment and Related Agencies Appropriations Subcommittee Chairwoman, Betty McCollum stated on March 6, 2019, "The Federal government entered into guaranteeing health care with their treaties to our Native American brothers and sisters. My visits to Tribal communities across the nation, has shown me how we are failing, and failing greatly, at meeting our treaty responsibilities. Congress must not take our Treaty and Trust Responsibilities lightly."

The Executive Summary of the *Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans*, also concludes, "Unfortunately, the Commission's current study reflects that the efforts undertaken by the federal government in the past 15 years have resulted in only minor improvements, at best, for the Native population as a whole. And, in some respects, the U.S. Government has backslid in its treatment of Native Americans, and there is more that must be done compared to when the Commission issued A Quiet Crisis. Federal funding for Native American programs across the government remains grossly inadequate to meet the most basic needs the federal government is obligated to provide. Native American program budgets generally remain a barely perceptible and decreasing percentage of agency budgets. Since 2003, funding for Native American programs has mostly remained flat, and in the few cases where there have been increases, they have barely kept up with inflation or have actually resulted in decreased spending power."

The Commission's Executive Summary further states, "One of the Commission's most significant recommendations is for Congress to honor the federal government's trust obligations and pass a spending package to fully address unmet needs, targeting the most critical needs for immediate investment. This spending package should also address the funding necessary for the buildout of unmet essential utilities and core infrastructure needs in Indian Country such as electricity, water, telecommunications, and roads.

According to one study, Native American women are 4.5 times more likely than non-Hispanic white women to die while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and site of the pregnancy or its management, but not from accidental or incidental causes. The Center for Disease Control and Prevention (CDC) found that, between 2005 and 2014, every racial group experienced a decline in infant mortality, except for Native Americans. Native Americans experience infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.

Due at least in part to the failure of the federal government to adequately address federal Trust obligations for American Indians and Alaska Natives over the last two centuries, Native Americans in 2021 still rank near the bottom of all Americans in health, education, and employment outcomes. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.

In 2016, 26.2% of AI/ANs were estimated to be living in poverty, compared to the national average of 14.0%. Just under one-fifth of AI/ANs lacked health coverage in the same year, while nationally, only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is difficult to obtain due to undercounting of AI/ANs in the U.S. Census, rates of

overcrowded housing indicate a significant shortage of available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally. According to CDC, in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population. In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease, and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

These unacceptable health conditions, can be directly linked to the persistent chronic underfunding of the IHS, and the other social and economic circumstances which exist in many Tribal reservations and villages. *The discretionary nature of the federal budget that systemically fails to fulfill trust and treaty obligation is a legal, ethical, and moral violation of the greatest order.* Unfulfilled Trust and Treaty obligations results in American Indian and Alaskan Native people *living sicker and dying younger* than other Americans. Bipartisan collaboration between Congress and the Administration, has allowed the IHS budget to maintain at its same level of current services with the minimum amount necessary to fund annual binding obligations such as Contract Support Costs, staffing for new facilities, funding for new Tribes, Health Care Facilities Construction Projects, and 105(l) leases. In some years, the IHS has received a small percentage of targeted funding for certain programs. However, even with an overall increase of 50% from FY 2010 to FY 2020, the increases fall far short of even addressing inflation. As one Tribal Leader pointed out, when you get a percentage increase to an inadequately funded base, you still end up with very little to move the needle toward making any measurable change in health outcomes. The 2-3% annual increase to the IHS budget does not keep pace with year to year increases in medical inflation, which is now projected to be 4-10% in 2021, according to PricewaterhouseCoopers annual medical cost trend study. Moreover, with the exception of FY 2006, in every other year the IHS appropriation has not been passed on time, leading to a partial or full-year Continuing Resolution (CR). Because of the inherent budget constraints under a CR, which also does not account for medical inflation, the IHS budget is effectively *decreasing* over time in terms of its purchasing power and competitiveness with the mainstream healthcare system.

Tribal Nations are also severely underfunded for public health and were largely left behind during the nation's development of its public health infrastructure. When you compound the impact of broken treaty promises, chronic underfunding, and endless use of continuing resolutions, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do. The Administration, with the support of Congress, must work more assertively in partnership with Tribes to build health equity for American Indians and Alaska Natives (AI/AN).

In his first joint address to Congress, President Biden said, "Healthcare should be a right, not a privilege in America." While we whole heartedly agree with his statement, we must also respect the promises made through treaties to Tribal Nations which obligate the federal government to deliver high quality health care in perpetuity.

As President Biden stated in his address, "There is nothing — nothing — beyond our capacity — nothing we can't do — if we do it together." We applaud the President for publicly stating his commitment to addressing the needs and issues regarding Indian health, and as Tribal Leaders, we are intent to hold him to his promise.

For the past several decades, Tribal leaders have provided budget recommendations to phase in funding increases over 10-12 years to address growing health disparities. These recommendations have been largely ignored and the tragic results of this chronic underfunding has become even more obvious during the Coronavirus pandemic. This novel pandemic has impacted Tribes to a higher degree than other populations in this country, similar to the Spanish Flu pandemic of 1918. This injustice perpetuated by inaction is no longer acceptable. The U. S. government must take action *now* to finally appropriate full funding for the Indian Health system. The past incremental appropriated increases have only been enough to maintain a flattened level of services. When considering inflation and funds essential to cover new expenses related to population growth, and legal obligations for full funding of CSC and 105(l) leases, the current $6 billion budget falls far short of what is needed to build health equity for the First Peoples of this great nation. Also, the practice of providing funding through grants to Tribes is not a substitute for the federal government to meet its

Trust obligations. Grants provide only short-term funding for a few Tribes and total grant funds available are generally insufficient to develop long-term services which are necessary to reverse decades of health disparities to all AI/AN. Grants also come with additional administration burden which many Tribes do not have the staff capacity to perform. For this reason, Tribes have consistently recommended that the agency support funding through direct appropriations to the IHS, which can then flow through to Tribes within their Self-Determination contracts and Self-Governance compacts.

Leaders of our Tribal Nations are unified in their request that this Administration and Congress work in partnership with Tribes to build health equity for all AI/ANs. This will require a minimum $49.8 billion in FY 2023, a small amount when considering what the Tribes' conceded in the historic agreements which were essential to the growth of wealth and power of these United States. These critical investments in the failing IHS delivery system will provide the resources necessary to achieve health parity for our people. Advancing a reasonable recurring budget which will finally eradicate the atrocious health disparities which put AI/AN lives at high risk during the 2020-21 Coronavirus pandemic, is the right thing to do. This Administration must find ways to eliminate the legislative and policy barriers which heretofore have prevented full funding from occurring. HHS must prioritize the IHS in its budget formulation. Healthy People 2030, which is intended to build a healthier future for all, must also set ambitious health objectives for Tribal citizens, to ensure equality with other American citizens. To do otherwise is to further violation of the civil rights and injustice as noted in *The Broken Promise's* report. A true partnership with Tribal Nations, whom were the first conservationists for the vast resources of the United States, will only strengthen this Nation's global standing in Human Rights. Chief Red Cloud said of this nation, "They made us many promises but they kept only one. They promised to take our land and they did." Let this administration be the trailblazer to rectify these broken promises made to our forefathers. We urge the Biden Administration to forward a $49.8 billion budget as recommended by the National Tribal Budget Formulation Workgroup. Doing so will prove that great nations, like great men, do indeed keep their promises.

The following recommendations are put forward by the Tribal Budget Formulation Workgroup as the national Tribal request for FY 2023. The narrative describes the national Tribal priorities for proposed program budget increases and describes the importance of each program within the Indian Health system.

Contents

INDIAN HEALTH SERVICE

FY 2023 Summary of National Tribal Budget Recommendation

Planning Base (FY 2022 National Tribal Budget Recommendation)	**$12,759,004**
Current Services - All 12 Areas recommended full funding	**$197,058**
Staffing Costs for Newly-Constructed Facilities Health Care Facilities	$75,000
Contract Support Costs Need (estimate)	$100,000
Health Care Facilities Construction Projects Priority List (estimate)	$100,000
105(l) Lease Cost Agreements	$28,125
Total Binding Obligations	**$303,125**
Total Binding Obligations & Current Services - All 12 Areas recommended full funding	**$500,183**

RANK	PROGRAM EXPANSION	INCREASE AMOUNT
1	Hospitals and Health Clinics	8,563,432
2	Purchased/Referred Care (formerly CHS)	5,224,397
3	Health Care Facilities Constr./Other Authorities	3,586,721
4	Mental Health	3,231,722
5	Alcohol and Substance Abuse	2,308,452
6	Indian Health Care Improvement Fund	2,161,417
7	Maintenance & Improvement	2,274,622
8	Dental Services	2,489,302
9	Sanitation Facilities Construction	1,879,039
10	Community Health Representatives	1,167,173
11	Equipment	726,843
12	Health Education	646,017
13	Public Health Nursing	627,516
14	Urban Indian Health	749,262
15	Electronic Health Record	355,786
16	Community Health	153,861
17	Indian Health Professions	195,738
18	Tribal Management Grants	23,692
19	Facilities & Environmental Health Support	141,579
20	Self-Governance	43,900
21	Direct Operations	19,645
22	Alaska Immunization	1
Total (Program Expansion)		**$36,570,117**
Total (Planning base + Program Expansion)		**$49,329,121**
Percent over Planning base		287%
Total (Base + Current Services + Program Expansion)		**$49,829,304**
Percent Over Planning Base		291%

FY 2023 National Tribal

12 Area Rollup Level over FY 2022 National Tribal Budget Recommendation

Planning Base (FY 2022 National Tribal Budget Recommendation): $12,759,004	Average	Total	Alaska [2/]	Albuquerque	Bemidji	Billings	
CURRENT SERVICES							
Federal Pay Costs	42,648	511,776	42,648	42,648	42,648	42,648	
Tribal Pay Costs	43,555	522,660	43,555	43,555	43,555	43,555	
Inflation (non-medical)	5,987	71,844	5,987	5,987	5,987	5,987	
Inflation (medical)	18,203	218,436	18,203	18,203	18,203	18,203	
Population Growth	86,665	1,039,980	86,665	86,665	86,665	86,665	
Total Current Services	**$197,058**	**$2,364,696**	**$197,058**	**$197,058**	**$197,058**	**$197,058**	
New Staffing for Newly-Constructed Facilities	75,000	900,000	75,000	75,000	75,000	75,000	
Contract Support Costs-Need	100,000	1,200,000	100,000	100,000	100,000	100,000	
Health Care Facilities Construction (planned)	100,000	1,200,000	100,000	100,000	100,000	100,000	
105(l) Lease cost Agreements	28,125	337,500	337,500	337,500	337,500	337,500	
Total, Binding Obligations	**$303,125**	**$3,637,500**	**$612,500**	**$612,500**	**$612,500**	**$612,500**	
SERVICES							
Hospitals & Health Clinics	8,563,432	102,761,180	29,954,743	7,286,820	4,484,443	6,836,751	
Electronic Health Record	355,786	4,269,431	0	282,488	749,987	0	
Dental Services	2,489,302	29,871,618	11,797,611	2,558,402	1,731,400	3,629,823	
Mental Health	3,231,722	38,780,664	0	5,775,794	2,431,197	6,378,620	
Alcohol and Substance Abuse	2,308,452	27,701,421	0	3,559,431	2,007,893	3,876,510	
Purchased/Referred Care (formerly CHS)	5,224,397	62,692,769	0	4,927,387	3,924,445	2,713,557	
Indian Health Care Improvement Fund	2,161,417	25,937,003	0	731,031	820,022	1,409,640	
Total, Clinical Services	**24,334,507**	**292,014,086**	**41,752,354**	**25,121,353**	**16,149,387**	**24,844,901**	
Public Health Nursing	627,516	7,530,195	0	1,119,129	450,835	2,713,557	
Health Education	646,017	7,752,205	0	992,197	259,018	2,819,280	
Community Health Representatives	1,167,173	14,006,071	0	1,688,340	844,726	2,819,280	
Community Health [1/]	153,861	1,846,336	0	1,791,336	40,000	0	
Alaska Immunization	1	16	0	0	16	0	
Total, Preventive Health	**2,594,569**	**31,134,823**	**0**	**5,591,002**	**1,594,595**	**8,352,117**	
Urban Indian Health	749,262	8,991,147	0	0	715,946	2,043,978	
Indian Health Professions	195,738	2,348,851	0	0	917,366	0	
Tribal Management Grants	23,692	284,300	0	277,778	24	0	
Direct Operations	19,645	235,735	0	0	2,771	0	
Self-Governance	43,900	526,805	0	277,778	102	0	
Total, Other Services	**1,032,237**	**12,386,838**	**0**	**555,556**	**1,636,209**	**2,043,978**	
Services Total	**$27,961,312**	**$335,535,747**	**$41,752,354**	**$31,267,911**	**$19,380,191**	**$35,240,996**	
FACILITIES							
Maintenance & Improvement	2,274,622	27,295,467	4,719,044	411,145	9,391,998	0	
Sanitation Facilities Construction	1,879,039	22,548,471	4,719,044	1,241,826	2,486,288	0	
Health Care Facilities Constr./Other Authorities	3,586,721	43,040,650	0	2,222,222	3,530,503	0	
Facilities & Environmental Health Support	141,579	1,698,943	0	0	51,156	0	
Equipment	726,843	8,722,120	0	97,892	400,860	0	
Facilities Total	**$8,608,804**	**$103,305,651**	**$9,438,088**	**$3,973,085**	**$15,860,805**	**$0**	
GRAND TOTAL	**$49,329,121**	**$451,600,402**	**$63,949,446**	**$48,000,000**	**$48,000,000**	**$48,000,000**	
$ Change over Planning Base	36,570,117	438,841,398	51,190,442	35,240,996	35,240,996	35,240,996	
% Change over Planning Base	286.62%	3439.46%	401.21%	276.20%	276.20%	276.20%	

[1/] This new budget line was proposed in the FY 2021 President's Budget. It includes Health Education, Community Health Representatives, and the nationalized Community Health Aide Program (CHAP). This proposal was not enacted in the final FY 2021 Budget.

[2/] The Alaska Tribes endorse full funding for the IHS, as illustrated in the FY 2022 Tribal Budget Recommendations and summarized on page 16. This endorsement was submitted in place of the annual budget worksheet.

Budget Recommendation

	California	Great Plains	Nashville	Navajo	Oklahoma	Phoenix	Portland	Tucson
	42,648	42,648	42,648	42,648	42,648	42,648	42,648	42,648
	43,555	43,555	43,555	43,555	43,555	43,555	43,555	43,555
	5,987	5,987	5,987	5,987	5,987	5,987	5,987	5,987
	18,203	18,203	18,203	18,203	18,203	18,203	18,203	18,203
	86,665	86,665	86,665	86,665	86,665	86,665	86,665	86,665
	$197,058	**$197,058**	**$197,058**	**$197,058**	**$197,058**	**$197,058**	**$197,058**	**$197,058**
	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000
	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000
	337,500	337,500	337,500	337,500	337,500	337,500	337,500	337,500
	$612,500	**$612,500**	**$612,500**	**$612,500**	**$612,500**	**$612,500**	**$612,500**	**$612,500**
	5,990,969	5,341,393	11,547,111	9,257,705	3,171,690	9,384,846	3,866,151	5,638,558
	1,762,050	0	981,102	0	0	0	493,804	0
	3,876,510	2,275,778	2,085,786	0	0	404,000	102,669	1,409,639
	4,933,739	6,130,717	2,672,553	5,431,187	0	504,000	1,703,578	2,819,279
	3,524,100	5,797,035	2,861,632	1,481,233	0	706,000	1,773,128	2,114,459
	5,286,149	1,973,217	6,023,424	0	5,286,149	1,000,000	21,690,966	9,867,475
	1,057,230	106,902	667,580	0	21,144,598	0	0	0
	26,430,747	**21,625,042**	**26,839,188**	**16,170,125**	**29,602,437**	**11,998,846**	**29,630,296**	**21,849,410**
	0	1,337,650	492,892	1,213,788	0	0	202,344	0
	0	1,653,240	572,894	1,213,788	0	71,200	170,588	0
	2,114,460	1,971,755	967,195	1,213,788	0	233,400	38,668	2,114,459
	0	0	0	0	0	15,000	0	0
	0	0	0	0	0	0	0	0
	2,114,460	**4,962,645**	**2,032,981**	**3,641,364**	**0**	**319,600**	**411,600**	**2,114,459**
	1,762,050	606,694	483,705	617,180	352,410	92,600	1,259,348	1,057,236
	0	0	199,306	0	0	71,200	1,160,979	0
	0	0	6,498	0	0	0	0	0
	0	0	190,262	0	0	0	42,702	0
	0	0	247,884	0	0	0	1,041	0
	1,762,050	**606,694**	**1,127,655**	**617,180**	**352,410**	**163,800**	**2,464,070**	**1,057,236**
	$30,307,257	**$27,194,381**	**$29,999,824**	**$20,428,669**	**$29,954,847**	**$12,482,246**	**$32,505,966**	**$25,021,105**
	2,114,460	1,097,951	1,530,910	0	5,286,149	1,144,750	1,599,060	0
	352,409	534,512	997,839	6,665,547	0	2,600,000	484,131	2,466,875
	2,466,870	3,207,076	1,759,485	7,406,164	0	18,860,000	64,232	3,524,098
	0	0	713,821	740,616	0	0	193,350	0
	0	3,207,076	239,117	0	0	154,000	394,257	4,228,918
	$4,933,739	**$8,046,615**	**$5,241,172**	**$14,812,327**	**$5,286,149**	**$22,758,750**	**$2,735,030**	**$10,219,891**
	$48,000,000	**$48,000,000**	**$48,000,000**	**$48,000,000**	**$48,000,000**	**$48,000,000**	**$48,000,000**	**$48,000,000**
	35,240,996	35,240,996	35,240,996	35,240,996	35,240,996	35,240,996	35,240,996	35,240,996
	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%	276.20%

Introduction

Building Health Equity with Tribal Nations

THE REALITY OF BROKEN TREATIES

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

Today, our nation is confronted by the COVID-19 pandemic that continues to disproportionately ravage the most marginalized among us, and Indian Country has been right at the center of the pandemic. In order to understand how to address and overcome these challenges and realize the opportunity for transformation before us, we must first insist on an honest reckoning of our history. The challenges we face today — most recently evidenced through the impacts of COVID-19 on Tribal communicates — are the fruits of colonization.

This system of exploitation, violence and opportunism is the foundation on which this Nation was constructed. Despite the poor social determinants of health most frequently found in the Indigenous and other communities of color — circumstances that proceed from hundreds of years of colonization — we are often blamed for our poor circumstances. What our communities are experiencing during this COVID-19 pandemic is simply the expected outcome of this historical truth.

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

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

TRIBAL RECOMMENDATIONS TO BUILD HEALTH EQUITY

The following budget recommendations are put forward by the Tribal Budget Formulation Workgroup as the national Tribal request for FY 2023. As proposed, these necessary investments in the IHS delivery system will provide the resources needed to achieve improved health outcomes for our people. Throughout the document, you will see the Tribal priorities for program increases and details on the importance of each program area at the IHS.

- Increase the Tribal Budget Formulation Workgroup Recommendations to a total of $49.8 billion for the IHS in FY 2023 by adding *at a minimum*:

- +$197.1 million for full funding of current services
- +$303.1 million for binding fiscal obligations[1]
- +$36.57 billion for program increases for the most critical health issues (~287% above FY 2022 Budget Recommendations).

  Top priorities for program expansion include:

  1. Hospital & Clinics ..... +$8.65 Billion
  2. Purchased/Referred Care..... +$5.22 Billion
  3. Health Care Facilities Construction/Other Authorities.... +$3.59 Billion
  4. Mental Health..... +$3.23 Billion
  5. Alcohol and Substance Abuse.....+$2.31 Billion
  6. Indian Health Care Improvement Fund.....+$2.16 Billion
  7. Maintenance & Improvement .....+$2.27 Billion
  8. Dental Services..... +$2.49 Billion
  9. Sanitation Facilities Construction..+$1.88 Billion
  10. Community Health Representatives+$1.17 Billion
  11. Equipment ..... +$726.8 Million
  12. Health Education.....+$646.0 Million
  13. Public Health Nursing.....+$627.5 Million
  14. Urban Indian Health ..... +$749.3 Million
  15. Electronic Health Record..... +$355.8 Million
  16. Community Health .....+$153.9 Million
  17. Indian Health Professions..... +$195.7 Million
  18. Tribal Management Grants.....+$23.7 Million
  19. Facilities & Environmental Support..... +$141.6 Million
  20. Self-Governance..... +$43.9 Million
  21. Direct Operations.....+$19.6 Million
  22. Alaska Immunization ..... +$1 Thousand

1 Includes placeholder estimates for Contract Support Costs (CSC), 105(l) leases, and staffing for new facilities and newly recognized Tribes

OTHER TRIBAL RECOMMENDATIONS FOR FY2023

- Support the Preservation of Medicaid, the Indian Health Care Improvement Act (IHCIA) and other Indian-specific provisions in the Patient Protection and Affordable Care Act (P.L. 111-148), or any subsequent replacement bill, and provide dedicated funding to begin implementing the new authorities and provisions of the IHCIA, which have not yet been implemented and funded (~$100 Million in FY 2023)

- Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
  - Health IT for full implementation of interoperable EHR systems & telehealth capacity at ~$3 Billion over 10 years.
  - Funds should be provided outside of the discretionary budget, sequestered from the operating budget of health services.
  - Health Facilities Construction Funding & Equipment at ~$21 Billion over 10 years.

- Advocate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions

- Support Advance Appropriations for the Indian Health Service

- Allow federally-operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficient use of federal dollars at the local level

- Recommend the Department and the Office of Management and Budget (OMB) work with Congress to move and create a mandatory appropriation account

for the status and legal obligation to pay CSC and 105(l) lease agreements. The funding for this legal/statutory obligation competes with discretionary funding that could be directed to other program increases.

- Oppose IHS action to unilaterally restrict ISDEAA authorities in the absence of Tribal consultation and devise a mechanism to ensure that funding is transferred to IHS in a timely manner.

- Recommend that the Special Diabetes Program for Indians (SDPI) be permanently reauthorized and increase funding to $250 million per year, plus annual inflationary increases, and authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts.

- Expand the model of IHS as a jurisdiction for COVID-19 vaccines to future activities, and providing Tribes the opportunity to become jurisdictions as well.

Tribal Nations are separate and distinct domestic sovereign governments, but they exist as an integral part of the fabric and overall well-being of the United States. This status and distinction is recognized in the United States Constitution, several Supreme Court decisions, and numerous laws and treaties. In order to engage in peaceful co-existence with Tribal Nations and to support its own growth and expansion aspirations, which was to the detriment of Tribal Nations, the United States signed treaties and made sacred promises. As part of these agreements, millions of acres of Tribal lands and natural resources were ceded, often involuntarily, in exchange for the resulting federal trust obligations and responsibilities that exist in perpetuity, including, but not limited to, health care for American Indians and Alaska Natives. These obligations and responsibilities do not exist as welfare but as repayment on a nation-to-nation agreement. This special and unique relationship exists domestically only with AI/ANs due to our sovereign government-to-sovereign government relationship with the United States.

This duty to fulfill this Trust obligation is no less true today. Unfortunately, as stated in the Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans, which was released in December 2018 by the U.S. Commission on Civil Rights, "Due at least in part to the failure of the federal government to adequately address the wellbeing of Native Americans over the last two centuries, Native Americans continue to rank near the bottom of all Americans in health, education, and employment outcomes." Specific to health, Tribal Nation communities continue to suffer the highest rates of health disparities of any other citizen group. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.

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

These unacceptable health conditions can be directly linked to the persistent chronic underfunding of the IHS and the other social and economic circumstances which exist in many Tribal reservations and villages. The discretionary nature of the federal budget that systemically fails to fulfill trust and treaty obligations is a legal, ethical, and moral violation of the greatest order. Unfulfilled Trust and Treaty obligations result in AI/AN people living sicker and dying younger than other Americans.

"No responsible American president can remain silent when basic human rights are violated. A president has to represent the essence of our country. America is an idea — unique in the world. We are all created equal. It's who we are. We cannot walk away from that principle."

— President Biden Address to Congress April 28, 2021

The Administration, with the support of Congress, must devise a plan to appropriate funds that go beyond just

sustaining maintenance-level services, and which only provides minimal increases essential to cover expenses related to population growth, recognition of new Tribes, and legal obligations for full funding of Health Facility Construction projects and staffing, Contract Support Costs (CSC) and 105(l) leases. Leaders of our Tribal Nations strongly urge that this President take assertive action to fulfil the historic government-to-government agreements which were essential to the power and growth of these United States. This must start with HHS putting forth a real budget that will finally eradicate the atrocious health disparities which have overwhelmed Indian Country during these occupation decades. And it will take decisive action by this Administration to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States. This Administration must be an example to the rest of the world and show that the United States, if it sets its mind to do so, can bring justice by rectifying decades of unequitable health conditions endured by its Tribal citizens, whom were the first conservationists for the vast resources which make up our great country. To do otherwise is dishonorable to the Tribal Nations.

HEALTH INEQUITIES CREATE ADDITIONAL RISKS FROM COVID-19

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

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

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

When you compound the impact of broken treaty promises, chronic underfunding, and endless use of continuing

resolutions, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do. Indeed, AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.[2]

According to the CDC, in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.[3] In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)[4] ; higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives. CDC reported that the presence of underlying health conditions such as type II diabetes, obesity, cardiovascular disease, and chronic kidney disease significantly increase one's risk for a severe COVID-19 illness. AI/AN populations are disproportionately impacted by each of these chronic health conditions. For instance, type II diabetes incidence and death rates are three times and 2.5 times higher, respectively, for AI/ANs than for non-Hispanic Whites. Despite significant improvements in rates of End Stage Renal Disease (ESRD) as the result of the highly successful Special Diabetes Program for Indians (SDPI), AI/AN communities continue to experience the highest incidence and prevalence of ESRD.

Increased physical distancing and isolation under the COVID-19 pandemic have led to recent and alarming spikes in drug overdose deaths, suicides, and other mental and behavioral health challenges. Population-specific data on increased drug overdose and suicide deaths during the pandemic are currently unavailable; yet if trends prior to the rise of COVID-19 are any indicator of risk, it is safe to assume that AI/AN People are experiencing serious challenges. One of the major drivers of increased mortality rates among AI/ANs overall has been significantly higher rates of drug overdose and suicide deaths than the general population

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

SYSTEMIC BARRIERS IN COVID-19 RESPONSE

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

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

Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. **The federal obligation to fully fund health services in Indian**

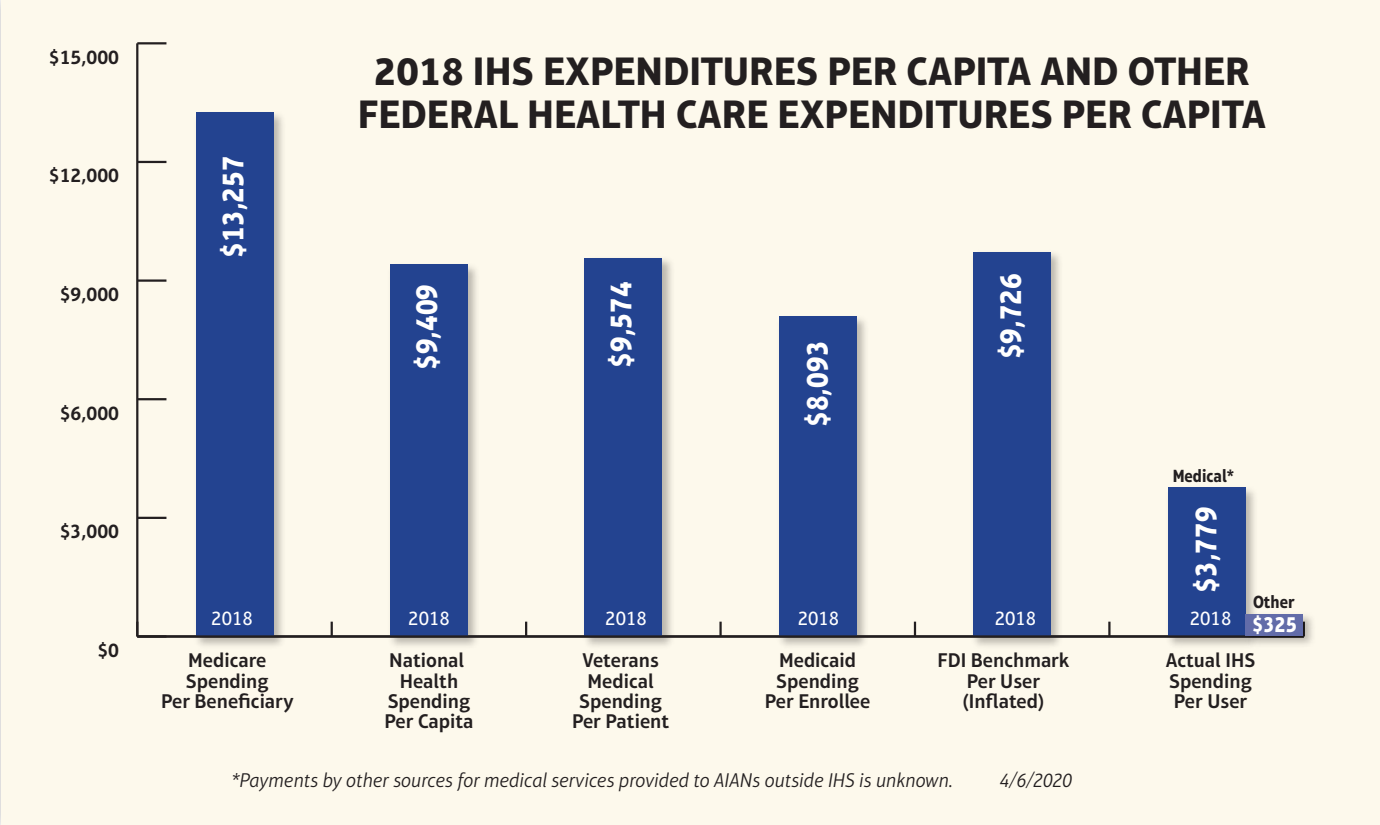
2 South Dakota Department of Health. Mortality Overview. Retrieved from https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf

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

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

Country was never meant to be contingent upon the quality of a grant application — yet that is the construct that the federal government has forced Tribes to operate under. That is unacceptable.

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



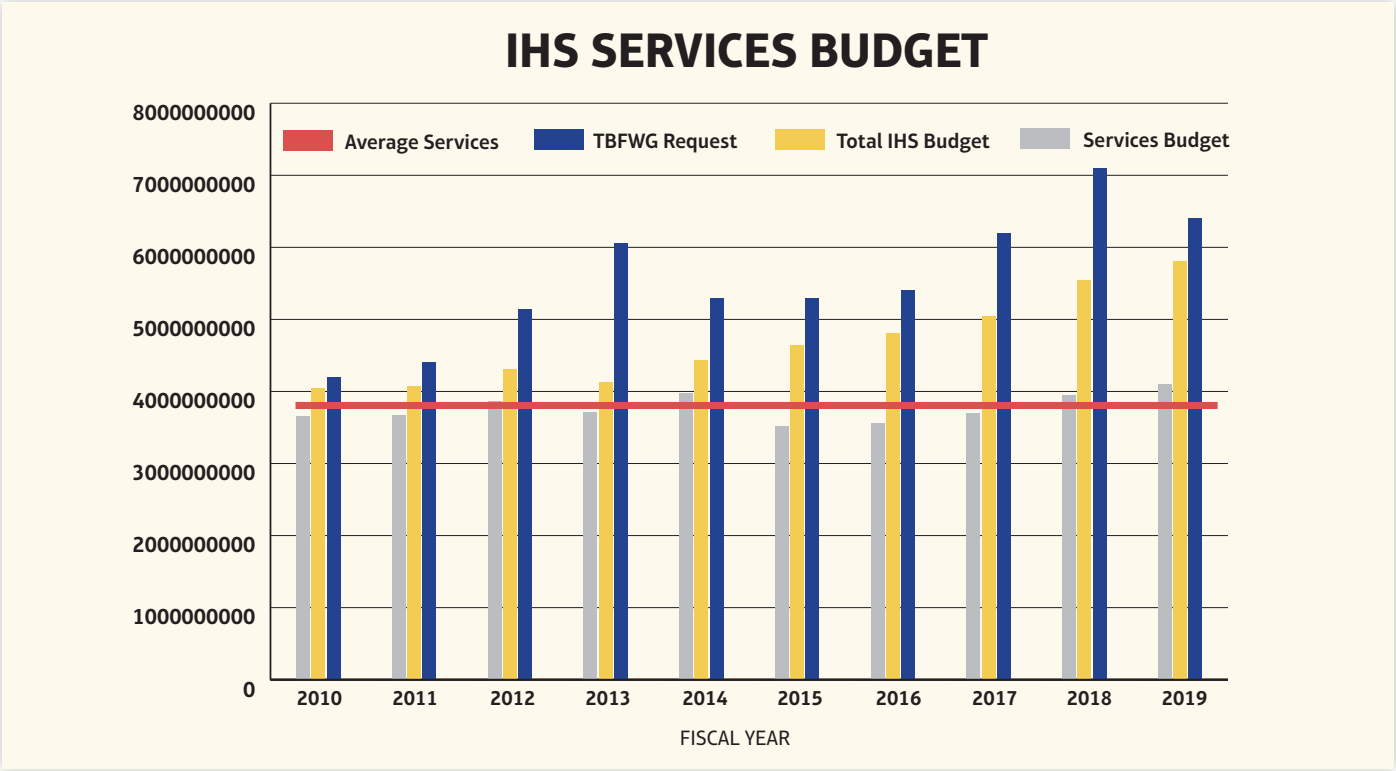
ENDING THE HEALTH CRISIS: WHY HAVEN'T PRIOR-YEAR INCREMENTAL INCREASES WORKED?

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Incremental Increases are essential to cover expenses related to population growth and the rightful full funding of binding agreements such as Contract Support Costs (CSC). However, even with an overall increase of 50% from FY 2010 to FY 2020, this falls far short of even addressing medical inflation. The roughly 2-3% annual increase to the IHS budget does not even keep pace with year-to-year increases in medical inflation, which are projected to be 4-10% in 2021, according to PricewaterhouseCoopers annual medical cost trend study. With the exception of FY 2006, in every other year, the IHS budget has not passed on time, leading to a partial or full-year Continuing Resolution (CR). Because of the

inherent budget constraints under a CR, which also don't account for medical inflation, the IHS budget is effectively decreasing over time in terms of its purchasing power and competitiveness with the mainstream healthcare system.

Leaders of our Tribal Nations insist that a true and meaningful investment be made to finally eradicate the atrocious health disparities which have overwhelmed Indian Country for years. It will take a true commitment between the United States and Tribal Nation Leadership to put a strategy and budget in place. Tribes have put their best strategy and budget together in this FY 2023 Budget Request; it is time for these United States to put forward their best strategy and budget to fulfill Trust responsibilities. Decisive action by this Administration must occur to prioritize department resources to bring the health of AI/AN citizens closer to parity with the rest of the citizens of the United States. We must rise above just settling for maintenance funding to sustain what has proven to be an unacceptable level of health care in Tribal reservations and villages.

The chart below services depicts how funding for services has remained flat over time even as the overall IHS budget has seen increases in actual dollars to address other obligations.



ENDING THE HEALTH CRISIS WILL TAKE A MAJOR INVESTMENT

This year, the Workgroup recommends a 291% increase over the FY 2022 Workgroup recommendations, for IHS Current Services, Binding Agreements and Program Increases which will raise the bar to address crisis level quality and safety issues inherent in I/T/U health facilities. We cannot begin to address substandard health outcomes in Tribal communities by only providing maintenance-level funding for current services. The major administrative challenges which plague the IHS, will not be resolved until we face the fact that we cannot continue to financially starve the core system. To only fund services at maintenance levels while demanding different results is disingenuous.

Significant consideration must also be placed on the known social determinants of health which impact the ability to impact results. Economic conditions play a huge

factor when looking to address health concerns, especially in under-developed, high-cost rural communities. In 2016, 26.2% of AI/ANs were estimated to be living in poverty, compared to the national average of 14.0%. Just under one-fifth of AI/ANs lacked health coverage in the same year, while nationally, only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is difficult to obtain due to the undercounting of AI/ANs in the U.S. Census, rates of overcrowded housing clearly indicate a significant shortage of available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally. On some reservations, unemployment is as high as 80 or 90%. The inability to provide for one's family often leads to a sense of loss of identity, despair, depression, anxiety, and ultimately substance abuse or other social ills such as domestic violence. When the IHS is underfunded, it affects the ability to recruit, retain and train staff, and facilities deteriorate, resulting in safety being compromised. This leads to a vicious cycle of forced closure by CMS of services or facilities, further exacerbating the economic opportunities for Tribal Nations.

These facts, combined with down-spiraling health disparities experienced by AI/ANs, demonstrate the human consequences of underfunding IHS. Deferral of care due to funding and workforce shortages has pushed more and more Tribal members into health conditions wherein prescription opioids are used to treat chronic pain that would otherwise successfully be treated earlier with non-opioid therapies, if they were available. Failure to address basic health needs through routine visits and preventative care also has led to preventable diseases becoming fatal when the diagnoses are too late to seek treatment. The underfunding of IHS is not just a fiscal challenge — time and time again, it means the difference between life, disability, or even death for many AI/ANs.

HONORING THE TRIBAL PROCESS AND PARTICIPATION REQUESTS

On February 18, 2021, the Congressional Research Service (CRS) released a brief report titled "Tribal Consultation: Administration Guidance and Policy Consideration published On January 26, 2021, President Biden issued a Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships (2021 P.M.). The 2021 P.M. requires agencies to create "detailed plan of actions" to implement Executive Order 13175 (E.O. 13175), issued November 6, 2000, which mandates federal agencies to consult with tribes when developing federal policies with "tribal implications." The 2021 P.M. reaffirms the policy announced in the Presidential Memorandum of November 5, 2009 (2009 P.M.) requiring agencies to "prepare and periodically update…detailed plan of actions" to implement E.O. 13175. According to the 2021 P.M., the Biden Administration's priorities include the following: respecting tribal sovereignty and self-governance, fulfilling federal trust and treaty obligations, and engaging in "regular, meaningful, and robust" consultation with tribes.

The 2021 P.M. cites two prior presidential actions on tribal consultation: E.O. 13175 and the 2009 P.M. E.O. 13175 mandates tribal consultation when federal agency policies involve regulations, proposed legislation, or other policy actions that have a "substantial direct effect" on tribes. Among other things, E.O. 13175 requires agencies to develop a process ensuring "meaningful and timely input" by tribes under these circumstances.

Notably, in 2019, the Government Accountability Office (GAO) issued a report identifying factors hindering effective tribal consultation in federal infrastructure projects. Some factors identified by Tribes included timing of consultation, such as consulting late into project

development stages; insufficient Tribal resources to participate in consultation, such as staffing resources to respond to consultation requests; and inadequate agency training on consultation requirements. Some factors identified by agencies included difficulties in initiating consultation, such as identifying the relevant tribes to consult; limited Tribal response and participation in consultation; and insufficient agency resources to conduct consultation, such as limited funding and staff to support consultation.

> *"I've often said that our greatest strength is the power of our example — not just the example of our power."*
>
> — President Joseph R. Biden, Jr.

ADDITIONAL WAYS TO FULFILL TREATY AND TRUST RESPONSIBILITIES

The 35-day government shutdown at the end of 2018 and the start of 2019, destabilized Native health delivery and health care provider access; as well as Tribal Governments, families, children and individuals. Many programs were forced to ration care, forced providers to go without pay and some facilities closed their doors altogether. With the further likelihood of shutdowns and delayed federal appropriations, we firmly believe that advanced appropriations for IHS will allow for greater planning, more efficient spending, and higher quality care and government services for AI/ANs. Advance appropriations would help honor the federal trust responsibility and help ensure that the federal government meets its obligations to the Tribes in the event that Congress cannot enact the federal appropriations by the start of the fiscal year.

Within his first one hundred days in office, President Biden has proposed bold and meaningful proposals through the American Jobs and Amerian Families Plans. In his first joint address to Congress, the President outlined his goals for improving the health and livelihood of every American, including proposing changes to the Affordable Care Act, the legislation that permanently authorized the IHCIA such as lowering drug prices and expanding Medicaid and Medicare coverage benefits. We commend his commitment to improving and expanding health care coverage to the most vulnerable, but we must remind him and his administration that all these initiative must specifically include fulfilling Treaty and Trust obligation to AI/ANs.

Advance appropriations also helps promote government efficiency. In September 2018, GAO-18-652 found that IHS and Tribes are given significant administrative burdens due to the fact that the IHS has to modify hundreds of contracts each time there is a CR. In addition, the GAO found that "uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs." Advance appropriations would create parity between IHS and other federal health providers and create better program stability. We urge the Administration to fully support IHS advance appropriations in the FY 2023 budget request as that will significantly aid advocacy efforts in Congress.

It is also important to ensure that the government meets its Trust obligations through the Medicaid program as authorized through the IHCIA. The ability to access Medicaid reimbursements helps our severely underfunded health systems receive third-party revenue meant to backfill a portion of the federal government's trust responsibility. The trust responsibility creates an enhanced duty for the federal government to provide funding to the Indian health system, and the Provider Relief Fund is an opportunity to deliver on that promise.

1st Recommendation

Fully Fund IHS at $49.8 Billion

Every year, the IHS budget increases by roughly 2-3%, with the majority of increased funding going towards binding obligations, current services, and the statutory and legal requirements for full funding of Contract Support Costs (CSC) 105(l) leases. In recent years, and since court decisions mandated continued payment irrespective of funding availability, and as more and more Tribal Nations elect to enter into such agreements, costs for 105(l) lease agreements continue to increase. In fact, roughly 51% of the increase to the annual discretionary IHS budget from FY 2020 to FY 2021 went to 105(l) lease agreements alone. It is essential that Congress continue funding 105(l) leases and CSCs, as these are staturoy and legal obligations due to sovereign Tribal governments. Requiring these payments to be made out of discretionary accounts may displace meaningful increases that could be provided to medical services, facilities, sanitation, and other needs.

Since 2003, sovereign Tribal leaders have been working collaboratively to develop national Tribal priorities for healthcare to arrive at a fully-funded IHS budget. Every year since, Tribal leaders, health policy experts, and advocates convene to revise the estimates to adjust for medical and non-medical inflation, but also to comply with new costly federal mandates, full funding of all provisions in the Indian Health Care Improvement Act (IHCIA), modernization of the IHS electronic health record (EHR) system, and other emergent needs. In 2018, the Workgroup first recommended transitioning to a new methodology for calculating a full needs-based IHS budget. Starting with the FY 2021 recommendations, the Workgroup replaced the Federal Employee Health Plans (FEHP) per user cost benchmark with a benchmark based on national health expenditures (NHE). The NHE classification presents a more accurate and complete picture of need, and allows for better comparison among categories over time.

Every year, per capita funding gaps between IHS and national health expenditures continue to grow, and the annual increases to the IHS budget fail to adequately account for facilities upgrades, including newly authorized facilities under IHCIA. Existing space in IHS facilities is only at 52% of need based on the size of the IHS population. While the average age of hospitals nationwide is 10 years, it is nearly four times older in Indian Country, at 37.5 years. In FY 2022, the Workgroup estimated that full funding for IHS would need to equal $48 billion. However, upon more critical assessment, the Workgroup has revised and increased this estimate to $49.8 billion. The new figure for full funding more comprehensively accounts for current facilities services, sanitation facilities construction, and new facilities authorized under IHCIA.

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

Congress will never achieve full funding of IHS through the discretionary appropriations process given the restrictive spending caps of the Interior, Environment and

Related Agencies Appropriations account. The Interior account has one of the smallest spending caps at only $36 billion in FY 2020, making it extremely difficult to achieve meaningful increases to the IHS budget. While the IHS budget increased by roughly 50% between FY 2010 and FY 2020, those increases largely only kept pace with population growth, staffing funding for new or existing facilities, and rightful full funding of contractual obligations such as Contract Support Costs (CSC) and 105(l) lease agreements. The slight year-to-year increases have not even kept full pace with annual medical and non-medical inflationary increases, translating into stagnant healthcare services, dilapidated healthcare facilities, antiquated equipment, severe deficiencies in water and sanitation infrastructure, and significant work-force shortages

Furthermore, Department of Health and Human Services (HHS) is working with IHS to evaluate the poorly resourced Health IT infrastructure. The IHS Resource and Patient Management System (RPMS) is used to manage clinical, financial and administrative information in all IHS, and some Tribal and Urban healthcare facilities. Tribes are closely monitoring a forthcoming HHS/IHS report on IHS health IT infrastructure to ensure that funding estimates align with Tribal priorities for a modern and interoperable health IT system.

The failure to produce necessary funding each year have caused per capita health funding gaps to grow, and the health disparities between AI/ANs and other populations to widen. The cost and amount of time required to close theses funding and health disparity gaps has predictably also grown. The full-funding estimate is updated every year, using the most current available population and per capita health care cost information. The full funding estimate has been updated every year, using the most current available population and per capita health care cost information. The IHS need-based funding aggregate cost estimate for FY 2023 is now approximately **$49.8 billion**, based on the FY 2018 estimate of 3.04 million eligible AI/ANs eligible to be served by IHS, Tribal and Urban health programs.

FY 2022 AI/AN NEEDS BASED FUNDING PROPOSED TOTAL FUNDING ESTIMATE

GROSS COST ESTIMATES

Source of Funding is not estimated

	Need Based on FY 2018 Existing Users at I/T Sites	Need based on FY 2018 Expanded for Eligible AIAN at I/T/U Sites*
	1,725,999	3,040,558

CURRENT SERVICES	$ Per Capita	Billions	Billions
Medical Services	$9,726	$16.79	$29.57
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; Services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits.	Based on 2018 FDI benchmark; which is based on the National Health Expenditure (NHE) model.	$ Per Capita FY 2018* Existing Users	$ Per Capita FY 2018* All Eligible AI/AN Served at ITU sites
Current Facilities Services		$10.28	$10.28
Existing space in IHS facilities (14 million ft2) is substantially less than required (~27 million ft2) needed. The shortage is a consequence of AI/AN demographic trends, especially: population growth; modern facility codes/standards; and obsolete older space. IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of $10.3 billion to upgrade and modernize. 25 U.S.C. 1631 et seq., requires the HHS Secretary to submit to Congress a report every five years that describes the IHS health care facilities needs (including inpatient health care facilities; outpatient health care facilities; specialized health care facilities such as for long-term care, alcohol and drug abuse treatment, wellness centers, and staff quarters; and the renovation and expansion needs).			
Health Information Technology Improvements		$0.00	$0.00
Department of Health and Human Services (HHS) is working with Indian Health Service (IHS) to evaluate the Resource and Patient Management System (RPMS). RPMS is used to manage clinical, financial and administrative information in all IHS, and some Tribal and Urban healthcare facilities. Tribes are closely monitoring a forthcoming HHS/IHS report on IHS health IT infrastructure to ensure that funding estimates align with Tribal priorities for a modern and interoperable health IT system.			
IHCIA Scholarship/Workforce Development		$1.00 (initial)	$1.00 (initial)
The IHCIA authorizes the IHS scholarship, loan repayment, and health professions training programs to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). IHS, Tribal and urban Indian facilities experience chronic and pervasive health provider shortages that contribute to lower quality and less accessible care for AI/ANs. As Tribes work to calculate an estimate of full-funding for health workforce in Indian Country, an initial placeholder estimate of $1 billion is included.			
Total Annualized Services	$9,726	$28.07	$40.85

FACILITIES	Billions	Billions
New IHCIA Authorized Facilities	$4.26	$4.26
The IHS has begun assessing facility needs to provide newly authorized service types in the IHCIA. These service categories have not been historically provided through the IHS health care network. These specific service types require corresponding unique facility types. The IHS's facility planning and design methodology does not include criteria for such services yet; however, developing and adopting planning criteria are currently underway.		
Sanitation Facilities Construction	$2.90	$2.90
The SFC Program provides American Indian and Alaska Native homes and communities with essential water supply, sewage disposal, and solid waste disposal facilities. IHS environmental engineers plan, design, and manage most SFC projects; many of those engineers are assigned to one of the twelve IHS Area Offices. The SFC program is an integral part of the IHS disease prevention effort that impact 405,000 AI/AN homes.		
TOTAL		
Total Annualized Services + One-time Upfront Facilities Upgrades	$35.23	$48.01

Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the number of AIAN eligible — which varies place-to-place and time-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

*Crudely Estimated — AI/ANs residing in service areas, including urban areas, discounted for AIANs already partially served by I/T sites.

Current Services & Binding Agreements

Tribal leaders are adamant that the FY 2023 budget request, as a starting point, provides an increase of $500.183 million over the FY 2022 Workgroup recommendation to cover Current Services and all other binding obligated requirements. Tribes have long insisted that the annual request must transparently disclose all known expected cost obligations in order to demonstrate the true funding base required to sustain current services and meet obligated fiscal requirements. Deliberately understating the amount necessary to meet the entire fiscal obligation for binding agreements beyond current services creates a false expectation that a slight funding increase is available to expand needed program services. In fact, in past years, a 2-3% funding increase has not even been sufficient to maintain the status quo, effectively resulting in an actual decrease from the prior year. These real cost obligations include actual federal & Tribal pay costs, true medical and non-medical inflation, population growth, planned increases in staffing for new and replacement facilities, contract support costs, healthcare facilities construction priorities, Section 105(l) lease costs, and all expected off-the-top mandatory assessments. The workgroup strongly recommends that full funding for current services and other "binding" fiscal requirements at the true projected costs of $26.8 billion be requested as reflected in this section.

CURRENT SERVICES (FIXED COSTS) +$197 MILLION

The Workgroup recommends an increase of $197 million over the FY 2022 Workgroup Recommendation for direct and Tribally provided health care services to cover increased costs associated with population growth, pay cost increases for workers, medical and non-medical inflation, and ensure continued levels of health care services.

Tribal and federal facilities cannot continue to offer salaries below the competitive market. Current IHS pay rates are so far below what other providers offer, (including the VA that physician vacancy rates at IHS continue to linger at 34%; dentist vacancy rates are at 26% and physician assistant vacancy rates are at 30%. No health system can run a quality program lacking one-third of the necessary staff. Further, the Workgroup feels strongly that commissioned officers, civil service, and Tribal employees should be exempt from any federal pay freeze that may be imposed in FY 2023. IHS cannot allow pay scales for our health professionals to be so substandard that they are forced to look elsewhere to seek a fair wage.

The Current Services request also includes $5.99 million for Non-Medical Inflation and $18.2 million for Medical Inflation. This is the minimum amount necessary to inflation-proof services as the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), the index for all items less food and energy increased 2.1% over the past 12 months. The medical inflation in 2020 is predicted to be 6.5%. The Workgroup asserts that the rates of inflation be applied to Hospitals and Clinics, Dental Health, Mental Health, and purchased/referred care (PRC) in developing the IHS budget should correspond to the appropriate components in the CPI to reflect the true level of funding needed to maintain current services.

While the budget has received upward adjustments since 2008, these increases have done little to address the huge disparities in funding for Tribal health care compared to similar expenditures for the rest of the U. S. population. With the total funding need now estimated at $49.3 billion, the Indian Health system remains severely underfunded at $6.04 billion. When compounded with rising medical inflation and population growth, Indian Health budgets are, in real dollars, trending backwards.

BINDING AGREEMENTS (FIXED COSTS) +$303.125 MILLION

The Workgroup recommends a program increase of $303.125 million over the FY 2022 Workgroup Recommendation, including an additional $75 million for staffing costs for new facilities, $100 million for Contract Support Costs, $100 million for binding obligations related to the Health Care Facilities Construction (HCFC) Priorities List, and $28.13 million for 105(l) leases.

STAFFING COSTS +$75M*

The Workgroup recommends an increase of $75 million in FY 2023 to pay for staffing for new facilities. This amount is an estimate and must be adjusted to match the requirements for current facility staffing obligations.

Contract Support Costs + $100M*

The Workgroup recommends an increase of $100 million in FY 2023 to pay for statutory and legally obligated Contract Support Cost (CSC) funding for current, new, and expanded programs. This is in addition to the $197.1 million required to fund current service estimates that include federal and tribal pay costs, inflation, and population growth. The Workgroup recognizes that this amount is subject to change based on the actual CSC obligations and reconciliation requirements of the IHS-CSC Manual. Approximately 60% of the IHS budget is operated by Tribes under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). The Act allows Tribes to assume the administration of programs, services, functions, and activities previously carried out by the federal government. The IHS transfers operational costs for administering health programs to Tribes through the "Secretarial amount," which is the amount IHS would otherwise have spent to administer the health programs. In addition, Tribes are authorized to receive an amount for CSCs that meet the statutory definition and criteria. The additional $197.1 million for FY 2023 is required to fund administrative costs associated with ISDEAA contracts and compacts entered into with the federal government. The ISDEAA, in addition to past court decisions, requires that 100% of these costs be paid and are a statutory and legal requirement for the IHS to comply.

Additionally, the Workgroup recommends that the HHS Secretary, IHS Director, and OMB work with Congress to create a mandatory appropriation account for the statutory and legal obligation to pay Contract Support Costs (CSC) and 105(l) lease agreements. While there is an indefinite discretionary account to fund CSC and now 105(l) leases, the manner in which this funding for a legal/statutory obligation continues to compete with the discretionary allocation caps within Congressional Appropriation Committees. This diverts potential funding that could be directed to other program increases in the IHS accounts. Moving CSC and 105(l) funding to a mandatory account would alleviate this problem.

Health Care Facilities Construction +$100M

Currently, IHS uses its HCFC appropriations to fund projects off the "grandfathered" HCFC priority list until it is fully funded. As noted in the section of this report titled, "Binding Obligations," in 1989, Congress directed IHS to develop the current HCFC priority system. Originally there were 27 projects on the priority list. There are 12 remaining projects on the list which are currently estimated to cost $2 billion. Once those projects are funded, IHS is required to implement a new priority system which is outlined in the Indian Health Care Improvement Act of 2010.

It requires each IHS Area to generate an updated priority list every three years for a combined submission of top Area priorities to the U.S. Congress. Priority lists may now include, in addition to inpatient and outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and other health related renovation and expansion projects. Not later than one year after the establishment of the new priority system, criteria for ranking or prioritizing facilities other than hospitals or clinics will be submitted to Congress for consideration. The law also allows the development of innovative approaches to address the unmet need for health facility construction and authorizes that a portion of construction funding may be used as an Area Distribution Fund to each IHS Area. It is envisioned by the National Budget Formulation Workgroup that the recommended program increase may support other projects, such as Small Ambulatory Health Clinics and Health Stations, the Joint Venture Construction Program and innovative approaches that are developed in consultation with Tribes and in accordance with the policy to confer with urban Indian organizations.

Many of the existing facilities are obsolete with an average age of 47 years and have long surpassed their useful lives. These facilities are grossly undersized for the identified user populations, which has created crowded conditions for staff, patients, and visitors. In many cases, existing services have been relocated outside the main health facility; often times to modular units, in order to provide additional space for primary health care services. These conditions create difficulties for staff and patients, increases wait times, and inefficiencies within the health care system become problematic. As the existing health care facilities age, associated building equipment and components are also deteriorating to a point of failure and the decreasing availability of replacement parts on aged equipment disrupt health care service delivery. For example, water supply systems which provide potable water to older health facilities frequently experience failures, requiring the systems to be shut down for extended

periods of time. This often results in patient care to be discontinued until appropriate repairs can be made.

The rural and often isolated conditions associated with many health facilities complicate and extend the time required to make needed repairs. Constant system failures deplete maintenance and improvement funds and sometimes require the use of third party collections or other funding sources that would otherwise be used for direct patient care. In terms of medical and laboratory equipment, the IHS makes every attempt to keep pace with changing and updated technologies; however, due to limited equipment funds, IHS health facilities will typically use equipment well beyond their expected useful life. The construction of new health care facilities alleviates many of the problems associated with the failing infrastructure.

Section 105(l) Leases +$28.3M*

The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324(l) authorizes IHS to enter into a lease for a facility upon the request of a Tribal Nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have grown exponentially in the past 4 years, with many Tribal Nations increasingly turning to 105(l) leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

As held by the U.S. District Court for the District of Columbia under *Maniilaq Association v. Burwell* in 2016, Section 105(l) leases must be paid in full by IHS. However, in response to growing lease proposals and after failing to adequately project costs in both FY 2018 and FY 2019, IHS chose to disregard Tribal recommendations, obtained through government-to-government consultation, by unilaterally reprogramming critical funding twice from other line items to fund these obligations. This included $25 million in FY 2018 from inflationary increases, as well as $72 million in FY 2019 from inflationary increases and staffing packages due to delays in construction. For FY 2020, Congress provided $125 million for 105(l) lease funding, an $89 million increase from the FY 2019 enacted level. While this increase helped to prevent another large reprogram within the IHS budget, it impacted overall funding for IHS by consuming approximately 50% of the agency's total appropriations increase in FY 2020.

For FY 2021, IHS supported a separate, indefinite appropriation for 105(l) leases, in accordance with long-standing recommendations from Tribal Nations. While Tribal Nations are pleased that Congress honored our guidance and provided a separate, indefinite appropriation for this binding obligation, this is only a short-term solution to address the impacts of rising 105(l) costs. Although this mechanism insulates other IHS budget lines from future reprogramming, IHS's estimate of total funding for 105(l) obligations is funded as a part of its total allocation from Congress.

With every likelihood that this obligation, and therefore, IHS's estimate, will grow, Tribal Nations are concerned that 105(l) costs could have a detrimental impact on overall increases for IHS, including funds for patient care. It is with this in mind that the Workgroup continues to urge funding for 105(l) leasing be moved to the mandatory side of the federal budget. We urge IHS to support this move as a way to ensure that its other lines are truly insulated from its binding obligations.

In addition, we note that, in the FY 2021 Budget Request, IHS proposed statutory limitations to 105(l) leases in the absence of Tribal consultation. Rather than making unilateral proposals that undermine IHS's obligation to seek the guidance of Tribal Nations, the Workgroup asks that IHS convene a joint Tribal-federal workgroup to assist with policy development around 105(l) lease negotiations and calculations. The Workgroup further expects that any 105(l) leasing policy be developed in consultation with Tribal Nations.

**these placeholders are estimates only and are subject to adjustment based on actual requirements*

Program Expansion Increases — Services Budget

The National Tribal Budget Formulation Workgroup recommends the FY 2023 program increases outlined in this section that represent a critically needed infusion of resources, totaling $36.57 billion above the FY 2022 Workgroup Recommendation. These national priorities identified and agreed to by Tribal leaders is the result of a year-long Tribal consultation process that includes discussion by individual Tribes and urban Indian health programs, meetings held by each IHS Area Office, and a final national session in which Tribal Leaders representing each region of the country came together to develop the national priorities for the Indian health care system. These recommendations build upon prior progress that has been gained through efforts by IHS, Tribes and Urban Indian programs to improve the delivery and quality of health care and reduce the high level of health care disparities that are magnified among the AI/AN population.

HOSPITAL & CLINICS: +$8.56 BILLION

For FY 2023, the Workgroup recommends an increase of $8.563 billion above the FY 2022 recommendation. for the Hospitals and Clinics (H&C) line item. Sufficient funding for H&C remains the top priority for FY 2023, as it provides the base funding for 605 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the core funding that provides direct medical care services to American Indian and Alaska Natives (AI/AN). Increasing H&C funding is critical as it supports medical care services provided at IHS and Tribally-operated facilities, including emergency care, inpatient and outpatient care, and specialized care, including for diabetes prevention, maternal and child health, youth services, communicable and infectious disease treatment, and women's and men's health. H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs.

The demands on direct care services are continuous challenges in our facilities. We experience constant and increased demand for services due to population growth and the increased rates of chronic diseases that result in growing patient workloads. In addition, rarely do the 2-3% increases to the annual appropriated IHS budget adequately account for rising medical inflation year to year. This effectively means that, over time, IHS and Tribal health systems are losing funding over time. Medical inflation particularly impacts the H&C line item as IHS, and Tribal sites fail to keep up with rising medical costs. Underfunding of H&C translates to rationed care that is less accessible and of lower quality, further limiting efforts towards making meaningful improvements to AI/AN health disparities.

Adding chronic challenges in recruiting and retaining providers in rural health care settings and the lack of adequate facilities and equipment, H&C resources are stretched. Any underfunding equates to limited health care access, especially for patients that are not eligible for, or who do not meet the medical criteria for, referrals through Purchased/Referred Care (PRC) to the private sector that shall be discussed in another section of this report. For many in Indian Country, there are no alternatives other than the direct care provided at an IHS or Tribal facility. For these reasons and the numerous access to care issues that Tribal members experience, an increase of $569 million is not exorbitant, but realistic in terms of fulfilling unmet needs across Indian country.

Tribes are committed to working with IHS and HHS to make meaningful impacts in terms of improved health outcomes. AI/AN communities experience significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury and substance abuse than other populations. Preventative and primary care programs reduce costly medical expenditures for specialty care and treatment.

A critical component to achieve the full potential of hospitals and clinics is fully funding the Indian Health Care Improvement Act. The provisions in this law represent a promise made by the federal government to significantly improve the health of our people, yet this law remains unfunded. For Tribes, this is a huge disappointment. We renew our request to the federal government to keep its promise by funding IHCIA authorities. Tribes also request that funding these new authorities should be in addition to the base level H&C funding.

COMMUNITY HEALTH AIDE PROGRAM (CHAP) EXPANSION

The Community Health Aide Program (CHAP) was established in Alaska more than 50 years ago. Community Health Aides are the only medical providers in smaller rural communities in Alaska and receive their training at certified CHAP training Centers in Alaska. Community Health Aides are trained to systematically assess all patients for their presenting conditions, using the Community Health Aide Manual (CHAM) and are able to treat certain conditions under standing orders from a referral physician, and / or after consultation with an assigned provider.

In Alaska, the Tribal health organizations receive limited resources from IHS for CHAP and many Tribal health organizations are using non-IHS resources to staff and outfit their training centers, pay for their staff to be trained, and to update the CHAM. Further, a CHAP's medical scope of practice is clearly defined and is very different from the role of Community Health Representative (CHR). A Community Health Aide and a CHR are not interchangeable.

The Indian Health Care Improvement Act (IHCIA) at Section 111 provides the authorization to establish a CHAP throughout the Lower 48. Tribes in Alaska and across other the Areas have made it clear that standing up a Community Health Aide Program will require additional financial resources. Tribes have also instructed that CHAP nationalization should occur without negative impacts to the already insufficient resources awarded to Alaska. For the first time, the FY 2020 budget included $5 million for nationalization of CHAP. In the proposed 2021 President's budget the CHAP, CHR, and Health Education line-items were combined into one 'Community Health' line-item and the total proposed amount was reduced by 50%. Not only is consolidation of the line-items detrimental to the CHR program, but it does not provide any meaningful funding towards the expansion of the Community Health Aide Program throughout the Lower 48.

The CHAP – Tribal Advisory Group (CHAP-TAG) was established by IHS as an unfunded mandate and was tasked to determine how to establish a Community Health Aide Program in other regions, outside of Alaska. Under IHS guidance, the focus of the CHAP-TAG has been on creating a policy to establish a National Federal Certification Board. The draft policy was sent to IHS and was formatted as chapter of the Indian Health Manual and was published as Circular 20-06. HHS office of Minority Health has awarded a contract to James Bell Associates to identify factors that promote or restrict implementation of National CHAP and to develop, test and implement a toolkit by Sept. 2022, to support tribal communities in assessing their readiness for CHAP implementation. IHS should task the CHAP-TAG to provide further guidance regarding the development of CHAP Training Centers and CHAP programs for areas outside of Alaska and determine the funding needs to expand CHAP throughout the Nation. IHS must take advantage of the 50 plus years of experience with CHAP in Alaska.

PURCHASED/REFERRED CARE +$5.224 BILLION

For FY 2023, the Workgroup recommends an increase of $5.224 Billion above the FY 2022 Workgroup recommendation for the Purchased/Referred Care (PRC) line item. IHS and Tribally-operated facilities serve primarily rural populations and provide limited primary care and community health services. With only 46 hospitals throughout the Indian Health Care Delivery System, PRC is vital to ensuring adequate care is provided to American Indian and Alaska Natives and continues to remain a top funding priority.

PRC was established to allow for IHS and Tribally-operated facilities to secure essential health care services from private sector providers when such services, especially emergent and specialty care services, are not available within our systems. Much of the secondary care, and nearly all of the tertiary care needed, must be purchased from non-IHS facilities. PRC funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition and pharmacy services.

Inadequate funding for the Indian Healthcare Delivery System and PRC forces IHS and Tribal Nations to ration

health care based on an antiquated ranked medical priority system because the federal government has not met its trust and treaty obligations. Often PRC funding does not extend beyond Priority I or Priority 2 status, which creates significant challenges in the health status of individual AI/ANs and communities.

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

Investments in PRC would be used to improve both access to care and the quality of care. Increasing access to outside health care services and working with off-site providers to improve the quality of care provided under PRC will help to reduce health disparities within our Nation's first people.

HEALTHCARE FACILITIES CONSTRUCTION & OTHER AUTHORITIES +$3.587 BILLION

The Indian Health Service system is comprised of 46 hospitals (24 IHS operated, 22 Tribal) and 556 health centers, health stations, village clinics, and school health centers (85 IHS operated, 471 Tribal). At these facilities there were an estimated 40,494 inpatient admissions and 13.752 million outpatient visits in 2018.[6]

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations	School Health Centers
IHS	24	50	N/A	24	11
Tribal	22	285	127	54	5

On average, IHS hospitals are 40 years of age, which is almost four times more than other U.S. hospitals with an average age of 10.6 years.[7] A 40-years-old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized — about 52% — for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; often times to modular office units, to provide additional space for primary health care services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the health care system. Furthermore, these aging facilities are largely based on simplistic, and outdated design which makes it difficult for the agency to deliver modern services.[8] Improving healthcare facilities is essential for:

- Eliminating health disparities;
- Increasing Access;
- Improving patient outcomes;
- Reducing operating and maintenance costs;
- Improving staff satisfaction, morale, recruitment and retention;
- Reducing medical errors and facility-acquired infection rates;
- Improving staff and operational efficiency; and
- Increasing patient and staff safety.

At current rates of funding, if a new facility was built today, it would not be replaced for 400 years! The absence of adequate facilities frequently results in either treatment not being sought; or sought later, prompted by worsening symptoms; and/or referral of patients to outside communities. This significantly increases the cost of patient care and causes travel hardships for many

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

6 Source: Indian Health Service. Fiscal Year 2021 Congressional Justification. See page CJ-279.

7 *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179): https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/

8 *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. Indian Health Service. July 6, 2016. Accessed at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf on November 7, 2016. p. 12

patients and their families. The amount of aging facilities escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. AI/AN populations have substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited that outdated facilities directly threaten a patient's care.

For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance" with the Medicare Hospital Conditions of Participation (CoPs).[9] "Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in backlogs totaling approximately $166 million."[10] In fact, over one third of all IHS hospitals deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.[11]

For many AI/AN communities, these failing facilities are the only option that patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere. As several Tribal leaders have testified, all our patients want is to feel comfortable and safe within the environment in which care is being provided; this is difficult to do when facilities are in disrepair, overcrowded, and medical equipment has outlived its useful life.

This section addresses the HCFC Priority List, Unmet Facilities Construction Needs in all IHS Areas, plus Urban Facility Needs. A major increase is needed to fund projects nationwide that are already identified by the IHS The FY 2023 recommendation provides funds to address the Health Care Facility Construction (HCFC) backlog reported to the U.S. Congress which includes the necessary projects and funding levels that ultimately will be necessary to fund. These include the following:

- Health Care Facilities Construction Priority List +$2.02 billion
- New IHCIA construction system/projects already identified by IHS Areas +$14.5 billion

Tribes also seek the continuation of the vital resources for the Small Ambulatory Program. In FY 2023, $20 million is requested. There is dire need to make progress on the implementation of several sections of the Indian Health Care Improvement Act (IHCIA). These authorities include:

SUBCHAPTER III — HEALTH FACILITIES
- § 1631(c) (1) (A) (B) (C) (D). Health Care Facility Priority System

SUBCHAPTER IV — HEALTH SERVICES FOR URBAN INDIANS
- § 1659 Facilities Renovation

BACKGROUND

The total funding required to complete the projects on the current Health Care Facilities Construction Priority List is at $2.02 billion, plus the funding required for the new construction system and projects already identified by IHS Areas at $14.5 billion were identified in the 2016 IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress.

The summary of the findings note that "the cost to increase IHS facilities to needed capacity is enormous, about $14.5 billion with expanded and active authority facility types"

"Our findings identify an aging infrastructure in which many facilities were constructed before the advent of contemporary health care delivery models. The aging network escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. Facility space capacity is inadequate for actual and projected AI/AN user populations. The shortage is a consequence of AI/AN demographic trends, modern facility codes/standards, and gradual obsolesce of older

9 Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI-06-14-00011.

10 *Ibid*, p. 14.

11 *Ibid*, p. 15.

space and equipment. The problem will worsen if current demographic trends continue in future years."

An updated report, the "2020 Facilities Appropriations Information Report (Package)," was completed by IHS on January 30, 2020. It updated the 5 line items within the IHS Facilities Appropriation in order to describe in more detail under its own section the potential benefits, challenges, and impact of various funding levels.

MENTAL HEALTH +$3.232 BILLION

Mental Health is a significant priority for FY 2023. Tribal leaders recommend a $3.232 Billion increase above the FY 2022 Workgroup recommendation. Funding increases would be used to implement Section 127 of the Indian Health Care Improvement Act (IHCIA) allowing for the increase of the number of mental health providers and funding training/education; Section 702 to expand behavioral health care for prevention and treatment; Section 704 to provide more comprehensive care through detox, psychiatric hospitalization and community-based education and rehabilitation programs; Section 705 to expand the use and dissemination of a Mental Health Technician Program to serve patients; as well as, Section 715 to expand Behavioral Health research grants to allow tribes to find more asset-based, innovative and effective approaches to address issues like Indian youth suicide. The additional increase would also fund the new provisions in the IHCIA (Sections. 707, 708, 710, and 712) such as: Comprehensive Behavioral Health and Treatment Programs, Fetal Alcohol Spectrum Disorders Programs, Long-Term Treatment Programs for Women and Youth. Current State Reimbursement Rates are inadequate for small programs to be self-sustaining. Additional funds would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs.

This would result in more than a 600% increase in funding for mental health services in Indian Country above the FY 2021 enacted level. This significant increase is needed to allow Tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that build upon the resiliency factors and inherent strengths already existing in Tribal communities. AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. Inadequate funding resources limit Tribes implementing cultural and asset-based approaches to address these issues. Thusly, Tribes seek additional resources to enhance current services and to fund the implementation of the above-listed provisions highlighting the following two as examples:

- *Behavioral Health Prevention and Treatment Services:* Establishes the authorities for comprehensive services and emphasizes collaboration among alcohol and substance abuse, social service and mental health programs.
- *Mental Health Technician Program:* Authorizes comprehensive training of community mental health paraprofessionals, including Behavioral Health Aides under CHAP, to provide community based mental health care that includes identification, prevention, education and referral for treatment services and the use and promotion of traditional health care practices.

The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among AI/ANs is well documented. Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, studies are suggesting that AI/ANs are not receiving the services they need to help

reduce the disparate statistics.[12] Healthcare is increasing its focus on prevention and wellness, and more must be done to address mental health, which impacts co-morbidities and outcomes related to chronic illness. Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical *and* mental health. It is important to note that the recent increases in behavioral health funding has only been allocated through limited time-sensitive competitive grants. The grant-funded nature is an inefficient funding mechanism that does not support long-term program sustainability and has created haves and have-nots in Indian Country which serves a barrier to address behavioral health crisis and interventions and does not support an integrated continuum of care. Mental Health resources must be recurring and allocated equitably across the I/T/U system via a non-grant and non-competitive distribution.

Coordinated telehealth psychiatric services for complex cases with multiple medications is crucial to patient care. Funds are needed to support infrastructure development and capacity in tele-behavioral health, workforce development and training, recruitment and staffing, integrated and trauma-informed care, long-term and after-care programs, screening, asset-based approaches, and community education programs. Mental Health program funding supports community-based clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities, as well as address adverse childhood events and historical traumas to break the cycles and conditions that contribute to perpetuating or exasperating poor mental health outcomes.

With regard to addressing mental health crises, after-hours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. The goal in the emergency setting is to stabilize patients, assess and refer to the appropriate level of care. Many communities and areas lack a sufficient number of hospital beds for patients with mental health emergencies requiring further hospitalization, which puts pressure on emergency rooms and urgent care services to provide this care beyond initial stabilization. It is the costliest method of care and, unfortunately, leads to patients not receiving the appropriate level of care and emergency rooms routinely being on divert for regular medical emergencies due to beds being occupied with mental health patients who are waiting for appropriate beds to open up.

Lack of behavioral resources is evident in the disproportionate number of suicides, acts of domestic violence, and drug and alcohol addiction in Indian Country. The Centers for Disease Control and Prevention (CDC), reported in 2018 that reviewing data from 2003-2014 approximately 70% of AI/AN decedents resided in non-metropolitan areas, including rural areas. The residential status can affect the circumstances surrounding suicide. In addition, programs that focus on individual life skills development and interpersonal social emotional learning programs to promote healthy relationships and conflict resolution might address the higher occurrence of intimate partner problems and arguments preceding AI/AN suicides. Also, the need for postvention, such as establishing survivor support groups, are key to interrupting or reducing the potential of suicide contagion.[13] An increase in funding can support increased use of tele-behavioral health services and support training of local mental health paraprofessionals which would allow a greater percentage of the AI/AN population to be screened, seen by behavioral health specialists and most importantly, treated.

Tribes have expressed Mental Health program increased funding needs specifically to be for long-term treatment, housing first, and after-care facilities/staffing to combat mental health diseases. Strengthening funding for Section 702 of the IHCIA would include support in meeting these needs. For example, displaced or homeless veterans returning home from active duty service, individuals returning home after a long period of incarceration, and/or returning home after substance use treatment will benefit from a transitional living environment that assists them while they readjust to their environment and surroundings. The TBFWG has made behavioral health services a major budget priority for many years and continues this emphasis in FY 2023 as investment in behavioral health services has shown positive return. For example, treating depression and anxiety has shown between 3.3 to 5.7:1 return on investment in reduced/avoided medical costs, improved productivity,

12 Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. American Journal of Psychiatry, 162, 1723-1732. Heilbron, C. L., & Guttman, M. A. J. (2000). Traditional healing methods with first nations women in group counseling. Canadian Journal of Counseling

13 Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides Among American Indian/ Alaska Natives - National Violent Death Reporting System, 18 States, 2003-2014. MMWR. Morbidity and mortality weekly report, 67(8), 237-242. doi:10.15585/mmwr.mm6708a1

and improved health status. This request identifies the need to improve programs' ability to reduce health-related complications, prevent the onset of unhealthy lifestyles, and educate our communities to deal with behavioral health issues.

ALCOHOL & SUBSTANCE ABUSE +$2.308 BILLION

Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities continue to be afflicted with the epidemic of alcohol and other drug abuse including, but importantly not limited to, opioid addiction. Tribal leaders agree that this topic remains a high priority for FY 2023. The Workgroup recommends a program increase of $2.308 billion above the FY 2022 Workgroup recommendation. The purpose of the Indian Health Service Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral and physical health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent.

The 2018 National Survey on Drug Use and Health (NSDUH) found that 10% of Native Americans have a substance use disorder; 4% an illicit drug use disorder and 7.1% an alcohol use disorder. Nearly 25% of Native Americans reported binge drinking in the last month. The same survey also showed that nearly 1 in 5 Native American young adults (age 18-25) have a substance use disorder, 11% with illicit drugs and 10% with alcohol.[14]

In 2015, AI/ANs had the highest drug overdose death rates (metropolitan: 22.1 and non-metropolitan: 19.8 per 100,000) and the largest percentage change increase in the number of deaths over time than any other group.[15] Concerning youth and the critical need for prevention and early intervention, reservation-based American Indian students are at high risk for substance use compared with US youths in general. According to Swain et.al. rates of alcohol and marijuana abuse among Native American Youth on reservations are 3.4 times higher than According to SAMHSA data from 2018, nearly 13% of AI/AN population need substance use treatment, but only 3.5% actually receives any treatment. Current I/T/U alcohol and substance abuse treatment approaches employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. There is also a need for funds to provide alternative treatment modes such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to the overused and abused medications along with development and support of regional treatment centers. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming. New approaches are also needed to reduce alcohol and substance abuse related health disparities in motor vehicle death rates, suicide rates, rates of new HIV diagnoses, binge drinking and tobacco use. In Alaska, for example, 1 in 3 motor vehicle and boating fatalities in 2012-2016 was alcohol related.

Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability and the challenges with the grant-funded model, several culturally responsive in-patient treatment centers have had to close their doors leaving major gaps in service availability and more specifically availability of detox beds with the rising number of opioid and/or other addictions. Methamphetamine, opioid and heroin use is high in many IHS regions, with limited treatment facilities available.

In FY 2008, Congress appropriated $14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, those funds continue to be allocated through competitive grants, despite Tribal objections. For over a decade, Tribes have noted that IHS reliance on grant programs is counter to the federal trust responsibility and undermine self-determination tenets. If an area for example is suffering more from alcohol addictions than from meth or opioids, that area cannot redesign the available programs to meet the needs of that area, due to grant restrictions. Furthermore, because grant funding is never guaranteed, vulnerable communities, with the greatest needs but least capacity, often slip through the cracks. The needed increase must be applied to IHS

14 Substance Abuse and Mental Health Services Administration (2019). 2018 National Survey on Drug Use and Mental Health

15 Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and care to our struggling Tribal members and their families.

Breaking the cycle means that we must prevent and offer early intervention with our at-risk youth and expand the scope of treatment in Youth Regional Treatment Centers. Alcohol and Substance Abuse funds are needed to hire professionals and staff intermediate adolescent services such as group homes, sober housing, youth shelters and psychiatric units. Our communities need increased adolescent care and family involvement services, primarily targeting Psychiatry Adolescent Care. The science is starting to catch up, but there is a need for a paradigm shift in thinking in order to break down the stigmas that are a barrier to addressing the disease of addiction.

One Tribal leader said it most plainly and simply, "Left untreated, alcoholism is a terminal disease." In fact, if left untreated, as indicated earlier, addiction places considerable burden on the health system in unintentional injuries, chronic liver disease, cirrhosis, and facilitates the transmission of communicable diseases such as HIV and Hepatitis C, both having catastrophic effects on our health system. Effects from historical trauma, adverse childhood events, poverty and other social determinants of health, and lack of patient resources compound this problem. AI/ANs have consistently higher rates relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues.

In addition to funding needed to support detox and rehabilitation services, Tribes have also reported a critical need for aftercare services and transitional housing. Time and again, Tribal members are re-entering the community or reservation without access to professional support services to prevent them from falling into the same crowds and behaviors that led to the past abuse. Additional funding would be directed to support groups, sober-living opportunities, job placement and other resources to encourage a clean and drug-free lifestyle.

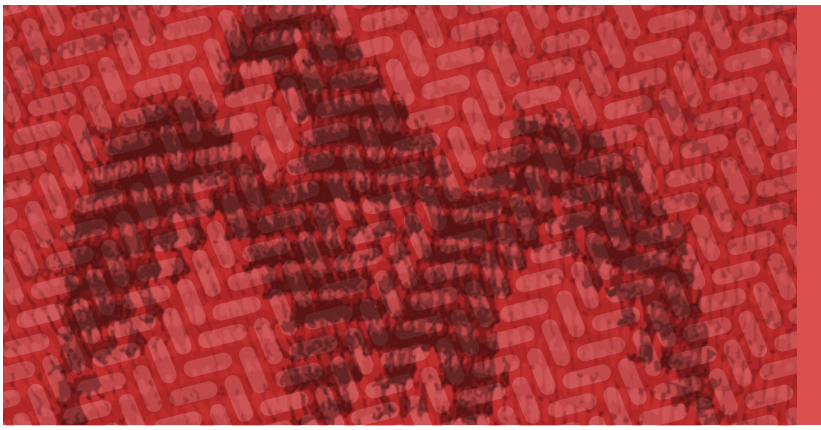
Smoking and smokeless tobacco is often the first drug with which individuals first experiment; furthermore, research has demonstrated that it increases risk to using illegal drugs. Smoking rates are significantly higher among American Indian and Alaska Natives when compared to non-AI/AN populations. Alaska Native people experienced the highest rate of death contributed to smoking during 2012-2016; the highest prevalence was among Native men age >65, who were twice as likely to die from smoking related causes as females of the same age group.

Increased funding will support the need for prevention and education on this topic and particularly targeting youth while promoting non-tobacco using adults as role models for establishing social norms in Indian communities. The need for prevention and education regarding all drugs is evident in recent verbal reports from Tribal leaders in Alaska that drug dealers had thrown little bags with crystal- meth in with the regular candy that gets distributed among children and youth at the end of potlach gatherings.

Domestic violence rates are alarming, with 39% of AI/AN women experiencing intimate partner violence - the highest rate in the U.S. The need to address issues of violence and sexual and domestic abuse against AI/AN women is critical in breaking the cycle. This is apparent in the alarming statistics among Alaska Native children regarding witness to violence and the serious implications from this exposure in relationship to children's cognitive development. The National American Indian/Alaska Native Behavioral Health Strategic Plan provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. IHS, Tribal and urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture and asset-based prevention and treatment.

INDIAN HEALTH CARE IMPROVEMENT FUND +$2.16 BILLION

In FY 2023, the workgroup recommends an increase of $2.161 billion for the Indian Health Care Improvement Fund (IHCIF). Indian health system faces significant funding disparities when compared to other Federal health care programs. Because of its limited funding, IHS currently spends only $4,078 per user nationwide compared to the average national healthcare spending of



$9,726 per user. More funding disparity exists within IHS among Areas and Tribes within each Area.

The IHCIA established the IHCIF to eliminate these deficiencies and inequities in health status and health resources of Indian Tribes. The legislation requires a report to Congress documenting the level of funding needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal organization.

Despite significant AI/AN health disparities, a rising user population, and legislative authority to fund the IHCIF to address resource deficiencies and inequities, Congress has only provided $259 million for distribution to IHS Service Units, Indian Tribes, or Tribal organizations through the IHCIF via the Level of Need (LNF) formula since adopted in 2001. Unfortunately, gains in parity are negated by rescissions and sequestration. While Tribes are appreciative of the allocation of $72.3 million, the IHCIF has not been allotted additional funding since the FY2018 allocation. Given that user population is increasing year over year and health disparities continue to grow, steady consistent funding is necessary to achieve the goals of the ICHIF.

In FY2018, a joint IHCIF Tribal/Federal Workgroup met to review and update the existing IHCIF data and develop recommendations for IHS to consider and make a final determination on the allocation methodology. The final report was due to the IHS Director in July 2019, but to date no report has been released. The NTBFWG suggests the workgroup complete the report soon and forward to the IHS Director so a final determination can be made.

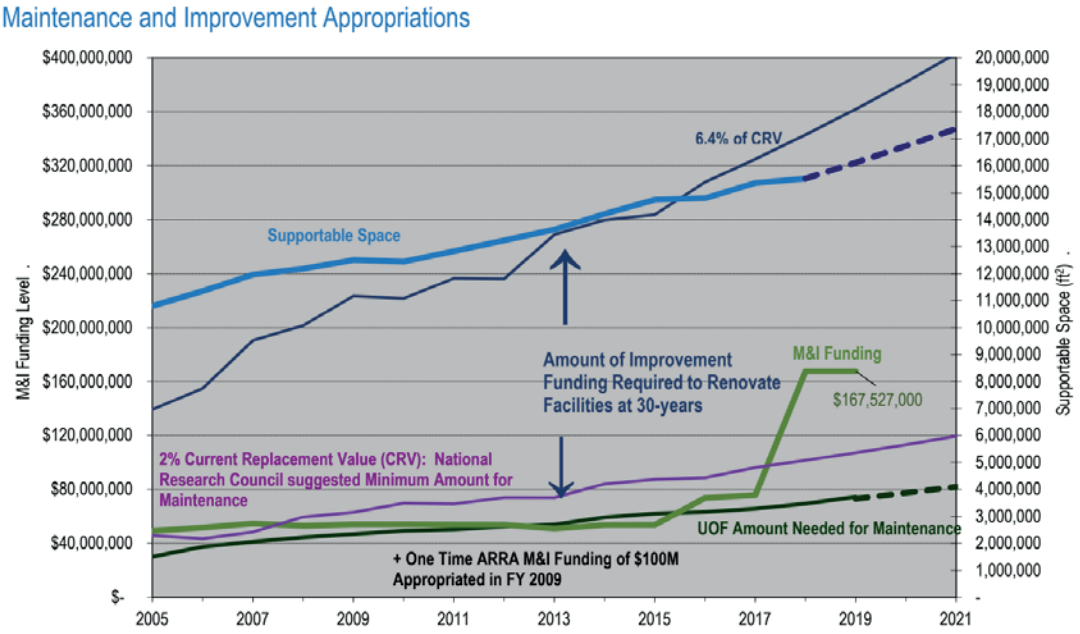
The NTBFWG specifically requests the following:

- The IHCIF Tribal/Federal Workgroup should finalize the IHCIF report;
- Through Tribal consultation, the IHS Director should adopt the recommendations on the new allocation methodology for better articulation of the IHCIF in the future; and
- The IHS should update the data in the IHCIF allocation methodology and release to all Tribes annually; and

Increases and equitable distribution of the IHCIF will ensure greater access to high quality, culturally appropriate care and services across the I/T/U system.

MAINTENANCE & IMPROVEMENT +$2.275 BILLION

The recommended program increase for Maintenance and Improvement (M&I) is $2.275 billion above the FY 2021 Workgroup Recommendation, including an additional $9.6 million to account for medical inflation and population growth. M&I funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. Investing in current facilities infrastructure is a critical need within the Indian Health Delivery system. Allowing the continued deterioration of critical health facilities goes against the mission of the Indian Health Service and Tribes to provide quality healthcare to all Tribal citizens. The Indian Health Service Facilities Appropriations Advisory Board (FAAB) provided the following data on the M&I program in the Facilities Appropriations Information Report dated March 7, 2019:



Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for facilities which house IHS funded programs, whether provided directly or through P.L. 93-638 contracts/compacts. The M&I program funding is distributed through a formula allocation methodology.

The FY-2019 Maintenance and Improvement (M&I) funding is $167.5 million which is a 121% increase from 2017. From 2007 to 2015, M&I appropriations remained flat at about $53 million annually. Consequently the annual M&I funding was less than the amount needed for Preventive, Routine and Non-routine Maintenance from 2011-2015. By 2015, M&I funding was only about 80% of the amount required to properly maintain the existing facilities. The backlog of deferred maintenance is about $650 million, which if unaddressed could cost significantly more if systems fail.[44]Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards. The table below show the activities that use M&I funding along with an estimate of need predicated upon facilities being renovated at 30-years of life and replaced at 60-years of age.

The M&I program funding is distributed through a formula allocation methodology. The FY 2019 Maintenance and Improvement (M&I) funding is $167.5 million which is a 121% increase from 2017. From 2007 to 2015, M&I appropriations remained flat at about $53 million annually. Consequently the annual M&I funding was less than the amount needed for Preventive, Routine and Non-routine Maintenance from 2011-2015. By 2015, M&I funding was only about 80% of the amount required to properly maintain the existing facilities. The backlog of deferred maintenance is about $650 million, which if unaddressed could cost significantly more if systems fail. Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

The table below show the activities that use M&I funding along with an estimate of need predicated upon facilities being renovated at 30 years of life and replaced at 60 years of age.

Maintenance and Improvement (M&I) Actual M&I Appropriation ~2.8% of "Current Replacement Value" (CRV) or ~$167 million annually M&I Funding is intended to cover:	**M&I Annual Need***
	~6.4% of CRV = UPF+1/5 BEMAR +Improvements = $355 million annually
Improvements: Renovations; Alterations; upgrades/replacement of primary mechanical, electrical, or other building systems; and site improvements. Improvements increase the facility's useful life and are capitalized in accordance with the accounting principles.	Assumes Major Renovation at 30 years or ~3.0% of CRV ~$180 million
Deferred Maintenance: Maintenance not performed as scheduled and delayed to a future period. The Backlog of Essential Maintenance Alteration and Repair (BEMAR) deficiencies deferred because of a lack of staffing or funds to implement corrective measures.	Assumes 5-year BEMAR Cycle 1/5 BEMAR of ~2.2% of CRV ~$130 million
Non-Routine Maintenance: Unscheduled emergency work to restore services or remove problems that could interrupt services. **Routine Maintenance**: Curative work to restore or repair systems that fail due to action of the elements, fire, storm or other disasters, or use near to or beyond the expected useful life. **Preventive Maintenance (PM)**: Scheduled work to preserve/restore facility (inspect, lubricate, replace components, paint, etc.).	University of Oklahoma Formula (UOF = ~1.3% of CRV ~$75 million
M&I Funding is also used for: • Maintaining compliance with accreditation standards of the Joint Commission or other accreditation bodies; • Ensuring that health care facilities meet building codes and standards; • Environmental compliance including audits, remediation, and improving energy and water efficiency; • Demolition of vacant, excess, or obsolete federally-owned buildings; and • Executive Orders and public laws, e.g., energy conservation, seismic, environmental, accessibility, and security.	

** Based on Major Facility Renovation at 30 years, a 60-year facility replacement cycle and 5-year BEMAR Cycle.*

The average age of IHS healthcare facilities is ~40 years with only limited recapitalization in the plant. The average age, including recapitalization and reinvestment, of U.S. private sector hospitals is approximately 10 years. Maintenance costs increase as facilities and systems age. Available funding levels are impacted by:

- Age and condition of equipment may necessitate more repairs and/or replacement;
- Lessened availability of service/repair parts for aging equipment and limited vendor pool in remote locations;
- Increases in supportable space. Between 2011 and 2015, supportable space increased 3.5 percent per year;
- Increased costs due to remote locations;
- Costs associated with correcting accreditation-related deficiencies;
- Increasing regulatory and/or executive order requirements; and
- Environmental conditions impacting equipment efficiency and life.

The FY 2023 Tribal M&I budget request will bring Tribes closer to addressing critical backlog, and will support maintenance and improvement objectives including routine maintenance as well as ensuring compliance with accreditation standards of The Joint Commission (TJC) or other applicable accreditation bodies. Investments that improve the patient outcomes, increase access, and reduce operating costs are proven to be cost-effective.

DENTAL SERVICES +$2.49 BILLION

The Workgroup recommends a program increase for Dental Services of $2.489 billion. One of the long-standing unresolved health issues in American Indian and Alaska Native (AI/AN) Communities is the lack of Dental Care and Dental Providers available to serve our Tribal community members. Overall, AI/ANs experience significantly more dental caries (tooth decay) and periodontal disease in all age groups. Untreated tooth decay causes pain and infections that may lead to problems with eating and speaking for all age groups, and in children growing and learning.

IHS and Tribal Dental Programs have long been challenged to meet the very high level of need for oral healthcare services. AI/AN children with dental caries do not receive the treatment they need. In 2018, 52% of AI/AN children ages 1-5 had experienced dental decay, with 33.7% having decay that remained untreated.[16] 71.4% of AI/AN children ages 3-5 had Early Childhood Caries (ECC) from 2018 to 2019.[17] This is nearly three times the

16 Kathy R. Phipps, Dr.P.H. and Timothy L. Ricks, D.M.D., M.P.H., *The Oral Health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2018-2019 IHS Oral Health Survey,* Indian Health Service Data Brief April 2019, https://www.ihs.gov/doh/documents/surveillance/2018-19%20Data%20Brief%20of%201-5%20Year-Old%20AI-AN%20Preschool%20Children.pdf.

17 *Id.*

ECC experience of white children (24.9%).[18] AI/AN adult dental patients are more likely to report poor oral health, oral pain, and food avoidance because of oral problems than the general U.S. population.[19] AI/AN dental adult patients are more than *twice as likely* to have untreated decay as the general U.S. population of the same age, with 59% of adults over age 65 having untreated decay.[20] Of the AI/AN dental patients aged 40-64 years of age, 83% had teeth pulled because of tooth decay or gum disease compared to the national average of 66%.[21]

Many communities do not have on-site services to provide dental services to treat advanced caries. The lack of services available affect both adults and children alike. Adult dental treatment typically ends in extractions. Services for children require transports to larger communities for specialty care, where many children require restorations and extractions under general anesthesia. Precise data are not available, but with about 25% of children requiring general anesthesia, this rate is at least 50 times (i.e., 5000%) higher than the US all races rate. Officials estimate that 25 percent of AI/AN children in some communities require full mouth restoration under general anesthesia, a rate 50 to 100 times that of the general population. Some experts have stated that it could be the largest health disparity in the country.

Factors such as poverty, geography, lack of oral health, education, language or cultural barriers, fear of dental care and the belief that people who are not in pain do not need dental care significantly impact these rates. AI/AN experience extreme disparities in oral health. AI/AN preschool children have the highest rate of tooth decay than any population group in the country. For example, on the Pine Ridge Reservation the W.K. Kellogg Foundation found 40 percent of children and 60 percent of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. One potential reason is that the dental hygienist-to-population ratio within the Indian Health Service is 1:9,300 while the general population is at 1:2,000. Additionally, the IHS is unable to fill all vacant positions for dentists with vacancy rates ranging between 10%-32%.[22]

The COVID-19 pandemic will have lasting impacts on dental services in FY 2023. Many Tribal Dental Programs stopped or reduced dental services to limit face-to-face exposure. This disruption to services not only impacts dental care for AI/AN people, but considerably reduces third party reimbursements. Tribal Dental Programs rely on third party reimbursements to maintain the financial stability of their services because the federal government chronically underfunds the Indian healthcare system.[23]

SANITATION FACILITIES CONSTRUCTION +$1.879 BILLION

Tribal Leaders continue to prioritize environmental health concerns and request a $1.879 billion program increase for the IHS Sanitation Facilities Construction (SFC) line item in FY 2023 above the FY 2022 Workgroup Recommendation. As with other infrastructure issues in Tribal communities, the need to complete sanitation projects is great. The IHS Facilities Appropriations Report (March 7, 2019) which provided to the Tribal Facilities Appropriations Advisory Board, identifies that the nationwide sanitation deficiency in 2019, now totals approximately $2.7 billion and severely affects Alaska Area, Navajo Area, Great Plains Area and the California Area. In fact, all IHS Areas reported high numbers of homes that require sanitation improvements. With sufficient resources for the SFC line item aids the prevention of communicable and environmentally related diseases such as pneumonia, influenza, and respiratory syncytial virus by providing for these basic necessities:

- Water, wastewater and solid waste facilities for existing AI/AN homes and/or communities;
- Water, wastewater and solid waste facilities for newly identified AI/AN Tribal housing projects; and
- Special or Emergency Projects.

Projects are cooperatively developed with and transferred to Tribes, which in turn assume responsibility for the operation of safe water, wastewater, and solid waste systems, and related support facilities. Tribes must seek funding through other sources, such as the U.S.

18 Kathy R. Phipps, Dr.P.H. and Timothy L. Ricks, D.M.D., M.P.H., *The Oral Health of American Indian and Alaska Native Children Aged 1-5 Years: Results of the 2018-2019 IHS Oral Health Survey,* Indian Health Service Data Brief April 2019, (citing National Health and Nutrition Examination Survey 2013-2014), https://www.ihs.gov/doh/documents/surveillance/2018-19%20Data%20Brief%20of%201-5%20Year-Old%20AI-AN%20Preschool%20Children.pdf.

19 Kathy R. Phipps, Dr.P.H. and Timothy L. Ricks, D.M.D., M.P.H., *The Oral Health of American Indian and Alaska Native Adult Dental Patients: Results of the 2015 IHS Oral Health Survey,* Indian Health Service Data Brief March 2016, https://www.ihs.gov/doh/documents/IHS_Data_Brief_March_2016_Oral_Health%20Survey_35_plus.pdf.

20 *Id.*

21 *Id.*

22 Give Kids a Smile Day: An IHS-ADA Collaboration, Special IHS CDE Webinar, presented on Nov. 20, 2019.

23 U.S Commission on Civil Rights. The Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans (2018).

Department of Agriculture's Water and Environmental Programs (WEP) to fund technical, managerial and financial capacity for water, wastewater and solid waste management. In addition, funding for tribally led water/waste water operator certification and training is principally funded by the HHS-ACF-OCS Community Services Block Grant Rural Community Development (RCD) program through the U.S. Department of Health and Human Services. Without the combined resources of IHS and these agencies, access to safe drinking water and vital public health services, in many Tribal communities would not be met. The TBFWG is concerned that the President's FY 2021 budget had zeroed-out the RCD program. The human health and economic well-being of low-income rural Tribal communities throughout the nation are directly dependent on the services funded by the RCD program. At minimum, the RCD program must be restored to $11.0 million.

COMMUNITY HEALTH REPRESENTATIVES: + $1.168 BILLION

Tribal Leaders on the National Tribal Budget Formulation Workgroup recommend that the FY 2023 budget provide a $1.168 billion increase to the Community Health Representative (CHR) line item above the FY 2022 Workgroup Recommendation. CHRs are highly trusted members in the community in providing preventive health information to Tribal members in home and community settings for the last 50 years. Many continue to provide health information in our Native languages that is culturally relevant and appropriate with a focus on the holistic wellness that encourages Tribal members to receive health and public health services clinically and at home. CHRs are also considered a valued member of the medical team whose role is to follow-up on patients discharged from health facilities.

CHRs are part of the direct provision of health services to Native Americans, and are authorized in in the Indian Health Care Improvement Act (25 U.S.C. § 1616). Without the services provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients will not receive their necessary follow-up services and many will have difficulty accessing health services only for health conditions to worsen. In FY 2018, IHS reported that more than half of the visits performed by CHRs were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained Tribal community members. Therefore, the tribal CHR programs must remain present in Tribal communities.

Inadequate and continued elimination of funding for the CHR Program will result in staff reduction leaving minimal staff to address the chronic health and infectious diseases. Elimination of provider-patient communication through the CHRs will be detrimental to improving health outcomes. This will result in a serious public health threat wherein high risk, elderly and disabled clients with chronic diseases will be left without home health care services such as bathing, personal care, feeding and medication adherence. Overall, the inadequate funding and the elimination of the CHR Program will severely affect high-risk clients who receive preventive health screening education, monitoring, patient assessments and home visits.

The Navajo Nation is an example of where CHRs are not only addressing chronic diseases, but also advancing knowledge to patients on a broad range of health risks. These have included oral health care, preventing tuberculosis and influenza and addressing sexually transmitted infection outbreaks. CHRs at the White Mountain Apache Tribe have engaged in Rocky Mountain Spotted Fever (RMSF) public health prevention measures,

including animal control. The Yavapai Apache Nation has trained CHRs how to administer Narcan to prevent death due to an opioid overdose. Without an adequate increase to maintain these efforts, Tribes who rely on CHR programs to coordinate and conduct preventive education efforts will have difficulty maintaining adequate health services to support to high-risk clients in need of screening, education and monitoring visits.

In 2020 and 2021, the CHRs have been instrumental in responding to the COVID-19 pandemic. CHRs have served as frontline workers for victims of COVID-19 and their families to much needed resources. CHRs are the trusted messengers for all COVID-19 prevention education including addressing vaccine hesitancy, misinformation and mistrust about the COVID-19 vaccines. Post-COVID impact will be immeasurable, but it is significant to keep the CHRs as vital members to follow-up with recovery efforts.

To maintain these efforts, Tribes who rely on CHR programs to coordinate and conduct preventative education efforts will have difficulty maintaining their current system of support to high risk clients who need screening, education and monitoring visits as well as lose their local knowledge that helps keep communities safe.

EQUIPMENT: +$726.843 MILLION

The Tribal Leaders along with the IHS are committed to the quality of care. It is a tribal and agency priority in providing the highest level healthcare delivery system to the AI/AN people we serve. It is with this in mind the Equipment program budget line request increase is $726.843 million. This fund is needed to maintain quality bio-medical equipment insuring the 1,500 tribally and federally managed health care facilities are timely replacing, performing preventive maintenance and repair of the over 90,000 biomedical devices.

Medical equipment has a high level of complexity, typically having high installation and maintenance costs associated with them. Repair of components, training and service contracts are also high costs associated with highly technical medical equipment. As the demand for medical equipment to interface with electronic health records increases, the need for compatible equipment replacing outdated, inefficient and unsupported equipment will greatly increase. The newer equipment will enhance speed, accuracy of diagnosis, heighten quality decision making, increased efficiency, quality, and productivity, thereby reducing referrals to the private sector and saving on Purchased Referred Care (PRC) costs.

HEALTH EDUCATION: + $646 MILLION

Tribal Leaders seek a $646.017 million increase to the Health Education line item. Since the COVID-19 pandemic was declared a national emergency, the national Health Education programs have redeployed health educators and reoriented its activities to face the pandemic head on. Health Educators have been the front line of defense in tribal communities to respond to public health and emergency preparedness, respond to communicable disease outbreaks, and mitigate or delay the onset of diseases; also, they are a resource to the Tribal communities as a Health Education expert. Health Educators provide a myriad of services such as injury prevention, sexual transmitted infection prevention education, promote preventative cancer screenings, and educating the community on immunizations. Health Educators help people navigate the healthcare system, improve adherence to health recommendations, and reduce the need for emergency and specialty services resulting in improved overall health status.

Tribal communities are facing the morbidity and mortality of cancer, heart disease, diabetes, chronic liver disease and cirrhosis, suicide, and both unintended and intentional injuries resulting in death and/or disability. These health disparities must be reversed if we are to provide primary prevention and care to tribal communities. Preventive services provided by Health Educators who are trained to provide communities with education and awareness relating to preventive health, emergency response, and communicable diseases, has been shown that health education and prevention does work — such as HIV screening, colorectal screening. Health Educators are extremely valuable in Native communities by raising awareness of lifestyle choices and decisions, they help prevent countless sick days for workers and students, also assist individuals to restore or maintain optimal health, and they guide individuals to practice sanitary and hygiene habits that prevent crippling and deadly diseases from being transmitted and spread. Health Educators are a vital source to interpret health education messages from English to a Native language, i.e. breaking the chain of infection, prevention measures on new and emerging diseases, detailed provider instructions during patient visits and medication tutoring; the availability of Native speaking staff trained in Medical Interpretation will

become compromised, including bridging the generation gap between elders and youth.

With past funding shortfalls, Health Educators were limited in the scope of services offered to a AI/AN population. All of the Indian Health Areas are underfunded and require immediate attention, as demonstrated during the COVID-19 pandemic. Tribal Leaders request no less than a $646 million increase to this line item in FY 2023 aboved the FY 2022 Workgroup Recommendation. This justification for the proposed budget increase outlined in this request is aligned with the authority of IHCIA, Title 25, Section 1621b, health promotion/disease prevention services. This proposed budget increase is aimed at the control of, intervention, and prevention of health issues such as diabetes, cancer, obesity, depression, behavioral health, alcohol use, HIV, and domestic violence.

To ensure that Health Educators are prepared to meet the unique cultural preventive healthcare needs of this growing population, the tribes request continued investment in the Health Education programs which are an integral component of primary, secondary and tertiary prevention, as well as, bridging primary care with community health outreach and preventive education. Health Education is linked to several authorized programs on the Indian Health Care Improvement Act, 25 U.S.C. §1621b, §1621c, §1621h, §1621n, §1621q and §1665i. Health Education supports the IHS Strategic Plan FY 2019-2023, Goal 1 Objectives 1.2 Build and strengthen and sustain collaborative relationship, 1.3: Increase access to quality health care services and Goal 2 Objective 2.1: Create quality improvement capability at all levels of the organization, 2.2.: Provide care to better meet the health care needs of AI/AN communities, 3.1: Improve communication within the organization with tribes, urban Indian organizations, and other stakeholders, and with the general public, and 3.2: Secure and effectively manage the assets and resources.

PUBLIC HEALTH NURSING +$627.516 MILLION

Public Health Nursing (PHN) is a community health nursing program that focuses on promoting health and quality of life and preventing disease and disability. The PHN program provides quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families and community groups. Homebased services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. However, PHN also offers traditional food programs that focus on food choices that are not only culturally appropriate but consider health challenges for AI/ANs, health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, and education programs. The request includes $627.516 million in expanded services.

URBAN INDIAN HEALTH +$749.4 MILLION

The federal government owes a trust responsibility to tribes and American Indians and Alaska Natives (AI/ANs) that is not restricted to the borders of reservations. That trust responsibility includes the provision of health care. Following the Termination[24] and Relocation[25] Eras of federal Indian policy, tribes advocated for the trust and treaty health rights for AI/ANs living off of tribal land — "urban Indians" —and thus urban Indian organizations (UIOs) were established. Today there are currently 41 UIOs, which operate 74 facilities in 22 states. UIOs provide a wide range of culturally-competent health care and social services to urban AI/AN communities, including primary care, oral care, HIV treatment, substance use disorder treatment, behavioral health, and other preventive services.

The TBFWG recommends a $749.26 million increase above the FY 2022 planning base. UIOs receive direct funding from primarily the one line item — urban Indian health — and do not receive direct funds from other distinct IHS line items, including the Hospital and Health Clinics, Mental Health, Alcohol & Substance Abuse, Indian Health Care Improvement Fund, Health Education, Indian Health Professions, or any of the line items under the IHS Facilities account. Due to historically low funding levels for urban Indian health, UIOs are chronically underfunded. Full funding of UIOs will directly benefit urban Indians that rely on UIOs to access culturally-competent care.

As we inch closer to increased parity for urban Indians, it is imperative to highlight that up until the end of 2020 and beginning of 2021, UIOs have been deemed

24 Act of August 15, 1953, Public Law 83-280, 67 Stat. 588.
25 Act of August 3, 1956, Public L.aw 84–959, 70 Stat. 986.

ineligible for cost-saving measures available to the other components of the IHS I/T/U system, including, among others, 100% Federal Medical Assistance Percentage (FMAP) for services provided at UIOs, reimbursement from the Department of Veterans Affairs (VA) for services provided to dually-eligible AI/AN Veterans, and liability coverage under the Federal Tort Claims Act (FTCA). Implementation of these hard-fought legislative victories at the agency level will require close attention to ensure that proper procedures and policies are put into place. Although these changes represent a step forward, associated issues remain. For example, UIOs will only remain eligible for 100% FMAP for two years and still are not receiving the IHS all-inclusive rate. Permanent policy fixes to address these issues are required.

Hot topics and priorities for Urban Indian Health appear below:

1. **Ensure Urban Indian Health funding keeps pace with population growth:** Although more than 70% of AI/ANs reside in urban or suburban areas (according to the most recent Census), less than 1% of the IHS budget is spent on urban Indian health care. In fact, most recent funding increases for urban Indian health fail to even keep up with health care inflation. The urban Indian population is growing. Increased population will require UIOs to increase access to care by hiring additional staff and expanding services to meet the need. UIOs are also unable to access Purchased/Referred Care (PRC) funding or numerous other categories of funding in the IHS budget (including line items under the Facilities account) and have been overlooked for newly available grant funding. Funding for urban Indian health must be significantly increased if the federal government is, to finally, and faithfully, fulfill its trust responsibility. However, it is also imperative that such an increase not be paid for by diminishing funding for already hard-pressed IHS and tribal providers. Title V funding should adequately support staff in terms of being paid a fair wage and expanding personnel. UIOs have also expressed the need for Title V funding to be expanded to other services, such as sober living programs and dental care.

2. **Funds for construction or expansion of urban facilities:** UIOs are currently limited in their ability to construct or improve upon their facilities in order to meet their communities' needs. UIO funding should include funds for these purposes and should be read to be as flexible as possible. Additionally, UIO facilities renovation under Section 509 of the Indian Health Care Improvement Act (IHCIA) is one of the many provisions of IHCIA that continue to be unfunded.

3. **Dental Services:** Many urban Indian patients are unable to access regular dental exams from an Indian health care provider. Regular dental visits are a standard of care for all adults, especially for pregnant women and those with diabetes or HIV. In accordance with its original policy interpretation, IHS should allow UIOs to participate in the nationalization of the Community Health Aide Program (CHAP). Many UIOs would benefit from a national CHAP, as well as Dental Health Aide Therapists, and Behavioral Health Aide Therapists. It is thus imperative that UIOs are included in the nationalization of CHAP so that the entire I/T/U system can offer patients increased access to quality dental care.

4. **Retain eligibility for IHS UIOs to participate in grant programs**: Because UIOs have long suffered from significant underfunding, they often must seek additional funding opportunities in order to provide more services and serve more patients, including grants. If grant-making is eliminated for IHS and tribal facilities in lieu of direct funding, UIOs should separately retain eligibility for grants under these programs — or they would lose critical funding. This includes behavioral health funding for IHS's current initiatives and the Special Diabetes Program for Indians (SDPI). 24 UIOs are current recipients of IHS's behavioral health initiatives and 30 UIOs currently receive SDPI funds. The preservation of grant funds for UIOs should not impact the ability of grants distribution to transfer to direct funding for IHS and tribal facilities. Similarly, UIOs should be eligible for new IHS programs, like CHAP (see above) and other programs IHS creates from novel funding opportunities as appropriated by Congress from time to time (for instance, the FY 2019 Special Behavioral Health Program for Indians). As UIOs work to provide for a growing population of urban Indians, their continued eligibility for grant or funding initiative opportunities, including behavioral health initiatives and SDPI, is essential.

5. **No funding from Urban Indian Health line item withheld or reprogrammed from UIOs**: In recent years, critical funding for UIOs has been reprogrammed to fulfill unrelated budgetary shortfalls under programs for which UIOs are ineligible. In FY 2018 and FY 2019, IHS reprogrammed more than $1.5 million from already budget-constrained UIOs in order to satisfy the cost of 105(l) leases. The federal government should ensure that UIOs are held harmless from unrelated budget shortfalls or funding diversions. When the federal government fails to fund or operate at full capacity, such as periods of a government shutdown, IHS is unable to provide the majority of funds to UIOs, resulting in a loss of critical funding and operational shortfalls. This was evident during the 2018-2019 federal government shutdown, which had the following impacts on UIOs: facility closures, staff layoffs, reduced hours, canceled programs/ services, and more — ultimately impacting the abilities of UIOs to provide services to their AI/AN patients. When more shutdowns loomed in 2019 and then again in 2020, IHS only requested an exception apportionment from the Office of Management and Budget for some Indian health programs and did not request an exception apportionment for programs operated by IHS (serving direct service tribes) and UIOs. The decision of IHS to not include or attempt to include two out of the three already-ailing prongs of the Indian health care delivery system in a mechanism to ensure the continuity of care raises many questions, especially with regards to appropriations priorities. Fortunately, Congress was able to reach agreement on FY 2020 and 2021 appropriations to avoid shutdowns. However, the safety of patients' lives are important at all times of the year and should not be dictated by a shutdown. The mission of IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, and that mission does not comprehend a facility limitation. Further, tribal and UIO leaders, as well as IHS beneficiaries themselves, have an interest in understanding how inclusion or exclusion from exception apportionment requests impact Indian health program operations, and how the IHS interprets its own authority or discretion on budgetary matters.

ELECTRONIC HEALTH RECORD/ HEALTH IT +$355.786 MILLION

The TBFWG requests a program increase of $355.786 million over the FY 2022 Workgroup recommendations. Indian Health Service (IHS) provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions, including an Electronic Health Record and more than 100 applications. A properly resourced IHS HIT program directly supports better ways to: 1) care for patients; 2) pay providers; 3) coordinate referral services; 4) recover costs; and 5) support clinical decision-making and reporting, resulting in better care, efficient spending, and healthier communities.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. TBFWG also has recommended a meaningful investment into the IHS HIT system to address the impact of the VHA's recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. In preparation for future modernization, the Department of Health and Human Services (HHS) and IHS evaluated the current electronic health record system, the Resource and Patient Management System (RPMS), and, based on the evaluation, developed the Roadmap Report to guide modernization efforts over the next five years. The Roadmap Report lays out a number of opportunities for FYs 20-22, including establishing a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection, and procurement, implementation planning, and testing.

Tribes are very concerned that a more accelerated funding strategy is critical to appropriately and realistically advance the $3 billion 10-year investment, which will be needed to allow IHS to either update the current EHR & RPMS suite or initiate an alternatives analysis similar to the VHA. Therefore, TBFWG maintains its recommendation for a separate HIT budget line item investment to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients.

An adequately-resourced IHS Health Information Technology (HIT) program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY23 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment, and must include funding for both the IHS and Tribal Health IT modernation efforts.

The Indian Health Professions Program has seen much success throughout the years including, but not limited to, the following:

- Enabling AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian Self-Determination in the delivery of health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.

INDIAN HEALTH PROFESSIONS +$195.7 MILLION

A total of $195.738 million is recommended for the Indian Health Professions line item in fiscal year 2023. IHS and Tribes continue to struggle to recruit and retain qualified medical professionals to work in facilities serving Indian Country. This is an on-going issue and comprehensive efforts are needed to "grow our own" AI/AN health professionals. In 2018, IHS reported that the estimated vacancy rates at federal IHS sites, are as follows: Physicians - 34%; pharmacists - 16%; nurses - 24%; dentists - 26%; physician's assistants - 32% and advanced practice nurses - 35%. Broader efforts to encourage and support AI/ANs entering into health careers are needed including accessing federal and state scholarships, loan repayment programs and working with educational institutions.

BACKGROUND

IHS reported in 2016, that a total of $48.3 million was needed to fund all of the professional loan applicants, but it was only able to fund 437 out of 939 applicants. IHS also reported that only 456 of the new scholarship applicants could be awarded out of 1,250 new online scholarship applications that year. An additional $3.3 million in funding was needed to fund all of the qualified applicants. It must be noted that the automatic designation of outpatient IHS, Tribal facilities and Urban Indian Organizations that receive funds through Title V of the IHCIA are automatically designated as Federally Qualified Health Centers (FQHCs) and therefore classified as Health Professional Shortage Areas (HPSAs). Tribes are automatically designated as 'population' HPSAs. Automatic HPSA designations do not expire, but the Health Resources Services Administration (HRSA) advises that the designations need to be updated periodically to ensure that the score is accurate. The benefits of the score include improving access to primary care, dental and mental health National Health Service Corp (NHSC) providers. HRSA announced to Tribal Leaders in 2019, plans to modernize the HPSA designation process and then update the Auto-HPSAs in 2020. In advance of the changes, HRSA recommended that facilities update their information and include the data requested (demographic data, access to fluoridated water and rates of alcohol and substance abuse.

RECOMMENDATIONS

The proposed increase of $195.7 million for the Indian Health Professions line item in FY 2023 would help to increase funding for scholarships, loans and expand loan forgiveness options to individuals seeking to work in Tribal communities. With regard to the Community Health Aide Program (CHAP) implementation in the lower 48 states, a portion of the recommended amount should be made available for scholarships for students seeking a career as a CHAP mid-level provider. A portion of the funding should be made available for grants to establish course work for Dental Therapists, Behavioral Health Aides and Community Health Aides at Tribal colleges, universities and partner institutions. Expanding the use of these funds in this manner remedies a major need for training on or near Tribal communities. These measures elevate our ability to train, recruit and retain AI/AN professionals and mid-level providers seeking to enter health professions through comprehensive efforts.

TRIBAL MANAGEMENT GRANTS + $23.692 MILLION

$23.692 million is the recommended increase for the Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103 (b) (2) and 103 (e) of Public aw (P.L) 93-638, Indian Self Determination and Education Assistance Act (ISDEEAA), as amended. Under the authority of the ISDEAA the program was established to assist all federally recognized Indian Tribes and Tribally sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services and activities (PFSAs) and to further develop and enhance their health program management, capability and capacity. The purpose of the Tribal Management is to assist federally recognized tribe and tribally sanctioned Tribal organizations in assuming all or part of existing IHS programs, services, functions and activities (PSFAs) through a Title I contract and to assist established Title I and Title V compactors to further develop and improve their management capability. Recently reaffirmed federally recognized tribes have been able to apply for these grants to plan, develop, evaluate or implement new tribal health PFSA's or to assume these from the IHS to fully meet the needs of their tribal citizens. This grant opportunity is an important resource for Tribal capacity building and technical assistance if needed

Although the IHS agency has made this discretionary competitive grant program a lessor priority than direct health services, there continues to be increase in awareness in by Tribes and Tribal organizations to explore their inherent right to assume management of their own health delivery systems and now with options for recovering contract support costs or 105 leasing this offers tribes increased options to explore for long term sustainability. Ongoing attempts by previous administration to zero out the TMG funding has not been supported by tribes.

TMGS are available to Tribes and Tribal Organizations to pursue feasibility studies and or planning and evaluation studies or health management structure framework. The intent of the TMG program provides Tribes/ Tribal organization the option to enter in or not into ISDEAA contracts or Self Governance compact agreements which are equal expressions of self-determination. There are four types of awards designed to assist tribes which are: Planning, Evaluation and Feasibility are 1-year grants. Health Management Structure is a 3-year grant.

- Planning grants awards up to $50,000. Planning allows establishment of goals and performance measures for current health program or to design their health programs and management systems.
- Evaluation funds awards up to $50,000. Evaluation projects determines the effectiveness and efficiency of a program or if new components are needed to assist T/TO improvements to its health care delivery system.
- Feasibility funds award up to $70,000 to analyze programs to determine if T/TO management is practicable.
- Health management structure (HMS) grant awards up to $300,000. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems management systems, health accreditation as well as correction of audit material weaknesses.

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT: +$141.6 MILLION

$141.579 million is requested for the FEHS which provides resources to staff and support its headquarters, regional, area, district, and service unit activities. These

activities include Facilities Support, Environmental Support and Office of Environmental Health & Engineering (OEHE) Support. Facilities support include operations and management staff for facilities and staff quarter and construction management support. Environmental Health Support provides staff and operating costs for environmental health service, injury prevention, institutional environmental health and sanitation facilities construction staffing. OEHE support includes IHS headquarters staff, engineering services staff and direct support and management of overall facilities appropriation services and activities. The IHS delivers a comprehensive, national and community-based and evidence-based Environmental Health program which has 5 focus areas: Children's environment, Safe drinking water, Vector-born and communicable disease, Food safety, and Healthy homes. They work hard to identify environmental health hazards and risk factors in communities and propose control measures. Additionally, they conduct investigations of disease and injury incidents, and provide training to federal, Tribal, and community members.

ADDRESSING THE ENVIRONMENTAL AND HEALTH IMPACTS OF CLIMATE CHANGE ON INDIAN COUNTRY

"Even as our nation emerges from profound public health and economic crises borne of a pandemic, we face a climate crisis that threatens our people and communities, public health and economy, and, starkly, our ability to live on planet Earth."

— President Joseph R. Biden, Jr.

American Indians and Alaska Natives are disproportionately impacted by the climate crisis. We suffer excess mortality and morbidity having more susceptible populations with multiple health disparities residing in preexisting and geographic conditions that put our people at greater risk. "Climate change significantly impacts tribal air, water and food. It has resulted in: rising coastal water levels; more frequent forest and grass fires; increased pests and vector-borne disease; more extreme weather conditions; decreased food availability; lower inland water and underground aquifer levels and non-native plant encroachment. Weather pattern changes and warming waters can disrupt traditional ways of life by threatening the health of local plants and animals."[1]

In addition, our relationship with the land and water is at the core of our respective cultures and traditions, and any change in our environment impacts our physical, mental, emotional and spiritual health. Some of these impacts include, increased heat-related illnesses; respiratory irritation and exacerbation of asthma and other lung diseases; water-related illnesses, including spikes in cases of Salmonella and E. Coli; First Foods and water security; and negative impacts to the mental health and well-being of AI/AN people.[2]

As the United States considers its response in addressing the climate crisis — particularly the impact on health —Tribes must be included in the design, planning and implementation of the response. Tribes must have access to resources necessary to address these issues, including appropriations to the IHS to address climate crisis needs, including, but not limited to: data collection, research, facility modification, develop water and sanitation infrastructure, energy and HVAC system needs. Similar to how Tribes/IHS were designated as a distinct public health jurisdiction for COVID-19 vaccine administration, Tribes/IHS need to be designated as its own jurisdiction for efforts such as the CDC's Building Resilience Against Climate Effect (BRACE) Framework and similar initiatives. Funds and technical resources for such efforts need to be made available to the I/T/U system through direct appropriations or via interagency transfer to IHS. Tribes must be able to forecast climate impacts, project disease burden, assess public health interventions, develop and implement a climate and health adaptation plan, and evaluate and improve the quality of activities in responding to the climate crisis. Tribes commend President Biden for requiring that tribal governments be engaged with the National Climate Taskforce and be included in the all of government response in his January 27, 2021 Executive Order on Tackling the Climate Crisis at Home and Abroad.

The climate crisis and health must be addressed holistically. Ensuring environmental justice and spurring economic opportunity will contribute to improving the health status and quality of life for America's First Peoples. The President's inclusion of Tribes in his policy "to secure environmental justice and spur economic opportunity for disadvantaged communities that have been historically marginalized and overburdened by pollution and underinvestment in housing, transportation, water and wastewater infrastructure, and health care," [3] goes towards meeting the Federal Trust Responsibility to Tribes.

1 https://www.apha.org/topics-and-issues/climate-change/tribal-and-indigenous

2 *Climate Effects on Health, Regional Health Effects — Northwest,* Centers for Disease Control and Prevention, Regional Health Effects - Northwest | CDC, (last visited on Mar. 3, 2021).

3 ibid. Biden (2021).

SELF-GOVERNANCE +$43.9 MILLION

To support and expand Self-Governance training and technical support in FY 2022 through the Office of Tribal Self-Governance (OTSG), the Workgroup is requesting a program increase of $43.9 Million, including an additional $225,000 for adjustments to federal pay, non-medical inflation, population growth, for an overall budget request of $50.25 million. OTSG is responsible for a wide range of agency functions that are critical to honoring the IHS's relationship with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups, under authorization of Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137. Title V authorizes Tribes and Tribal Consortia to enter into Self-Governance compacts, self-determination contracts and related funding agreements to assume federal programs, functions, services, or activities (PFSA), and associated Tribal Shares, placing the accountability of PFSA service provision with Tribal nations. This request supports expansion of the implementation of the IHS Tribal Self-Governance program, funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and funds Tribal shares needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program.

Today, Indian Tribes and Tribal organizations administer more than one-half of IHS resources through ISDEAA self-determination contracts and Self-Governance compacts. There is a growing interest by Tribes to explore Self-Governance as an option to exercising its self-determination rights. The Self-Governance budget supports activities, including but not limited to: government-to-government negotiations of Self-Governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALNs); technical assistance on Tribal Consultation activities; analysis of Indian Health Care Improvement Act (IHCIA) authorities; Self-Governance planning and negotiation of Cooperative Agreements; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee which advises the IHS Director on Self-Governance policy decisions.

SELF-GOVERNANCE PLANNING AND NEGOTIATION COOPERATIVE AGREEMENTS

Title V of the ISDEAA provides the IHS statutory authority to enter Planning and Negotiation Cooperative Agreements. These agreements assist Tribes in planning and negotiation activities; technical assistance, analysis and systems review are all part of those negotiation activities. IHS ALN's, Tribal technical advisors and financial expertise are required to successfully advance Tribes wanting to assume administration of their health systems. The budget supporting Planning and Negotiation Cooperative Agreements assist Tribes to secure expertise, and IHS to ensure staff are available to respond to technical assistance requests. There are two types of cooperative agreements to assist Tribes in attaining Self-Governance:

The Planning Cooperative Agreement provides resources to Tribes entering into Title V compacts and to existing Self-Governance Tribes interested in assuming new or expanded PSFAs. Costs supported by the planning cooperative agreements includes legal and budgetary research, internal Tribal government planning, and organization preparation relating to the administration of health care programs. The planning phase helps Tribes to make informed decisions about which PSFAs to assume and what organizational changes or modifications are necessary to successfully support those PSFAs.

The Negotiation Cooperative Agreement provides resources to Tribes to help defray the costs related to preparing for and conducting Self-Governance program negotiations. The design of the negotiation process: 1) enables a Tribe to set its own priorities when assuming responsibility for IHS PSFAs, 2) observes the government-to-government relationship between the United States and each Tribe, and 3) involves the active participation of both Tribal and IHS representatives, including the OTSG. These cooperative agreements provide funds to support Tribal and federal negotiation teams, who work together in good faith to enhance each Self-Governance agreements.

LACK OF TRIBAL CONSULTATION-TUCSON AREA

'The Pascua Yaqui Tribe expressed concern about public comments made by IHS Director, RADM Michael Wehakee in 2018 during a Tribal Leader Diabetes Committee (TLDC) meeting about overview of several Indian Health Service (IHS) initiatives. There was mention that IHS was considering various ways to be more efficient and effective, emphasizing the consolidation of existing IHS Area Offices. The Tucson Area was specifically mentioned, serving two Tribes, who recently became self-governance under ISDEAA. The Pascua Yaqui Tribe is very concerned about these statements as there was not prior tribal consultation with either Tribe. The consolidation of the Tucson Area would greatly affect both Tribes, IHS should have spoken with the Pascua Yaqui Tribe and conducted consultation along with the Tohono O'odham Nation, and the Tucson Indian Center before raising among a public attendance the idea of consolidation.'

— Vice-Chairman Robert Valencia, Pascua Yaqui Tribe

"As the Tucson Area Tribal Representative we object to movements to combine Tucson Area with the Phoenix Area due to the population served under each area, also that the invested partnership established with both tribes (Tohono O'odham, Pascua Yaqui and the Tucson Indian Center which serves the Urban natives. The Tucson Area population it serves if combined to Phoenix Area would create limited services, funding, and have more Native tribes venting out their priorities for Health Care services. Although no formalized action has been taking including consultation with the affected areas, it's critical our position be respectfully adhered to."

— Vice-Chairwoman Wavalene Saunders, Tohono O'odham Nation

As the leader of the Indian Health Service, it is imperative that the IHS Director work with tribes to protect, preserve and expand health care services in Indian Country. Tribes dedicate substantial resources to the budget formulation process each year. It is more important than ever that such efforts are recognized and respected. Tribes must be able to rely on the IHS Director to work in concert with Tribal leadership on matters related to Tribal budget formulation in order to strengthen our advocacy with one unified voice. The workgroup is representative of all Direct Service and Self Governance Tribes as well as Urban Indian programs across the Nation. This commitment is reflected when the IHS Director and agency leadership communicates support for the Tribal recommendations put forward by the National Tribal Budget Formulation workgroup. For example, some recommendations from FY 2023, which should be supported and communicated include but are not limited to the following:

- Promote full funding for the IHS all funding should be provided non-competitively;
- Provide dedicated funding to implement all authorities and provisions of the Indian Health Care Improvement Act (IHCIA), which were passed almost a decade ago;
- Support full access/authority to and funding from the Medicare/Medicaid program; and
- Hold consultation when consultation is necessary because decisions that impact Tribes must include tribal consultation as plans are formulated, not after.

It is paramount that Tribes are honored by working together with IHS to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level.

DIRECT OPERATIONS +$19.65 MILLION

The overall funding increase request for Direct Operations for FY 2023 is $19.645 million. The Direct Operations budget supports the IHS provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to AI/ANs. The IHS is the only HHS agency whose primary function is direct delivery of health care. Funds are used to promote the efficient and effective administration and oversight of national functions such as: human resources (HR), financial management, acquisitions, internal control and risk management, health care and facilities planning, health information technology, Contract Disputes Act claims analysis, and other administrative support and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

The IHS Headquarters provides overall program direction, authorities, and oversight for the 12 IHS Areas and 170 Service Units: it formulates policy and distributes resources; also provides technical expertise to all components of the Indian health care system, including IHS direct service, Tribally operated programs, and urban Indian organizations (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters works in partnership with HHS and sister agencies to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters also works with HHS to formulate the annual budget and necessary legislative proposals, and respond to congressional inquiries.

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services management and delivery.

Program increases for Direct Operations will allow the continued implementation of all quality and patient safety and will enable the agency to be responsive to deficiencies cited in the previous GAO High Risk Report. A funding increase will enable operational support necessary for carrying out the functions of the new Office of Quality (OQ). The OQ provides for quality systems integration and address quality assurance, patient safety, business intelligence, risk management, and quality improvement. Funds will also be used to strengthen the agency's capacity for oversight in key areas such as workforce management and development, finance, acquisitions, and other evolving areas identified by agency leadership. This will increase the efficiency and effectiveness of Headquarters programs focused on policy management and compliance, competency training, evaluation, data analysis and reporting, and accountability. The non-inherent federal function portion of Direct Operations funds are available for Tribal Shares distribution if a Tribe or Tribal Health Organization exercises its right to assume management of federal functions under ISDEAA Title I or Title V.

ALASKA IMMUNIZATION +$1 THOUSAND

The Alaska Immunization Program works to eliminate disparities in vaccine-preventable disease in Alaska Native people. The immunization program works with statewide Tribal health partners to coordinate and advocate for the needs of Tribal immunization programs, educate Tribal staff on immunization recommendations, and administer vaccine for preventable disease in Alaska Native communities. In FY 2023 the Workgroup recommends an increase of $1 Thousand above the increase for medical inflation and population growth for the Alaska Immunization program. The Hepatitis B Program: Viral hepatitis, including hepatitis B, and other liver diseases continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor hepatitis-B infection, as well as hepatitis-A, immunizations maintained high vaccine coverage rates; health curricula, workforce policy and educational materials for patients as emerging health risks effect the populations.

2nd Recommendation

Support the Preservation of Medicaid, the Indian Health Care Improvement Act and other Indian-specific provisions in the Affordable Care Act, and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act (IHCIA), which have not yet been implemented and funded

Over 40 years ago, Congress authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible American Indians and Alaska Natives to supplement inadequate IHS funding. The House Report stated: "These Medicaid payments are viewed as a much needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."

The Indian Health Care Improvement Act's (IHCIA's) enactment and permanent authorization in 2010 protects the future of Indian health and also secures a solid foundation for Tribes, Tribal organizations and Urban Indian Organizations (UIOs) to see that authorized programs and services become realized. Indian Country continues to advocate Congress for accompanying appropriations while engaging with IHS to ensure that the agency's budget reflects Tribal priorities.

In renewing the IHCIA, Congress reaffirmed the duty of the federal government to AI/ANs declaring "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians."

The Medicaid system is a critical lifeline in Tribal communities. Efforts that decrease scarce Medicaid resources also jeopardize the ability to cover our cost of care, and further restrict the eligible patient population. This puts an unequal burden on the IHS budget which is dependent upon these resources to make up for funding shortfalls. The unique relationship between Medicaid and the Indian health system means that the Administration has the tools it needs to allow states to design Medicaid programs that best fit non-Indian populations while simultaneously respecting Tribal sovereignty and maintaining Medicaid as a critical source of funds for the Indian health system. Like States, Tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them.

We urge the administration to work with Tribes and strengthen its Tribal Consultation practices on issues like Medicaid work requirements and block grants, so that fiscal strain doesn't unintentionally fall back to the IHS and Tribal Health programs.

Also, important existing Tribal protections in the Medicaid program must be preserved. These include:

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Purchase and Referred (PRC) is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under PRC.
- If an AI/AN elects to enroll in a Managed Care Organization (MCO), they are allowed to designate an Indian health care provider as their primary care provider if in-network.
- A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as "resources" for purposes of determining Medicaid eligibility for AI/ANs.
- Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery.
- An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider.

INDIAN HEALTHCARE IMPROVEMENT ACT IMPLEMENTATION AND PRESERVATION

The IHCIA provides a wealth of resources and opportunities for Tribal health care institutions, families, providers and patients. Tribes worked collaboratively with Congress to develop legislation that included impactful and bipartisan reforms. Provisions included in the IHCIA are the result of years of negotiations, meetings and strategy sessions. The permanent reauthorization of the IHCIA safeguards the resources of the Indian health care system and has re-ignited hope the of quality health care delivery.

Despite efforts to augment funding through third party revenue, the IHS remains a vastly underfunded foundation of the I/T/U health system - representing yet another broken promise to Indian Country. Mainstream America increases its healthcare focus on prevention as a priority and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs and more recently, modernizing its Health Information Technology infrastructure. Supporting these improvements for Tribes in the IHCIA and other Indian-specific provisions is critical.

Tribes have worked tirelessly for over a decade to renew IHCIA and it remains critical for Congress and the Administration to ensure that the full intentions of the law are realized. To provide context for how much of the law has not been implemented, the following represents several categories of programs that have not been implemented and funded, though authorized by IHCIA:

1. **Health and Manpower** –
   - » Includes: Continue to support Community Health Representatives despite the President's recommendation to transition to Community Health Aide Program (support both programs); demonstration programs for chronic health professions shortages

2. **Health Services** –
   - » Includes: authorization of dialysis programs; authorization hospice care, long term care, and home /community based care; new grants for prevention, control and elimination of communicable and infectious diseases; and establishment an office of men's health.

3. **Health Facilities** —
   - » Includes: demonstration program with at least 3 mobile health station projects; demonstration projects to test new models/ means of health care delivery

4. **Access to Health Services** —
   - » Includes: Grants to provide assistance for Tribes to encourage enrollment in the Social Security Act or other health benefit programs

5. **Urban Indians** —
   - » Includes: funds for construction or expansion of urban facilities; authorization of programs for urban Indian organizations regarding communicable disease and behavioral health

6. **Behavioral Health** —
   - » Authorization of programs to create a comprehensive continuum of care; establishment of mental health technician program; grants to for innovative community-based behavioral health programs; demonstration projects to develop tele-mental health approaches to youth suicide; grants to research Indian behavioral health issues, including causes of youth suicides

7. **Miscellaneous** —
   - » Includes: Provision that North and South Dakota shall be designed as a contract health service delivery area

Clearly, a plan must be put in place to ensure that the intended outcomes of this law are actually realized. It is critical that additional funds are allocated so the full implementation of these programs can continue without compromising other critically needed services. We urge the Administration to add appropriations to the FY 2023 request so that the dream of the IHCIA can finally become a reality.

Furthermore, any rulings by the courts on the unconstitutionality of the ACA must sever the Indian Health Care Improvement Act and certain Indian-Specific provisions in the ACA that are of critical importance to the delivery of health services to Indian country, from the larger ACA. These Indian health provisions have a separate purpose and genesis from the larger ACA and should remain in effect.

3rd Recommendation

Fully Fund Critical Infrastructure Investments, like EHR Modernization to include Tribal facilities, health care facilities construction, and demonstration projects.

The Indian Health Service (IHS) provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions, including an Electronic Health Record (EHR) and more than 100 applications. A properly resourced IHS HIT program directly supports better ways to: 1) care for patients; 2) pay providers; 3) coordinate referral services; 4) recover costs; and 5) support clinical decision-making and reporting, resulting in better care, efficient spending, and healthier communities.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. TBFWG also has recommended a meaningful investment into the IHS HIT system to address the impact of the Veterans Health Administration's (VHA) recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. In preparation for future modernization, the Department of Health and Human Services (HHS) and IHS evaluated the current electronic health record system, the Resource and Patient Management System (RPMS), and, based on the evaluation, developed the *Roadmap* Report to guide modernization efforts over the next five years. The Roadmap Report lays out a number of opportunities for FYs 20-22, including establishing a Project Management Office and governance structure, acquisition planning, Health Information Technology (HIT) selection, and procurement, implementation planning, and testing.

Tribes are very concerned that a more accelerated funding strategy is critical to appropriately and realistically advance the $3 billion 10-year investment, which will be needed to allow IHS to either update the current EHR & RPMS suite or initiate an alternatives analysis similar to the VHA. Therefore, TBFWG maintains its recommendation for a separate HIT budget line item investment to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients.

An adequately-resourced IHS Health Information Technology (HIT) program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. The President's Budget request for FY23 must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment, and must include funding for both the IHS and Tribal Health IT modernation efforts.

HEALTH CARE FACILITIES CONSTRUCTION: OTHER NEWLY AUTHORIZED FACILITIES

The Portland Area has proposed the Regional Specialty Referral Center Demonstration Project that will provide culturally sensitive access to specialty care. The three regional facilities are planned to enhance the services already available from existing tribally operated and direct services facilities and to offset the inequity in healthcare facilities.

Tribes have waited for years for the funding to alleviate lack of space and old infrastructure in order to increase the quality of patient health care. Navajo Area has three facilities on the Priority List which are the Pueblo Pintado Health Center, the Bodaway-Gap Health Center and the Gallup Indian Medical Center). Phoenix Area's

two major inpatient replacement projects include two hospitals - the Phoenix Indian Medical Center (PIMC) and the White River Indian Hospital and in the Tucson Area, the Sells Indian Hospital. Tribes in Nevada in the Phoenix Area had begun discussions in their Master Plan in 2015 to increase specialty care services in that state as there are no IHS hospitals in that region since the closure of the facility in Schurz, Nevada. They sought alternatives other than traveling to PIMC in Phoenix for these services which is not optimal and puts patients at risk or exponential use of PRC resources. They worked on the concept of a specialty care facility through the PIMC project, but were apprised that it may require congressional authorization.

The IHCIA encourages the establishment of projects that use alternative or innovative methods of delivery of health care services. Essential specialty health care services are difficult to access for many AI/AN people in Contract Health Service dependent areas. One solution is to fund demonstration projects that include planning, design, construction, and staffing of a regional specialty referral centers to improve access to specialty care.

An important provision of the law under the new priority system, is the establishment of an Area Distribution Fund (1) in which a portion of health facility construction funding could be devoted to all Service Areas. It requires that the Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities. It also requires each IHS Area to generate an updated priority list every three years for a combined submission of top Area priorities to the U.S. Congress. A robust consultation and conferring process will help to identify the most pressing facility and infrastructure needs in each Area and insure that these needs are addressed more expeditiously.

Lastly Tribal Leaders commend the IHS policy that all new HCFC funded projects include an additional 4% of the necessary resources dedicated to the incorporation of sustainability features into construction projects. Tribal values align with promoting human health and energy efficiency which lessen any negative environmental impacts on our lands in the construction process.

4th Recommendation

Advocate that Tribes, Tribal Programs, and Urban Indian Organizations be Permanently Exempt from Sequestration and Recissions

In FY 2013, Indian health programs were subject to a 5.1% automatic, across the board cut. This means a staggering $220 million left the IHS, which is already severely underfunded. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS direct service programs were left with an impossible choice — either deny services or subsidize the federal trust responsibility. In fact, many did close their doors for several days per month and forced others to deliver only PRC for Priority I. The Indian Health Service is one of only four federally funded services providing direct patient care; however, it was the only one of the four not exempted from sequestration. This oversight, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected.

While the Bipartisan Budget Act of 2019 (P.L. 116-37) ended discretionary sequestration through FY 2021, it did not include a permanent exemption for IHS. In short, Indian health simply cannot take any more sequestration cuts.

The Workgroup strongly encourages the Administration to work with Congress to ensure that Tribes do not find themselves in this situation again, and that the FY 2023 budget reflect that by including a request to permanently exempt the IHS from sequestration.

5th Recommendation

Mandate Advance Appropriations for the Indian Health Service

The Indian health system, which includes- health care facilities operated by the Indian Health Service (IHS), Tribes and Tribal Organizations, and Urban Indian Organizations (UIOs), is funded through annual appropriations, unlike other major federal providers of health care. For example, the Veterans Health Administration (VHA) at the Department of Veterans Affairs (VA) receives most of its funding through advance appropriations. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. If IHS were to receive advance appropriations, it would not be subject to government shutdowns, automatic sequestration cuts, and continuing resolutions (CRs) as its funding for the next year would already be in place. However, because this is not the case, IHS and I/T/U facilities are unable to plan long-term and are frequently subject to significant disruptions in funding.

According to the Congressional Research Service, since FY 1997, IHS has once (in FY 2006) received full-year appropriations by the start of the fiscal year. Last year, during the pandemic ravaging Indian Country, Congress enacted two continuing resolutions. When funding occurs during a CR, the IHS can only expend funds for the duration of a CR, which prohibits longer-term, potentially cost-saving purchases. In addition, with respect to Indian health services provided by Indian tribes and UIOs under contracts with the federal government, there must be a new contract re-issued by IHS for every CR. In the last year, IHS was forced to allocate resources to contract logistics twice in the height of the pandemic when the resources could have better spent equipping the Indian health system for pandemic response. Moreover, during the most recent 35-day government shutdown at the start of FY 2019, the Indian health system was the only federal healthcare entity that was directly impacted by the shutdown. This had devastating impacts throughout the I/T/U system. For instance, during the 2018-2019 shutdown, several UIOs had to reduce services, lose staff or close their doors entirely, forcing them to leave their patients without adequate care. In a UIO shutdown survey, 5 out of 13 UIOs indicated that they could only maintain normal operations for 30 days without funding.

6th Recommendation

Authorize Federally-Operated health facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic fund flexibility across account at the local level, in consultation with Tribes

Our sixth request supports flexibility for federally-operated health facilities and IHS headquarters to have the authority to adjust programmatic funds across accounts. This will maximize efficiency and effective use of federal dollars at the local level. Local control means that resources will be addressed by need, instead of priorities that might not be relevant to immediate health issues. Current appropriations law often creates a barrier for the IHS to fully utilize authorized annual funding. For FY 2019 and FY 2020, the IHS was granted two-year authority to obligate/re-obligate funding, which has provided some needed flexibility to fully and efficiently utilize its appropriation. However, additional flexibility is still needed to allow IHS ability to reprogram funding if savings are achieved in one fund.

For example, programs such as PRC severely lack funds to meet critical health needs, and services are often denied due to lack of funding. Such programs can benefit from reallocation of savings to provide additional health services. It is requested that IHS be granted greater budget flexibility to reprogram funding to meet health service delivery priorities, in consultation with Tribes.

SUPPORTING FUNDING OF TRIBES OUTSIDE OF A GRANT-BASED SYSTEM

The health needs of Indian people are chronic and multi-faceted; such needs must be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes may receive awards and benefit from occasional increases, while other Tribes do not. This creates two categories of Tribes – those that have the technical experience and financial resources to secure competitive awards, and those that do not. Many Tribes without the capacity to secure competitive grant funding do not benefit from increases to appropriations as a result. There are too many restrictions and requirements to federal grants including excessive reporting, limitations on use of funds, and timelines, which all detract from patient care. This also creates additional administrative burden for receiving Tribes, who sometimes do not have the capacity to perform those tasks. Ironically, Contract Support Costs (CSC), the administrative funds to pay for these performing of these tasks, obligated in addition to direct base funding, are not provided to manage grant awards. Only indirect costs are allowed with grant funds and must be subtracted from the total grant award, resulting in far less funding for the provision of health services. Grant programs harm the relationship between Tribal Nations and the federal government and do not uphold the federal trust responsibility.

IHS SHOULD NEVER USE A GRANT PROGRAM TO FUND ONGOING CRITICAL INDIAN HEALTH NEEDS

IHS has received a total of $30 million to fund its new "Community Opioid Intervention Pilot Project" program. While Congress did specify that IHS must use the funds to award grants, Congress did not dictate that a competitive grant process be used. Appropriations language did not prohibit the use of formula grant awards through compacts or contracts, which would allow tribes to collect CSC in addition to grant funding. Instead, IHS decided to use the competitive grant award process, even after most tribal consultation responses objected to this methodology. As a result, the initial grant cycle will award approximately $16.5 million to only two grantees per Area; six grant awards are set-aside for Urban organizations and one additional will be awarded to IHS's highest priority Alaska, Bemidji and Billings Areas. Each grant requires semi-annual progress and quarterly financial reporting and compliance with the burdensome HHS grants management policies and procedures. There are many administrative requirements, yet additional CSC funding was not provided for grant administration even though 1) statutes do not exempt special projects or grant funding from the mandate to pay CSC in full and 2) Congress now appropriates CSC based on actual need. The grant-making process often burdens the neediest tribal communities who lack the capacity to secure or administer such funds. And even though one IHS Area or community may struggle most with opioid addiction, others continue to fight alcohol and methamphetamine addictions; yet, under this grant which limits qualifying needs to a single problem, tribes cannot access additional funds to meet their community's most pressing needs.

Funding for ongoing health services in FY 2023 should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. Across Indian Country, the high incidence of heart disease, suicide, cancer, substance abuse, diabetes, and cirrhosis is well documented. Grants used to address any Indian health issue limits funding for and restricts access to culturally appropriate care.

7th Recommendation

Recommend the Department and the Office of Management and Budget (OMB) work with Congress to create a mandatory appropriation account for the status and legal obligation to pay CSC and 105(l) lease agreements, to avoid competition with discretionary funding that could be directed to other program increases.

The Indian Self-Determination and Education Assistance Act (ISDEAA) at 25 U.S.C. § 5324(l) authorizes IHS to enter into a lease for a facility upon the request of a Tribal Nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. Lease requests have grown exponentially in the past four years, with many Tribal Nations increasingly turning to 105(l) leases in response to the chronic underfunding of facility maintenance, repair, and replacement costs.

As held by the U.S. District Court for the District of Columbia under *Maniilaq Association v. Burwell* in 2016, Section 105(l) leases must be paid in full by IHS. However, in response to growing lease proposals and after failing to adequately project costs in both FY 2018 and FY 2019, IHS chose to disregard Tribal recommendations, obtained through government-to-government consultation, by unilaterally reprogramming critical funding twice from other line items to fund these obligations. This included $25 million in FY 2018 from inflationary increases, as well as $72 million in FY 2019 from inflationary increases and staffing packages due to delays in construction. For FY 2020, Congress provided $125 million for 105(l) lease funding, an $89 million increase from the FY 2019 enacted level. While this increase helped to prevent another large reprogram within the IHS budget, it impacted overall funding for IHS by consuming approximately 50% of the agency's total appropriations increase in FY 2020.

For FY 2021, IHS supported a separate, indefinite appropriation for 105(l) leases, in accordance with long-standing recommendations from Tribal Nations. While Tribal Nations are pleased that Congress honored our guidance and provided a separate, indefinite appropriation for this binding obligation, this is only a short-term solution to address the impacts of rising 105(l) costs. Although this mechanism insulates other IHS budget lines from future reprogramming, IHS' estimate of total funding for 105(l) obligations is funded as a part of its total allocation from Congress.

With every likelihood that this obligation, and therefore, IHS' estimate, will grow, Tribal Nations are concerned that 105(l) costs could have detrimental impact on overall increases for IHS, including funds for patient care. It is with this in mind that the Workgroup continues to urge that funding for 105(l) leasing be moved to the mandatory side of the federal budget. We urge IHS to support this move as a way to ensure that its other lines are truly insulated from its binding obligations.

In addition, we note that in the FY 2021 Budget Request IHS proposed statutory limitations to 105(l) leases in the absence of Tribal consultation. Rather than making unilateral proposals that undermine IHS' obligation to seek the guidance of Tribal Nations, the Workgroup asks that IHS convene a joint Tribal-federal workgroup to assist with policy development around 105(l) lease negotiations and calculations. The Workgroup further expects that any 105(l) leasing policy be developed in consultation with Tribal Nations.

8th Recommendation

Permanently Reauthorize the Special Diabetes Program for Indians and increase funding to $250 million per year, with built-in automatic annual inflationary increases.

The Workgroup recommends that the Administration propose permanent authorization of the Special Diabetes Program for Indians (SDPI). Also the Workgroup recommends providing tribes flexibility in choosing how to receive SDPI funds: through 638 contracts or compacts or through direct service provided by Indian Health Services.

Although Tribes are thankful for the current SDPI funding, major concern is that SDPI renewal does not provide permanent funding. Tribes and tribal organizations have endured a high degree of uncertainty since 2019. Many tribal health services experienced disruption of delivery of care amid the COVID-19 pandemic. This pandemic has impacted American Indians and Alaska Native who already live with pre-existing health conditions at risk 3.5 — 4.5 times higher than the general population. Many programs experienced budgetary cuts, reduction in ability to purchase necessary diagnostic equipment and even furlough healthcare providers. Permanent funding would ensure the implementation of diabetes outreach, education and prevention for Tribal Patients. A recent three-year extension of SDPI funding is definitely helpful in providing short-term resources. But our current strategic planning is hindered due to the lack of guaranteed funding after the year 2023. If the SDPI funding after 2023 is not renewed or is reduced, this will negatively impact resources and tribal members' clinical outcomes will be adversely affected.

No public health program compares to the achievements of SDPI. The continued resources provided by SDPI funding would allow us to carry on a life-saving diabetes prevention and management program. Reduction in the likelihood of diabetes means a reduction of disease rates including renal failure, heart disease and hypertension.

Secured permanent funding is the keystone toward prevention, health promotion, and diabetes awareness. Without permanent SDPI grant funding, preventative care, direct services and community outreach will be difficult to sustain. Permanent reauthorization of SDPI is a common-sense approach that will support a highly successful program.

9th Recommendation

Provide Recurring Funding to Support Public Health Infrastructure to Address Current and Future Public Health Emergencies

The sovereign status of Tribal nations allows for enhancing and sustaining public health capacity for generations to come. Assurance from federal agencies to honor federal trust responsibility in providing health services and to support public health capacity through self-determination and self-governance is a priority of Tribal nations.

A recent 2019 report by the National Indian Health Board on public health capacity concluded that:

"Advancing public health capacity in Tribal Communities remains a continued priority across Indian Country... Tribal public health is inadequately resourced"

Public health professionals of Tribal nations strive to decrease disparities by providing adequate immunizations, monitoring and prevention of diseases, cancer prevention, water and sanitation, health promotion, and injury prevention across Indian Country. The prevalence of chronic diseases is common in Tribal nations and leading causes of death are mostly preventable. A strong public health infrastructure is necessary to effectively provide public health services to prevent disease, respond to emerging public health threats and to promote the well-being of individuals.

In 2020, a new disease named coronavirus from abroad disrupted the lives of Tribal communities and the United States. The weaknesses of our public health infrastructure played a major factor in higher transmissions of COVID-19, especially in our remote communities where our elders were supposed to be protected. As a result of these deficiencies, COVID-19 mortality rate for Tribal nations surpassed all racial and ethnicity populations. The lives lost to COVID-19 can never be forgotten, but we must move forward to build a strong public health workforce to assess and address community health needs, plan, implement and evaluate interventions.

The following are recommendations to improve and sustain the public health infrastructure for Tribal nations:

- Recognize Tribal health departments similar to state-like health departments
- Redefine Tribal health systems across Tribal nations
- Understand and consult with Tribal nations regarding public health infrastructure development and/or sustainability
- Expand public health accreditation efforts well after sufficient resources are provided
- Bridge public health and clinical interventions to support patient-centered care
- Provide adequate resources for training and staffing development
- Establish set asides to support establishment of public health infrastructure

10th Recommendation

Declare IHS a jurisdiction for federal vaccine distributions, and maintain the flexibility of Tribes to choose between States and IHS for distribution.

The disparity in COVID-19-related death rates is not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the largest disparities. Among AI/ANs aged 20-29 years, 30-39 years, and 40-49 years, the COVID-19-related **mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts.**[26] Across 23 states, the cumulative incidence rate of laboratory-confirmed COVID-19 infections was **3.5 times (350%) higher among AI/ANs persons than that of non-Hispanic white persons**[27]

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

As of March 16, 2021, there have been 1.243 million vaccines distributed through IHS, and 761,646 doses have been administered. The latest number from IHS regarding the number of vaccines administered by the tribes who received the vaccine through states is 178,000 doses. NIHB is optimistic how this funding will impact this continued effort in eradicating the disease.

For some states in the country, vaccine administration, or "shots in arms," have been less than ideal. However, Tribal government vaccine rollouts have been far outpacing their state counterparts. Regardless of how a Tribe obtained the vaccines, once they had them in hand, Tribes were able to get the doses in the arms of their citizens faster and more efficient than most of their surrounding communities and states. For instance, the state of Alaska had vaccinated 91,000 people at the end of January 2021 and 10,000 of those shots were administered to Tribal patients. Various Tribes in Oklahoma has done so well in vaccinating their citizens, they have recently opened their vaccine efforts to the community, regardless of if they are IHS eligible or not. Anyone in Oklahoma can now receive the vaccine through the tribe. For the Rosebud Sioux Tribe, they have been vaccinating those in their community nearly double the rate of South Dakota.[28] In an analysis by the AP, **federal data showed Native Americans were getting vaccinated at a higher rate** than all but five states by the end of February 2021.[29]

A key success of the vaccine rollout has been including Tribes/IHS as a jurisdiction for vaccine distribution. By allowing Tribes to exercise self-governance and make decisions for their People, Tribes have been able to coordinate and distribute the vaccine and get them into arms faster than many of their surrounding communities. This has been the perfect example as to how and why self-governance and self determination works.

In previous public health emergencies, Tribes were left to fend for ourselves with little to no resources from the government. While those previous emergencies were not at the same level of urgency and were as wide spread as COVID-19, this time around Tribes were prepared. This is because Tribes were declared a jurisdiction, directly received the vaccine, and were provided needed flexibilities to ensure they could exercise self-governance and make decisions that were best for their people to receive the vaccine.

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

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

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

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

12th Recommendation

Engage the Office of Management and Budget in Tribal Budget Formulation for Meaningful Consultation

In order to have a more effective process, Tribes must have the opportunity to meet directly with the Office of Management and Budget (OMB) to ensure that they clearly understand the budget priorities put forward by the Tribes. OMB must be present during the national budget formulation work session, normally held in February. Engagement prior to and in follow up from that meeting is also imperative. Having this direct engagement during the national budget formulation would allow for better communication and transparency on the process the government uses at a key point in time, and it would also allow Tribes to focus more directly on the specific concerns which might be raised by key decision makers by providing them with clarifying information about the funding requirements of IHS and Tribal health programs. The trust responsibility to the Tribes cannot be compartmentalized and having OMB present and participating in meaningful national budget formulation would be a step toward honoring that responsibility.

Conclusion

The social determinants of health and poor health status of health and poor health status for AI/ANs could be dramatically improved with adequate investment into the health, public health and health delivery systems in Indian Country. Tribes are grateful for the recent incremental increases to the IHS Appropriation over the last several years. We have increasing concerns however that the failure to fulfill the full Trust and Treaty obligations cannot be met with significant investment in infrastructure including equipment, buildings and technology. Additionally, that funding for program costs are needed, including staffing capacity, in order have a real impact on improving health outcomes. Increases in the IHS annual appropriated budget since FY 2008 have not been sufficient enough to even cover costs associated with medical and non-medical inflation. Increases have barely kept pace with population growth and the rightful full funding of Contract Support Costs. Funding must be identified to actually realize marked improvements in health outcomes and to build public health infrastructure for all AI/ANs.

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Unfortunately, the 2-5% incremental increases to the IHS budget over the past decade have not adequately kept pace with expenses related to population growth and medical and non-medical inflation. Leaders of our Tribal Nations insist that a true and meaningful investment be made to finally eradicate the pervasive health disparities which has overwhelmed Indian Country for years. It will take a true commitment between the United States and Tribal Nation Leadership to put a strategy and budget in place. AI/AN Tribes have put our best strategy and budget together in this FY 2023 Budget Recommendation; it is time for these United States to put forward their best strategy and budget to fulfill Trust responsibilities. Decisive action by this Administration must occur to prioritize department resources to bring the health of AI/AN citizens closer to parity with the rest of the citizens of the United States. We must rise above just settling for maintenance funding to sustain what has proven to be an unacceptable level of health care in Tribal reservations and villages.

The TBFWG implores the Administration to work with Congress in FY 2023 to enact a serious investment in Indian health that will honor and fulfill the promises made to our ancestors. One important first action is to support the enactment of Advance Appropriations for IHS. This will reaffirm that the government is committed to eliminating disruption to the IHS health delivery system, no matter what delays in the discretionary appropriations budget might occur. Advance appropriations is a common sense solution that will not place undue burden on the federal budget, but create greater sustainability for Tribal communities.

As important, and as noted multiple times in this document, the Administration must put in place a strategy to support stable and full funding for the IHS through any and all available means. Medicaid and other payer resources, for example, were used by many IHS and Tribally operated health systems to cover essential costs during the recent government shutdown. It is critical that the Administration honor the trust responsibility through permitting IHS and Tribal facilities to access to the Medicaid program; allowing states to tailor their benefit plans and requirements to fit unique Indian needs will ensure that Medicaid works in Indian Country.

Tribes welcomed the supplemental funds through the various COVID-19 relief legislative packages over the past year for Indian health, however there is still so much

work left to be done. We stand with President Biden that these funds only serve as a down payment for the true funding needed to meet the Treaty and Trust responsibilities. The Tribes have repeatedly and thoughtfully stated our true health funding needs for decades through this budget formulation process.

The Indian Health Service budget represents a sacred promise made between these United States and our ancestors to fulfill the trust and treaty obligation to provide healthcare services to all American Indians and Alaska Natives. Time and again, Congress and the courts have affirmed this federal trust responsibility. This Administration must take actionable steps to fulfill this promise by putting forward a true and impactful budget proposal. Our proud Nations continue to suffer from preventable or treatable diseases and our citizens die younger than other Americans. This hidden truth must be addressed quickly and in a meaningful way. Failure to apportion an adequate level of funding for health services and programs within the IHS as well as continued failure to investment in Tribal Public Health systems and basic health system infrastructure, are the primary reason for these unconscionable and avoidable health disparities. This document reflects the Tribal budget priorities for this Administration to consider as it formulates the FY 2023 budget request. We believe that it provides a clear road map to make meaningful progress toward satisfying fulfillment of the agreement made by the United States, as our federal trustee, to provide quality health care to the 574 federally recognized Tribes in America.

We, as Tribal leaders appointed to serve on the national budget formulation workgroup, firmly believe that by working collaboratively through our government-to government relationship, together we can achieve real progress to eliminate health disparities and create wellness in AI/AN nations. It is imperative that the budget recommendations be acted on immediately if we are to build a strong and sustainable Indian health system. Doing so will honor Tribal sovereignty and the federal fulfillment of the historic trust responsibility to our Nations. We look forward to working with you directly as you engage in conversations on the FY 2023 budget.

ACKNOWLEDGEMENTS

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