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April 12, 2023

Testimony of United South and Eastern Tribes Sovereignty Protection Fund Submitted to the United States House of Representatives Committee on Natural Resources Indian and Insular Affairs Subcommittee for the Record of its Oversight Hearing on "Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities."

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

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

IHS Reform Efforts

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

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

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

Fulfill Trust and Treaty Obligations Through Full and Mandatory IHS Funding

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

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

While USET SPF does not dispute that the IHS has challenges to overcome, we assert that they are largely due to the chronic underfunding of the agency and could be solved in a full funding atmosphere. For example, the memorandum issued for the hearing cited challenges in the Purchased/Referred Care (PRC) program, including problems with the formula and cost overruns. The PRC program, which provides for specialty health care services not available within the IHS, exists mainly because of the IHS's lack of resources for specialty and intensive care. Many of the challenges associated with the PRC program currently could be avoided with proper investments in hospital and clinical services within Indian Country - investments that would be made in a full, mandatory funding atmosphere.

The Biden-Harris Administration's FY 2024 Request continues to propose a shift in funding for IHS from the discretionary to the mandatory side of the federal budget, including a 10-year plan to close funding gaps and an exemption from sequestration, a move that would provide even greater stability for the agency and is more representative of perpetual trust and treaty obligations. This 10-year plan would shift the IHS to mandatory funding beginning in FY 2025 with funding increases each year to account for inflation, cost

increases, staffing needs and current deficiencies within the system. By FY 2033, the total annual funding level for the IHS would reach $44 billion, a figure that approaches the resources necessary to fund the agency more comprehensively. The plan includes a proposal to establish a new dedicated funding stream for innovative public health infrastructure investment in Indian Country and, importantly, the President's proposed plan also includes a mandatory indefinite appropriation for Contract Support Costs (CSC) and Section 105(l) Lease agreements beginning immediately. USET SPF strongly supports immediately shifting CSC and 105(l) lease agreements to mandatory funding. Year after year, USET SPF has urged multiple Administrations and Congresses to request and enact budgets that honor the unique, Nation-to-Nation relationship between Tribal Nations and the U.S., including providing full and mandatory funding that accounts for all agency authorities, including currently unfunded Indian Health Care Improvement Act (IHCIA) authorities. While we firmly believe all Indian Country funding should be fully funded today, including the IHS, we continue to strongly support this proposal, recognizing that additional detail and planning is necessary to provide a fully developed plan to fund IHS on a full and mandatory basis. USET SPF strongly urges Congress to take up this proposal, and we look forward to working with the Committee on potential legislative language.

Expand Self-Governance Compacting and Contracting

The United States government bears a responsibility to uphold the trust obligation, and that obligation includes upholding Tribal sovereignty, self-determination, and self-governance. The Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes the federal government to enter into compacts and contracts with Tribal Nations to provide services that the federal government would otherwise be obligated to provide under the trust and treaty obligations. Although self-government by Tribal Nations existed far before the passage of ISDEAA, Tribal Nations have demonstrated through ISDEAA authorities since the bill's enactment that we are best positioned to deliver essential government services to our citizens, including through the assumption of federal program and services. Tribal Nations are directly accountable to and aware of the priorities and problems of our own communities, allowing us to respond immediately and effectively to challenges and changing circumstances.

The success of self-governance under the ISDEAA is reflected in the significant growth of Tribal self-governance programs since its passage. In the USET region, the majority of our Tribal Nations engage in self-governance compacting or contracting to provide essential health care services. Across Indian Country, nearly two-thirds of federally recognized Tribal Nations engage in self-governance, either directly through the IHS or through Tribal organizations and intertribal consortia. In Fiscal Year (FY) 2020, approximately 50% of the IHS budget was distributed to self-governance Tribal Nations. However, despite the success of Tribal Nations in exercising these authorities under ISDEAA, the goals and potential of self-governance have not yet been fully realized. Many opportunities still remain to improve and expand self-governance, particularly within HHS. USET SPF, along with Tribal Nations and other regional and national organizations, has consistently advocated for all federal programs and dollars to be eligible for inclusion in self-governance compacts and contracts.

Attempts to expand self-governance compacting and contracting administratively have encountered barriers due to the limiting language under current law, as well as the misperceptions of federal officials. In 2013, the Self-Governance Tribal Federal Workgroup (SGTFW), established within the HHS, completed a study exploring the feasibility of expanding Tribal self-governance into HHS programs beyond those of IHS and concluded that the expansion of self-governance to non-IHS programs was feasible, but would require Congressional action. USET SPF maintains that if true expansion of self-governance is only possible through legislative action, Congress must prioritize this action. We strongly support legislative proposals that would create a demonstration project at HHS aimed at expanding ISDEAA authority to more programs

within the Department. In addition, a major priority for Tribal Nations during the upcoming reauthorization of the Special Diabetes Program for Indians (SDPI), along with increased funding and permanency for the program, is ISDEAA authority. USET SPF looks forward to supporting legislation aimed at fulfilling these priorities during this Congress.

Improve Public Health Funding and Data Sharing

Many of the challenges and shortfalls plaguing the Indian Health Care System are the result of sustained, chronic underinvestment in prevention and public health measures paired with generations of historical trauma and structural discrimination. As the United States's public health infrastructure took shape and grew throughout the twentieth century, Tribal Nations were routinely left out of resource distribution. While Tribal Nations have always and continue to invest in the health and wellbeing of our citizens, our efforts continue to be hampered by lack of funding and inconsistently applied data sharing authorities. In order to more effectively respond to the challenges in our communities, including those posed by current and future public health crises, Tribal Nations need increased resources as well as the ability to efficiently and easily obtain necessary public health data.

In an already strained funding environment, there are often little resources left for public health prevention and surveillance activities in Tribal Nations. Although the IHS supports limited public health activities at federally operated facilities, the primary responsibility for the development and delivery of public health infrastructure and services often lies with Tribal Nations, particularly in regions with high concentrations of self-governance Tribal Nations. While many Tribal Nations and IHS regions have worked to incorporate some public health components in their governments, these entities often do not operate at the same capacity as state programs, and certainly lack much of the authority afforded to state entities. The Indian Health Care Improvement Act (IHCIA) authorized the formation of Tribal Epidemiology Centers (TECs), and since 1996, the TECs have been working to improve the capacity of Tribal health departments to deal with public health issues and priorities. TECs are charged with seven main functions, including data collection, evaluation of systems, and the provision of technical assistance to Tribal Nations. The USET TEC, which serves Tribal Nations in the Nashville IHS Area, provides both aggregate and Tribal Nation-specific public health and mortality data in addition to its other functions. However, despite the critical nature of this invaluable work and Congressional directives to share data, TECs struggle with accessing public health data not only on the federal and state levels, but the Tribal levels as well. Access to timely, accurate data is vital to the delivery of healthcare services in Indian Country, as it is difficult to direct resources appropriately without fully understanding the challenges facing our people.

Congress has the obligation to correct these challenges within Indian Country. In addition to providing full funding to the IHS, Congress must meaningfully invest in public health capacity building in Indian Country. Funding for expanding the Community Health Aide Program (CHAP) to the lower 48 is one example of necessary investments in public health and preventative care in Tribal Nations. To mitigate challenges in data access, the federal government should compel agencies like the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) to issue specific guidance to states and other public health entities directing them to comply with legislative directives to share usable data with Tribal Nations. USET SPF is appreciative of efforts within the Subcommittee to conduct oversight in these matters.

Conclusion

While the challenges in delivering healthcare in Indian Country are numerous, the opportunities for correcting them are simple and widely supported. The United States has a trust responsibility to provide for the "highest possible health status" of Tribal communities, and that necessitates funding the entities and

organizations that provide that healthcare fully. It also requires an expanded recognition of Tribal sovereignty and self-determination in our health care. Tribal Nations are unequivocally best positioned to provide for the health and wellness of our communities, but we require the proper resources to which we are legally and morally entitled. USET SPF appreciates the work of the Subcommittee in calling additional attention to the challenges within the Indian Health System, and we look forward to working with the Subcommittee and its members to advance solutions to these challenges this Congress.