March 20, 2020

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
204 U.S. Capitol Building
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
H-204 U.S. Capitol Building
Washington, DC 20515

Dear Speaker Pelosi and Minority Leader McCarthy:

This letter is on behalf of the undersigned American Indian and Alaska Native organizations, which collectively serve all 574 federally-recognized American Indian and Alaska Native tribal nations. The recommendations outlined in this letter encompass critical funding and policy needs to help protect and prepare American Indian and Alaska Native communities to effectively respond to the current 2019 novel coronavirus (COVID-19) pandemic.

As the urgency, infection rate, and death toll of the COVID-19 pandemic intensifies, it has become increasingly clear that Indian Country needs significantly more resources to protect and preserve human life and address the grave economic impacts tribal nations face, as they close government operations and tribal enterprises to protect the health of their citizens and surrounding communities. American Indian and Alaska Native communities are disproportionately impacted by the health conditions that the Centers for Disease Control and Prevention (CDC) notes increase risk for a more serious COVID-19 illness, including respiratory illnesses, diabetes, and other health conditions. We urge you to include the following requests as you work on any current, and future supplemental package to stem the COVID-19 pandemic. In addition to the specific funding and policy requests outlined below, tribal nations are strongly urging maximum flexibility in the use of new and existing funds to be able to comprehensively address COVID-19 response efforts.

This letter is one of three letters addressing: economic development and employment; tribal governance and housing/community development; and health, education, and nutrition. The language included in this letter covers the health, education, and nutritional needs for Indian Country and is organized in the following way:

<u>Health</u>

Health Section 1: Critical Funding and Access Needs
Health Section 2: Technical Medicaid/Medicare Fixes

Health Section 3: Technical Amendments Needed
Health Section 4: Legislative Fixes and Reauthorizations

Education

Education Section 1: Higher Education
Education Section 2: K-12 Education

Nutrition

Nutrition Section 1: Funding and Access Needs

Thank you for your consideration of the recommendations outlined in this letter. We look forward to working with you to ensure that Indian Country's concerns and priorities are comprehensively addressed, as we respond to the COVID-19 emergency.

Sincerely,

National Congress of American Indians
National Indian Health Board
National Council of Urban Indian Health
National Indian Education Association
American Indian Higher Education Consortium
Self-Governance Communication & Education Tribal Consortium
USET Sovereignty Protection Fund
Native Farm Bill Coalition

HEALTH

Health Section 1: Critical Funding and Access Needs

- **Provide $1.2 billion in funding for IHS Services Account.**

Background: We are appreciative of the $64 million included in the House-passed H.R. 6201. However, Indian Country needs an additional $1.2 billion in funding for the IHS Services Account. This funding is critical to meet the increased demand for health services and education, recruit providers, increase testing capacity, address the needs of Urban Indian Organizations (UIOs), secure medical supplies, and other priorities. The Indian health system already experiences a roughly 25 percent vacancy rate for providers, including physicians, nurses, nurse practitioners, and other provider types. Despite the urgent need for more providers, IHS and Tribal sites have actually *lost* nearly 200 Commission Corps to deployments in response to the COVID-19 emergency.

This has left the Indian health system even less prepared to meet the influx of need as more and more Tribal citizens elect to come home to be with family during this emergency. IHS and Tribal sites are already reporting critical shortages for medical supplies such as personal protective equipment (PPE), respirators, extracorporeal oxygenation tables, and ventilators. In fact, as IHS and Tribal facilities deplete PPEs and further lose Commission Corps officers to deployments, midlevel providers such as Community Health Representatives and Community Health Aides will be forced to carry a larger burden to meet patient demand. In addition, UIOs are already experiencing immediate needs for critical funding. For instance, the UIO in Seattle, WA, is projecting a monthly loss of $734,922 during the COVID-19 pandemic. The UIO in San Jose, CA, has had COVID-19 cases increase more than threefold over the past few days. The $1.1 billion will provide significant relief and allow the Indian health system to prepare and respond to the COVID-19 emergency by:

- Significantly expanding the availability of health services within IHS, Tribal, and urban Indian hospitals, clinics, and health programs;
- Providing $94 million in funding for the urban line item in the IHS Services Account
- Bolstering staffing and personnel capacity by hiring new Community Health Representatives and/or Public Health Nurses;
- Boosting COVID-19 disease surveillance by funding technical assistance and training efforts to improve disease reporting and data sharing between Tribal Epidemiology Centers and IHS and Tribal facilities; and
- Providing culturally appropriate mental health care for Tribal citizens experiencing depression or other mental health symptoms as a result of COVID-19 isolation.

***Legislative Text*:**
For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, an additional

$1,200,000,000 above the FY 2020 enacted level to remain available until expended for services furnished by the Indian Health Service related to COVID-19 preparedness, prevention, treatment, and response efforts: Provided, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract ward and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: Provided further, That such amount is designated by the Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

- **Provide $200 million in funding for IHS Facilities Account**.

Background: IHS and Tribes need an additional $200 million in funding for facilities construction to help address the COVID-19 emergency. Many IHS and Tribal hospitals and clinics already have capacity limitations such as a shortage of beds in intensive care units (ICUs), or lack of inpatient facilities altogether. Many American Indian and Alaska Native households already experience significant overcrowding, which is likely to be exacerbated by the influx of Tribal citizens returning home during this crisis. Given the significant resource shortages facing the Indian health system, there is significant concern that without immediate relief to bolster hospital capacity, the Indian health system will buckle under this emergency. IHS needs flexible funding to increase capacity for shelters of opportunity from medical tents to gymnasiums, beds, triage units, and other priorities. There is an urgent need to:

- Increase capacity for shelters of opportunity;
- Build auxiliary facilities and nonmedical facilities for social isolation;
- Bolster hospital capacity;
- Build temporary lodging for healthcare providers; and
- Improve sanitation infrastructure to address increased demand and use of water, sewer, and waste systems.

Legislative Text:
For COVID-19 related needs pertaining to construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, an additional $200 million above the FY 2020 enacted level to remain available until expended: Provided further, That such amount is designated by the Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

- **Provide $1 billion in funding to ensure Tribal communities have immediate access to safe water and sanitation systems.**

Background: According to the World Health Organization (WHO), the provision of safe water, sanitation, and hygienic conditions is essential to protecting human health during all infectious disease outbreaks, including the COVID-19 outbreak. In addition, WHO reports that safe drinking water and sanitation infrastructure helps to prevent human-to-human transmission of the COVID-19 virus. Unfortunately, approximately thirteen percent of Native American homes lack safe water or adequate wastewater disposal facilities, as compared with under one percent of homes nationwide. Federal efforts to address this crisis have been inadequate due to significant underfunding. In 2018, the U.S. Government Accountability Office reported that $3.2 billion is needed to provide safe drinking water and adequate sewage systems for Indian Country. If Indian Country is to follow CDC guidelines for disease prevention, we need $1 billion in assistance to get immediate safe water and sanitation systems to our Tribal communities and request the full need of $3.2 billion to be provided over the next 5 years.

- **Provide $24 million in funding for Tribal Epidemiology Centers.**

Background: Tribal Epidemiology Centers (TECs) provide invaluable, culturally competent support and services to Tribal communities through public health data collection, surveillance, and reporting, as well as response to public emergencies. As TECs seek to address COVID-19 across Indian Country, they are faced with limited access to critical public health preparedness resources that are provided to states, such as Prevention and Public Health funding from the Centers for Disease Control and Prevention (CDC). In order for TECs to provide a robust COVID-19 response to Tribal Nations, TECs must have parity with states by having access to funding that would provide critical support to Tribal Nations and Urban Indian populations. This includes resources for emergency response planning, training, and technical support, communications, outreach and education, and other public health surveillance activities. As such, $24 million must be provided to TECs for COVID-19 response efforts with the availability of funding provided in a manner that offers flexibility for the unique surveillance needs within each TEC.

Legislative Text:
"Provided further, that $24,000,000 shall be provided to Tribal Epidemiology Centers (TECs) (as defined in 25 U.S.C 1621m) for COVID-19 response efforts in alignment with the seven TEC Core Functions."

- **Expand Telehealth Capacity in Indian Country.**

Background: In light of the COVID-19 pandemic, the Centers for Disease Control and Prevention (CDC) has operationalized a policy of social distancing, isolation, and quarantine to reduce the

spread of the virus. In addition, the Centers for Medicare and Medicaid Services (CMS) has loosened regulatory restrictions on telehealth in recognition of the need for more flexible delivery of health services in a manner that protects the safety of healthcare workers. But telehealth capacity is largely limited in Indian Country for several reasons, including lack of broadband capabilities on most Indian reservations and antiquated medical equipment in most IHS and Tribal facilities. But there are also statutory barriers, particularly around billing and reimbursement. The Snyder Act and the Indian Health Care Improvement Act provide broad authority for IHS and Tribes to operate telehealth programs, including the provision of telehealth services between originating and distant sites that operate across state lines. However, under current law, Medicare does not reimburse for telehealth services provided across state lines. This is problematic for the Indian health system, as most telehealth providers are located in a different state from the patient.

Importantly, federal law already exempts Tribal employees and health programs from in-state licensure requirements.[1] Thus, as stated in the IHS FY 2021 Congressional justification, "…*because state laws are generally inapplicable to such programs, IHS and Tribal health programs are in a unique position to implement telehealth programs that operate across state lines in any number of ways that are not currently recognized or reimbursed by Medicare*." Explicitly authorizing IHS and tribal health programs to receive applicable Medicare reimbursement when telehealth services are provided across state lines will accommodate the unique structures and federal authorities available to IHS and Tribal sites.

- **Provide Tribal Nations, Tribal Consortiums administering healthcare programs, and UIOs with access to supplies needed to administer COVID-19 tests and lab resources for analyzing the tests.**

Background: The World Health Organization reports that every suspected case of COVID-19 should be tested if we are going to be successful isolating this virus and preventing further spread within communities. For tests to be administered, health clinics must have access to numerous materials, including protective gear such as gloves, N-95 masks, and face shields; appropriate swabs and media for taking a sample; vials for submitting swabs to labs for analysis; and sealed bags for transporting the vials. Many, if not all, of these items have become scarce and Tribal health clinics are struggling to get the supplies they need to administer a test. After administering a test, the swabs must be analyzed to determine the presence of COVID-19 and there are a limited number of public or private labs authorized to conduct the analysis. If we are going to isolate this virus, we need the Federal government to immediately distribute supplies currently held in reserves to our clinics that are needed for testing and for increased access to labs that can analyze the results.

- **Ensure continued funding for Community Health Centers.**

[1] See 25 U.S.C. 1621t and 1647a, respectively

Background: The Community Health Centers program, established in 1965, serves as the primary medical home for over 29 million people in more than 12,000 rural and urban communities across America, including in Indian Country. A number of tribes and tribal organizations operate Community Health Centers side by side along with Indian Health Service facilities to serve local populations. The program is heavily utilized by tribes in Alaska and by urban Indian health centers. Ensuring that these facilities are adequately funded during the COVID-19 crisis is critical. The immediate needs for these facilities, including for emergency preparedness:

- An *immediate* $320 million so health centers are provided with the resources they need for PPE and other equipment, staffing and other needs;
- An additional $1 billion is estimated to be needed *within 60 days* which should then become an annual fund to address and prepare for future natural disasters, as it has been done in the past related to other natural disasters, including wildfires, the Zika outbreak, and contaminated water; and
- A stable annual fund of $1 billion (5-year authorization).

- **Provide an additional $200 Million for Maintenance and Improvement of Indian Health Service and tribal facilities used to provide health care services under the Indian Self-Determination Education Assistance Act.**

Background: 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 based on health facility industry standards. Unfortunately, current funding levels for M&I are below about 78% of the total needed for all eligible facilities. The backlog of essential maintenance and repair is estimated to be $767 million to fully fund all M&I needs. The $200 million requested will help reduce this need considerably. Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy health accreditation standards. If adequate funding is not available IHS and Tribes need to reallocate program funds that could be used to help address health needs, including increased needs resulting from the COVID-19 crisis, for facility needs.

Health Section 2: Technical Medicaid/Medicare Fixes

- **Authorize Medicaid Reimbursements for Qualified Indian Health Provider Services and urban Indian programs**.

Background: IHS and Tribal facilities are experiencing significant economic disruption as a result of the COVID-19 pandemic. This has intensified the need to maximize 3rd party reimbursements into the Indian health system. Currently, Indian health care providers only receive reimbursement for health services that are authorized for all providers in a state. Thus, we request that Congress authorizes Indian health care providers across all states to receive Medicaid reimbursement for all mandatory and optional services described as "medical assistance" under Medicaid and specified services authorized under the Indian Health Care Improvement Act (IHCIA)—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible American Indians and Alaska Natives.

Legislative Text:
<u>For Qualified Indian Health Providers:</u>

Amend subsection 1905(a)(2) by striking the "and" before subparagraph (C) and inserting the following:

"and (D) Qualified Indian Provider Services (as defined in subsection (l)(4) of this section) and any other ambulatory services offered by an Indian Health Care Provider and which are otherwise included in the plan."

Add a new subsection 1905(l)(4) as follows:

"(A)(i) The term "Qualified Indian Provider Services" means all services described in paragraphs (1) through (29) of section 1905(a) and all services of the type described in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) sections 1616, 1616l, 1621b, 1621c, 1621d, 1621h, 1621q, 1665a, 1665m[2], when furnished to an individual as a patient of an Indian Health Care Provider (as defined in (B) of this subsection) who is eligible to receive services under the State plan and is eligible to receive services from the Indian Health Service."

"(ii) Notwithstanding any other provision of law, Qualified Indian Provider Services may be provided by authorized non-physician practitioners working within the scope of their license, certification, or authorized practice under federal, state, or tribal law." [Provision might be best placed in an alternative section.]

CODIFY IN FEDERAL LAW THE DEFINITION OF IHCP FROM FEDERAL REGULATIONS AT 42 CFR 447.51 --

[2] These citations include the Community Health Aide Program (1616l), health promotion and disease prevention (1621b), diabetes prevention, treatment, and control (1621c), home- and community-based services (1621d), and behavioral health services (1665a).

Amend Social Security Act Section 1905 (l)(4) by inserting the following as a new subparagraph (B):
"(B) The term "Indian Health Care Provider" means a health program operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of title 25) or inter-tribal consortium (as defined in section 5381 of title 25) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) operating pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program."

For Urban Indian FMAP:

SEC. 1. EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO URBAN INDIAN ORGANIZATIONS.
Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking "Indian Health Care Improvement Act)" and inserting "Indian Health Care Improvement Act) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program."

- **Ensure Reimbursements for services furnished by Indian Health Care Providers outside of an IHS or Tribal Facility.**

Background: The COVID-19 emergency has created a significant need to meet Tribal citizens where they are at and provide more nimble delivery of health services outside the traditional "four walls" of a clinic or hospital. Many IHS and Tribal sites are already having to set up mobile units and outdoor triage centers, and provide more outpatient care. Without the ability to bill for these services, it will create a significant financial strain on the Indian health system. Ensuring reimbursements for IHS and Tribal providers follow wherever the service is delivered will improve the timeliness and accessibility of care during the COVID-19 emergency, and help bolster desperately needed financial resources.

Legislative Text:
Amend section 1905(a)(9) [42 U.S.C. 1396d(a)(9)][3] by inserting after "address":

"and including such services furnished in any location by or through an Indian Health Care Provider as defined in (l)(4)(B)"

- **Exempt American Indians and Alaska Natives from cost-sharing under Medicare.**

Background: IHS and Tribal facilities are experiencing significant economic disruption as a result

[3] The citation is to the definition of "Federally-qualified health center".

of the COVID-19 pandemic and need all of the federal resources they can get. American Indians and Alaska Natives are exempt from premiums and cost-sharing in the Medicaid program, but not the Medicare program. The United States has a federal trust responsibility to provide health care for American Indians and Alaska Natives, and cost-sharing requirements are inconsistent with this obligation. The Medicare cost-sharing requirements disproportionately impact Indian health care providers. Other Medicare providers are reimbursed by the Medicare program at 80 percent of reasonable charges, but get paid the remaining 20 percent by their patients or the plans they are enrolled in. IHS and tribal programs do not bill their patients, so they have to waive collection of the additional 20 percent. As a result, IHS and tribal programs are being paid 80 cents on the dollar by the Medicare program compared to other providers. This legislation is needed to ensure that the United States reimburses Indian health care providers in full for Medicare services they provide to Indian people, and to ensure that American Indians and Alaska Natives can seek services outside the Indian health system without having to face significant cost sharing burdens they may not be able to afford.

Legislative Text:

(a) IN GENERAL.—Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended—
by inserting before the period at the end the following:

‘‘, and (g) notwithstanding any provision of law,
(1) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

(2) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such title, shall be at 100 percent of the applicable rate and may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.’’.

Health Section 3: Technical Amendments Needed

- **Provide Tribal and UIO access to the Strategic National Stockpile.**

***Background*:** Currently, IHS and Tribal health authorities' access to the Strategic National Stockpile (SNS) is very limited and is not guaranteed in the SNS statute. In contrast, states' and large municipalities' public health authorities have ready access to the SNS, a federal repository of drugs and medical supplies that can be tapped if a public health emergency could exhaust local supplies. The stockpile is designed for those who need it most in times of emergency and Indian Country should not be left behind.

***Legislative Text*:**
Please refer to S. 3514 introduced on March 17, 2020.

- **Provide Tribal and UIO access to the Public Health Emergency Fund.**

***Background*:** Currently, Tribes and UIOs are not eligible to apply to the Public Health Emergency Preparedness (PHEP) funds from the Centers for Disease Control and Prevention (CDC). Tribes have the same access to resources as everyone else to face down public health emergencies like the COVID-19 pandemic. While the IHS serves as the primary federal agency charged with providing healthcare in Indian Country, all federal agencies – including the CDC – share equally in the requirement to fulfill our trust and treaty obligations

***Legislative Text*:**
Please refer to S. 3584 introduced on March 12, 2020.

Health Section 4: Legislative Fixes and Reauthorizations

- **Move Contract Support Costs, 105(l) lease expenditures, and Purchased/Referred Care to mandatory appropriations.**

Background: The Committee is well aware of case law mandating that the United States pay in full all contract support costs and 105(l) lease expenditures to American Indian and Alaska Native (AI/AN) Tribal Nations and Tribal organizations as authorized under the Indian Self-Determination Act (P.L. 93-638). Court decisions such as *Salazar v. Ramah Navajo Chapter* (2012) and *Maniilaq Association v. Burwell* (2016) have reaffirmed the requirement that the federal government pay in full the costs of CSC and 105(l) lease agreements. However, in recent years, increased expenditures for CSCs and 105(l) have placed immense strains on discretionary caps in the Interior budget, leading to less available dollars to invest in healthcare services, facilities upgrades, and other needs. For instance, the IHS budget increased by approximately $235 million from FY 2019 to FY 2020. Roughly 37 percent of the increase to the IHS budget that year - $89 million – went to 105(l) lease expenditures alone. Tribes appreciate the additional funding and note the necessity of funding 105(l) as a contractual obligation of the federal government. However, it is leading to less and less money in the discretionary budget for actual health services. To ensure the continued viability of these critical line items, Indian Country strongly urges Congress to move CSC and 105(l) lease agreements to mandatory appropriations. Doing so would also open up over $1 billion in the discretionary IHS budget to reinvest in better quality healthcare and necessary updates to, and construction of, IHS and Tribal health facilities.

Lack of meaningful increases to the IHS Services Account has particularly impacted the PRC line item. 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 the Indian healthcare delivery system. But PRC is beset by inadequate funding that has been made worse by the COVID-19 pandemic. So far, Indian Country has lost over 200 Commission Corps officers to deployments outside the Indian health system for COVID-19 related reasons. This is on top of the existing provider shortages facing IHS and Tribal sites, with eight out of twelve IHS Areas experiencing an average 25 percent provider vacancy rate for physicians, nurses, nurse practitioners, and other critical provider types. Loss of providers during this pandemic is placing a particular strain on PRC, as Indian Country is further losing the capacity to treat patients within the Indian health system. In FY 2018 alone, before the COVID-19 pandemic, PRC had to deny over $676 million in services for an estimated 163,058 AI/AN health care service requests due to inadequate funding. In addition, because PRC dollars are used to purchase care in the volatile private market, it is heavily impacted by annual increases in medical inflation. However, because PRC has been largely flat-funded several years in a row, its buying power continues to decrease. Lack of sufficient funding for PRC forces IHS and Tribal Nations to ration health care based on an antiquated ranked medical priority system. Moving PRC to mandatory would help ensure that the Indian health system has crucial resources to provide patient care during the COVID-19 pandemic and beyond.

Legislative Text:
<u>For Contract Support Costs:</u>

There are hereby appropriated for the fiscal year beginning October 1, 2020, and for each fiscal year thereafter, out of any funds in the Treasury not otherwise appropriated, such amounts as may be necessary to make payments required by Subsections 106(a)(2), (3), (5), and (6) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 450j-1(a)(2), (3), and (5)) to Indian tribes and tribal organizations for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements entered into pursuant to that Act.

For 105(l) lease expenditures:

There are hereby appropriated for the fiscal year beginning on October 1, 2020, and for each fiscal year thereafter, out of any funds in the Treasury not otherwise appropriated, such amounts as may be necessary to make payments required by section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) to Indian tribes and tribal organizations (as those terms are defined in section 4 of that Act (25 U.S.C. 5304)) for lease costs under that section arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements entered into pursuant to that Act (25 U.S.C. 5301 et seq.).

For Purchased/Referred Care:

There are hereby appropriated for the fiscal year beginning October 1, 2020, and for each fiscal year thereafter, out of any funds in the Treasury not otherwise appropriated, such amounts as may be necessary to make payments required under the Snyder Act (25 U.S.C. § 13), Transfer Act of 1954 (25 U.S.C. § 2001 et seq.), and Indian Health Care Improvement Act (P.L. 94-437, as amended), for items or services authorized under the purchased/referred care system funded by the Indian Health Service whether provided directly by the Indian Health Service or by a n Indian tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

- **Permanently reauthorize the Special Diabetes Program for Indians with automatic annual adjustments tied to medical inflation, and permit Tribes and Tribal organizations to receive funds through self-determination or self-governance contracts and compacts.**

Background: The CDC has noted diabetes as one of the pre-existing conditions that increase a person's risk for a more serious COVID-19 illness. Diabetes rates among American Indians and Alaska Natives are twice the rates of the national average, placing AI/AN communities at significantly higher risk of contracting a more serious COVID-19 infection. Congress established the Special Diabetes Program for Indians (SDPI) to address high rates of Type-2 diabetes among American Indians and Alaska Natives. It has worked. SDPI is one of the most successful public health programs ever implemented. Because of SDPI, rates of End Stage Renal Disease and diabetic eye disease have dropped by more than half. In fact, a report from the Assistant Secretary for Preparedness and Response found that SDPI is responsible for saving Medicare $52 million per year. Despite its great success, SDPI has been flat funded at $150 million since 2004, and has lost

over a third of its buying power to medical inflation. On top of that, since September 2019, Congress has only renewed SDPI in short increments of several weeks, or several months. Right now, SDPI is set to expire on May 22. These short-term extensions have caused significant distress for SDPI programs and have created undue challenges for our patients and community members. They have also led to the loss of providers, curtailing of health services, and delays in purchasing necessary medical equipment due to uncertainty of funding – all while Tribes are also battling the COVID-19 pandemic. A permanent reauthorization with added flexibility for Tribes to receive funds through contracts and compacts would ensure IHS, Tribal, and urban Indian programs have the necessary funds to address diabetes and the increased risk it poses for a more serious COVID-19 illness.

Legislative Text:

SEC. 330C. [254c–3] SPECIAL DIABETES PROGRAMS FOR INDIANS.

(a) IN GENERAL.—The Secretary may make non-competitive grants for providing services for the prevention and treatment of diabetes and related chronic diseases in accordance with subsection (b).

(b) SERVICES THROUGH INDIAN HEALTH FACILITIES.—For purposes of subsection (a), services under such subsection are provided in accordance with this subsection if the services are provided through any of the following entities:

(1) The Indian Health Service.

(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act.

(3) An urban Indian health program operated by an Urban Indian Organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

(c) DELIVERY OF FUNDS.—For purposes of subsection (b), the Secretary shall, upon receipt of a request from an Indian tribe or tribal organization, make awards under this section pursuant to Title I or Title V of the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

(d) FUNDING.—

(1) TRANSFERRED FUNDS.—Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000, to remain available until expended, is hereby transferred and made available in such fiscal year for grants under this section.

(2) APPROPRIATIONS.—For the purpose of making grants under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

(A) $70,000,000 for each of fiscal years 2001 and 2002 (which shall be combined with amounts transferred under paragraph (1) for each such fiscal years);

(B) $100,000,000 for fiscal year 2003;

(C) $150,000,000 for each of fiscal years 2004 through 2017; and

(D) $150,000,000 for each of fiscal years 2018 and 2019, and $96,575,342 for the period beginning on October 1, 2019, and ending on May 22, 2020, to remain available until expended.

(E) for the period beginning May 22, 2020, and for each fiscal year thereafter, out of any funds in the Treasury not otherwise appropriated, $200 million for each fiscal year, to include annual automatic adjustments matched to the rate of medical inflation.

- **Provide mandatory appropriations for Village Built Clinics.**

Background: The Indian Health Service's Village Built Clinic (VBC) Leasing Program provides the foundation for the village health care system in 136 villages in rural Alaska. These clinics, staffed with Community Health Aides or Practitioners, provide the only source of primary and emergency care available to Native and many non-Native residents of remote villages. Unfortunately, the lease program has been chronically underfunded for decades, with a recent study by the Alaska Native Health Board concluding that IHS pays only about 50% of operation and maintenance costs, leaving the villages to subsidize this vital federal program. This situation reduces the health care available locally to village residents and threatens the $270 million investment in these facilities by the federal government, Alaska villages, and the regional tribal health organizations in the Alaska Native Health System.

Legislative Text:
There are hereby appropriated for the fiscal year beginning on October 1, 2020, and for each fiscal year thereafter, out of any funds in the Treasury not otherwise appropriated, such amounts as may be necessary to make payments needed to fully fund Village Built Clinic Leases to Indian tribes and tribal organizations (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)) for lease costs associated with Village Built Clinics used for the Community Health Program arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements entered into pursuant to that Act (25 U.S.C. 5301 et seq.).

EDUCATION

Education Section 1: Higher Education

- **Provide $27 million in the Interior-Bureau of Indian Education account to meet the immediate and critical needs of Tribal Colleges and Universities (TCUs).**

Background: The nation's 37 TCUs already have incurred significant costs related to closing and securing campuses, ensuring that students are able to relocate off campus or sheltering in place with safety patrols; and beginning the first phase of online courses. Nearly all TCUs are moving to online instruction and closing their physical campuses, due to tribal or state directives. TCUs face immediate challenges in addressing: (a) Career and technical courses, which often cannot be converted to online courses; (b) Professional development and course redesign for faculty; (c) Equipment for online delivery of courses; and (c) Lack of internet access in students' homes. The best estimate of the immediate and short term (8-10 weeks) costs that TCUs have and will incur is $**745,520**/institution, for a total of $**26,838,720.**

- **Authorize Tribal Colleges and Universities as eligible entities to participate in the E-Rate program.**

Background*:* Congress should direct the Federal Communications Commission to designate TCUs as eligible entities to participate in the federal E-rate program. This is a low cost, long-term solution to part of the digital divide/homework gap in Indian Country. If TCUs were already part of the E-rate program, the mobile hot spots needed to address the "homework gap" on many reservations already would be in place. The cost is estimated to be $5-8 million per year. This is a modest request compared to the amount of funding available to the E-rate program. (The current annual funding cap is $4.15 billion, of which barely half has been spent this year.)

- **Ensure a robust share for Tribal Colleges and Universities, Alaska Native and Native Hawaiian Serving Institutions (ANNHSIs), Native American Serving nontribal Institutions (NASnTIs) of the requested $1.5 billion for the Department of Education-Postsecondary Education (Strengthening Institutions) account.**

Background*:* Congress must ensure the stability of the institutions of higher education that serve the majority of postsecondary students in Indian Country. Any appropriation for this fund must specifically designate the eligible institutions and should provide flexibility to allow TCUs and others to meet the specific needs of their students, communities, and Tribal nations. For example, TCUs have a range of documented needs. For example, IT infrastructure and training needs of approximately $46 million have been identified through an NSF-funded assessment of TCU cyberinfrastructure (needs, capacity, and strategic planning to upgrade). The study revealed that

TCU internet speeds are the slowest of all institutions of higher education in the country, and that, on average, TCUs pay more than other IHEs for internet connectivity. One TCU has the most expensive, and slowest internet speed of all IHEs in the country. TCU equipment refresh rate is 8.3 years, while 3-5 years is standard practice. If TCUs are to deliver high quality online/distance learning to American Indians and Alaska Natives in times of emergency, these gaps must be addressed as rapidly as possible. Further, low income, rural students lack consistent, reliable internet access at home, and many lack the equipment necessary to engage in coursework and homework (tablets, computers, laptops). Even if TCU campuses are fully equipped, without internet access in the community, TCU students will not fully benefit. Identified solutions include mobile hot spots in semi-public places in the community, where TCU students could drive or walk, to get access closer to home, while ensuring social distancing. This funding would allow TCUs to address a range of needs in a sustainable, community of practice manner while ensuring that online teaching and learning modalities and processes are compliant with accreditation directives and that student and employee health and well-being are protected.

- **Provide a TCU-specific set-aside of $40 million, to be administered by the BIE, if a National Emergency Student Financial Aid Fund is established in the Department of Education account.**

Background*:* Certain provisions of the *Supporting Students in Response to Coronavirus Act, H.R. 6275 and S. 3489*, may be included in an upcoming emergency spending bill. To ensure that American Indian and Alaska Native students can participate in this competitive program, Congress should set-aside a minimum of $40 million (of the proposed $1.2 billion) for a TCU-based program. The history of federal program participation shows that small, under-resourced TCUs are not competitive in pools where they must compete with large state and private institutions. Most TCUs do not even have sponsored programs office or full-time grant writers. Yet, we know that emergency aid is critically important to TCU students and that it is extremely effective. In a recent survey of a small emergency aid program for TCUs ($15,000 per TCU), TCUs students who received small emergency aid grants of $1,000 or less had a retention rate of more than 90 percent, compared to overall retention rates of 30-40 percent. As TCUs transition to online learning, students need food support, supplies for family members, assistance with bill payment, including internet access and phones. It is essential that a set-aside be established, or our students will see very little of this critically needed support.

Education Section 2: K-12 Education

- **Authorize Tribally Controlled Grant Schools to Access Federal Employee Health Benefits (FEHB).**

Background: Tribally controlled grant schools operate pursuant to the Tribally Controlled Schools Act of 1988, Pub. L. 100-297 (TCSA), and the Indian Self Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and are funded by the Bureau of Indian Education (BIE). Many of these facilities operate under tremendous daily pressure due to years of chronic underfunding and under-resourcing. These conditions are being exacerbated by the COVID-19 pandemic. Without intervention, these schools may incur irreparable financial harm that will directly affect their ability to provide educational opportunities to vulnerable and at-risk Native youth. A simple way to free up hundreds of thousands of dollars – or more – per school in resources that can be redirected to COVID-19 response efforts, like ensuring tele-education services are available and teachers and staff are paid, is by authorizing tribally controlled grant schools to access FEHB for providing health insurance to their employees. A one-line amendment to the Indian Health Care Improvement Act would directly benefit these schools by allowing them to access lower cost insurance options for their employees at significant overall savings – a benefit that is already provided at all other BIE system schools.

Legislative Text*:
Section 409 of the Indian Health Care Improvement Act (25 U.S.C. 1647b) is amended by inserting ''or the Tribally Controlled Schools Act of 1988 (25 U.S.C. 2501 et seq.)'' after ''(25 U.S.C. 450 et seq.)''.

*This text has already been cleared by the Senate Committee on Indian Affairs, the House Natural Resources Committee, and the House Committee on Oversight and Reform.

- **Ensure that a tribal state of emergency is included in the definition of a qualifying emergency.**

Background: As drafted, the Supporting Students in Response to Coronavirus Act (S. 3489) includes a state of emergency declared by governors of states and territories in the definition of a qualifying emergency. Schools in areas where a tribe has declared a state of emergency must also be eligible for funding under this Act to ensure equity in access to funding for critical emergency programs that support the needs of Native students during the coronavirus outbreak.

Legislative Text:
Page 3, line 24; Page 21, line 23; Page 46, line 13 - Add "or appointed tribal leader" after "territory"

- **Provide $40 million for the extension of classes for an estimated four weeks at Bureau of Indian Education schools, including institutions of higher education such as Haskell and SIPI.**

Background: While many schools facing closure have switched to a virtual format, many students attending Bureau of Indian Education schools do not have access to adequate internet for virtual learning in the home. According to the National Center for Education Statistics, 37 percent of Native students do not have access to internet in the home compared to 12 percent of their white peers and the 14 percent nationwide average. As a result, the BIE is facing a potential extension of the school year well into the summer, and dramatically expanding costs of education service delivery in Indian Country. Additional funding is essential to ensuring that students are able to return and learn in safe and healthy classrooms.

- **Ensure access to healthy meals for all students that are impacted by school closures and have no other means to get these meals.**

Background: Due to high rates of participation in the National School Lunch and Breakfast Programs, Native students are disproportionately impacted by school closures that limit access to healthy meals. 510,000 American Indian and Alaska Native students across the country are eligible to receive free or reduced lunches. Participation is even higher in rural and reservation areas, where 48% of eligible rural Native students attend schools where more than 75% of students receive free and reduced lunches. Families often rely on such programs to provide affordable and healthy meals for their children throughout the school year. All students, including Native students, must continue to have access to meals that support their health and wellbeing during a public health emergency.

NUTRITION

Nutrition Section 1: Funding and Access Needs

- **Provide an additional $100 million for the Food Distribution Program on Indian Reservations (FDPIR), waive restrictions, and provide certain flexibilities**

Background*:* As businesses close and people are left out of work, often in areas of high unemployment and persistent poverty, the FDPIR program provides critical assistance for food insecure families in Indian Country. Additional funding will ensure food can be purchased for the anticipated increases to participation, as well as the ability to make updates to infrastructure, facility improvements, and equipment upgrades to store food supplies for this demand and to account for potential food supply chain disruption. Further, a waiver of restrictions is needed to acquire and store food supplies to address the increase in demand and disruptions in the food supply chain for tribal communities.

Legislative Text:

EMERGENCY FUNDING AND AUTHORITIES FOR THE FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS.

(a) Emergency Funding the Food Distribution Program on Indian Reservations.—

(1) For the costs relating to the Food Distribution Program on Indian Reservations, as established under section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)), the Secretary of Agriculture shall make available to Indian Tribal Organizations and State agencies:

(A) ***$50,000,000*** *for additional food purchases; and*

(B) ***$50,000,000*** *for the costs relating to administrative costs, facility improvements, and equipment upgrades.*

(2) No administrative cost-sharing requirements shall be applicable to funds provided under subparagraphs (a)(1) and (a)(2) in accordance with this provision; and

(3) Any remaining funds under subparagraphs (a)(1) and (a)(2) can be used to cover any additional costs or expenses of the programs not accounted for under this provision.

(b) Purchasing Authority and Administrative Flexibility.—

(1) Beginning immediately after the date of passage of this Act, the Secretary of Agriculture shall allow all tribal organizations and state agencies that operate the Food Distribution Program on Indian Reservations, as established under section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)) to have the authority to:

(A) Purchase foods locally and regionally that are nutritionally equivalent to foods provided and authorized for the program;

(B) Expand any service methods and service areas to be responsive to need;

(C) Determine and exercise the necessary administrative flexibility, including verifications and certifications, to serve existing and new program participants as needed.

- **Provide Tribal Access to the Emergency Food Assistance Program (TEFAP)**

Background: Tribal governments and their agencies do not have the full access to the Emergency Food Assistance Program (TEFAP), which is a critical component of the federal government response to food needs during emergency situations. Under the current law and authorities, the donated foods USDA provides for TEFAP only go to "State agencies" who then work with recipient agencies to distribute, control, and use such donated foods. Tribal governments are excluded from directly accessing the food and the resources provided by USDA during an emergency, except in one narrow instance that only applies to less than 5 of the over 574 federally recognized tribes. There are no other known instances of tribal governments, including over 112 approved FDPIR Indian Tribal Organization feeding sites that serve 276 tribes, being able to access these vital emergency donated food sources. With the rapidly growing demand on Food Distribution Program on Indian Reservations (FDPIR) and the need for establishing additional methods of accessing and distribution of essential emergency foods during the COVID-19 crisis, tribal governments, as well as FDPIR Indian Tribal Organizations, must be made directly eligible for the TEFAP program to ensure their citizens have access to essential food resources.

Legislative Text:
Amend 7 U.S.C. 7501(3) by inserting the following at the end:
(D) *is an "Indian tribe" which has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304), and an "tribal organization" which has the meaning given the term in section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)).*

Amend 7 U.S.C. 7501 by adding the following:
(11) Indian Tribes and Indian Tribal Organizations Eligibility
An "Indian tribe" which has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304), and a "tribal organization" which has the meaning given the term in section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)), shall be considered included within the definitions of "state," "state agency," and "eligible recipient agency" for the purposes of carrying out this program.