April 8, 2020

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
S-230 U.S. Capitol Building
Washington, DC 20510

The Honorable Charles E. Schumer
Minority Leader
U.S. Senate
S-221 U.S. Capitol Building
Washington, DC 20510

Re: COVID-19 Recovery Legislative Proposal (Phase #4)

Dear Majority Leader McConnell and Minority Leader Schumer:

On behalf of undersigned national and regional American Indian and Alaska Native (AI/AN) Tribal organizations, who collectively serve all 574 federally-recognized AI/AN Tribal Nations, this letter outlines Tribal healthcare and public health priorities for the fourth supplemental congressional package to address the 2019 novel coronavirus (COVID-19) pandemic. The recommendations outlined in this letter encompass critical funding and policy needs to help protect and prepare AI/AN communities in response to the current COVID-19 pandemic. These are necessary for the Indian health system to be fully functional to address the pandemic and other related critical health care priorities.

As of April 7, 2020 the Indian Health Service (IHS) has reported conducting 8,934 COVID-19 tests across IHS, Tribal, and urban Indian (collectively "I/T/U") sites, of which 661 have been confirmed positive and 5,713 remain pending final results. The number of confirmed cases in Indian Country is likely underreported given a significant shortage of available testing kits, but also because of a critical shortage of medical supplies like respiratory swabs used to collect the COVID-19 specimen. I/T/U facilities across the country have either completely depleted, or are dangerously close to depleting, necessary supplies such as personal protective equipment (PPE), ventilators, swabs, testing kits, and other medical countermeasures.

We applaud your leadership for including significant funding for IHS and Tribal sites under the CARES Act, including $1.032 billion for the IHS Services Account; however, it has become increasingly clear that this funding was not enough. The Indian health system had pervasive provider shortages, antiquated healthcare infrastructure, and severe funding shortfalls before the COVID-19 emergency began. For instance, space capacity at IHS facilities is at only 52% of capacity needed based on the size of the AI/AN population. There are reported to be only 33 intensive care unit (ICU)

beds across Indian Country, and the average age of IHS hospitals is four times that of mainstream hospitals. Further, AI/AN People 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 and diabetes.

In short, the Indian health system was woefully unprepared to address this pandemic to begin with; is facing immense pressures responding to COVID-19 at its current pace; and is likely to buckle in the absence of significant financial investment in the phase 4 COVID-19 response package.

We urge you to include the following recommendations as you work on a phase 4 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.

The following recommendations are based on input received from Tribal leaders and Tribal health care providers who are the first responders to this pandemic. Taking these actions will improve the health outcomes for our people and increase our chances to protect and save lives. Moreover, the language included in this letter covers the healthcare and public health priorities for 574 Tribal Nations and is organized in the following way:

Health

- 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

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 health care concerns and priorities are comprehensively addressed, as we respond to the COVID-19 pandemic.

This version of the letter includes background and legislative text for each Tribal priority. To view a bulleted list of the Tribal priorities only, please see ATTACHMENT 1.

Sincerely,

National Indian Health Board
National Congress of American Indians
Self-Governance Communication and Education Tribal Consortium
Alaska Native Health Board
Rocky Mountain Tribal Leaders' Council
California Rural Indian Health Board
Great Plains Tribal Chairmen's Health Board
Southern Plains Tribal Health Board
United South and Eastern Tribes Sovereignty Protection Fund
Inter-Tribal Association of Arizona
Northwest Portland Area Indian Health Board

Health Section 1: Critical Funding and Access Needs

- **Provide $1 billion for Purchased/Referred Care**

Background: Purchased/Referred Care (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 tertiary, critical, emergent and specialty care services – are not available within the Indian healthcare delivery system. Many Tribes would prefer to have the available level of care to treat critically ill patients within the Indian health system; however, the unfortunate reality is that many Tribes simply do not have the resources to care for critically ill patients and some IHS Areas do not have IHS or Tribal hospitals altogether. But PRC is beset by inadequate funding and has come under particular strain as a result of the COVID-19 pandemic.

The increased need to refer patients outside of IHS and Tribal facilities for high cost emergency and/or specialty care services due to COVID-19 continues to deplete PRC resources. While the Families First Coronavirus Response Act holds AI/AN patients harmless of any cost-sharing that may occur while receiving services through a PRC-authorized referral, there is no relief for the IHS or Tribal facility. And because there are only a limited number of labs with limited capacity in IHS or Tribal facilities that are certified to run certain COVID-19 tests, the vast majority are being referred out at significant cost to the IHS or Tribal PRC program.

Clinics in rural and remote locations often do not have the providers or the equipment to handle complicated emergency care and rely on Medevac flights to transport patients to larger hospitals/communities. In Alaska in particular, 80% of the small, rural communities are not on the road system so air transportation is the main mode of transportation for both people and supplies in or out of communities. In the Southwest some communities must rely on helicopter transport. With the current pandemic, airline travel restrictions are enacted across the board. Some airlines are screening prior to allowing people on the flight and calling Tribal Leadership in advance to grant permission to fly someone to their village or community.

Some communities have implemented a travel ban that doesn't even allow residents back into the community until they have completed a 14-day quarantine in the community they are trying to leave. Some communities are requiring everyone, including medical personnel who are flying out for coverage, to self-quarantine for 14 days upon returning. In addition to travel restrictions, in Alaska, a statewide carrier, RAVN Air, announced that it is ending all service, laying off all employees and filing for bankruptcy. The reduction in air traffic and cancelled services is making it difficult for communities to get supplies and to transport patients and clinical specimens to larger hospitals or labs in other communities for further care or laboratory testing. Medevacs have very limited capacity and if we see a sudden increase in numbers of patients who need to be transported, they will be overwhelmed.

Lack of sufficient funding for PRC forces IHS and Tribal facilities to ration health care when AI/AN lives are at stake. $1 billion in funding for PRC is needed to ensure IHS and Tribal sites have the resources to purchase emergency and/or specialty care and other essential medical services related to COVID-19.

Legislative Text:

Provided further, That $1,000,000,000 for Purchased/Referred Care, including for the Indian Catastrophic Health Emergency Fund, shall 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 $1.215 billion for Hospitals and Health Clinics**

Background: The Hospitals and Health Clinics (H&HC) line item in the IHS Services Account funds essential medical and ancillary services including inpatient care, routine and ambulatory care, and medical support services including diagnostics, pharmacy services, and laboratory services. In total, the H&HC line item supports 46 IHS and Tribally operated hospitals, 335 health centers, 78 health stations, 127 Alaskan Village clinics, and 16 school health centers. The H&HC line item supports the important work of Tribal Epidemiology Centers (TECs), many of which are on the frontlines and working with Tribal governments to engage in COVID-19 disease surveillance. Importantly, it also helps support funding for IHS and Tribal sites to purchase personal protective equipment (PPE) and other critical medical countermeasures that are in dire short supply. In short, it is the backbone of the Indian health system and its response to COVID-19. An additional influx of $1.215 billion is essential so that IHS and Tribal health programs can provide preventive and treatment-based services for COVID-19.

We also request $15 million for the Community Health Aide Program (CHAP) providers for COVID-19 preparedness, mitigation, suppression, and treatment. In rural Alaska there simply are no other health providers except for CHAP providers who are front-line health providers and will have primary responsibility to care for COVID patients. Further, we request that monies for local on-reservation dialysis treatment, in those large rural communities that can support it, be included in the reoccurring care funding of IHS. We cannot isolate a Tribal community if a sizable number of its citizens have to travel back and forth to a large urban hospital three times a week for this mandatory treatment. Finally, Tribes strongly recommend that any funding that Congress provides for electronic health records, or other health information technology purposes, must be provided in a proportional amount to Tribes and Tribally-operated health programs through self-determination and self-governance contract and compact agreements.

Legislative Text:

For an additional amount for 'Hospitals and Health Clinics' under 'Indian Health Service', $1,215,000,000, to remain available until September 30, 2021, to prevent, prepare for, and respond to coronavirus, domestically or internationally, including for preventive and treatment services, personal protective equipment, diagnostics, pharmacy, Tribal Epidemiology Centers, and other activities to protect the safety of patients and staff: Provided further, $15,000,000 of the amount in the first proviso shall be for the Community Health Aide Program: 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.

- **Establish a $1.7 billion Emergency Third-Party Reimbursement Relief Fund for IHS, Tribes, Tribal Organizations, and Urban Indian Organizations**

Background: Third-party reimbursements from Medicare, Medicaid, the Veterans Health Administration, and private insurance are integral to the fiscal stability of the Indian health system. As reported in the FY 2021 IHS Congressional Justification, in FY 2019 alone, IHS collected $1.14 billion in third-party reimbursements from these payers, equaling nearly 20% of the entire IHS discretionary budget for that year. Tribal health programs are typically more successful in securing third-party reimbursement dollars, with up to 50-60% of their healthcare budgets derived from such payers. Urban Indian organizations (UIOs) are also heavily reliant on 3rd party dollars to supplement their healthcare resources. Unfortunately, the COVID-19 pandemic is upending this system. As states enact shelter in place ordinances, require health care providers to cancel all non-emergent procedures to prepare for the COVID-19 surge, and social distancing guidelines continue, IHS and Tribal sites are emphasizing patients stay at home if they are able, reducing in-person visits and thus third-party dollars with them. These resources are especially important towards maintaining elder care services that have become fragmented or difficult to provide under shelter in place orders. The removal of all this routine care is leaving only non-billable services halted by government mandate nearly all revenue generating services which are critical to operations. Even worse, social distancing has led to the closure of Tribal business enterprises nationwide that we know help to finance healthcare services – meaning Tribes are experiencing double the financial hit.

While IHS and Tribal sites are trying to transition more towards remote health service delivery mechanisms like telehealth, these services are not consistently reimbursed at the same level as in-person care. Many Tribes are experiencing millions in lost third-party reimbursement as a result. However, Tribes strongly urge Congress to ensure that relief funds **NOT** be in the form of a loan. Further, we assert that Tribes should be able to access relief funds for the purpose of covering past or current COVID-19 healthcare expenses, or to compensate for shortfalls in 3rd party reimbursement dollars as a result of the pandemic. Because each Tribe's financial situation is unique, we urge the creation of a $1.5 billion relief fund, whereby IHS and Tribal sites can submit claims for relief funding based on their health care service needs or losses related to COVID-19.

Legislative Text:

For an additional amount for 'Public Health and Social Services Emergency Fund', $1,700,000,000, to remain available until expended, to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through contracts, compacts, or other agreements as authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), or through other mechanisms for federally-operated Indian Health Service facilities, for care related expenses or lost revenues incurred by Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations that are attributable to coronavirus: Provided, That these funds may not be used to reimburse expenses or losses that have already been reimbursed from other sources: Provided further, That payments under this section shall not be in the form of an interest loan or otherwise, but rather shall be one-time payments for related healthcare expenses or lost revenues; Provided further, That recipients of payments under this paragraph shall submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with conditions that are imposed by this paragraph for such payments, and such reports and documentation shall be in such form, with such content, and in such time as the Secretary may prescribe for such purpose: Provided further, That 'Indian Tribes and Tribal organizations' have such meaning as defined under section 4 of the Indian Self-Determination and Education Assistance Act, that provide diagnoses, testing, or care for individuals with possible or

actual cases of COVID‑19: Provided further, That 'urban Indian organization' has such meaning as defined under section 4 of the Indian Health Care Improvement Act: Provided further, That the Secretary of Health and Human Services shall, on a rolling basis, review applications and make payments under this paragraph in this Act: Provided further, That funds appropriated under this paragraph in this Act shall be available for, but not limited to, healthcare services, building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and for workforce trainings, emergency operation centers, retrofitting facilities, and surge capacity: Provided further, That, in this paragraph, the term 'payment' means a pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary: Provided further, That payments under this paragraph shall be made in consideration of the most efficient payment systems practicable to provide emergency payment to Indian Health Service and Tribal sites: Provided further, That to be eligible for a payment under this paragraph, an Indian Health Service or Tribal site shall submit to the Secretary of Health and Human Services an application that includes a statement justifying the need of the Indian Health Service, Tribal, or urban Indian site for such payment

- **Provide $2.5 billion for Health Care Facilities Construction to Include Support for New and Current Planned Projects, the Small Ambulatory Health Center Program, and the Joint Venture Construction Program**

Background: The Indian health system is beset by antiquated and largely deficient health care facilities that are largely unequipped to respond to the COVID-19 pandemic. The average age of an IHS hospital is 37.5 years, compared to 10 years for mainstream hospitals. Space capacity at IHS facilities are only able to accommodate about 52% of need based on AI/AN population sizes. Especially in small villages and remote Tribal locations, there is no ability to place a patient in isolation especially while waiting for a care referral. While most medical equipment has an average useful lifespan of six years, medical and laboratory equipment in most IHS facilities are more than twice as old as that. In many places, there are no negative pressure rooms to put people into isolation and there are no facilities to allow people who live in overcrowded, multigenerational families to self-quarantine. This poses a serious public health risk for entire Tribal communities. In the short-term, there is immediate need for mobile clinics that can help isolate and quarantine patients.

In addition, IHS and Tribal hospitals have a severe shortage of beds in intensive care units (ICUs), or lack of inpatient facilities altogether. Going further, many of our hospital and clinic facilities lack the space to provide mandatory reoccurring services such as dialysis treatment. There is an urgent need for $2.5 billion to not only fund those facilities on the Health Care Facilities Construction Priority List (Priority List), but to help fund the construction costs for the Joint Venture Construction Program (JVCP) and for the Small Ambulatory Program (SAP). The JVCP is a joint agreement between IHS and Tribes to fund construction projects. Given the economic downturn and revenue losses resulting from the COVID-19 pandemic, there is significant concern that without an influx of funding many JVCP projects will be delayed or lose resources for construction projects. There is a need to fund the construction costs of all the JVCP projects for all Tribes and Tribal organizations that satisfied eligibility for the past and current JVCP competition. The SAP provides funding to Tribes and Tribal organizations for the construction, expansion, or modernization of ambulatory health care facilities. These funds are particularly important for Tribes that are not on the Priority List or participating in JVCP to address COVID-19 health care facility construction needs.

Moreover, the SAP is especially critical for those Areas that have no IHS or Tribally operated hospitals. It is important to note that the cost of building and initially staffing a single hospital is more than $30 million. As such, it is critical that Health Care Facilities Construction (HCFC) funds be equitably distributed across all twelve IHS Areas, and ensure all Areas can participate in Health Care Facilities Construction.

There is significant concern that without immediate funding relief for health facilities in Indian Country, the Indian health system will buckle under this emergency. Lastly, IHS and Tribes need equitable and flexible funding not only to increase hospital and clinic capacity and the shortage of hospital beds, but also to acquire and construct shelters of opportunity – such as by renovating Tribal gymnasiums or other suitable facilities to serve as triage units along with other priorities. There is an urgent need to:

- Increase capacity for shelters of opportunity;
- Provide funding for new and replacement healthcare construction projects, support Joint Venture programs between IHS and Tribes, and enhance funding for Small Ambulatory Program needs;
- Build auxiliary facilities and nonmedical facilities for social isolation;
- Bolster hospital capacity;
- Build temporary lodging for healthcare providers; and

Legislative Text:

For an additional amount for 'Health Care Facilities Construction' under 'Indian Health Service Facilities' $2,500,000,000 to remain available until expended for COVID-19 related needs pertaining to expansion, construction and repair of health and related auxiliary facilities, including quarters for personnel and additional service space for mandatory reoccurring services such as dialysis and diabetes care; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for the Joint Venture Construction Program and Small Ambulatory Program: Provided further, That construction funding will be provided to all tribes and tribal organizations that satisfied eligibility for the current joint venture construction program announcement: Provided, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: 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 for Sanitation Facilities Construction**

Background: According to the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC), the provision of safe water, sanitation, and hygienic conditions is essential to protecting human health in response to the COVID-19 outbreak. Unfortunately, according to the 2018 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities, over 31% of homes in Tribal lands are in need of sanitation facility improvements, while nearly 7% of all AI/AN homes do not have adequate sanitation facilities. Even more troubling is that roughly 2% of AI/ANs do not even have access to safe drinking water. It is impossible for

AI/AN communities to abide by CDC's sanitation and hygiene standards in response to COVID-19 without the necessary water and sanitation infrastructure.

It is essential that these funds be made flexible enough to address other related new and existing housing support projects for AI/AN individuals and families. In their FY 2021 budget request, IHS reported that $2.57 billion is needed to raise all IHS and Tribal sanitation sites to a Deficiency Level 1 classification. If Indian Country is to follow CDC guidelines for disease prevention, there is urgent need for at least $1 billion in assistance to get immediate safe water and sanitation systems to our Tribal communities.

Legislative Text:

For an additional amount for 'Sanitation Facilities Construction' under 'Indian Health Service Facilities' $1,000,000,000 to remain available until expended for COVID-19 related need including for new and current housing support projects; 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: 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 $750 Million for Maintenance and Improvement of Indian Health Service and Tribal facilities**

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 $750 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.

Legislative Language:

For an additional amount for 'Maintenance and Improvement' under 'Indian Health Service Facilities' $750,000,000 to remain available until expended for COVID-19 related needs pertaining to maintenance and improvement of health and related auxiliary facilities, including quarters for personnel: 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 $85 million for Equipment Purchases and Replacements**

Background: IHS and Tribal sites are running dangerously low on necessary equipment to prepare and respond to the COVID-19 pandemic, including ventilators, rapid COVID-19 tests, and other critical medical equipment. The serious lack of available equipment is putting patient and provider lives in jeopardy. An influx of $75 million in funding is critical to assist IHS and Tribal sites in purchasing medical equipment, and to replace old and outdated equipment which can be twice as old as the medical equipment used in mainstream hospitals and clinics. Tribal Emergency Medical Transport programs are also in severe need of the necessary equipment to carry out their services in a pandemic environment. Equipment is utilized on all emergency calls and needs to be replenished on an on-going basis. We request that up to $10 million of this funding be for stationary and mobile Tribal dialysis equipment.

Legislative Text:

For an additional amount for 'Equipment' under 'Indian Health Service Facilities' $85,000,000 to remain available until expended for COVID-19 related equipment needs such as ventilators, rapid tests, and other equipment needed to prevent and treat COVID: Provided further, that up to $10,000,000 of such funds may be reserved for stationary and mobile dialysis equipment: 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.

Health Section 2: Technical Medicaid/Medicare Fixes

- **Authorize Medicaid Reimbursements for Qualified Indian Provider Services and Urban Indian Organizations**

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 for 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 authorize 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 Provider Services:</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[1], 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."

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

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 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603]) 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 100% FMAP for Services Provided by Urban Indian Organizations:

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."

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

Background: The COVID-19 pandemic has created a safety need for providers to see AI/AN patients in non-traditional settings outside of the traditional "four walls" of a clinic or hospital. Many

[1] 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).

IHS and Tribal sites are setting 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)][2] 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)"

- **Ensure Parity in Medicare Reimbursement for Indian Health Care Providers**

Background: IHS and Tribal facilities are experiencing significant economic disruption and loss of third party revenues, including Medicare billing, as a result of the COVID-19 pandemic. This crisis is exacerbated by the fact that Indian health care providers are not fully reimbursed for the cost of providing Medicare covered services. Unlike other Medicare providers, Indian health care providers do not bill the AI/AN Medicare patients they serve. This means that as a general rule, Indian health care providers only receive 80 percent of reasonable charges, and are not paid the remaining 20 percent by their patients. As a result, IHS and Tribal facilities are only 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 AI/AN people, and to ensure that AI/AN People can seek services outside the Indian health system without having to face significant cost sharing burdens they may not be able to afford. The United States has a federal trust responsibility to provide health care for AI/AN People, and cost-sharing requirements are inconsistent with this obligation. Medicaid exempts AI/AN People from cost-sharing, and Medicare should do the same.

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

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

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.''.

- **Include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to IHS, Tribal, and Urban Indian Health Programs**

Background: There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country. Particularly in more remote and rural locations, IHS and Tribal health care programs struggle to attract and retain qualified providers. Because of this shortage, Indian Healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists.

These practitioners receive rigorous training that equips them to furnish many of the same services that physicians and other Medicare-recognized professionals do, and like them, they are subject to strict licensing, certification, ethical, and continuing education requirements. CHAPs are trained to provide primary and emergency health care services, and they are the only healthcare providers in dozens of remote Alaska Native communities. LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, CSWs, and psychologists do. For example, pharmacists are professionally trained to furnish a wide array of related healthcare services and they serve a vital role in many Indian health programs. Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including anticoagulation, tobacco cessation, cardiovascular risk reduction, asthma/COPD stabilization, and medication-assisted treatment (MAT) for substance use disorders.

All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead. This deprives Indian Health programs of critically needed federal reimbursement for vital healthcare services to American Indians and Alaska Natives, needlessly straining the programs' already overtaxed resources and jeopardizing their ability to serve their patients. This is a longstanding problem that has become even more urgent as Indian Country struggles to bring adequate resources to the fight against COVID-19.

Legislative Text:

--Amend subsection 1861(s) of the Social Security Act [42 U.S.C. 1395x(s)] (Definition of "Medical and Other Health Services") by adding a new subparagraph (II) as follows:

(II) Indian health program pharmacist and non-physician practitioner services as defined in subsection (kkk).

--Amend subsection 1861 [42 U.S.C. 1395x) (Definitions) by adding a new subsection as follows:

(kkk) "Indian health program pharmacist and non-physician practitioner services" means services furnished by or through the Indian Health Service or any Tribal Health Program (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. section 1603]) or any urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. section 1603]) that would otherwise be covered if furnished by a physician or as an incident to a physician's service and that are furnished within the scope of licensure or certification by a licensed marriage and family therapist, licensed professional counselor, community health aide or practitioner certified by the Community Health Aide Program Certification Board, behavioral health aide or practitioner certified by the Community Health Aide Program Certification Board, licensed pharmacist, and such other licensed or certified professionals as the Secretary may authorize.

Health Section 3: Technical Amendments Needed

- **Expand Telehealth Capacity and Access in Indian Country by Permanently Extending Waivers under Medicare for Use of Telehealth and Enacting Certain Sections of the CONNECT to Health Act**

Background: During the COVID 19 crisis, telehealth and telemedicine are critical to providing health care services to AI/AN People. Unfortunately, rural Tribes may be unable to provide these services due to the lack of broadband capacity or infrastructure in their area. COVID-19 has dramatically increased the need to connect Medicare patients to their providers through telehealth. This increased need is likely to continue after the national emergency has passed, particularly for patients in the Indian health system. In addition, as more AI/AN patients become accustomed over time to the telehealth model, it is likely to play a more significant role as a mechanism for delivering healthcare well beyond the end of this pandemic.

To this end, the *Coronavirus Preparedness and Response Supplemental Appropriations Act* provided the Secretary of HHS with the ability to waive telehealth restrictions during national emergencies. In doing so, it enacted Section 9 of the bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (H.R. 4932, S. 2741). The CONNECT for Health Act was most recently introduced in October 2019 and has the support of the American Medical Association and over 100 other organizations.

Section 3 of the CONNECT to Health Act would provide HHS with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on provider types, technology, geographic area, and services. Section 8 of the CONNECT to Health Act would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization, or a Native Hawaiian health care system. Originating site requirements currently mandate that a patient be in a particular location such as a physician's office,

hospital, or other specified clinical setting. These requirements prevent patients from being able to receive telehealth services in their homes, community centers, or other non-clinical locations. In addition, Sections 4, 5, 7, and 14 of the CONNECT Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expands the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian Health system. With the urgent need to maximize telehealth flexibility in response to COVID-19, Tribes strongly recommend that Congress not only permanently extend the existing waiver authority for use of telehealth under Medicare, but to also enact certain sections of the CONNECT for Health Act.

Legislative Text:

See Sections 3-5, Sections 7-8, and Section 14 of H.R. 4932 or S.2741

- **Make the IHS Scholarship and Loan Repayment Program Tax Exempt**

Background: IHS and Tribal health programs have been dealing with chronic and severe provider shortages that existed long before the COVID-19 pandemic. However, the pandemic is further straining the heavily under-resourced and understaffed Indian health system. According to a 2018 Government Accountability Office (GAO) report, average vacancy rates for physicians, nurses, nurse practitioners, and other provider types across eight IHS regions is at 25%, but stretches as high as 31%. IHS has tried to implement incentives to better recruit and retain quality providers, but lack of competitive salary rates and benefits have inhibited this, among other challenges. These vacancies are leading to more rationed and less accessible care for AI/AN People in response to COVID-19.

The IHS Health Professions Scholarship provides financial aid to qualified AI/AN undergraduate- and graduate-level students in exchange for fulfillment of a minimum two-year service commitment at an IHS or Tribal facility. Similarly, under the IHS Loan Repayment Program, health professionals agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding. However, unlike similar federal loan repayment and scholarship programs like the National Health Service Corps Scholarship and Loan Repayment Program or the Armed Forces Health Professions Scholarship and Financial Assistance Program, the IHS programs are not tax exempt. In fact, up to 20% of IHS appropriations for its Scholarship and Loan Repayment Programs are going towards federal taxes. This translates into less funding to recruit and retain providers, and also disincentives any substantive increases to appropriations for IHS Health Professions.

The COVID-19 pandemic has reaffirmed the urgency of making the IHS Scholarship and Loan Repayment Programs tax exempt. We urge Congress to enact the bipartisan Indian Health Service Health Professions Tax Fairness Act of 2020 introduced by Representative(s) Gwen Moore and Tom Cole, and Senator(s) Lisa Murkowski and Tom Udall.

Legislative Text:

See Indian Health Service Health Professions Tax Fairness Act of 2020 (S. 2871; House version introduced by Rep. Moore and Rep. Cole)

- **Implement ways to facilitate interagency transfers of funding that Tribal Nations can access to address COVID-19 and its impacts so that funding can be disbursed to Tribal Nations quickly**

Background: COVID-19 response funding will not serve its purpose if it is not quickly made available to Tribal Nations working on the ground. Time is of the essence as the federal government seeks to provide immediate resources and relief to Indian Country. We ask that you develop and immediately implement measures to facilitate interagency transfers of funds that tribal nations can access to address COVID-19 and its impacts. Not all federal agencies are created equal when it comes to expeditious and broad distribution of dollars to Tribal Nations. Many agencies lack expertise with regard to quickly disbursing funds to Indian Country. Further, there are numerous barriers that exist within a variety of federal agencies and their respective funding structures that will cause unequal and delayed access to funding intended for Indian Country. To facilitate rapid deployment of resources to tribal nations, it is critical that federal agencies are able to transfer funding for Indian Country to those agencies that are able to most quickly disburse such funding to tribal nations and AI/AN organizations.

We ask that you examine the authorities you currently possess for interagency transfers of funds in coordination with other relevant agencies and the White House. Funds made available to Tribal Nations should be transferred to the agency most able to quickly release those funds to a Tribal Nation. There have been many instances in the past when federal funding was made available to Indian Country but its disbursement was delayed due to bureaucratic hurdles.

***Legislative Text*:**
At a Tribal Nation's or Tribal Nation Organization's request or at the discretion of a Federal agency, any amount available under law to any Federal agency for any purpose related to addressing the coronavirus or its impacts may be withdrawn from one appropriation account and credited to another or to a working fund to facilitate the prioritized and rapid deployment of coronavirus relief within Indian country as that term is defined in 18 U.S.C. § 1151. This authority applies to Indian specific funding and also to other funding for which Tribal Nations or Tribal Nation Organizations are eligible recipients. Except as specifically provided by law, an amount authorized to be withdrawn and credited is available for the same purpose and subject to the same limitations provided by the law appropriating the amount. A withdrawal and credit is made by check and without a warrant.

- **Implement ways to disburse funding to Tribal Nations using existing funding mechanisms already in place when possible**

Background:
As you know, many Tribal Nations already have in place funding mechanisms through which they receive federal funding. In order to facilitate rapid deployment of COVID-19 resources to Tribes, it is critical that Tribal Nations and AI/AN organizations are able to receive funding through existing funding mechanisms, processes, agreements, and partnerships, including ISDEAA contracts and compacts. When paired with interagency transfer authority, Tribal Nations would be able to receive COVID-19 funding from across federal agencies through their existing funding mechanism. We ask

that you examine ways in which existing funding mechanisms can be utilized to quickly disburse to Tribal Nations funding that can be used to address COVID-19 and its impacts.

For Tribal Nations or AI/AN organizations that do not currently have a funding mechanism in place, we ask that you expedite execution of such a funding mechanism in consultation and coordination with the relevant Tribe or AI/AN organization. It is critical to ensure equitable distribution of funding across all Tribal Nations and IHS Areas. We emphasize that use of such funding mechanisms should not affect the allocation of COVID-19 funding made available to each Tribal Nation. We only suggest that, once funding allocation determinations have been made, funding available to a particular tribal nation or AI/AN organization be made available through existing funding mechanisms at the option of the Tribal Nation or AI/AN organization.

***Legislative Text*:**
Any and all amounts available under law to any Federal agency for any purpose related to addressing the coronavirus and its impacts, regardless of what agency they are apportioned to, must be made available, at the option of a Tribal Nation or a Tribal Nation Organization, to be transferred to Tribal Nations and Tribal Nation Organizations through any existing funding mechanism, including but not limited to contracts, grants, compacts, or annual funding agreements under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304), to facilitate the prioritized and rapid deployment of coronavirus relief within Indian country as that term is defined in 18 U.S.C. § 1151. Federal agencies shall amend existing funding mechanisms on an expedited basis to the extent necessary to disburse such funds.

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

***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 or nonexistent across Indian Country, leaving IHS and Tribal health clinics struggling to get the supplies they need to protect patients and workers alike.

Currently, IHS and Tribal health authorities' access to the Strategic National Stockpile (SNS) is extremely limited and is not guaranteed in the SNS statute. Further, there remains significant confusion on part of how IHS and Tribal sites can access the SNS. Before the President declared a national emergency under the Stafford Act, the Assistance Secretary for Preparedness and Response (ASPR) was coordinating SNS. Now, it is being administered by the Federal Emergency Management Agency (FEMA). Only in the past week have the agencies worked with IHS to establish a formal process for I/T/U access to the SNS. However, just in the past few days the SNS website has been changed and no longer lists Tribes as one of the entities that can access SNS. This is extremely concerning, and speaks volumes about the importance of guaranteeing access in statute for I/T/U facilities. In contrast, states' and large municipalities' public health authorities have ready access to the SNS. We urge Congress to immediately enact bipartisan legislation to

***Legislative Text*:**
See S. 3514 and H.R. 6352

- **Provide Tribal and UIO access to the Public Health Emergency Preparedness 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 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 capabilities, creating both a public health and national security threat. Unlike states, Tribes do not have a local tax base to supplement public health funding. However, as sovereign governments, Tribes have the same responsibilities as states to protect their citizens and face down public health emergencies like the COVID-19 pandemic. As such, authorizing direct PHEP funding for Tribes and UIOs can help ensure Indian Country has the resources to address this 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.3486 introduced on March 12, 2020 and H.R. 6274 introduced on March 13, 2020.

Health Section 4: Legislative Fixes and Reauthorizations

- **Move Contract Support Costs to mandatory appropriations**

Background: The Committee is well aware of case law mandating that the United States pay in full all Contract Support Costs (CSC) 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) reaffirmed the requirement that the federal government pay in full the costs of CSCs. In recognition of this, several years ago Congress enacted an indefinite appropriation for CSCs funded through the discretionary IHS budget. However, in recent years, increased expenditures for CSCs 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. The federal government must continue paying CSCs in full every year. However, because of how CSCs are funded, 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, Tribes strongly urge Congress to move CSC funding to mandatory appropriations. Doing so would open up over $800 million in the discretionary IHS budget to reinvest in better quality healthcare and necessary updates to, and construction of, IHS and Tribal health facilities.

Legislative Text:

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.

- **Move 105(l) lease agreements to mandatory appropriations**

Background: In addition to court cases mandating that IHS pay CSC obligations in full, there are court cases that impose similar requirements on IHS related to paying 105(l) lease expenditures. Court decisions under *Maniilaq Association v. Burwell* (2016) mandate that IHS continue paying 105(l) leases even in the absence of available funding. Under current law, the only mechanism in place for IHS to cover 105(l) leases is through the IHS Services Account. There is no dedicated line item in the IHS budget for 105(l) lease expenditures. In recent years, many more Tribes have elected to enter into 105(l) lease contracts with IHS; however, without a dedicated source of funding in the IHS budget for this expense, IHS has been forced to reprogram dollars from other critical line items to pay for this obligation. In FY 2019 alone, IHS reprogrammed roughly $72 million in funding from the Hospitals & Health Clinics line item and the Urban Indian line item to pay for 105(l). While it's critical that the federal government pay for 105(l) lease costs in full, its funding should not come at the expense of other crucial IHS funds.

Similar to CSCs, increased need related to 105(l) leases continues to consume a larger share of the IHS discretionary budget. 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 support the recommendation in the IHS FY 2021 Congressional Justification to establish an indefinite appropriation for 105(l); however, the agency included many arbitrary restrictions on use of 105(l) funds alongside the request for an indefinite appropriation that were also not vetted through Tribal consultation. While an indefinite appropriation is a move in the right direction, Tribes strongly assert that the only long-term solution is for Congress to move 105(l) lease funds to mandatory appropriations.

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 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.).

- **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 renewed SDPI ***four times*** in short increments of just several weeks or several months. Right now, SDPI is set to expire on November 30, 2022. 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.).