WRITTEN TESTIMONY OF WILLIAM SMITH ALASKA AREA REPRESENTATIVE AND CHAIRMAN, NATIONAL INDIAN HEALTH BOARD

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS

"HEARING ON TRIBAL PRIORITIES OF THE 119TH CONGRESS"

February 12, 2025

Chairwoman Murkowski, Ranking Member Schatz, and distinguished members of the Committee, on behalf of the National Indian Health Board (NIHB) and the 574+ sovereign federally recognized American Indian and Alaska Native Tribal Nations we serve, thank you for this opportunity to provide testimony on the Tribal Health Priorities for the 119th Congress. My name is William Smith. I am Eyak and I am a veteran of the United States Army. I serve as the Alaska Area Representative and Chairman of the National Indian Health Board (NIHB). I also serve as the Chairman of the Alaska Native Health Board and the Vice President of the Valdez Native Tribe, of Valdez, Alaska.

TRUST AND TREATY OBLIGATION

The U.S. Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. As sovereigns, Tribes predate the United States, and retain rights of self-government.[1] When the United States was established, the Constitution's Indian Commerce Clause granted Congress the authority to pass legislation specific to Indian Affairs.[2] The Supreme Court has upheld Indian-specific legislation, determining that it is political in nature, rather than based on an unconstitutional racial classification.[3] Health care reform legislation that reflects the unique federal trust responsibility to provide health care for American Indians and Alaska Natives is subject to rational basis review and does not violate the equal protection clause so long as it is "tied rationally to the fulfillment of Congress' unique obligation toward the Indians."[4]

Congress has the constitutional authority and responsibility to provide for Indian health care. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples.[5] Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the United States has "moral obligations of the highest responsibility and trust."[6]

Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and passing the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 *et seq.* In the IHCIA, for instance, Congress found that "Federal health

---

[1] *Worcester v. State of Ga.*, 31 U.S. 515, 559 (1832).

[2] U.S. CONST., art. I, § 8, cl. 3; *see also Morton v. Mancari*, 417 U.S. 535, 552–55 (1974).

[3] *Morton*, 417 U.S. at 555; *see also Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); *United States v. Antelope*, 430 U.S. 641, 645–47 (1977); *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 520-21 (D.C. Cir. 2003).

[4] *Morton*, 417 U.S. at 555.

[5] *See United States v. Winans*, 198 U.S. 371, 380–81 (1905).

[6] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942); *see also* U.S. CONST., art. VI, cl. 2; *Worcester*, 31 U.S. at 539.

services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." *Id.* § 1601(1). Congress has also legislated to provide Indians with access to general health programs, such as Medicaid, while creating Indian-specific protections within those programs that reflect this unique political relationship.

Congress has full constitutional authority to legislate with regard to Indian health care, and should continue to promote Tribal sovereignty and uphold the government-to-government relationship between the United States and Tribes in fulfillment of its trust and legal responsibilities in any health care reform proposal it considers.

TRIBAL IMPACTS OF RECENT EXECUTIVE ORDERS AND GUIDANCE

Recent Executive Orders and guidance have had inadvertent impacts on the Indian health system. From the recent hiring freeze, deferred resignation solicitation, and pause on federal financial assistance, the Indian health system trying to understand how these orders and guidance impact the system while continuing to meet the federal government's trust and treaty obligations. For example, the Office of Management and Budget (OMB) memorandum (M-25-13) put an immediate halt on federal financial assistance, including grants and loans to Tribal programs. Despite the memorandum being rescinded under OMB M-25-14, the risk of immediate implementation of administrative policies like this harm the operation of the Indian health system by restricting critical resources. During the pause of federal funding, many Indian healthcare clinics were immediately impacted, delaying and pausing services so individuals had to be rescheduled. The halt in funding brought many back to an era before advance appropriation, readying plans to furlough program staff, reduce program hours, and temporarily close specific programs. During previous periods of financial pause, staff and providers left the Indian health system, seeking job security exacerbating clinics which are already understaffed. The Indian health care clinic cannot risk any harmful changes during this Administration that negatively impact our operations and our ability to serve our citizens.

Our workforce is also being compromised by the Executive Order instituting a federal hiring freeze for civilian employee positions and instructing the creation of the plan to reduce the size of the federal workforce. This has been accompanied by a deferred resignation solicitation which went out to federal employees in Tribal programs and the IHS. Currently, IHS has a workforce gap of 30% and a 36% vacancy rate for physicians, that hinders our ability to provide timely care to American Indian and Alaska Native (AI/AN) beneficiaries.[7] On January 31, 2025, NIHB, along with three other national Tribal organizations, sent a letter requesting exemptions for IHS from any plans, policies, or incentives that freeze hiring or seek to decrease the federal workforce, including any planned federal layoffs, attrition, or reduction quotas. While we understand that 600-series providers may still be hired, there are conflicting reports whether this is being honored at present. The Indian health system must have the ability to onboard, administer, and operate its programs with the staffing necessary to meet accreditation standards and keep facility doors open. IHS operations need to be able to bring in staff in behavioral health, clinical administration and oversight, community health representatives, scheduling, and billing. The Department of Veterans Affairs has issued a list of staff exempt from the hiring freeze which goes beyond the 600-series of providers. The IHS needs at least the same exemptions and more. As the United States has a responsibility to care to AI/AN people, it also has a responsibility to ensure clinics have their needs

---

[7] 25 U.S.C. § 1601.

met[8] – this includes having the appropriate workforce to improve the health status of AI/AN beneficiaries.

We commend the Chairwoman for her letter of February 4, 2025 to the Administration urging the need to continue to meet the trust and treaty obligations of the federal government to Tribes. We concur that the Department of Health and Human Services should issue a secretarial order which acknowledges the political status of Tribal Nations and their citizens, plainly states the federal trust and treaty responsibilities to Tribes, and exempts all Tribal departmental programs from the impacts of recent Executive Orders and guidance. Further, we urge this Committee and Congress to continue to educate and work with the new Administration to fulfill its legal obligations to Tribal Nations.

THE INDIAN HEALTH SERVICE FUNDING

AI/ANs experience worse health outcomes compared with the rest of the U.S. population. AI/ANs continue to experience historical trauma from damaging federal policies, including those of forced removal, boarding schools, and taking of Tribal lands, and continuing threats to culture, language, and access to traditional foods. These compounding events have resulted in AI/AN populations experiencing high rates of poverty, high unemployment rates, barriers to accessing higher education, poor housing, lack of transportation, geographic isolation, and lack of economic mobility which all contribute to poor health outcomes. Historic and persistent under-funding of the Indian health system has resulted in problems with access to care and has limited the ability of the Indian health system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

IHS exists to serve the health care needs of AI/ANs and to address those disparities. Despite the efforts of IHS, the Centers for Disease Control and Prevention (CDC) reported that the life expectancy for AI/ANs has declined by nearly 7 years, such that the life expectancy for our People is only 65.2 years, which is the same life expectancy of the total U.S. population in 1944. This is 11.2 years less than the non-Hispanic White population's life expectancy of 76.4 years. Today the Indian health system includes 43 Indian hospitals (51 percent of which are Tribally operated) and 650 Indian health centers, clinics, and health stations (86 percent of which are Tribally operated).[9] When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 41 urban Indian programs offer services ranging from community health to comprehensive primary care.

Year after year, the federal government has failed AI/ANs by drastically underfunding the IHS far below the demonstrated need. For example, in 2023, IHS spending for medical care per user was only $4,078, while the national average spending per user was $13,493. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Indian communities. This is despite years of statements to this effect. In 2018, the U.S. Commission on Civil Rights found that: "Federal funding for Native American programs across the government remains grossly inadequate to meet the most basic needs the federal government

---

[8] U.S. Government Accountability Office, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies, GAO-18-580, published August 15, 2018, available at: https://www.gao.gov/products/gao-18-580, accessed on: January 27, 2025.

[9] Indian Health Service. (2024). The Indian Health Care System – Fact Sheet. Retrieved from: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

is obligated to provide. Native American program budgets generally remain a barely perceptible and decreasing percentage of agency budgets."[10]

During the last four years, bipartisan collaboration between Congress and the Administration has resulted in just a 11.6% increase to the IHS budget, although actual inflation has been significantly higher. In reality, many of the increases in funding over the past several years have barely supported population growth, rising medical inflation, staffing funding for specific new/expanded facilities, and the rightful funding of legal obligations such as Contract Support Costs (CSC). For example, based on the House and Senate budgets drafted for consideration for FY 2025, CSC and section 105(*l*) leases made up 87-93% of the increase assessed. These costs will continue to grow following the *Becerra v. San Carlos Apache Tribe* and *Becerra v. Northern Arapaho Tribe* Supreme Court rulings. A more significant funding increase, including necessary investments in adequate facilities, modernized infrastructure, and a qualified workforce, is needed so that quality healthcare services can be delivered in a safe manner within all AI/AN communities. Only then will we expect to see a noticeable correlating improvement in health outcomes for our people.

The IHS National Tribal Budget Formulation Workgroup has estimated that full funding for the Indian health system should be $63 billion in FY 2026. Providing full and mandatory funding will ensure the federal government is meeting its trust and treaty obligations to Tribal Nations for health care. As a step toward achieving this goal, we request Congress to make common sense budgetary changes to help advance the IHS budget by immediately reclassifying CSC and section 105(*l*) lease payments to mandatory appropriations. We further request Congress support and enact full and mandatory funding for the Indian Health Service.

MAINTAINING FEDERAL FUNDING FOR MEDICAID PROVIDED THROUGH THE INDIAN HEALTH SYSTEM

As Congress approaches Medicaid reform, it should ensure that any reform proposal honors the federal responsibility for Indian health care, rather than passing that obligation on to the states through per capita allocations, block grants, mandatory work requirements, or other mechanisms that may be under consideration. The United States has a unique trust responsibility to provide Tribal health care, founded in treaties and other historical relations with Tribes, and reflected in numerous statutes. In recognition of that federal obligation, Congress amended the Social Security Act over 40 years ago in 1976 to authorize Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated health care facilities.[11] The House Report explained that "These Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian. [...]"

At the same time to meet the trust responsibility, Congress acted to ensure that States would be reimbursed at a 100 percent federal medical assistance percentage (FMAP) for Medicaid services to American Indians and Alaska Natives that are received through the Indian health system. The House Committee observed that since the United States already had an obligation to pay for health services to Indians as IHS beneficiaries, it was appropriate for the U.S. to pay the full cost of their care as Medicaid beneficiaries. The Committee noted that because the 100% FMAP provision was limited to services provided by or through the Indian health system, it was being provided for IHS eligible Indians and Alaska Natives for whom the United States has an obligation and who are

---

[10] U.S. Commission on Civil Rights. "Broken Promises: Continuing Federal Funding Shortfall for Native Americans." December 2018. Available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf
[11] 42 U.S.C. § 1395qq and § 1396j

already eligible for "full Federal funding of their services."[12] This key provision ensures that the responsibility to pay for Medicaid services to AI/ANs remains with the federal government, and is not shifted onto the States. The Committee recognized that many States with large native populations also have large amounts of public land, and thus a limited tax base for providing health services, making it doubly unfair to shift the federal health obligation to them.

Medicaid reimbursements are critically important in filling the gap created by chronic underfunding of IHS and are a critical source of funding for Tribes seeking to take over IHS hospital systems through self-governance agreements. Medicaid funds provide $1.2 billion to the IHS[13], and provides coverage for 36% of non-elderly AI/ANs and over half of AI/AN children.[14]

As important as Medicaid is to the Indian health system, Medicaid reimbursements received through the Indian health system only represent a fraction of one percent of total Medicaid funding. For instance, IHS Medicaid spending in 2025 is projected to be only 0.21 percent of total Medicaid spending. As a result, preserving full federal funding for Medicaid services received through the Indian health system will not adversely affect the overall effort to cap and control federal Medicaid spending. Per capita caps and changes to FMAP, even when limited to the general population or Medicaid expansion, can cause States to reduce eligibility requirements or services levels, which also impact Indian health programs adversely.

It is critical that Congress maintain full federal funding of Medicaid services provided in IHS and Tribal healthcare facilities. Tribal healthcare delivery systems need Medicaid funding to be financially viable, as many of their patients are low income and have no other form of coverage. Indian health facilities see anywhere from 30 to 60 percent of their funding from Medicaid alone. Tribal healthcare delivery systems are the only systems that can ensure coordinated, quality of care for the beneficiaries they serve, and the only providers with the incentive to ensure that care is not fragmented. Tribal healthcare providers reinvest in their communities, and Tribal healthcare delivery systems are essential to local Tribal communities and economies. Ensuring full federal funding for Medicaid services received through the Indian health system is also essential to Tribal self-governance. Self-governance Tribes have achieved some remarkable health care improvements and efficiencies, but without the ability to bill Medicaid, those systems are not financially viable.

As Congress considers Medicaid reform, it is essential that the federal trust responsibility for Indian health care be honored and 100 percent FMAP for services received through the Indian health system is preserved. This policy position has been previously been supported by the National Governor's Association during past Medicaid reform efforts.[15] Exempting AI/AN beneficiaries from such reforms, including work requirements, is consistent with the United States trust and legal responsibilities to Tribes. Medicaid reform must be deliberative and understand that it will impact Indian health programs, even when those changes do not immediately appear to do so.

ADDRESS THE BEHAVIORAL HEALTH CRISIS IN INDIAN COUNTRY

---

[12] H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.
[13] FY 2025 Congressional Justification, Indian Health Service.
[14] "Medicaid's Role in Health Care for American Indians and Alaska Natives", MACPAC. February 2021. Accessed 1/28/25, (https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf)
[15] National Governors Association, Resolution HHS-18, "Indian Health Services," March 1, 2006.

American Indian and Alaska Native populations carry generations of historic trauma which continue to impact our communities through myriad medical and behavioral health. The removal of Tribal nations from their lands, the breaking of cultural and familial bonds through removal of AI/AN children to boarding schools, and the broken promises of the federal government have contributed to some of the greatest disparities in mental health and substance use disorder diagnoses in our communities. AI/AN populations experience the highest rate of misuse for opioids, prescription pain relievers and other medication misuse. Since 2018, AI/AN opioid overdose deaths have increased by 174%. Despite an increase in Tribal Opioid Response (TOR) awards, competitive funding is difficult for many Tribes to acquire. The strain of readily available resources for the I/T/U system cannot meet the demand of rising behavioral health issues nationwide.

Use of grants as the primary vehicle to deliver behavioral health funding, or any other funding, limits Tribal providers' ability to deliver clinical services, reporting requirements deter patients from accessing care, and lack of access to culturally competent providers and treatments all compound the behavioral health crisis in Indian Country. We ask Congress to strengthen Tribal behavioral health treatment and programs by increasing resources, providing for flexibility and self-governance of funding, and support expanded access to Tribal traditional healing services.

HHS/IHS should invest in culturally centered and Tribally driven behavioral health programming and facilities. For example, HRSA can support infrastructure outside of state-awards to support aging and dilapidated behavioral health facilities that are Tribal and Native-operated. IHS can expand the types of projects eligible under the Joint Venture Construction Program (JVCP) to include standalone behavioral health and substance use disorder (SUD) treatment facilities. Provide additional and proactive technical assistance to Tribal Nations to access and apply for available funding to treat and prevent SUD and modify existing standards for cultural considerations such as extending timelines and allowing for non-evidence-based practices as our cultural models are often underreported.

Allow for behavioral health funding to be flexible and broadly applicable to behavioral health conditions. Current grants silo funding and prevent its use in treating mental health and SUD conditions together, limit integrated care with medical teams, and prevent polysubstance treatment or culturally informed approaches.

Investment in critical workforce development is essential to moving forward by ensuring HHS Divisions support AI/AN workforce development by authorizing and expanding additional provider types like behavioral health aides and tax exemption the IHS Scholarship and Loan Repayment programs as an incentive for participation. Also, midlevel providers should receive equal compensation with other provider types under Medicare and Medicaid

Finally, we recommend reduce federal bureaucracy by allowing SAMHSA programs to be available to Tribal Nations by amending access to the Alcoholic and Substance Abuse Block Grant (SUBG), under SAMHSA, to be available to Tribal Nations. Further, make common sense reforms to the Government Performance and Results Act (GPRA) to allow Agencies to lower reporting barriers for access to behavioral health services.

PROTECTING THE NEXT GENERATION

Congress should support improved maternal and infant outcomes for Native mothers and children by providing a funding set-aside in the Maternal Child Health Services Block Grant, investing in a robust maternal and birthing health workforce, and improving data on AI/AN mothers and infants.

Historical trauma compounded with social, economic, political, and environmental factors have impacted the health status of AI/AN mothers and infants. The lack of federal investments, culturally appropriate workforce, and quality data on AI/AN maternal and infant health stifle effective programming to improve health outcomes for our next generation.

Many Native women miss prenatal care visits due to lack of accessible services and lack of trust with their provider. Giving birth in Indian Country frequently means leaving your family, home, and support system to travel hundreds of miles to the nearest birthing center or hospital. For Native mothers with complicated pregnancies, this could mean months away from home. When expecting mothers have to travel so far from home to give birth, it can immediately complicate a pregnancy. Many times, new mothers may begin labor, drive hundreds of miles to reach their birthing hospital and then be turned away because they are not far enough along in labor to be admitted. Other times, Native women are stereotyped in their prenatal visits causing them to avoid necessary services. Due to preconditions like diabetes and hypertension, untreated conditions during pregnancy can increase a women's risk of maternal mortality.

As a result, AI/AN women are three times more likely to die from pregnancy-related causes than non-Hispanic White women. Further, AI/AN infants are born prematurely, underweight, and twice as likely to die before the age of one.

To address these disparities, HHS must create set-asides for Tribal and Native-led organizations, invest in a robust maternal health workforce, and improve data on AI/AN mothers and infants to address socioenvironmental factors that inhibit healthy outcomes for our next generation of AI/AN populations. The funding in the MCH Block grant can be used to increase mid-wife and doula training to support a larger birthing workforce in Native and rural communities. Improving access to the birthing workforce can also help Native moms-to-be also stay in their communities to deliver, which supports cultural traditions and keeps mothers and newborns closer to supportive networks which can improve infant health outcomes.

We must provide Tribal set-aside for the Maternal Child Health Services Black Grant. Today, this funding goes to state governments and leaves out Indian Country. There is a need for expanded prenatal health education. This extra funding can provide screening for suicide, SUD, and intimate-partner violence during prenatal and perinatal care. This funding would also improve continuum of care coordination with medication assisted treatment (MAT) providers. It would also provide health promotion efforts to reduce maternal and infant mortality.

Congress and the Administration should invest in workforce development for maternal health. Create a temporary set-aside in the IHS Loan Repayment Program for doulas and midwives. Require cultural humility training for providers who regularly engage with AI/AN populations. Work with Tribal Colleges and Universities to build a pipeline of AI/AN practitioners.

Maternal and child health data is often inaccurate or incomplete, leading to underrepresentation of the true impact of AI/AN maternal and child health needs. IHS and state data systems should report on maternal and child health. Additionally, mandate the collection of race and ethnicity data from IHS awardees.

Many of these recommendations have been highlighted in two recent reports, the first *The Way Forward: Report of The Alyce Spotted Bear & Walter Soboleff Commission on Native Children* and the NIHB's *Tribal Prenatal-3 Policy Agenda*. Further, the care for our children does not stop at birth, post-natal care for new mothers is critical for providing education and access to beahvioral health resources that help mothers and their children. As children age, many of them access health

care through school-based clinics. More should be done to meet children's needs by providing care where they are and by providing access to behavioral health services that help them understand the links of historical trauma to suicide and other behavioral health indicators and seek to connect them with cultural traditions which can strengthen their identities and links to community.

ADOPTION OF THE 2024 HEALTHCARE PACKAGE

An early iteration of the Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act of 2025 (H.R. 10455), introduced in the 118th Congress on December 17, 2024, included a series of popular and critically important healthcare legislation. Many of the proposals included long-time requests and priorities of Indian Country.

The Special Diabetes Program for Indians (SDPI) would have received a two-year extension at $200 million per year. Until last year, SDPI had been flat-funded for over 20 years at $150 million per year. This program is the only public health program to have reduced the instances of diabetes, and has to date save $520 million for Medicare in the prevention of end stage renal disease. The piecemeal, short-term extensions of this valuable public health program jeopardize program stability and make it difficult to plan for staffing and programmatic activities. Adopting a long-term extension with an increase is a long-standing request of Tribal Nations.

Medicare telehealth flexibilities would have been extended through December 31, 2026. Among other important Medicare flexibilities included in the package, Medicare telehealth has become a significantly important tool to provide health care services for Elders. Because Indian Country exists across vast expanses of rural and frontier, having access to telehealth services, particularly audio-only services, can improve access to distant site specialty care and supports better monitoring of chronic conditions. Extension of these flexibilities will continue to support improved health outcomes for our Elders.

Additional legislative reauthorizations and policy changes were included in the initial legislation. These reauthorizations are critical to providing services to our Elders, our nation's and Indian Country's readiness for future public health crises, and supporting behavioral health, and more. Among the legislation and policy changes: Medicaid pharmacy payment reform, reauthorization the Older Americans Act, the Pandemic and All-Hazards Preparedness Act (PAHPA), and the SUPPORT Act. Without adoption or reauthorization, these programs will continue to be in limbo.

EXPAND TRIBAL SELF GOVERNANCE BEYOND IHS AT THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fifty years ago, Congress passed the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 *et seq*. Through the passage of ISDEAA, Congress enabled Tribes to contract and compact to run their own health care programs while also preserving Tribes' right to choose that services continue to be provided directly by the Indian Health Service. ISDEAA has proven to be one of the most important policy choices that has restored to Tribes their rightful sovereignty to determine and improve the health and well-being of our People.

In 2000, P.L. 106-260, included a provision directing HHS to conduct a study to determine the feasibility of a demonstration project extending Tribal Self-Governance to HHS agencies other than the IHS. The HHS Study, submitted to Congress in 2003, determined that a demonstration project was feasible. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696, the Department of Health and Human Services Tribal Self-Governance Amendments Act, that

would have allowed these demonstration projects. The legislation unfortunately did not advance out of that Congress, but it continued an important discussion on the success and feasibility of Tribal self-determination and self-governance beyond IHS. A second study was completed in 2011 by the U.S. Department of Health and Human Services Self-Governance Tribal Federal Workgroup which reiterated the feasibility and underscored the need for legislation. Since 2024, the HHS Secretary's Tribal Advisory Committee Tribal Self-Governance Expansion Workgroup has worked to build momentum for a demonstration proposal and proposed legislative language. On the 50th anniversary of ISDEAA, it is time to reaffirm Tribal sovereignty and the success of self-determination and self-governance.

INDIAN HEALTH SERVICE SCHOLARSHIP AND LOAN REPAYMENT PROGRAM REFORMS

IHS provides scholarship and loan repayment opportunities as an incentive for medical professionals to work in the Indian health system due to chronic short staffing issues. Unlike other similar federal programs, these payments are taxable. This means, that the agency is paying taxes on top of the loan and scholarship payments, which means fewer providers are able to be given loan repayment and scholarship under the current appropriations. In the IHS's FY 2025 Congressional Justification, it estimated that if the scholarship and loan repayment programs were tax exempt, it could have awarded an additional 218 loan repayment contracts. Further, this program does not provide for part-time commitments or include mid-level providers which could further extend the reach and bring more providers in to help address the chronic provider shortage at Indian health facilities. Any tax reform legislation considered in the 119th Congress should make reforms to the IHS scholarship and loan repayment programs to increased their success in support of an adequate workforce for Indian health.

CONCLUSION

The above highlighted Tribal priorities are not exhaustive, but they can be accomplished in the 119th Congress. These priorities, if enacted by Congress, will bring us a step closer to meeting the trust and treaty obligation of the federal government to Tribal Nations. The federal government made promises in its Tribal treaties to provide for, among other things, the healthcare of Tribal citizens. The policies and legislation outlined throughout this testimony will help repair one portion of the broken promises of the federal government and will support a step towards healthier Tribal communities.