April 15, 2020

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
H-232 Capitol Building
Washington, D.C. 20515

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

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

Dear Speaker Pelosi and Minority Leader McCarthy:

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

As the urgency, infection rate, and death toll of the COVID-19 pandemic intensifies, it has become increasingly clear that Indian Country needs significantly more resources to protect and preserve human life and address the grave economic impacts tribal nations face due to the closure of government operations and tribal enterprises to protect the health of their citizens and surrounding communities. AI/AN communities are disproportionately impacted by the health conditions that the Centers for Disease Control and Prevention (CDC) notes increase risk for a more serious COVID-19 illness, including respiratory illnesses, diabetes, and other health conditions. We urge you to include the following 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.

This letter is one of three letters addressing: economic development and employment; tribal governance and housing/community development; and health, education, nutrition, and human services. The language included in this letter covers the health, education, nutrition and agriculture, and human service needs for Indian Country. For your convenience, we have created an abbreviated list to coincide with the specific funding and policy requests found later in the letter. This abbreviated list previews how the letter is organized.

The summary list of funding and policy requests begins on the following page.

Health

Health Section 1: Critical Funding and Access Needs..... Pg. 7

- Provide $1 billion for Purchased/Referred Care (PRC).
- Provide $1.215 billion for Hospitals and Health Clinics.
- Establish a $1.7 billion Emergency Third-Party Reimbursement Relief Fund for IHS, Tribal Programs, and Urban Indian Organizations.
- Provide $85 million for equipment purchases and replacements.
- Provide $161 million for Urban Indian Health.

Health Section 2: Critical Infrastructure..... Pg. 12

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.

- Provide $1 billion for Sanitation Facilities Construction.
- Provide $750 million for maintenance and improvement of Indian Health Service and Tribal facilities.

Health Section 3: Technical Medicaid/Medicare Fixes..... Pg. 15

- Authorize Medicaid reimbursements for Qualified Indian Provider Services and Urban Indian Organizations.
- Provide reimbursements for services furnished by Indian Health Care Providers outside of an IHS or Tribal Facility.
- Ensure parity in Medicare reimbursement for Indian Health Care Providers.
- 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 health programs, and Urban Indian Organizations.

Health Section 4: Technical Amendments Needed..... Pg. 19

Expand telehealth capacity and access in Indian Country by permanently extending waivers under Medicare for the use of telehealth and enacting certain sections of the CONNECT to Health Act.

- Make the IHS Scholarship and Loan Repayment Program tax exempt.
- 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.
- Implement ways to disburse funding to tribal nations using existing funding mechanisms already in place when possible.
- Provide Tribal and UIO access to the Strategic National Stockpile.
- Provide Tribal and UIO access to the Public Health Emergency Fund.

Health Section 5: Legislative Amendments and Reauthorizations..... Pg. 23

- Move Contract Support Costs to mandatory appropriations.
- Move 105(l) lease agreements to mandatory appropriations.
- 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 contracts or Self-Governance compacts.
- Provide mandatory appropriations for Village Built Clinics.

Education

Education Section 1: K-12 Educational Needs..... Pg. 26

- Authorize Tribally Controlled Grant Schools to access Federal Employee Health Benefits (FEHB).
- Ensure that a tribal state of emergency is included in the definition of a qualifying emergency.
- Ensure access to healthy meals for all students that are impacted by school closures and have no other means to get these meals.

Education Section 2: K-12 Education Infrastructure and Broadband Needs..... Pg. 28

- Provide $115 million for wireless hotspots for BIE students and teachers as an immediate solution to school closures.
- Provide $60 million for laptops for BIE students and teachers as an immediate solution to school closures.

Education Section 3: Higher Educational Needs..... Pg. 29

- Provide an additional $7 million in the Interior-Bureau of Indian Education account to meet the immediate and critical needs of Tribal College and Universities (TCUs).

Education Section 4: Education Infrastructure and Broadband Needs..... Pg. 30

- Authorize Tribal Colleges and Universities as eligible to participate in the E-Rate program.
- Establish a $16 million TCU set-aside in the USDA-Rural Utilities Service Program using existing funds.
- Provide at least $500 million in the Interior-BIE account for a TCU Deferred Maintenance & Rehabilitation Fund, as authorized under the Tribally Controlled Colleges and Universities Assistance Act.

Nutrition and Agriculture

Nutrition and Agriculture Section 1: Critical Funding and Access Needs..... Pg. 31

- Clarify CARES Act Food Distribution Program on Indian Reservations (FDPIR) funding covers administrative costs, reimbursement of emergency food purchases, and authorizes FDPIR Indian Tribal Organizations to procure food locally and regionally; waive the non-federal cost share requirements; and allow for necessary administrative flexibility for verifications, certifications, and service.
- Temporarily waive the prohibition on dual use of the Supplemental Nutrition Assistance Program (SNAP) and FDPIR during the same month.
- Provide assistance to Farm Service Agency (FSA) borrowers for relief and implementation of policies to provide support for tribal producers and entities.
- Increase the SNAP maximum benefit available to all households by 15 percent and the minimum benefit from $16 to $30 and delay implementation of the proposed and final SNAP rules.
- Provide parity and eligibility for tribal governments and Indian Tribal Organizations in the Emergency Food Assistance Program (TEFAP).
- Adequately Fund the Federally Recognized Tribes Extension Program (FRTEP) at $30 million.
- Provide for agriculture lending through Community Development Financial Institutions (CDFIs).
- Create a COVID-19 Perishable Products Loss Fund due to market disruption.

Nutrition and Agriculture Section 2: Infrastructure Funding and Broadband Needs..... Pg. 35

- Create a 15 percent tribal set aside in the USDA ReConnect Broadband program and Distance Learning and Telemedicine Grant Program to enhance broadband access and long-distance healthcare in Indian Country.
- Increase funding for tribal-specific projects under all USDA Water and Environmental Grant Programs by $200 million.
- Expand the use and increase funding for the Rural Development (RD) Community Facilities Programs.
- Provide tribal specific funding for the Local Access Market Programs (LAMP).
- Expand USDA RD programs Substantially Underserved Trust Area (SUTA) designation to all programs at RD to support tribal priority.
- Enhance Natural Resources Conservation Service (NCRS) programing for tribal producers, including: full advanced payments for socially disadvantaged producers; remove/waive requirements of one year prior control, the need for a Conservation Stewardship Program technical service provider, and compensation to former lessees of tribal lands for the installation of existing conservation practices; and ease requirements for beginning farmers/ranchers.

Human Services

Human Services Section 1: Temporary Assistance for Needy Families (TANF) ..... Pg. 37

- Appropriate funding in the amount of $2 billion to the TANF Contingency Fund (TCF) and allow tribal nations access in order to meet the significant needs of Tribal TANF recipients.
- Create and provide $5 billion to a TANF Emergency Fund similar to the fund created in the American Recovery and Reinvestment Act (ARRA) with a waiver of non-federal contribution for tribal nations and flexibility for tribal nations to spend in areas specific to each tribal grantee.

Human Services Section 2: Veterans..... Pg. 38

- Require the Veterans Health Administration (VHA) to reimburse IHS and tribal nations for services under PRC.
- Exempt Native veterans from copays and deductibles at VHA facilities.
- Authorize UIOs as eligible for VA reimbursement.

Human Services Section 3: Indian Child Welfare Services..... Pg. 39

- Provide $30 million for tribal governments under Title IV-B, Subpart 1 of the Social Security Act.
- Provide $45 million for tribal governments under Title IV-B, Subpart 2 of the Social Security Act to be divided as follows:
    - $20 million to mandatory funding for tribal nations.
    - $20 million to discretionary funding for tribal nations.
    - $5 million to the Tribal Court Improvement Project.
- Provide $20 million for tribal governments under Title IV-E Chafee funds.
    - Authorize language allowing tribal nations to directly access the Social Services Block Grant Program by establishing a 5 percent tribal nation set aside in the statute.

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

Sincerely,

National Congress of American Indians
National Indian Health Board
National Council of Urban Indian Health
Self-Governance Communication & Education Tribal Consortium
National Association of Food Distribution Programs on Indian Reservations
Native Farm Bill Coalition
Intertribal Agriculture Council
National Indian Education Association
American Indian Higher Education Consortium
National Indian Child Welfare Association
United South and Eastern Tribes Sovereignty Protection Fund

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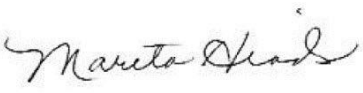

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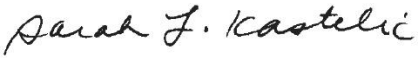

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United South and Eastern Tribes Sovereignty Protection Fund

HEALTH

Health Section 1: Critical Funding and Access Needs

- **Provide $1 billion for Purchased/Referred Care (PRC).**

Background: 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 tribal nations 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 tribal nations 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 percent of the small, rural communities are not on the road system, so air transportation is the primary 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. The reduction in air traffic and canceled services makes it difficult for communities to obtain 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, which includes 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 critical work of Tribal Epidemiology Centers (TECs), many of which are on the frontlines and working with tribal nations to engage in COVID-19 disease surveillance. Importantly, this funding also supports IHS and tribal sites to purchase personal protective equipment (PPE) and other critical medical countermeasures that are in direly 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 the primary responsibility to care for COVID-19 patients. Finally, we request that funding 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, tribal nations strongly recommend that any funding that Congress provides for electronic health records or other health information technology purposes, be provided in a proportional amount to tribal nations and tribally-operated health programs through Self-Determination contracts and Self-Governance compacts.

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, Tribal Programs, and Urban Indian Organizations (UIOs).**

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 percent 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 percent of their healthcare budgets derived from such payers. 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 continue social distancing guidelines, IHS, tribal, and UIO 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 critical 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, therefore, eliminating nearly all revenue generating services that 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 tribal nations are experiencing double the financial hit.

While IHS, tribal, and UIO 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 tribal facilities and UIOs are experiencing millions in lost third-party reimbursement as a result. However, tribal nations strongly urge Congress to ensure that relief funds NOT be in the form of a loan. Further, we assert that tribal nations 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 third party reimbursement dollars as a result of the pandemic. Because each tribal nation's financial situation is unique, we urge the creation of a $1.7 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, or through other mechanisms for urban Indian organizations, for care related expenses or lost revenues incurred by Indian Health Service, Indian Tribes and 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, and 'Urban Indian Organizations' has such meaning as defined under section 4 of the Indian Health Care Improvement Act, that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19: 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, Tribal, or Urban Indian Organization sites: Provided further, That to be eligible for a payment under this paragraph, an Indian Health Service, Tribal, or Urban Indian Organization 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 Organization site for such payment.

- **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 the lives of patients and their providers in jeopardy. An influx of $75 million in funding is critical to assist IHS and tribal sites in purchasing medical equipment, and replacing 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.

- **Provide $161 million for Urban Indian Health.**

Background: Today, 41 UIOs operate a network of 74 health facilities in 22 states providing primary care, behavioral health services, social and community services, and traditional healing and medicine services to tribal citizens in urban areas. In the calendar year 2019, IHS data show that 40 of 41 UIOs provided 655,552 visits to AI/ANs. Although UIOs are one of the three prongs of the Indian Health care delivery system IHS administers (IHS direct care facilities, Tribal health programs, UIOs – collectively referred to as the "I/T/U system"), UIOs are frequently interpreted as ineligible for essential cost saving measures that were created as part of the trust obligation to AI/ANs and are available to the remainder of the I/T/U system, including a full federal match for Medicaid services and malpractice insurance coverage, and only receive primary funding from one line item – urban Indian health. UIOs do not receive funds through other IHS budgets, such as facilities improvements and upgrades.

UIOs, like other Indian Health Care Providers, are on the front lines of this pandemic. Shortages in PPE, staff falling ill, inadequate testing supplies, significant additional unforeseen costs, and losses in revenue are having significant impacts on UIO facilities. Several facilities have implemented drive-thru testing, with one providing the only such site in the entire county in which it is located, and many have implemented new infection control protocols, including increases in telemedicine and new triage processes. However, all of this incurs significant costs – and three facilities have had to close their doors, leaving many people without jobs and even more without essential services. A recent survey found that 83 percent of UIO-respondents have been forced to reduce their services, with 48 percent reporting no capacity for medicine delivery, and 28 percent reporting no capacity for triage space. Notably, every UIO respondent reported supply shortages. Added costs due to COVID-19 reach nearly $2 million per month at many UIOs. This burden creates significant strains on the already chronically underfunded facilities and requires prompt Congressional action. An appropriation of $161 million for Urban Indian Health would cover the remaining budgetary strain and unforeseen costs incurred since February and provide resources to enable UIOs to continue to provide high

quality care to their patients while also managing local outbreaks and minimizing risks to their communities in the coming months.

Legislative Text:
For an additional amount for 'Urban Indian *Health' under 'Indian Health Service' $161,000,000 to remain available until expended to prevent, prepare for, and respond to coronavirus: Provided, that funds appropriated in the preceding proviso may be made available to restore amounts for obligations incurred prior to the date of enactment of this Act.*

Health Section 2: Critical Infrastructure

- **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 is only able to accommodate approximately 52 percent of the 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 an 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 not only to 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 the Small Ambulatory Program (SAP). The JVCP is a joint agreement between IHS and tribal nations 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 tribal nations and tribal organizations that satisfied eligibility for the past and current JVCP competition. The SAP provides funding to tribal nations and tribal organizations for the construction, expansion, or modernization of ambulatory health care facilities. These funds are particularly important for tribal nations that are not on the Priority List or participating in JVCP to address COVID-19 health care facility construction needs.

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 tribal nations 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 tribal nations, and enhance funding for Small Ambulatory Program needs;
- Build auxiliary facilities and nonmedical facilities for social isolation;
- Bolster hospital capacity; and
- Build temporary lodging for healthcare providers.

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 CDC, the provision of safe water, sanitation, and hygienic conditions are 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 percent of homes on tribal lands are in need of sanitation facility improvements, while nearly 7 percent of all AI/AN homes do not have adequate sanitation facilities. Even more troubling is that roughly 2 percent 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 an 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 Self-Determination contracts / Self-Governance 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 percent 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 tribal nations 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 Text:

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.

Health Section 3: 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:
For Qualified Indian Provider Services:

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

[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).

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 Percent 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 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/ANs, and cost-sharing requirements are inconsistent with this obligation. Medicaid exempts AI/ANs from cost-sharing, and Medicare should do the same.

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

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

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

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

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

- **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 health programs, and Urban Indian Organizations.**

Background: There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country and throughout the Indian healthcare system. 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 AI/ANs, 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, 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) 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 4: Technical Amendments Needed

- **Expand telehealth capacity and access in Indian Country by permanently extending waivers under Medicare for the 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 tribal nations 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 for Health Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expand 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, tribal nations strongly recommend that Congress not only permanently extend the existing waiver authority for the 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 percent but stretches as high as 31percent. IHS has tried to implement incentives to better recruit and retain quality providers, but

lack of competitive salary rates and benefits have inhibited these efforts, 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 the 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 percent 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 the 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 currently available for interagency transfers of funds between 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: 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 tribal nations, 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 for flexible legislative authorities that would help expedite execution of such a funding mechanism in consultation and coordination with the relevant tribal nations 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 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 weeks 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 tribal nations 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 provide Tribal and UIO access to the SNS.

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

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

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

Legislative Text:
Please refer to S. 3486 introduced on March 12, 2020, and H.R. 6274 introduced on March 13, 2020.

Health Section 5: Legislative Fixes and Reauthorizations

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

Background: Committees of jurisdiction are well aware of case law mandating that the United States pay in full all Contract Support Costs (CSC) to AI/AN tribal nations and tribal organizations as authorized under the Indian Self-Determination and Education Assistance 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 fewer 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, tribal nations 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 tribal nations 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. Tribal nations 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 the 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, tribal nations 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 contracts or Self-Governance 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 severe 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. 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, 2020. 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 tribal nations are also battling the COVID-19 pandemic. A permanent reauthorization with added flexibility for tribal nations 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 percent of operation and maintenance costs, leaving the villages to subsidize this vital federal program. This situation reduces the health care available locally to village residents and threatens the $270 million investment in these facilities by the federal government, Alaska villages, and the regional tribal health organizations in the Alaska Native Health System.

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

Education

Education Section 1: K-12 Educational Needs

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

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

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

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

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

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

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

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

Background: Due to high rates of participation in the National School Lunch and Breakfast Programs, Native students are disproportionately impacted by school closures that limit access to healthy meals. 510,000 AI/AN students across the country are eligible to receive free or reduced lunches. Participation is even higher in rural and reservation areas, where 48 percent of eligible rural Native students attend schools where more than 75 percent of students receive free and reduced

lunches. Families often rely on such programs to provide affordable and healthy meals for their children throughout the school year. All students, including Native students, must continue to have access to meals that support their health and wellbeing during a public health emergency.

Education Section 2: K-12 Education Infrastructure and Broadband Needs

- **Provide $115 million for wireless hotspots for BIE students and teachers as an immediate solution to school closures.**

Background: Limited broadband access in Native communities continues to hamper efforts to provide effective culture-based virtual education options for Native students, particularly those that attend Bureau of Indian Education schools. In 2017, the National Center for Education Statistics reported that 36 percent of Native students nationwide did not have internet access in their homes, compared to 17 percent of white students and 18 percent of students nationwide. A 2019 report from the Center for Indian Country Development at the Federal Reserve Bank of Minneapolis further clarified that this effect is more pronounced on tribal lands, where only 61 percent of households have broadband access, compared to the 70 percent average in the typical county that overlaps a reservation and the 69 percent nationwide average. Due to lack of internet access at home, BIE schools serving students on and near tribal lands have struggled to implement virtual education options during the novel coronavirus outbreak. Wireless hotspots provide essential internet service for Native students to continue core educational programs through virtual learning tools until it is safe to return to the classroom.

- **Provide $60 million for laptops for BIE students and teachers as an immediate solution to school closures.**

Background: Bureau of Indian Education (BIE) schools have long been underfunded, resulting in outdated technology, infrastructure, and computer equipment. As a result, many schools do not have enough, if any, laptop computers to send home with students, educators, and staff to continue education in a virtual classroom. Native students must have the same access to resources as other students to ensure that current achievement and opportunity gaps do not widen due to the COVID-19 outbreak. Immediate appropriations are necessary to ensure that each student and educator at Bureau-funded schools have access to essential educational tools during this unprecedented time.

Education Section 3: Higher Educational Needs

- **Provide an additional $7 million in the Interior-Bureau of Indian Education account to meet the immediate and critical needs of Tribal College and Universities (TCUs).**

Background: The nation's 37 TCUs already have incurred significant costs related to closing and securing campuses, ensuring that students are able to relocate off campus or shelter in place with safety patrols, and begin the first phase of online courses. Virtually all TCUs are moving to online instruction and closing their physical campuses, due to tribal or state directives. TCUs face immediate challenges in addressing: (a) career and technical courses, which often cannot be converted to online courses; (b) professional development and course redesign for faculty; (c) equipment for online delivery of courses; and (d) lack of internet access in students' homes.

The best estimate of the immediate and short term (8-10 weeks) costs that TCUs have and will incur is $745,520/institution, for a total of $26,838,720. In the CARES Act, TCUs received $20M. An additional $7 million is needed to more adequately address TCU immediate/short-term needs.

Education Section 4: Higher Education Infrastructure and Broadband Needs

- **Authorize TCUs as eligible to participate in the E-Rate program.**

Background: Congress should amend the Telecommunications Act to designate TCUs as eligible entities to participate in the federal E-rate program. This is a low cost, long-term solution to part of the digital divide/homework gap in Indian Country. If TCUs were already part of the E-rate program, the mobile hot spots needed to address the "homework gap" on many reservations already would be in place. The cost is estimated to be $8 million per year. This is a modest request compared to the amount of funding available to the E-rate program. (The current annual funding cap is $4.15 billion, of which barely half has been spent this year.) It is important to note that any program to provide tax credits to existing Internet Service Providers for providing free internet access to students provides little or no help in Indian Country because the IT infrastructure does not exist.

- **Establish a $16 million TCU set-aside in the USDA-Rural Utilities Service Program using existing funds.**

Background: Congress may be reluctant to amend the Telecommunications Act to designate TCUs as eligible entities to participate in the federal E-rate program, even though such action would be efficient and low-cost. As an alternative, Congress could establish a $16 million per year set-aside for TCUs under the USDA-Rural Utilities Service. Over the past several years, funding has gone unused in the program. A $16 million set-aside for TCUs, which are the 1994 Land-grant institutions, could be established using existing funds and, therefore, would be at no additional cost.

- **Provide at least $500 million in the Interior-BIE account for a TCU Deferred Maintenance and Rehabilitation Fund, as authorized under the Tribally Controlled Colleges and Universities Assistance Act.**

Background: The American Indian Higher Education Consortium recently conducted a survey of 22 TCUs, which revealed a list of chronic facilities-related needs, including student and faculty housing, classrooms, libraries, and laboratories. The 22 TCUs have an estimated total need of $332.5 million in deferred maintenance and rehabilitation and need $558 million to fully implement existing master plans. Extrapolating this to all 37 TCUs, the total current need is: Deferred Maintenance/Rehabilitation: $500 million; and Completion of Master Plans: $837 million.

Nutrition and Agriculture

Nutrition and Agriculture Section 1: Critical Funding and Access Needs

- **Clarify CARES Act Food Distribution Program on Indian Reservations (FDPIR) funding covers administrative costs, reimbursement of emergency food purchases, and authorizes FDPIR Indian Tribal Organizations to procure food locally and regionally; waive the non-federal cost share requirements; and allow for necessary administrative flexibility for verifications, certifications, and service.**

Background: The CARES Act (H.R. 748) provides critical funding for both food purchases ($50 million) and facility improvements and equipment upgrades ($50 million) in the FDPIR program. As these costs increase, so do the administrative costs for FDPIR Indian Tribal Organizations (ITOs) and the burdens on tribal governments and ITOs. Additional flexibility for administrative costs, emergency food purchases, local and regional food procurement, and new construction costs will support ITOs to continue to provide safe and effective service to FDPIR participants. Further, waiving the non-federal cost requirement and providing the administrative flexibility for verifications, certifications, and service will alleviate burdens on tribal governments and ITOs.

Legislative Text:

CLARIFICATION AND ADDITIONAL AUTHORITIES FOR THE FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS.

(a) *CARES Act of 2020 Funding for the Food Distribution Program on Indian Reservations*

(1) *To support the immediate access and use of the appropriations provided to the Food Distribution Program on Indian Reservations as established under section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)), in Division B of the Coronavirus Aid, Relief, and Economic Security Act of 2020, the Secretary of Agriculture shall:*

(A) *Immediately utilize the appropriated funding for Indian Tribal Organizations and State agencies for food purchasing, including emergency food purchasing, facility improvements, new construction, and equipment upgrades, and allow for the funds to be used to cover any administrative costs;*

(B) *Waive administrative cost-sharing requirements to all funds provided to the Food Distribution Program on Indian Reservations under Division B of the Coronavirus Aid, Relief, and Economic Security Act of 2020; and*

(C) *Allow any remaining funds provided to the Food Distribution Program on Indian Reservations under Division B of the Coronavirus Aid, Relief, and Economic Security Act of 2020 to be used to cover any additional costs or expenses of the programs not accounted for under this provision.*

(b) *Purchasing Authority and Administrative Flexibility.—*

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

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

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

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

- **Temporarily waive the prohibition on dual use of the Supplemental Nutrition Assistance Program (SNAP) and FDPIR during the same month.**

Background: FDPIR participants are prohibited from using both FDPIR and the Supplemental Nutrition Assistance Program (SNAP) in the same month. Temporarily waiving this restriction against dual participation in SNAP and FDPIR will allow Native households more food options at a time when it is greatly needed, reduce administrative burdens on FDPIR and SNAP staff, and slow the inventory depletion at FDPIR sites. Currently, FDPIR sites are seeing increased take rates of food, because people are now taking the maximum, they are allotted out of concern over local food availability. SNAP participants, especially those in rural areas, are seeing limited availability of food with fewer trucks making deliveries of many items including, fresh fruits and vegetables, coupled with price increases. Being able to utilize both SNAP and FDPIR would ameliorate these problems. FDPIR would not be overwhelmed by hundreds of new households but would be able to serve even the increasing numbers efficiently, as participants in FDPIR typically only take what they need (not the full food package), and SNAP participants would have access to items that are not currently available in stores. This temporary waiver of restrictions between the programs would also significantly decrease the administrative burden to FDPIR staff, who must ensure that new applicants to either program are not currently certified on SNAP before certifying them for FDPIR.

Legislative Text:

WAIVERS FOR THE FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS.

(a) *Temporary Waiver of SNAP/FDPIR Prohibition.—*

(1) *Beginning immediately after the date of passage of this Act, the prohibition on simultaneous usage of the Supplemental Nutrition Assistance Program and the Food Distribution Program on Indian Reservations in Section 4(b)(2)(c) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)(2)(c)) is initially waived/suspended through September 30, 2021, only to end after consultation with tribal governments to review any lasting economic impacts.*

- **Provide assistance to Farm Service Agency (FSA) borrowers for relief and implementation of policies to provide support for tribal producers and entities.**

***Background*:** With increased risk and uncertainty, FSA borrowers across the country will benefit from improved loan relief provisions, policies, and new programs to ensure continuity of operations and access to credit. Providing this relief will allow for stability in production in Indian Country and improve the sustainability and resiliency of Indian Country agriculture.

Legislative Text:

Create new Section under 7 U.S.C. Chapter 50 – Agriculture Credit, Subchapter IV:
Deferral of Principal Payments for COVID-19 Relief 7 U.S.C. XXXX

(a) Irrespective of any other guidance in this title, the Secretary shall defer all principal payments and extend the maturity date by two years on any farm program loan existing or made during the 2020 and 2021 production years.

(b) FSA Farm Ownership Loans may be used for refinance of FSA Guaranteed Loans or any other real estate debt if such application is made before December 31, 2020.

(c) The Secretary shall expend such funds as are needed to offer a 2 percent interest buy down on any existing agriculture debt through a guaranteed or direct loan provided the participating lenders grant the same principal deferral and maturity date extension, for 2020 and 2021.

- **Increase the SNAP maximum benefit available to all households by 15 percent and the minimum benefit from $16 to $30 and delay implementation of the proposed and final SNAP rules.**

Background: In order to reduce disruptions that the COVID-19 pandemic will bring families, Congress must make an investment to prevent large increases in poverty by increasing the maximum SNAP benefit by 15 percent. To the same effect, Congress must increase the monthly minimum SNAP benefit from $16 to $30, which will go a long way in helping AI/AN households keep food on the table. Finally, Congress must put a stop to the harmful rules from the Executive Branch that, if enacted, will weaken SNAP eligibility and benefits during the COVID-19 pandemic. The three rules: 1) broad-based categorical eligibility (BBCE); 2) able-bodied adults without dependents (ABAWDs); and 3) Standard Utility Allowance (SUA) should not be authorized until the economy shows significant improvement.

- **Provide parity and eligibility for tribal governments and ITOs in the Emergency Food Assistance Program (TEFAP).**

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

Legislative Text:
Amend 7 U.S.C. 7501(3) by inserting the following at the end:

(D) is an "Indian tribe" which has the meaning given the term in section 4 of the Indian Self Determination and Education Assistance Act (25 U.S.C. 5304), and a "tribal organization" which has the meaning given the term in section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)).

Amend 7 U.S.C. 7501 by adding the following:

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

- **Adequately Fund the Federally Recognized Tribes Extension Programs (FRTEP) at $30 million.**

Background: FRTEP has been funded at the exact same level since it started in 1990. With the 2018 Farm Bill including 1994 Tribal land grant institutions for the very first time, now is the time that this strong network of existing programs at 1862 land grants and newly eligible 1994s can mobilize and quickly deploy additional resources on the ground and hire additional staff. This will help address COVID-19 related emergent and urgent needs, rebuild resiliency, and provide technical support to agriculture production and community food resiliency in tribal communities.

- **Provide for agriculture lending through Community Development Financial Institutions (CDFIs).**

Background: While the U.S. Small Business Administration (SBA) received significant funding to support small businesses across the country, many of the most at-risk businesses will not receive immediate relief from SBA programming, such as agricultural enterprises. CDFIs, however, serve this section of businesses and entrepreneurs and are accustomed to underwriting borrowers that do not meet SBA requirements. Failures of these higher risk economy segments will result in a trickle up impact, impacting other businesses because of disruptions to or possible eliminations of supply chains.

- **Create a COVID-19 Perishable Products Loss Fund due to market disruption.**

Background: Market disruption due to COVID-19 has resulted in a decline or stoppage of U.S. food products bound for international markets across the globe, leaving large amounts of inventory without a market destination. Entities that are unable to sell products in alternate markets will experience increased storage costs and product loss due to expiration dates. Creating a Perishable Products Loss Fund will not only allow for these producers to not lose out on revenue, it can open up these perishable products to new domestic programs and purposes, especially at a time when food access and security is a growing concern.

Nutrition and Agriculture Section 2: Infrastructure Funding and Broadband Needs

- **Create a 15 percent tribal set aside in the USDA ReConnect Broadband program and Distance Learning and Telemedicine Grant Program to enhance broadband access and long-distance healthcare in Indian Country.**

Background: Tribal citizens lack access to broadband at rates that exceed the national averages, especially in rural and remote areas. With the number of healthcare facilities, schools, colleges, and the need for additional infrastructure throughout rural and remote places in Indian Country, building out and improving broadband infrastructure for telemedicine and distance learning will help ensure that all citizens in rural and remote areas that rely on tribally run facilities will have access to health care and educational services.

Legislative Text:
(a) Tribal Set-Aside.—Notwithstanding any other provision of law, effective beginning in fiscal year 2020 and for each fiscal year thereafter, the Secretary of Agriculture (referred to in this section as the "Secretary") shall set aside for broadband adoption and deployment on Tribal land not less than 20 percent of the amounts made available for that fiscal year for each of the following:

(1) The Distance Learning and Telemedicine Program established under the Federal Agriculture Improvement and Reform Act of 1996 (7 U.S.C. 950aaa et seq.); and

(2) The Telecommunications Infrastructure Loan and Loan Guarantee Program established under the Rural Electrification Act of 1936 (7 U.S.C. 901 et seq.).

- **Increase funding for tribal-specific projects under all USDA Water and Environmental Grant Programs by $200 million.**

Background: Tribal communities often have high rates of underserved populations due to water quality and infrastructure limitations. In order to maintain high levels of sanitation and hygiene from both a health and food safety perspective, additional funds are necessary to address absent infrastructure, underperforming infrastructure, and water quality, safety, treatment, and storage challenges. These programs include: Grants for Rural and Native Alaskan Villages; the Water and Waste Disposal Program; Water and Waste Disposal Grants to Alleviate Health Risks on Tribal Lands and Colonias; and Emergency Community Water Assistance Grants.

- **Expand the use and increase funding for the Rural Development (RD) Community Facilities Programs.**

Background: Emergency-related disruptions in supply chains and increased demands have showcased a need for better developed regional and local infrastructure to serve the needs of tribal communities across the board. A tribal-specific funding increase and additional support for building essential infrastructure, including: agriculture value-added infrastructure; quick build food medical and food storage facilities; TCUs building and technological resources; and temporary refrigerated morgues, will help address longstanding issues and build immediate capacity to address issues related to the COVID-19 emergency response.

- **Provide tribal specific funding for the Local Access Market Programs (LAMP).**

Background: Supply disruptions and increased assistance demands on tribally funded or tribally or administered programs have evidenced a need for a more robust local and regional food economy in Indian Country. Some tribal nations are already coordinating food stockpiles through Incident Command Systems in anticipation of sustained demand through uncertainty in supply and are implementing quantity limits of certain food items to prevent runs on grocery supplies.

- **Expand USDA RD programs Substantially Underserved Trust Area (SUTA) designation to all programs at RD to support tribal priority.**

Background: The "substantially underserved trust area" (SUTA) designation authorized by the 2008 Farm Bill allows USDA's Rural Utility Service (RUS) to offer entities residing in specific locations low interest rates on utility loans; waive non-duplication, matching, and credit support requirements; extend loan repayment terms; and provide funding priority to some utilities infrastructure programs. SUTA should be amended to allow the Secretary to exercise SUTA across all Rural Development programs. A broader application of SUTA will recognize unique and essential tribal infrastructure and business development needs and will be a tool to create communities of opportunity in Indian Country, especially to respond during and beyond the COVID-19 crisis.

- **Enhance Natural Resources Conversation Service (NCRS) programing for tribal producers, including: full advanced payments for socially disadvantaged producers; remove/waive requirements of one year prior control, the need for a Conservation Stewardship Program technical service provider, and compensation to former lessees of tribal lands for the installation of existing conservation practices; and ease requirements for beginning farmers/ranchers.**

Background: NRCS offers essential financial support to producers to maintain and build healthy lands to help ensure sustainable and regenerative production. With the increasing demands on the food supply chain, tribal producers need as much support as possible to continue and increase production to support their local tribal communities and provide products locally in tribal food systems.

Human Services

Human Services Section 1: Temporary Assistance for Needy Families (TANF)

- **Appropriate funding in the amount of $2 billion to the TANF Contingency Fund (TCF) and allow tribal nations access in order to meet the significant needs of Tribal TANF recipients.**

Background: The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193, as amended) created a $2 billion TCF to assist states in meeting the need for welfare assistance during periods of economic downturns. The TCF was exhausted in the last recession and Congress has appropriated $608 million per year to it with the fund being spent each year regardless of economic conditions. Unfortunately, tribal nations were not included in the statute as eligible for these critical funds, nor were the disproportionate levels of negative socioeconomic indicators in Indian Country in the creation of the TFC considered.

Tribal nations should be able to access the TFC with waivers from the state criteria of economic need, which includes, but is not limited to, increases in the state's unemployment rate formula, and increases in the state's SNAP caseload.

Legislative Text:
ELIGIBILITY FOR FEDERALLY RECOGNIZED TRIBES FOR THE TANF CONTINGENCY FUND.

(a) In General.--Section 403(b)(7) of the Social Security Act (42 U.S.C. 603(b)(7)) is amended by inserting ",Federally Recognized Tribes"

- **Create and provide $5 billion to a TANF Emergency Fund similar to the fund created in the American Recovery and Reinvestment Act (ARRA) with a waiver of non-federal contribution for tribal nations and flexibility for tribal nations to spend in areas specific to each tribal grantee.**

Background: The TANF Emergency Fund was authorized under the American Recovery and Reinvestment Act. It provides up to $5 billion to states, tribal nations, and territories through September 30, 2010. Emergency Funds were available to reimburse these jurisdictions for 80 percent of the cost of increased spending in three areas:

- Basic assistance, *i.e.*, cash or non-cash intended to meet ongoing basic needs for low-income families with children;
- Non-recurrent, short-term benefits, *i.e.*, benefits or services that are designed to deal with a specific crisis situation or episode of need, are not intended to meet recurrent or ongoing needs and will not extend beyond four months; and
- Subsidized employment for low-income parents and youth.

Human Services Section 2: Veterans

- **Require the Veterans Health Administration (VHA) to reimburse IHS and tribal nations for services under PRC.**

Background: AI/AN Veterans are often referred by VHA facilities to Tribal and IHS facilities that are eligible to receive reimbursements for providing specialty care. However, VA currently does not reimburse these referrals for services provided by external providers at Tribal health or IHS facilities, through the PRC program. This results in duplicative processes that limit access to care for AI/AN veterans and wastes federal resources. Additionally, VHA does not currently reimburse for services provided by external providers, which are paid for by Tribal or IHS facilities through PRC. This IHS program authorizes Indian healthcare facilities to purchase services from a network of private providers. VHA should accept referrals made by the tribal nations and IHS, in order to provide the best services to our AI/AN veterans. Therefore, we recommend that Congress clarify statutory language under section 405(c) of the Indian Health Care Improvement Act and make explicit the VHA's requirement to reimburse tribal nations and IHS for services under PRC.

Legislative Text:
Please refer to H.R.6237 introduced on March 12, 2020.

- **Exempt Native veterans from copays and deductibles at VHA facilities.**

Background: The federal government's trust responsibility for health services extends to all Native veterans. In recognition of this, AI/ANs do not have copays or deductibles for services received at an I/T/U facility. Unfortunately, AI/AN veterans must currently pay a copayment to receive care at a VHA facility. Therefore, Congress should pass legislation exempting AI/AN veterans from copayments and deductibles. Importantly, copay costs should not be shifted to IHS or tribal nations. The VHA must absorb these costs on behalf of AI/AN veterans in recognition of their trust and treaty obligations to AI/AN people.

Legislative Text:
Please refer to H.R. 4908 introduced on October 29, 2019.

- **Authorize UIOs as eligible for VA reimbursement.**

Background: In February 2003, the VA and IHS signed a Memorandum of Understanding (MOU) and updated this MOU in October 2010. In December 2012, the two agencies signed a reimbursement agreement allowing the VA to financially compensate IHS for health care provided to AI/ANs that are part of the VA's system of patient enrollment. While this MOU has been implemented for IHS and Tribal providers, it has not been implemented for UIOs, despite the fact that UIOs are explicitly mentioned in the original language of the 2010 MOU, and provide healthcare within IHS's own I/T/U system. Not reimbursing UIOs for services provided to AI/AN veterans limits this vulnerable, underserved population from the healthcare they need and deserve. Therefore, Congress should authorize urban Indian health organizations as eligible for VA reimbursement.

Legislative Text:
Please refer to S.2365 introduced on September 31, 2019.

Human Services Section 3: Indian Child Welfare Services

- ***Provide $30 million for tribal governments under Title IV-B, Subpart 1 of the Social Security Act.***

Background: Title IV-B, Subpart 1 funding supports tribal nation efforts to keep families together, which is critical during the response and recovery from COVID-19. As more and more families are being placed under stay at home orders, children who are one of Indian Country's most vulnerable populations may be at increased risk for child abuse or neglect during the COVID-19 pandemic, especially given the closure of schools and limited availability of routine health care services that are primary reporting sources for child abuse and neglect incidents. The Title IV-B, Subpart 1 program provides funds for a wide variety of child abuse and neglect prevention and intervention services with the largest amounts being spent on child protection investigations, case management for children in foster care, and staff training to improve skills and knowledge.

Legislative Text:
Provided further, that not less than $30,000,000 shall be for tribal governments, tribal consortia, or tribal organizations under Subpart 1 under Title IV-B of the Social Security Act, for which the funding shall be flexibly used to support children, families, and caregivers.

- **Provide $45 million for tribal governments under Title IV-B, Subpart 2 of the Social Security Act to be divided as follows:**
    - **$20 million to mandatory funding for tribal governments.**
    - **$20 million to discretionary funding for tribal governments.**
    - **$5 million to the Tribal Court Improvement Project.**

Background: Title IV-B, Subpart 2 funding supports tribal nations efforts to strengthen families so children can avoid the trauma of being removed and placed in foster care, improve family functioning so children can be returned home safely after a removal, and promote permanency for children who cannot be returned home or placed with relatives. COVID-19 has increased the workload of tribal child welfare agencies to monitor and support families during this time of high anxiety and increasing social isolation, which can increase risks for risks for child abuse and neglect. There are additional concerns related to the restrictions being placed on the delivery of services to families, such as in-home services that also factor into increased workload for tribal child welfare agencies as they navigate how to stay compliant with COVID-19 safe practices and adapt to virtual or telehealth services. The Title IV-B, Subpart 2 program funds in-home services that improve parenting skills for families at risk of child abuse and neglect, connect them to other service providers and support systems (*i.e.*, TANF, housing, behavioral health, and nutrition), provide temporary respite care to parents and caregivers, and help tribal agencies secure permanent placements for children who cannot return home safely. Additionally, the Tribal Court Improvement Project funds enable tribal courts to meet children's safety, permanency, and well-being needs in a timely manner, which is especially critical as tribal courts face slowdowns in their dockets and challenges to holding hearings in a virtual environment in communities where technology infrastructure is limited.

Legislative Text:
Not less than $45,000,000 shall be for tribal governments, tribal consortia, or tribal organizations under Subpart 2 under Title IV-B of the Social Security Act: Provided, that of the amount provided under this paragraph in this Act, of which amount $20,000,000 shall be flexibly used for mandatory funding to tribal governments, tribal consortia, or tribal organizations: Provided further, that of the

amount provided under this paragraph in this Act, of which amount $20,000,000 shall be used for discretionary funding to tribal governments, tribal consortia, or tribal organizations: Provided further, that of the amount provided under this paragraph in this Act, of which amount $5,000,000 million shall be used for the Tribal Court Improvement Project.

- **Provide $20 million for tribal governments under Title IV-E Chafee funds.**

Background: The Chafee program under Title IV-E of the Social Security Act provides funding to tribal nations that have an approved Title IV-E plan or are in an agreement with states to operate the program. The funding helps tribal governments support services to youth who have aged out of the foster care system and have no permanent family placement available. Many of these youth transition into adulthood with help from these funds and tribal services to secure job training and employment, complete their GED, attend college or enroll in vocational training programs, and receive help accessing housing, health care, and other services. COVID-19 has increased awareness that tribal youth that have aged out of the foster care system are one of the populations with the highest risk of losing employment, experiencing housing disruption, and not adapting well to school closures. Providing support and care as these youth age out of the system is vital to assuring their success as they transition into adulthood.

Legislative Text:
Provided further, that not less than $20,000,000 shall be for tribal governments, tribal consortia, or tribal organizations under Subpart 1 under Title IV-E of the Social Security Act, for which the funding shall be flexibly used to support current and former foster care youths achieve self-sufficiency and successfully transition into adulthood.

- **Authorize language allowing tribal nations to directly access the Social Services Block Grant Program by establishing a 5 percent tribal government set aside in the statute.**

Background: Tribal nations, like state governments, are facing unforeseen challenges resulting from COVID-19. They require creative solutions that support families struggling with a multitude of challenges that cross a variety of governmental service areas. States have depended upon flexible funding sources like the Social Services Block Grant (SSBG) to help them close the funding gaps in other federal and state sources and address community wide crisis like COVID-19. Tribal nations need the certainty of funding like the SSBG to address the gaps in funding that comes from having a patchwork of social services funding that typically provides only small amounts of funding and can fluctuate from year to year. Overall, tribal nations receive only one percent of all federal social services funding, and yet their citizens represent almost four percent of the United States population and have some of the highest rates of social problems. Only two states share any of their SSBG funds with tribal nations, while all states utilize tribal population numbers to determine their funding levels. Providing direct access to the Social Services Block Grant would be the most certain method for providing tribal governments with reliable funding from year to year that can meet a broad continuum of community needs, especially during times of crisis.

Legislative Text:
Section 2002 of the Social Security Act (42 U.S.C. 1397a) shall be amended by inserting after subpart (f)(2)(b) "(g) the Secretary shall reserve five percent of the total allotment for allotment to Indian Tribes, Tribal Organizations or tribal consortia from the Social Services Block Grant, each Indian Tribe, Tribal Organization or tribal consortia shall be entitled to payment under this division for each fiscal year to be used by such Indian Tribe, Tribal Organization or tribal consortia for services directed at the goals set forth in section 1397 of this title.