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POLICY ASSESSMENT

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| | |
|---|-----------|
| Overview and objective | 4 |
| Focus group and questionnaire | 5 |
| Full ambulatory (16/23 UIOs) | 5 |
| Limited ambulatory (4/6 UIOs) | 5 |
| Outreach and referral (3/6 UIOs) | 5 |
| Outpatient and residential (3/6 UIOs) | 5 |
| Summary of key findings | 6 |
| Part 1: Policy priorities | 7 |
| Overview of UIO priorities | 8 |
| Full ambulatory | 8 |
| Limited ambulatory | 9 |
| Outpatient and residential | 9 |
| Outreach and referral | 9 |
| Analysis of UIO priorities | 10 |
| For the second year in a row, increased funding remains a top priority for all UIOs | 10 |
| Part 2: Key findings from focus group discussions and questionnaire | 12 |
| Staff turnover and communication challenges lead to area office inconsistencies | 12 |
| NCUIH action | 13 |
| Inconsistent disbursement of continuing resolution funds disrupts critical services at UIOs | 14 |
| Funding flexibility is key to expanding services | 14 |
| Need for funding security remains a priority | 15 |
| Continuing Resolutions (CR) disrupt the provision of essential health services to patients at UIOs | 15 |
| Exception apportionment prevents funding breaks | 16 |
| Advance appropriations mitigates funding insecurities generated by government shutdowns and continuing resolutions | 17 |
| Facility funding directly impacting UIOs | 19 |
| Historic senate amendment aids UIOs in facilities expansion | 19 |
| Number of UIOs opening new facilities | 19 |

| | |
|---|-----------|
| Permanent 100% FMAP increases available financial resources to UIOs | 20 |
| NCUIH action | 21 |
| IHS reimbursement rate for UIOs | 22 |
| Workforce concerns amidst inflation and market changes | 23 |
| Traditional healing crucial to advance comprehensive Native healthcare | 24 |
| Addressing access and quality of Native veteran care | 25 |
| NCUIH action | 28 |
| Health information technology and Electronic Health Record (EHR) modernization | 29 |
| NCUIH action | 30 |
| New barriers limit UIO distributions of vaccines | 30 |
| HIV, behavioral health, and substance abuse support | 31 |
| UIOs highlight need for increased HIV resources | 31 |
| Addressing the lasting effects of covid-19 through increased behavioral health and substance abuse services | 32 |
| NCUIH action | 33 |
| Reauthorizing the special diabetes program for Indians | 33 |
| NCUIH action | 34 |
| UIOs find current NCUIH services beneficial | 35 |
| Part 3: Next steps | 36 |

The National Council of Urban Indian Health (NCUIH) hosted five focus groups to identify Urban Indian Organization (UIO) policy priorities for 2023, as they relate to Indian Health Service (IHS)-designated facility types (Full Ambulatory, Limited Ambulatory, Outreach and Referral, and Outpatient and Residential Alcohol and Substance Abuse Treatment). The focus groups were held on the following dates in 2022: October 18, 21, and 24. Information was also collected from UIOs via a questionnaire sent out on November 15, 2022. Together these tools allowed NCUIH to work with UIOs to identify policy priorities in 2023; identify HIV prevention, treatment, and care needs at UIOs; determine the policy areas where greater advocacy is needed in the coming year. Of 41 UIOs, 26 UIOs attended the focus groups or participated in the questionnaire, which is an increase in participation from 2021.

NCUIH has conducted focus groups for three consecutive years to collect data to accurately reflect the needs of UIOs in policy and advocacy efforts. Since the introduction of the focus groups and assessment, there have been tremendous strides for the Indian Health Service. For data from last year, please view the 2021 Policy Assessment and the 2022 Policy Priorities.

Objective

The objective of this assessment is to identify and analyze the policy needs and priorities of UIOs for the upcoming year and develop a comprehensive advocacy strategy for engaging, researching, educating, and informing UIOs, their invested partners, and the necessary government entities.

FOCUS GROUP AND QUESTIONNAIRE PARTICIPANTS (UIOS)

Total Participants: **26/41 UIOs**

Full Ambulatory (16/23 UIOs)

- ▶ American Indian Health & Services (Santa Barbara, CA)
- ▶ Helena Indian Alliance-Leo Pocha Clinic (Helena, MT)
- ▶ Hunter Health (Wichita, KS)
- ▶ Native Health (Phoenix, AZ)
- ▶ The Native Project (Spokane, WA)
- ▶ Nebraska Urban Indian Health Coalition (Omaha, NE)
- ▶ Oklahoma City Indian Clinic (Oklahoma, OK)
- ▶ Texas Native Health (Dallas, TX)
- ▶ Native Americans for Community Action (Flagstaff, AZ)
- ▶ American Indian Health & Family Services (Detroit, MI)
- ▶ Indian Health Care Resource Center (Tulsa, OK)
- ▶ Denver Indian Health and Family Services (Denver, CO)
- ▶ South Dakota Urban Indian Clinic (Sioux Falls, SD)
- ▶ San Diego American Indian Health Center (San Diego, CA)
- ▶ Seattle Indian Health Board (Seattle, WA)
- ▶ Tucson Indian Center (Tucson, AZ)

Limited Ambulatory (4/6 UIOs)

- ▶ Urban Indian Center of Salt Lake City (Salt Lake City, UT)
- ▶ American Indian Health Services of Chicago (Chicago, IL)
- ▶ Nevada Urban Indians (Reno, NV)
- ▶ Indian Family Health Clinic (Great Falls, MT)

Outreach and Referral (3/6 UIOs)

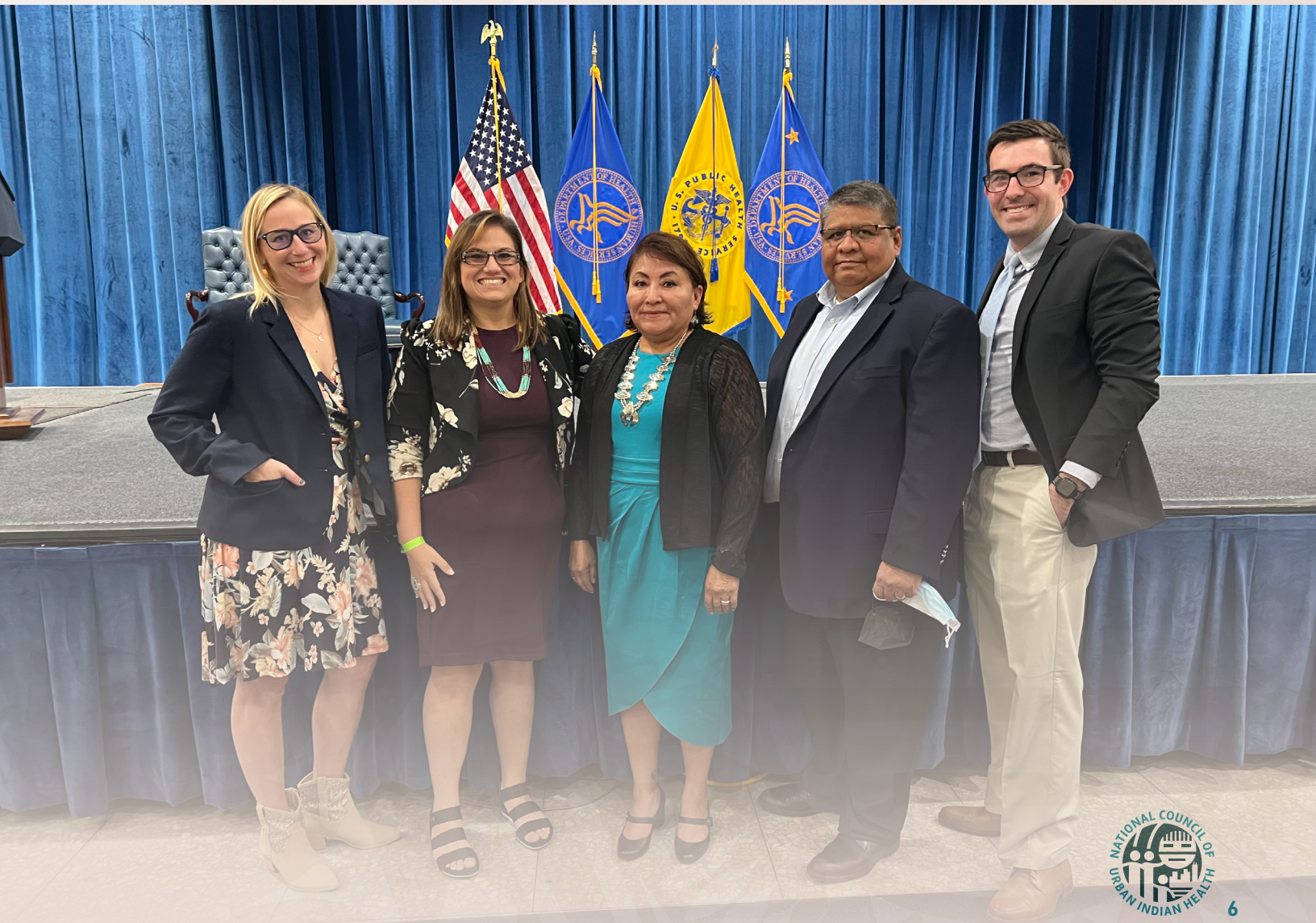
- ▶ Bakersfield American Indian Health Project (Bakersfield, CA)
- ▶ All Nations Health Center (Missoula, MT)
- ▶ Fresno American Indian Health Project (Fresno, CA)

Outpatient and Residential (3/6 UIOs)

- ▶ Native American Connections (Phoenix, AZ)
- ▶ Native Directions, Inc./Three Rivers Indian Lodge (Manteca, CA)
- ▶ The Friendship House Association of American Indians (San Francisco, CA)

SUMMARY OF KEY FINDINGS

Following the height of the COVID-19 pandemic, newfound priorities were identified for Fiscal Year (FY) 2023, including workforce development and retention, increased funding for traditional healing, and expanded access to care and telehealth services. Meanwhile, several priorities remained consistent across UIOs, including increased funding for the Urban Indian line item, permanent 100% Federal Medical Assistance Percentage (FMAP), as well as increased funding for behavioral health and the Special Diabetes Program for Indians (SDPI). Key findings from the discussions follow.



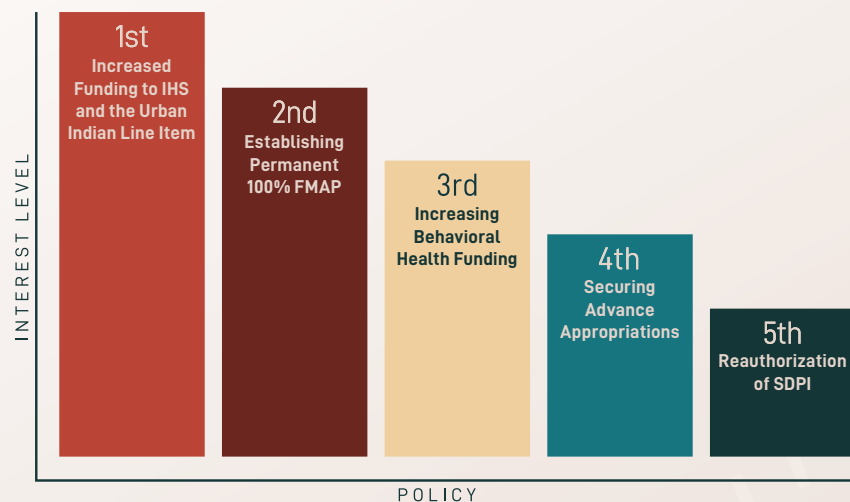
UIOs were asked to rank the following 13 policy priorities, of which the top 10 were selected as policy priorities for 2023:

- ▶ **Health Information Technology (HIT) or Electronic Health Record (EHR) Improvement**
 - ▶ **Increase Funding for the Indian Health Service and the Urban Indian Line Item**
 - ▶ **Advance Appropriations to Insulate Indian Health Care Providers from Shutdowns and Exception Apportionment for Continuing Resolutions (CRs)**
 - ▶ **Creating a Federal Commission on Indian Boarding School Policies**
 - ▶ **Increase Behavioral Health Funding**
 - ▶ **Permanent Full (100%) FMAP for Services Provided at UIOs**
 - ▶ **Establish an Urban Confer Policy for the Department of Health and Human Services (HHS) and the Department of Veterans Affairs (VA)**
 - ▶ **Inclusion of UIOs in Advisory Committees with a Focus on Indian Health**
 - ▶ **Increase Funding for Initiatives to End the HIV Epidemic through Expanded Treatment and Prevention**
 - ▶ **Reauthorize Special Diabetes Program for Indians (SDPI) through 2025 and Increase Funding to \$250 Million Annually**
-
- **Federal Tort Claims Act (FTCA) Coverage for Non-IHS beneficiaries**
 - **Improve the accuracy of UIO Data Reported by the IHS National Data Warehouse**
 - **Traditional Healing Funding**

The top five priorities, ranked overall and for each UIO facility type, are presented in the following graphs:

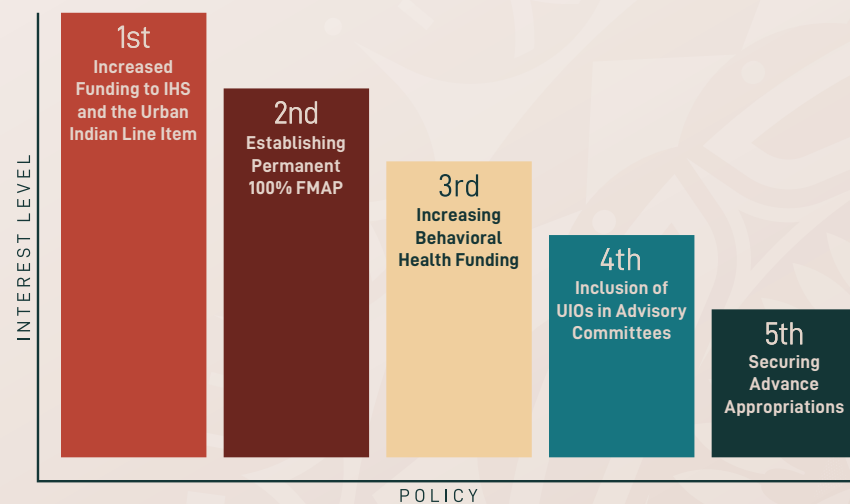
Overview of UIO Priorities

Policy Priorities (Rank) for all UIO respondents



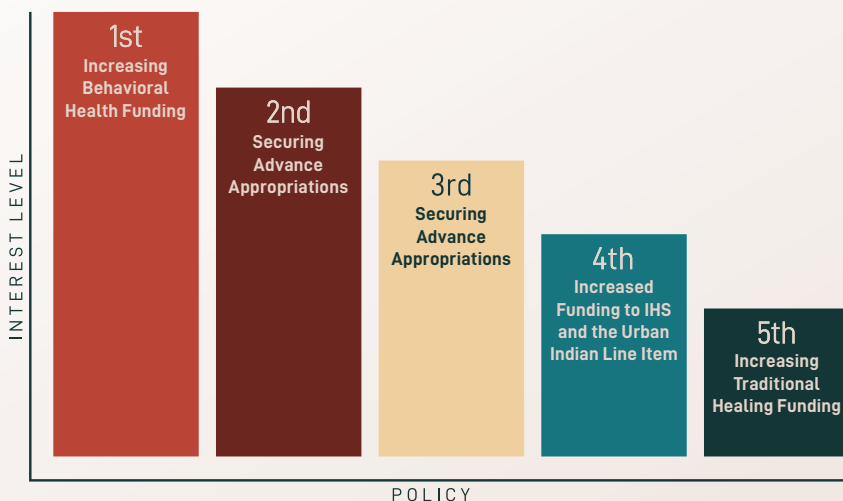
Full Ambulatory

Policy Priorities (Rank) for Full Ambulatory



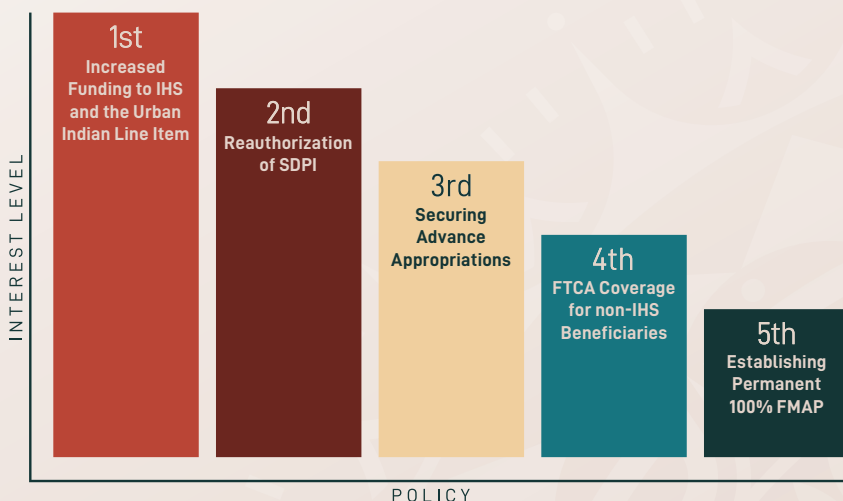
Limited Ambulatory

Policy Priorities (Rank) for Limited Ambulatory



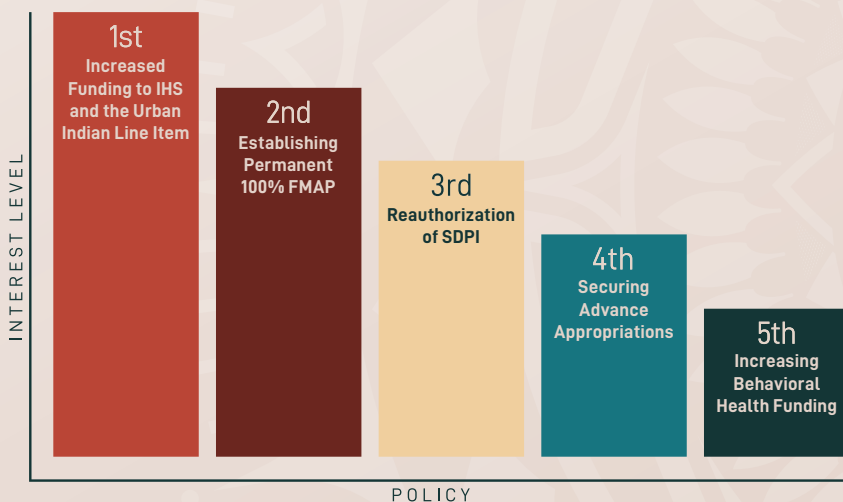
Outpatient and Residential

Policy Priorities (Rank) for Outpatient and Residential



Outreach and Referral

Policy Priorities (Rank) for Outreach and Referral



For the Second Year in a Row, Increased Funding Remains a Top Priority for All UIOs

Ultimately, the final appropriations package for FY23 funded IHS at \$6.9 billion, and urban Indian health at \$90.4 million.⁴ This is a \$300 million increase for IHS funding and a \$17 million increase for urban Indian health. Although funding for IHS and urban Indian health has generally increased over time, it still consistently fails to meet the full funding requirements requested each year. In addition, since 2000, most of the increases in funding for the Urban Indian Health line item have been absorbed by medical inflation, and when accounting for inflation, the line item only increased by approximately 3.7% between FY00 and FY22.⁵ Increased line-item funding that adjusts for medical inflation is essential to ensure that UIOs can address the growing needs of their communities.

3.7%

Urban Indian line item has increased by only 3.7% from FY'00 to FY'22

5 United States Bureau of Labor Statistics. Consumer Price Index. [How BLS Measures Price Change for Medical Care Services in the Consumer Price Index: U.S. Bureau of Labor Statistics](#)

The COVID-19 pandemic has also revealed the immense challenges UIOs face in addressing these needs, from workforce recruitment and retention to modernizing health technology systems. To ensure the steady flow of resources and combat the pandemic, Congress passed a series of bipartisan COVID-19 relief bills. The funding allotted to UIOs allowed them to advance existing programs by improving facilities, purchasing new equipment, and access to new transportation options. Overall full-ambulatory clinics noted how they now face difficulty maintaining this growth, especially in areas of technology improvements, including telehealth, as well as staff growth. For example, many UIOs stated in focus groups that there now exists a shortage of mid-level and specialized medical staff following the height of the COVID-19 pandemic. These shortages are compounded by the higher cost of living that generally exists in urban areas. In addition, UIOs receive lower Medicare reimbursement rates than IHS and Tribal facilities, which inhibits their ability to provide competitive salaries. Together, these factors disincentivize potential medical staffers from joining UIOs, which ultimately curtails staff growth and program expansion.

Survey results also maintained that parity for UIOs, specifically concerning the need for permanent 100% FMAP, was a top priority for 2023. FMAP has been a priority in Indian Country for over 20 years. Thanks to many years of extensive advocacy efforts by NCUIH, the American Rescue Plan Act of 2021 (ARPA) authorized eight fiscal quarters of 100% FMAP coverage for Medicaid services at UIOs for IHS beneficiaries. However, this hard-won provision has yet to be reauthorized and is set to expire in March of 2023.

KEY FINDINGS FROM FOCUS GROUP DISCUSSIONS AND QUESTIONNAIRE

Staff Turnover and Communication Challenges Lead to Area Office Inconsistencies

Similar to last year, UIOs noted their concern over the lack of consistent engagement among IHS Area Offices. Consistency is vital, as Area Offices are responsible for the disbursement of funds, contract modification processes, and the overall representation of UIO needs. Ultimately, UIOs are highly dependent on their Area office to address many of their most pressing issues, and inconsistencies generate severe consequences on the day-to-day operations of UIOs.

It is important that communication is consistent and uniform across all Area Offices. Given their unique position in the AI/AN healthcare system, it is vital that UIOs can share knowledge, give peer-to-peer assistance, and offer technical assistance to each other. UIOs do this independently and through organizations like NCUIH. However, inconsistency across Area offices hinders UIOs' ability to work together to develop best practices and standard processes, as well as improve their capacity to offer high-quality and culturally focused health care. This became especially clear throughout the COVID-19 pandemic, which revealed differences in the ways Areas communicate the processes for UIO funding. For instance, funding from the ARPA was not distributed in the same way nor at the same times, and Areas communicated the requirements to receive this funding in different ways. This meant that UIOs could not collaborate to establish best practices for accessing and using this funding to combat the COVID-19 pandemic while it impacted AI/ANs more drastically than most other groups in the United States. To avoid similar shortcomings in the future, it is essential to improve communication across all Area Offices.

Staff turnover and vacancies at Area Offices are often identified as another major source of this inconsistency impacting the relationship between Area Offices and UIOs. Many UIOs expressed concerns about the retirement of Area Office staff. One UIO mentioned that the Director for their Area Office has been vacant for a year and that hiring is incredibly slow. In addition, one full ambulatory clinic highlighted that their Area Office also suffers from a lack of personnel which slows the contracting process. Several UIOs noted that new appointees often demonstrate less knowledge about urban Indian

clinics, resulting in increased conflict over budget coordination. Finally, it should be noted that one UIO believed that while Headquarters should improve and streamline communications, "contract management of the urban contracts should remain at the IHS Area level, they are most familiar with the provider, health policy, and politics, of each UIO." This is important, as UIOs mentioned in focus group discussions and the questionnaire consistent engagement and familiarity with urban programs are the most significant factors impacting the relationship between UIOs and their Area urban coordinator.

It should also be noted that many UIOs felt they had strong, positive relationships with their Area Offices and were grateful for their work. One UIO said their Area office was helpful with the implementation of FMAP, and even helped launch a joint UIO meeting to discuss contracts. Another UIO mentioned that their Director and Deputy Director are very responsive to their requests for information. These relationships are vital to allocate funding to provide the necessary services for urban Indian populations. Thus, negative relationships can have a significant burden on UIOs, while positive relationships create opportunities for UIOs to provide the best standard of care.

NCUIH Action

Throughout 2022, NCUIH contributed comments to the IHS Office of Urban Indian Health Programs (OUIHP) on the development of the 2023-2027 Strategic Plan that included several recommendations as they relate to the Area Offices and consistency (informed by the 2021 Policy Assessment). Among NCUIH's recommendations was that IHS headquarters develop and provide standard guidance and training to area offices on matters which are central to the UIO-IHS partnership like Title V contracts, budget consultations, program administration, funding distribution, and site reviews to ensure consistency across area offices. NCUIH also recommended that IHS work with Area Offices and UIOs to develop and share recommended best practices and standard operating procedures. In 2023, NCUIH will continue to engage with OUIHP about the implementation of these recommendations and ensure they are communicated to Director Roselyn Tso.

Inconsistent Disbursement of Continuing Resolution Funds Disrupts Critical Services at UIOs

Our assessment of UIOs also revealed inconsistencies in the distribution and handling of CR funds. During the *Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023* passed on September 30, 2022, which maintained government funding until December 16, 2022, some UIOs experienced no delays in receiving their funds, but others had not yet received their CR funds months after the passage. In fact, one UIO that serves over 35,000 AI/ANs had yet to receive their CR funds said, “if it were not for other grants and COVID funding we would not be able to meet payroll.” Consistent disbursement of CR funding is critical to ensure that every UIO, rather than a select few, can maintain normal operations and provide critical services to their community during budgetary disagreements.

“If it were not for other grants and COVID funding we would not be able to meet payroll.”

Full Ambulatory UIO

Funding Flexibility is Key to Expanding Services

Funding restrictions imposed by Title V contracts and grant programs limit the capacity of UIOs to fully provide culturally appropriate services to their clients, assist individuals experiencing homelessness, and aid those struggling with addiction or experiencing general barriers to care. Most focus group participants expressed the desire for greater funding flexibility to cover the growing need for health services offered at UIOs to AI/AN patients. Less restrictive funding is essential to ensure that UIOs can address the growing health needs in their communities that go beyond direct medical care.

Less restrictive funding also allows UIOs to invest and expand critical services necessary to assist their communities. For example, during the height of the COVID-19 pandemic, flexible funding was temporarily extended to UIOs. Due to this, one limited ambulatory UIO could use the Storytellers Grant opportunity (part of NCUH's Emergency Preparedness and Vaccine Planning funded through the CDC) to make necessary hardware purchases, emergency preparedness, and increase overall investments in infrastructure. Another UIO described unrestricted funding as a facilitator for community outreach, allowing them to help with community needs such as power shutdowns and food shortages. Yet another UIO described unrestricted funds as the best way to “move the needle forward” in promoting community health.

“Finding technology and internet service to people who cannot afford it has been a barrier.”

Full Ambulatory UIO

Flexible funding also helped establish telemedicine services during the height of the COVID-19 pandemic, which allowed many UIOs to expand virtual access to care for their patients. One UIO mentioned telehealth as “the way for the future.” Due to the current ongoing demand for telemedicine

services, many UIOs expressed the need to provide more technology to their patients to reach them more effectively as telehealth continues to evolve as a preferred format of care. One UIO noted how many patients do not have access to tablets, phones, or the internet which is a barrier to establishing consistent care routines and maintaining high-quality relationships. Another UIO mimicked similar concerns, noting that, “finding technology and internet service to people who cannot afford it has been a barrier.”

Finally, unrestricted funding assists UIOs in reducing the physical barriers to care for patients. To elaborate, some UIOs have received special grants for transportation services, such as the purchase of vans to transport patients to appointments, for which there is a growing demand. One UIO described that for many urban Indians, despite living in an urban area, public transportation can take hours to reach their nearest UIO, which can dissuade patient visits. Ultimately, the allocation of flexible funds towards these issues can drastically increase access to care for AI/AN families, young adults, and elders alike.

Need for Funding Security Remains a Priority

Continuing Resolutions (CR) Disrupt the Provision of Essential Health Services to Patients at UIOs

IHS is the only federal healthcare delivery system that is not exempt from CRs and government shutdowns, forcing the Indian Health care system to continue operating without an enacted budget under a stopgap measure. In Calendar Year (CY) 2022, the government operated under three CRs, of which the most recent expired on December 30, 2022. Many UIOs raised a crucial point that there is no uniformity across UIOs on Title V contract funding allocations in the event of a CR. As mentioned before, there are inconsistencies in CR funding across UIOs as some reported receiving their contract funding all at once, and some UIOs have not received any funding at all. This forces UIOs with reserves to rely on their reserves to pay for their facility needs, threatening quality accessible healthcare. Yet, many UIOs do not have reserves, which threatens shutdowns of UIOs. Barriers to allocation include recruitment and retention of IHS contract officials, as well as communication errors regarding contract modifications to receive CR funding.

Because UIOs must rely on every dollar of limited federal funding they receive to provide critical patient services, any disruption in these dollars has significant and immediate consequences. Disruptions in funding for the essential medical services provided at UIOs reduce their ability to maintain normal operations, putting patients' lives at risk. While CRs impact all Indian Country, UIOs are disproportionately impacted. Liz Fowler, the former Acting

"While the IHS has received an exception apportionment to provide the full-year recurring base amounts to Tribal Health Programs operating their own programs through ISDEAA Title I contracts and Title V compacts since FY 2020, this option is not available during government shutdowns, and it is not available at all to IHS-operated health programs, or Urban Indian Organizations. As a result, Direct Service Tribes, and American Indians and Alaska Natives served by Urban Indian Organizations are disproportionately affected by disruptions in federal appropriations."

Exception Apportionment Prevents Funding Breaks

Exception apportionment is a colloquial term that describes the written apportionment that is issued for operations under a CR, in lieu of the Office of Management and Budget (OMB) issued automatic apportionment.

In recent years, IHS requested an exception apportionment from OMB for Tribal Health Programs only. Additionally, IHS has repeatedly cited the "extraordinary nature" of the ISDEAA agreements as an explanation for why IHS did not include UIOs in the exception apportionment request. Since the authorization of advance appropriations in the Omnibus, UIOs will be exempt from continuing resolutions for FY23 and FY24. That said, if advance appropriations are not reauthorized in subsequent bills, then UIOs will once again be affected by continuing resolutions and will need an exception apportionment. In the event that advance appropriations are not reauthorized, the need for an exception apportionment for UIOs would once again be a top priority to avoid a disruption in operations and to lift the unnecessary administrative burden that comes with recurring CRs. An exception apportionment would allow UIOs to spend funds as needed during the continuing resolution, rather than being restricted by the automatically apportioned amount provided under the continuing resolution. When there are multiple CRs, it is extremely disruptive to operations, especially for UIOs operating on thin margins. Furthermore, because of the ongoing impacts of the COVID-19 pandemic on UIOs, funding certainty is more essential than ever. NCUIH has requested an exception apportionment for the past 4 years from the Administration and continues to advocate for this to ensure funding security for UIOs.

"Urban Indian Organizations are disproportionately affected by disruptions in federal appropriations."

Liz Fowler
Former Acting Director
of IHS

If advance appropriations are not reauthorized in subsequent bills, then UIOs will once again be affected by continuing resolutions and will need an exception apportionment.

⁶ House Natural Resources Subcommittee for Indigenous Peoples of the United States. Legislative Hearing on H.R. 5549 (Rep. Don Young) Indian Health Service Advance Appropriations Act. Hybrid SCIP Legislative Hearing – July 28, 2022

In a letter regarding exception apportionment for UIOs, IHS Director Roselyn Tso wrote:

*"The exception apportionment also does nothing to prevent the negative consequences of government shutdowns for IHS-operated health programs and UIOs; it only prevents those consequences for Tribal Health Programs in some circumstances. The consequences of a government shutdown directly impact the ability of IHS-operated health programs, Tribal Health Programs, and UIOs to provide high quality health care to the American Indian and Alaska Native communities we serve."*⁷

Advance Appropriations Mitigates Funding Insecurities Generated by Government Shutdowns and Continuing Resolutions

One solution to abate the effects of continuing resolutions and government shutdowns is through advance appropriations. Advance appropriations is funding that becomes available one year or more after the year for which the appropriations act is passed.

Funding disruptions exacerbate the consistent underfunding of the Indian Health System. Whenever there is a gap or disruption in IHS funding, either because of a shutdown or continuing resolution, Tribes and Urban Indian Organizations are often forced to reduce or sometimes even cease healthcare services entirely. During the 2019 government shutdown, several UIOs had to reduce services or close their doors entirely, forcing them to leave their patients without adequate care. One UIO suffered 7 opioid overdoses, 5 of which were fatal. Since 2019, AI/AN life expectancy has declined by 6.6 years, and the COVID-19 pandemic claimed more AI/AN lives at a higher rate than any other racial group in America.⁸ Advance appropriations is thus crucial to ensure that unrelated budget disputes do not impact the health of AI/ANs.

NCUIH has always been a staunch supporter of advance appropriations, noting how the current policies of funding IHS through annual appropriations have led to habitual funding uncertainties. To make matters worse, every year, on average, there are five continuing resolutions to keep the government open, and there were long government shutdowns in 1996, 2013, and 2019.⁹ As mentioned before, this creates severe and immediate consequences for Native health.

Problem:

During the 2019 government shutdown, several UIOs had to reduce services or close their doors entirely, forcing them to leave their patients without adequate care.

Result:

1 UIO suffered 7 opioid overdoses, 5 of which were fatal.

Since 2019, AI/AN life expectancy has declined by 6.6 years, and the COVID-19 pandemic claimed more AI/AN lives at a higher rate than any other racial group in America.⁸

⁷ Tso, Roselyn. A Letter to Francys Crevier Regarding Exception Apportionment for Urban Indian Organizations. Letter. Indian Health Service, Rockville, Maryland. November 4th, 2022. NCUIH Statement on Letter from IHS on Protecting Native Patients From Funding Delays and Government Shutdowns - NCUIH

⁸ Arias, Elizabeth, and Farida B Ahmad, Provisional Life Expectancy Estimates for 2021, 2021, CDC. www.cdc.gov/nchs/data/vsrr/vsrr023.pdf

⁹ NCUIH. [Advance Appropriations - NCUIH](#)

Because of this, NCUIH doubled down on its advocacy efforts in 2022 and testified multiple times before Congress, sent letters to Congress and the Administration, submitted written comments to the Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB), had meetings with key Congressional offices, designed an interactive advance appropriations website, and launched several social media campaigns for supporters of Indian Health to voice their support for advance appropriations.

These efforts proved instrumental, as, for the first time, advance appropriations for IHS (totaling \$5.1 billion for FY24) were included in the final FY23 appropriations package (Consolidated Appropriations Act, 2023).

This historic inclusion was mentioned as a key legislative priority for the Biden Administration in the President's FY23 Budget. Upon passage of the final appropriations package, the Biden Administration released the following statement:

"The bipartisan funding bill provides advance appropriations for the agency for FY 2024 for the first time in history. This ensures more stable, predictable funding, and will improve access to high-quality health care, address health inequities, and modernize IHS's electronic health records system."¹⁰

Thanks to the extensive policy work by NCUIH, UIO leaders, Tribal organizations, and friends of Native health, the historic inclusion of advance appropriations in the appropriations package this year has become a crucial step towards ensuring long-term, stable funding for IHS.

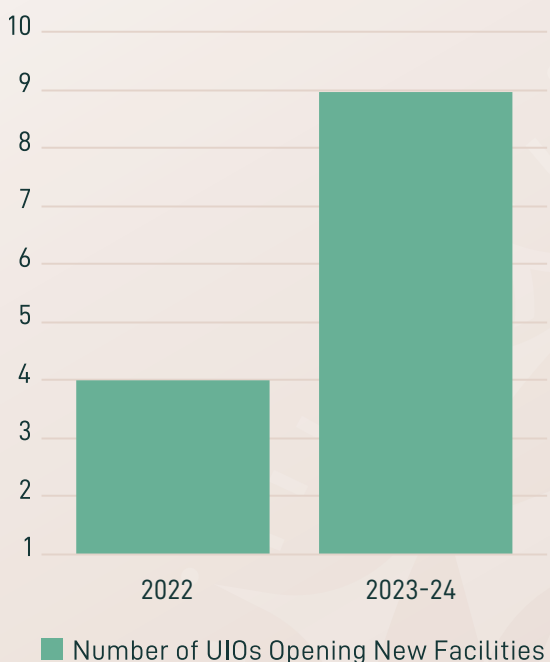
NCUIH plans to build on the passage of advance appropriations for IHS by ensuring funding mechanisms for the whole Indian Health Service/ Tribal/Urban Indian Organization (I/T/U) system are consistent, clear, and permanent. NCUIH will continue to work closely with IHS through listening sessions and the Urban Confer process to further ensure that advance appropriations become permanent for IHS to bring the agency to parity with other federal health programs. NCUIH remains firmly committed to improving quality care for AI/ANs no matter where they live and welcome the essential passage of advance appropriations to provide certainty to the IHS system and ensure unrelated budget disagreements do not put lives at risk.

¹⁰ The White House. The Biden-Harris Administration Applauds Passage of Bipartisan Funding Bill.2022. www.whitehouse.gov/omb/briefing-room/2022/12/23/biden-harris-administration-applauds-passage-of-bipartisan-funding-bill/

Historic Senate Amendment Aids UIOs in Facilities Expansion

Historically, UIOs have been excluded from crucial funding for facilities construction and lacked access to facilities funding under the general IHS budgetary scheme. Due to NCUIH's advocacy, the Padilla-Moran-Lankford Urban Indian Health Amendment was included in the FY21 bipartisan infrastructure package, otherwise known as the Infrastructure Investment and Jobs Act (H.R. 3684), which passed on November 15, 2021.¹¹ NCUIH's questionnaire respondents highlighted just how significant this amendment has been for their ability to expand their facilities, six UIOs mentioned they have opened a new facility in the past year, and an additional 16 UIOs have plans to open new facilities in the next two years.

Number of UIOs Opening New Facilities



¹¹ 25 U.S.C. § 1659

Permanent 100% FMAP Increases Available Financial Resources to UIOs

POLICY ASSESSMENT 2022

UIOs ranked the need for permanent 100% FMAP for Medicaid services provided at UIOs as the second-highest policy priority for 2023. FMAP is the share of covered services provided to Medicaid beneficiaries which is borne by the federal government.¹² The FMAP formula is based on a state's average personal income – states which have lower average personal incomes receive a higher FMAP.¹³ However, for services provided at IHS and Tribal facilities, FMAP is 100% because Congress viewed this support, "as a much needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian".¹⁴ The American Rescue Plan Act (ARPA) amended Section 1905(b) of the Social Security Act (SSA) to provide 100% FMAP for services provided at UIOs for eight (8) fiscal quarters which expires in March 2023.¹⁵ The Congressional intent behind ARPA 100% FMAP extension was, in part, to address the longstanding inequity within the Indian healthcare system detailed above and to provide an opportunity to increase financial resources to UIOs during the COVID-19 pandemic.¹⁶ IHS praised the decision of ARPA, noting how 100% FMAP would "help both the State and [UIOs] access more federal dollars to support health care[.]"¹⁷

Montana UIOs received over \$500,000 in additional funding, which is being used to construct a new clinic and establish a new behavioral health unit.

This eight fiscal quarter provision has allowed some states to increase reimbursement rates resulting in the expansion of services and improved facilities. For example, Montana UIOs reported that after working with the Governor and State Medicaid office, Montana was the first state in the country to successfully increase their Prospective Payment System (PPS) rates (by 61%). This was retroactive to January 1, 2021. Because of this, Montana UIOs received over \$500,000 in additional funding, which is being used to construct a new clinic and establish a new behavioral health unit.

In addition, the UIOs located in Washington and Colorado received a share of the savings the state realized due to 100% FMAP through funds provided directly by their state. One UIO located in Washington reported that because of this funding, they are preparing to construct a new youth services center. They also reported that should the 100% FMAP funding continue, they intend to create new programs the community has desperately requested, including

¹² 42 U.S.C. § 1396d(b); Kaiser Commission on Medicaid and the Uninsured, Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP) (Sep. 2012), <https://www.kff.org/wp-content/uploads/2013/01/8352.pdf>

¹³ 42 U.S.C. § 1301a(8)(A); 42 U.S.C. § 1396d(b); Kaiser Commission, Medicaid Financing

¹⁴ United States House of Representatives. The Indian Health Care Improvement Act. Report 94-1026 (Part III). 94th Congress, Second Session. [1976 Medicaid Report.pdf](#)

¹⁵ 42 U.S.C. § 1905(b)

¹⁶ See The White House, The White House Tribal Nations Summing Progress Report, pgs. 10-11 (Nov. 15-16, 2021), available at: <https://www.whitehouse.gov/wp-content/uploads/2021/11/WH-Tribal-Nations-Summit-Progress-Report.pdf>; See testimony from Senator Cortez Masto in the Inclusion of the Indian Health Parity Act in ARPA, Legislative Congressional Record Vol. 167, No. 20, S296, (Feb. 03, 2021)

¹⁷ Health and Human Services, Justification of Estimates for Appropriations Committees FY 2017, pgs. CJ-229-30 (Jan. 11, 2016), available at: <https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/documents/FY2017CongressionalJustification.pdf>

adult behavioral and mental health services and a youth STI treatment center. Another UIO described this provision as “absolutely key to the success of our program.”

Unfortunately, many states have not been increasing their Medicaid reimbursement rates to UIOs, citing the short-term authorization for the UIO 100% FMAP extension as a reason not to increase their reimbursement rates. The need for permanent 100% FMAP is critical to ensure that all states are increasing reimbursement rates, as many UIOs agreed that permanent 100% FMAP is key to expanding services and maintaining sustainable staffing.

Congress has declared it the policy of the United States “to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”¹⁷ Furthermore, Congress has recognized that 100% FMAP for services provided to IHS beneficiaries at facilities within the I/T/U system is consistent with the United States’ trust responsibility to provide health services to AI/AN people.¹⁸ Permanent 100% FMAP for UIOs will further the U.S. government’s trust responsibility to AI/ANs by increasing the available financial resources to UIOs and supporting them in addressing the critical health needs of their AI/AN patients.

NCUIH Action

Securing 100% FMAP continues to be a top priority for NCUIH. NCUIH worked closely with Representative Raul Ruiz (D-CA) and key Congressional leaders on the introduction of the Improving Access to Indian Health Services Act (H.R. 1888).¹⁹ This bill would establish permanent 100% FMAP for services provided to AI/AN Medicaid beneficiaries at UIOs. On September 16, 2022, NCUIH also sent letters to Chair Frank Pallone (D-NJ-06) and Ranking Member Cathy McMorris Rodgers (R-WA-05) on the House Committee on Energy and Commerce requesting a markup on this key legislation. NCUIH will continue to support the establishment of permanent 100% FMAP for UIOs in the 118th Congress.

Moreover, NCUIH has submitted several comments and letters to agencies including IHS, HHS, and CMS in an effort to set FMAP at 100% for Medicaid services provided at UIOs for the existing provision. Additionally, NCUIH has been a vocal member of the Tribal Technical Advisory Group (TTAG) and was successful in getting 100% FMAP for Medicaid services at UIOs on the TTAG Policy Priorities list that will be presented to CMS.

NCUIH will also continue to work with CMS and IHS to help them recognize that there is still time to help UIOs realize the benefit of the eight fiscal quarters on 100% FMAP for services provided at UIOs authorized by section

Permanent 100% FMAP is key to expanding services and maintaining sustainable staffing.

¹⁸ See H. Rept. 94-1026 pt. III (May 12, 1976) (explaining that 100% FMAP for AI/ANs at IHS facilities is appropriate because “the Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility.”)

¹⁹ H.R.1888 (2021-2022): Improving Access to Indian Health Services Act, H.R.1888, 117th Cong. (2021), <https://www.congress.gov/bills/117th-congress/house-bill/1888>

9815 of the ARPA. One way in which UIOs can benefit from 100% FMAP services provided at UIOs is for states to share the saving which they have realized as a result of this provision. While NCUIH has learned that many of the 22 states in which UIOs are located have still not claimed these available federal dollars and cannot share the unrealized savings with UIOs, federal regulation provides that states can continue to file Medicaid reimbursement claims, "within 2 years after the calendar quarter in which the State agency made the expenditure" and receive federal reimbursement.²⁰ This means that there is still time after ARPA Section 9815 expires in which states can claim 100% FMAP and subsequently share those savings with UIOs. As such, NCUIH will continue to inform IHS and CMS of the critical importance of providing technical assistance to both states and UIOs in an effort to receive any savings.

IHS Reimbursement Rate for UIOs

The IHS rate is reimbursed to facilities for Medicare and Medicaid-covered services, and these rates are published annually by IHS in the Federal Register. States rely on this publication to review the set reimbursement rates for Medicaid services at IHS and Tribal facilities.

Despite being a fundamental, inseverable component of the I/T/U system, UIOs are chronically underfunded. The Urban Health line item only makes up approximately one percent (1%) of IHS's annual appropriation, and UIO Medicaid reimbursement rates are generally significantly lower than the IHS rate. Medicaid reimbursement rates serve as an important source of funding for health facilities. Notably, Congress' annual appropriation for the Urban Indian health line item is less than the amount UIOs receive from Medicaid reimbursement in a similar one-year time frame.²¹ However, only one state uses the IHS rate as a reimbursement rate for UIOs.²² This means that even UIOs that are located in similar geographic areas as Tribal or IHS facilities and offer similar services as those facilities, still receive much lower reimbursement rates. For example, in 2018, the average Medicaid reimbursement rate for UIOs received was around \$245 – nearly half the 2020 IHS all-inclusive rate of \$479 available to tribal and IHS facilities.²³ The lowest encounter rate on record for a UIO was just \$70 in 2018.²⁴ This reimbursement disparity limits the number of services that clinics can offer

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²⁰ 45 CFR § 95.7

²¹ See National Council of Urban Indian Health, Recent Trends in Third-Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions, 2021, available at <https://ncuih.org/wp-content/uploads/ARPA-Draft-2022-09-28.pdf> (finding that UIOs received at least \$89.5M in Medicaid reimbursement in 2019 compared to just \$73.4M appropriated for the Urban Indian Health line item in FY22).

²² Oklahoma is the only state that uses the IHS AIR for UIOs

²³ National Council of Urban Indian Health, Recent Trends in Third-Party Billing at Urban Indian Organizations: A Focus on Medicaid, Telehealth, and Pandemic Response, 2021, Available at https://mcusercontent.com/97bf83f5514a3035e7978c5b2/files/14a0c385-2d30-3b4a-99fe-3af56fa02926/NCUIH_UIO_Third_Party_Reimbursement_Report_2021_09_02.pdf.

²⁴ NCUIH, Recent Trends in Third Party Billing at Urban Indian Organizations (2020), available at: [Recent-Trends-in-Third-Party-Billing-at-Urban-Indian-Organizations-1.pdf](https://ncuih.org/recent-trends-in-third-party-billing-at-urban-indian-organizations-1.pdf) (NCUIH.org)

to their patients. IHS has suggested establishing a UIO-specific Rate as a means of addressing low and variable Medicaid reimbursement rates for UIO providers.

Outpatient and Residential programs noted that they seek to be at the forefront of conversations with their States regarding the IHS rate for UIOs to ensure the rate will satisfy the costs of their programs. One UIO raised concerns about the process of random sampling to figure out a rate for UIOs when there are 41 UIOs with very different and unique programs.

Workforce Concerns Amidst Inflation and Market Changes

Following the pandemic workforce trends, UIOs have expressed how they struggle to recruit and retain staff and providers. UIOs have identified multiple barriers to attracting local university graduates as well as outside providers due to workforce budget constraints. Many UIOs have said that with a lack of third-party funding, UIOs cannot provide competitive pay, even in comparison to their county. Without more funding, UIOs cannot compete with inflation, high cost of living, or pay higher raises and hazard pay like other facilities. A full ambulatory UIO highlighted the impact of underfunding on staffing by saying, "due to inflation and market changes, salaries have grown exponentially. It is becoming exceedingly difficult to staff the organization with high-quality employees, especially medical providers, while IHS funding stays the same year after year."

The barriers to recruitment have resulted in shortages in behavioral health and IT staff. Outpatient and residential UIOs are experiencing credentialing issues that block providers from practicing at UIO facilities. The focus groups provided insight into the fact that recruitment from local colleges and universities is a priority, but there are many difficulties with credentialing and meeting state standards. Strict state policies and non-competitive salaries and benefits also deter potential candidates from joining clinics. One UIO recalled that they have access to talented individuals from out-of-state, but these barriers make it difficult to attract these individuals as potential clinic employees. Out-of-state recruitment can also be difficult since there exist no national standards on credentialing. The burden of providing education to help providers meet state minimums has fallen on UIOs. In terms of behavioral health, credentialing recent graduates and out-of-state providers harms UIOs because they cannot receive repayment for services provided by non-state certified providers. Currently, there is a general request from UIOs to have a grace period allowing paperwork to be processed at a faster pace if a provider is working within IHS.

"Due to inflation and market changes, salaries have grown exponentially. It is becoming exceedingly difficult to staff the organization with high-quality employees, especially medical providers, while IHS funding stays the same year after year."

Full Ambulatory UIO

Finally, several UIOs mentioned the difficulty in obtaining culturally competent staff. One UIO noted that due to the pandemic significantly reducing the workforce, it has become “difficult to hire and retain culturally competent staff”. Relatedly, many UIOs emphasized the need for increased funding to help with cultural training for staff. Without enough culturally competent providers, UIOs are limited in their ability to provide a culturally inclusive environment, and therefore may not be able to provide the quality of care their patients expect.

Traditional Healing Crucial to Advance Comprehensive Native Healthcare

UIOs continuously stress the importance of offering traditional healing services to patients. UIOs fill an essential gap in care for AI/AN people living off reservations by providing culturally sensitive and community-focused care options, including traditional healing services and programs. UIOs “are an important support to Native families and individuals seeking to maintain their values and ties with each other and with their culture,” which exist to provide “a wide range of culturally sensitive programs to a diverse clientele.”²⁵

Traditional healing services are centered on AI/AN culturally based practices, activities, workshops, ceremonies, etc. Either explicitly or implicitly, most UIOs incorporate the “Culture is Prevention” model, where utilization of culturally based experiences and activities are provided to improve the physical, spiritual, emotional, and/or mental health of a patient as well as that patient’s community. Because a typical UIO can serve patients affiliated with hundreds of different tribes, UIOs have developed practices that synthesize traditions across Tribes.

During the NCUIH focus groups and survey, many UIO leaders expressed the benefits of traditional healing, specifically when addressing behavioral health, intergenerational trauma, loss of culture, as well as overall healing. It is a priority of UIO leaders to increase access to quality health services through the incorporation of cultural practices in existing health and wellness programs.

UIOs have an understanding that “healing does not always come because of an MD or Ph.D.” Based on outreach and referral community assessments, UIOs provided feedback that the patients they serve wanted to embrace traditional healing and incorporate it into everything they do. Some

“Healing does not always come because of a MD or Ph.D.”

Outpatient and Residential UIO

The biggest barrier to the implementation of traditional healing is funding. Although UIOs receive annual funding through contracts awarded by IHS, they report there exists little to no funding for traditional healers, like herbalists, nor access to other necessary resources vital to traditional healing processes, such as land and rivers.

²⁵ Nat'l Urban Indian Family Coalition, Urban Indian America: The Status of American Indian & Alaska Native Children & Families Today 12 (2008). <https://assets.aecf.org/m/resourcedoc/AECF-UrbanIndianAmerica-2008-Full.pdf>

examples of traditional healing activities include drumming and talking circles, dancing, food to move programs with traditional food, culturally relevant Alcoholics Anonymous, beading groups, and sweat lodges.

There are several barriers to implementing traditional healing at UIOs. Multiple UIOs reported funding challenges in offering traditional healing services. Additionally, providing the right services can be a challenging task for a clinic, as evidenced by one UIO's statement, "we serve over 225 tribes - that makes it hard to pick one traditional healing practice."

The biggest barrier to the implementation of traditional healing is funding. Although UIOs receive annual funding through contracts awarded by IHS, they report there exists little to no funding for traditional healers, like herbalists, nor access to other necessary resources vital to traditional healing processes, such as land and rivers. As such, they must rely on other sources of revenue to provide traditional healing services, such as funding from private foundations, government grants, donations, and resources from community partners.

In addition to challenges to funding for traditional healing services, UIOs have also reported difficulty receiving reimbursement for these services as well. UIOs often rely on Medicaid claims, private insurance, or third-party payor revenue to maintain services, but many UIOs have reported difficulty receiving reimbursement for traditional healing services after services have been rendered. Some traditional healing services, such as talking circles, can be coded as behavioral health services to be eligible for reimbursement. Other services, such as smudging, cannot currently be coded as behavioral health services, which makes reimbursement difficult. This reliance on other avenues of limited funding for traditional healing services paired with reimbursement difficulties hinders the capacity of UIOs to provide culturally relevant services to their AI/AN patients. Despite these barriers, UIOs continue to strive to provide quality traditional healing services to their patients.

Addressing Access and Quality of Native Veteran Care

UIOs have constantly stressed the importance of improving the care and services provided to Native veterans living in urban areas. Notably, AI/ANs have served in the United States military in every armed conflict in the Nation's history and have traditionally served at a higher rate than any other population in the United States.²⁶ In return for their military service, the

26 Proclamation on National Native American Heritage Month, 86 C.F.R. § 60545 (2021), available at <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/10/29/a-proclamation-on-national-native-american-heritage-month-2021/>

United States promised all veterans, including Native veterans, “exceptional health care that improves their health and well-being.”²⁷ The need for exceptional health care for AI/AN veterans is especially important given that they are more likely to be uninsured and have a service-connected disability than other veterans.²⁸ NCUIH and UIOs are particularly concerned about Native veterans experiencing or at risk of homelessness, as NCUIH estimates that there are about 8 Native veterans per 1000 veterans experiencing homelessness, compared to about 1.5 white veterans per 1000 veterans. These veterans earn the same benefits to which all veterans are entitled, and they experience the same poor physical and mental health outcomes as Native veterans in rural areas.²⁹ AI/AN Veterans living in urban areas generally have lower incomes, higher unemployment, lower education attainment, higher VA-service connected disability, and generally live in poorer housing conditions than non-Native veterans also living in urban areas.³⁰ For example, 12.5 percent of AI/AN veterans living in urban areas have a VA service-connected disability rating of 70 percent or higher, compared to 7.7 percent of non-AI/AN veterans in urban areas.³¹ Despite being entitled to care and benefits³² through the VA, data indicates that Native veterans use VA benefits or services at a lower percentage than other veterans.

UIOs currently serve 7 of the 10 urban areas with the largest veteran AI/AN populations.

Given that NCUIH estimates 86.2 percent of the veteran population identifying as AI/AN live in urban areas, UIOs are essential partners in serving AI/AN veterans. In fact, UIOs currently serve seven of the ten urban areas with the largest veteran AI/AN populations, including the following areas: Phoenix, Arizona; Los Angeles, California; Seattle, Washington; Dallas, Texas; Oklahoma City, Oklahoma; New York City, New York; and Chicago, Illinois. Native veterans in urban areas earn the same benefits to which all veterans are entitled, and they experience the same poor physical and mental health outcomes as Native veterans in rural areas.³³ UIOs provide essential services to Native veterans throughout the country including primary care, mental health, traditional healing, and social services. Native veterans are entitled to receive healthcare through both the veterans' healthcare system and the Indian healthcare system. A study published

27 Veterans Health Administration, About VHA, <https://www.va.gov/health/aboutVHA.asp>

28 Department of Veterans Affairs, American Indian and Alaska Native Veterans: 2017 14-19 (2020), available at <https://www.va.gov/vetdata/docs/SpecialReports/AIAN.pdf>

29 Kimberly Huyser, Sofia Locklear, Connor Sheehan, Brenda Moore & John Butler, Consistent Honor, Persistent Disadvantage: American Indian and Alaska Native Veteran Health in the National Survey of Veterans, 33(7-8S) J. of Aging and Health 68S-81S, 70S (2021), <https://journals.sagepub.com/doi/pdf/10.1177/08982643211014034>

30 U.S. Census Bureau, 2015-2019 American Community Survey 5-year Public Use Microdata Samples (2020), retrieved from <https://usa.ipums.org/usa/sda/>. Urban Veterans are defined as respondents who 1. Reside in a Public Use Microdata Areas (PUMA) which lies fully or partially within a Metropolitan Area with a population of 50,000 or more; 2. Were formerly in the armed forces or are currently in the armed forces. CODEBOOK for Variable Descriptions: <https://sda.usa.ipums.org/sdaweb/docs/us2019c/DOC/nas.html>

31 *Id.*

32 Department of Veterans Affairs, American Indian and Alaska Native Veterans: 2017, (2020), at 21. Available at <https://www.va.gov/vetdata/docs/SpecialReports/AIAN.pdf>

33 Kimberly Huyser, Sofia Locklear, Connor Sheehan, Brenda Moore & John Butler, Consistent Honor, Persistent Disadvantage: American Indian and Alaska Native Veteran Health in the National Survey of Veterans, 33(7-8S) J. of Aging and Health 68S-81S, 70S (2021), <https://journals.sagepub.com/doi/pdf/10.1177/08982643211014034>.

in the Military Medicine Journal confirmed that more than 50 percent of Native Veterans use the I/T/U system for their health needs.³⁴ Many Native veterans who preferred using Indian healthcare services reported that this was because of its increased accessibility, including location, shorter waiting times, and the ability to receive culturally competent care.³⁵

Reimbursement from the VA for services provided to AI/AN veterans is a high priority for UIOs, with approximately 93 percent of UIO survey respondents stating that their UIO is interested in being reimbursed for these services. Historically, UIOs did not receive reimbursement from the VA for services provided to AI/AN veterans. It wasn't until December 2020, after advocacy from NCUIH, that the Health Care Access for Urban Native Veterans Act (S. 2365) was included in the Consolidated Appropriations Act of 2021, which provided authority for UIO reimbursement from the VA for these critical services to AI/AN veterans.³⁶ Through this program, UIOs can enter into a Reimbursement Agreement Program which facilitates reimbursement to UIOs by the Department of Veterans Affairs for certain health care services, provided by the UIO, to eligible veterans who are AI/AN. This agreement is meant to improve access to care for eligible AI/AN veterans. While many UIOs reported that they are in the process of enrolling in the program, several UIOs reported barriers to enroll in the program, and some UIOs remain unfamiliar with the program. Of the UIOs who stated they were unfamiliar with the program, 100 percent of these respondents stated they were interested in this reimbursement program. There is a need for reimbursement consistency so that Native veterans, can receive equitable, accessible, and culturally competent care.

In terms of care, UIOs have agreed that the priorities for veterans include behavioral health, affordable housing, and the incorporation of traditional healing. UIOs agreed that they struggle to meet "hierarchal" needs like housing, food, etc. One UIO said that in addition to experiencing difficulties assisting their veteran population to adjust to new housing, they also simultaneously struggle with addressing their Native veterans' behavioral health needs, especially PTSD. Thus, traditional healing has been utilized by many UIOs to fill in the gaps and reconnect them to their identity. One UIO said they are actively working towards finding reimbursement using Medicare and Medicaid.

Despite its creation, many urban programs are experiencing difficulty enrolling, and only 1 of 41 completed the process due to a lack of education and assistance for UIOs from the VA on this process.

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34 Harada ND, Villa VM, Reifel N, Bayhille R. Exploring veteran identity and health services use among Native American veterans. *Mil Med*. 2005 Sep;170(9):782-6. doi: 10.7205/milmed.170.9.782. PMID: 16261984

35 *Id.*

36 Consolidated Appropriations Act of 2021, Pub.L.No. 116-260, (Dec. 27, 2020), available at: <https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf>

NCUIH's work with Congress on the passage of the Health Care Access for Urban Native Veterans Act of 2019 as part of the Consolidated Appropriations Act of 2021, UIOs are now eligible to enter the VA Reimbursement Agreements Program.³⁷ The VA RAP program provides VA reimbursement to IHS, THP, and UIO health facilities for services provided to eligible AI/AN Veterans.³⁸ Despite its creation, many urban programs are experiencing difficulty enrolling, and only 1 of 41 completed the process due to a lack of education and assistance for UIOs from the VA on this process.

NCUIH has also submitted several comments to the VA on subjects including the Operational Plan to implement the IHS-VHA Memorandum of Understanding, the VA Pilot Program on Graduate Medical Education and Residency, and the VA Tribal Representation Expansion Program. In all of its written comments, NCUIH highlighted the urgent need to ensure that VA programs intended to serve Native veterans do so no matter where the veteran lives and the critical importance of partnering with UIOs to serve Native veterans in urban areas.

In October 2021, Sonya Tetnowski, President of NCUIH and CEO of the Indian Health Center of Santa Clara Valley, Army Veteran, and member of the Makah Tribe was appointed to the VA's first-ever Advisory Committee on Tribal and Indian Affairs to represent the voice of urban Indians. NCUIH serves as Ms. Tetnowski's Committee Technical Advisor. Ms. Tetnowski is chair of the Advisory Committee's Health Subcommittee where she has led the development of recommendations to the Secretary regarding several priority issues including unhoused urban Veterans, Native Healer utilization, and Behavioral Health and Substance Use. These efforts have emphasized the critical importance of working with UIOs to reach and serve the significant portion of Native veterans living in urban areas.

NCUIH is encouraged by the recent announcement of the joint effort between the VA, HHS, Housing and Urban Development (HUD), and the White House Committee on Native American Affairs on the Initiative to Address Homelessness for Urban Native Veterans.³⁹ According to Secretary McDonough, "the Initiative will involve enhanced partnerships with 41 urban Indian organizations and will focus on intake and referral services to ensure that Native veterans are aware of and have access to resources already set aside for them." NCUIH will continue to collaborate with UIOs and agencies

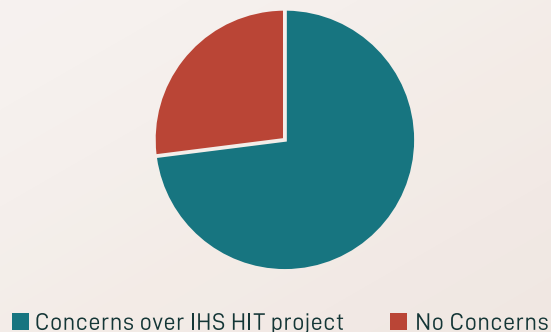
37 NCUIH, "MOU Between the VA and IHS Updated to Improve the Health Status of AI/AN Veterans and Include UIOs," 2021, <https://ncuih.org/2021/11/09/mou-between-the-va-and-ihs-updated-to-improve-the-health-status-of-ai-an-veterans-and-include-uios/>

38 Veterans Affairs, "General Information," 2023, Available at https://www.va.gov/COMMUNITYCARE/providers/info_IHS-THP.asp

39 See The White House, The White House Tribal Nations Summing Progress Report, at 46, (2022), available at: https://www.whitehouse.gov/wp-content/uploads/2022/11/2022_11_23-WH-Tribal-Nations-Summit-Progress-Report-Final.pdf

on this Initiative to strengthen the partnership between VA, HHS, HUD, and UIOs to ensure that AI/AN veterans at risk of homeless have access to the services they earned through their service.

Health Information Technology and Electronic Health Record (EHR) Modernization



In the focus group questionnaire, approximately 73 percent of UIO respondents expressed concerns over IHS' Health Information Technology (HIT) Modernization project, HIT "is an important means for helping health care providers provide high quality care that is safe, effective, timely, patient-centered, efficient and equitable."⁴⁰ HIT is no longer a "nice to have" tool for healthcare providers, it is "an integral component of healthcare delivery, and it is critical to improving our nation's health system." It is well established that "[a] major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."⁴¹ Without timely HIT modernization and maintenance of I/T/U HIT systems at the highest level, the United States will fail in its trust responsibility to maintain and improve the health of AI/ANs and its national goal to raise the health status of AI/ANs to the highest possible level.

In the questionnaire, several UIOs expressed concern over interoperability, the timeline for implementation, reimbursement costs for UIOs who have already purchased new Electronic Health Record systems (EHR), and the need for IHS to hire qualified IT staff to monitor and provide technical assistance to UIOs. For example, several UIOs stressed concern for the timeline of the HIT modernization process, with one UIO saying, "it [HIT Modernization] is going to take a decade and we can't wait that long."

Moreover, UIOs have expended significant funds for the replacement, upgrade, and maintenance of new HIT systems due to the federal government's failure to keep pace with HIT development in the wider healthcare industry. As a

⁴⁰ National Association of Community Health Centers, Health Information Technology, <https://www.nachc.org/health-center-issues/health-information-technologies-hit/> (last visited April 4, 2022)

⁴¹ 25 U.S.C. § 1601

result, UIOs have had no choice but to purchase off-the-shelf replacement systems to ensure that they can continue to provide high-quality and culturally-focused health care to AI/AN patients.

The costs incurred by UIOs are significant and unsustainable without assistance from the federal government. Last year, NCUIH hosted a focus group on HIT Modernization where one UIO shared that it costs between \$300,000-\$400,000 per year just to maintain their off-the-shelf EHR. Other UIOs reported that while they have worked to alleviate the initial purchase cost of HIT systems through outside funding resources like grants, they face growing monthly fees associated with system maintenance including monthly licensing fees, technical assistance fees, and others. NCUIH notes that the need for reimbursement is shared by both UIOs and Tribes. During the March 10, 2022, virtual Tribal Consultation and Urban Confer on HIT, leaders shared their concerns with not being reimbursed for purchasing HIT systems when IHS has failed to timely update or replace, despite acknowledging the challenges the RPMS has caused." IHS must provide resources, both human and financial, to continuously evaluate, support, and evolve HIT systems as new technology and processes become available.

NCUIH Action

Throughout 2022, NCUIH submitted several comments to IHS regarding HIT Modernization. In 2023, NCUIH will continue to ensure UIO input is included in the Modernization process and also seek to ensure IHS remains transparent in each step of the process. NCUIH will also continue to voice support for a designated Urban Office of IT to ensure a seamless transition into the new program. NCUIH will also continue to encourage IHS to work with Congress to address any budgetary constraints and fiscal law restrictions blocking reimbursement of HIT modernization costs to Tribes and UIOs.

New Barriers Limit UIO Distributions of Vaccines

During the height of the COVID-19 pandemic, HHS created a plan to coordinate the distribution of free COVID-19 vaccines to Indian Country. Tribal health programs and UIOs had the choice of receiving COVID-19 vaccines either through IHS or the state. Once this choice was made, vaccines were allocated to IHS and the states who would then distribute them to tribal health programs and UIOs. While this distribution program currently remains intact, several UIOs mentioned new barriers impacting vaccine access for their patients. For example, one UIO noted their financial concern over providing COVID-19 and Monkeypox vaccines once the federal government ceases to provide free vaccine doses. Another UIO also voiced their concern over waning intergovernmental communication regarding vaccine supply and distribution.

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Currently, the most requested vaccines by patients at UIOs include COVID-19 and Monkeypox. Reported barriers to vaccine access for patients at UIOs from focus groups and the survey include funding, low reimbursement for the administration of adult vaccines, physical distance, non-culturally relevant marketing, and a lack of general education and awareness. To overcome these barriers, many UIOs suggested strategies to address access, such as encouraging buy-ins (like offering gift cards), distributing a variety of requested vaccines at community events, and ensuring marketing strategies and branded merchandise are culturally appropriate.

HIV, Behavioral Health, and Substance Abuse Support

UIOs Highlight Need for Increased HIV Resources

UIOs highlighted their current work on HIV/AIDS and noted the current barriers and unmet needs surrounding this issue. The ongoing COVID-19 pandemic has posed barriers to testing and education regarding HIV. One UIO said that despite consistent funding to address HIV, there is a lack of interest and attendance at educational events, as well as decreases in testing. UIOs experience some increase in attendance when paired with other public health concerns, such as Monkeypox.

While UIOs have made significant strides in tackling HIV /AIDS, they require more funding to procure the additional resources necessary to fully address this issue within their AI/AN communities. UIOs reported needing more space, bandwidth, and staff to meet HIV-related needs, as well as additional support and resources for pre-exposure prophylaxis (PrEP) medication. One UIO stated that "HIV prevention, treatment, or care for people living with HIV is extremely important... [however, this] requires specialty care for which we are unable to afford/acquire." Another UIO highlighted that "staff trainings on how to talk to our LGBTQ2S relatives about this disease" are essential to further advancing their work on HIV/AIDS.

UIOs also requested increased funding for treatment services, hiring full-time employees (including medical providers), providing housing with support services, and expanding mental health care services for individuals living with HIV at their facilities. Lastly, UIOs requested "research that describes what has been done in the past to address the issue of HIV prevention, treatment, and care, and identifies a way to overcome the stigma of HIV in Indian Country."

Addressing the Lasting Effects of COVID-19 Through Increased Behavioral Health and Substance Abuse Services

Similar to last year, many UIOs expressed their concern over the significant lasting impact the ongoing COVID-19 pandemic has exerted on behavioral health. In the questionnaire, funding for behavioral health was ranked as the third-highest priority for 2023 and the highest priority for outpatient and residential UIOs.

Although national data on this subject is limited, the American Psychological Association (APA) notes that "historical trauma impacts populations who have experienced long-term widespread trauma over the span of generations".⁴² Thus, it can be reasonably expected that AI/AN populations, while simultaneously "reconciling the grief inherited from generations before them", are more at risk for behavioral health issues than other populations.⁴³ In 2018, the APA stated that approximately 15% of AI/AN adults report being substance dependent, while rates of PTSD among AI/AN adults are akin to rates amongst war veterans, with estimates ranging anywhere from 6-19%.⁴⁴ The COVID-19 pandemic has magnified this risk. A 2021 GAO report noted how AI/ANs died of COVID-19 at a rate of 2.2 times higher than other racial groups between March 2020 and August 2021, resulting in AI/ANs being defined as a potential 'high-risk' group for pandemic-related behavioral health effects.⁴⁵ In addition, new studies are indicating that social isolation and loneliness amongst individuals of high-risk groups (including AI/ANs) correlate to poorer behavioral health outcomes, including higher rates of suicide, depression, anxiety, and dementia.⁴⁶

These concerning statistics indicate that UIOs need help bolstering their behavioral health departments and capabilities to address these growing issues. This includes, but is not limited to, additional funding to hire full-time behavioral health employees, such as psychiatrists and traditional healers for mental health, to keep up with the demand for such services.

Many UIOs also expressed the need for funding for substance abuse services, citing concern about the increasing use of fentanyl and the high cost of Narcan. One UIO said they are starting to use new overdose treatments, like Vivitrol. There has been an emphasis on substance use in housing communities, highlighting the need for cross-training staff to administer these treatments in many settings. In terms of education and Narcan dispersal, community events such as Powwows for education and

"HIV prevention, treatment, or care for people living with HIV is extremely important... [however, this] requires specialty care for which we are unable to afford/acquire."

*Outreach and Referral
UIO*

⁴² American Psychological Association, Honoring Children: Treating Trauma and Adverse Childhood Experiences in American Indian and Alaska Native Communities, 2022, Available at <https://www.apa.org/pi/families/resources/newsletter/2018/11/Native-american-trauma>

⁴³ Cid.

⁴⁴ Cid.

⁴⁵ Government Accountability Office (GAO), Behavioral Health and COVID-19: Higher-Risk Populations and Related Federal Relief Funding, Behavioral Health and COVID-19: Higher-Risk Populations and Related Federal Relief Funding | U.S. GAO

⁴⁶ Cid.

training and drive-through supply dispersal have been effective in terms of outreach. There is also still work to be done in addressing the stigmas associated with harm reduction kits., as one UIO recalled that harm reduction kits were not as widely accepted in the community.

NCUIH Action

NCUIH has long advocated before Congress to fund and preserve behavioral health initiatives for UIOs under the Indian health care system, as urban AI/AN populations are at a much higher risk for behavioral health issues than the general population.⁴⁷

In the FY23 Omnibus, seven provisions made funds available to UIOs for mental and behavioral health programs, as well as substance use treatment.⁴⁸ For example, the Behavioral Health and Substance Use Disorder Resources for Native Americans provision appropriates \$80 million for the IHS to allocate to UIOs for culturally appropriate mental health and substance use disorder prevention, treatment, and recovery services.

Funding for behavioral health was ranked as the third-highest priority for 2023 and the highest priority for outpatient and residential UIOs.

Reauthorizing the Special Diabetes Program for Indians

The Special Diabetes Program for Indians (SDPI) includes research-based interventions for diabetes prevention and cardiovascular disease (CVD) risk reduction in AI/AN community-based programs and healthcare settings. AI/ANs have the highest diabetes prevalence rates of all racial and ethnic groups in the United States, with AI/AN adults almost three times more likely than non-Hispanic white adults to be diagnosed with diabetes.⁴⁹ The program has demonstrated success with a 50% reduction in diabetic eye disease rates, drops in diabetic kidney failure, and a 50% decline in End Stage Renal Disease.⁵⁰ SDPI is therefore a critical program to address the disparate high rates of diabetes among AI/ANs. In addition, SDPI has proven to be primarily responsible for Medicare savings as high as \$52 million per year.⁵¹ Currently, 31 UIOs receive SDPI funding, and the program has directly enabled UIOs to provide critical services to their AI/AN patients, in turn significantly reducing the incidence of diabetes and diabetes-related illnesses among urban Indian communities. For example, this funding allowed one UIO to provide much-needed medical services to their

47 Office of Planning, Research, and Evaluation, *Understanding Urban Indians' Interactions with ACF Programs and Services (Report 2014-41)*, *Understanding Urban Indians' Interactions With ACF Programs and Services: Literature Review* (hhs.gov)

48 H.R.7666: Restoring Hope for Mental Health and Well-Being Act of 2022, H.R.7666, 117th Cong. (2022), <https://www.congress.gov/bill/117th-congress/house-bill/7666>

49 Department of Health and Human Services Office of Minority Health, Diabetes and American Indians/Alaska Natives, <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=33>

50 Indian Health Service, Special Diabetes Program For Indians: 2020 Report to Congress, 2020, Available at www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

51 Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, The Special Diabetes Program for Indians: Estimates of Medicare Savings (May 10, 2019), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/189221/SDPI_Paper_Final.pdf

patients, such as blood sugar monitoring devices, medication, wound care, endocrinology, and retinal imaging services. Another UIO developed a robust preventative education and support system that includes an on-site Wellness Center. Finally, one UIO used these funds to develop a Garden Project to teach classes about creating and maintaining a healthy diet.

The current SDPI is authorized through FY23 at \$150 million. During both focus groups and the survey, UIOs maintained that reauthorizing SDPI through 2025 and increasing funding to \$250 million annually is another high priority. For the second year in a row, among all UIOs, SDPI reauthorization was ranked fifth on the priority chart.

NCUIH Action

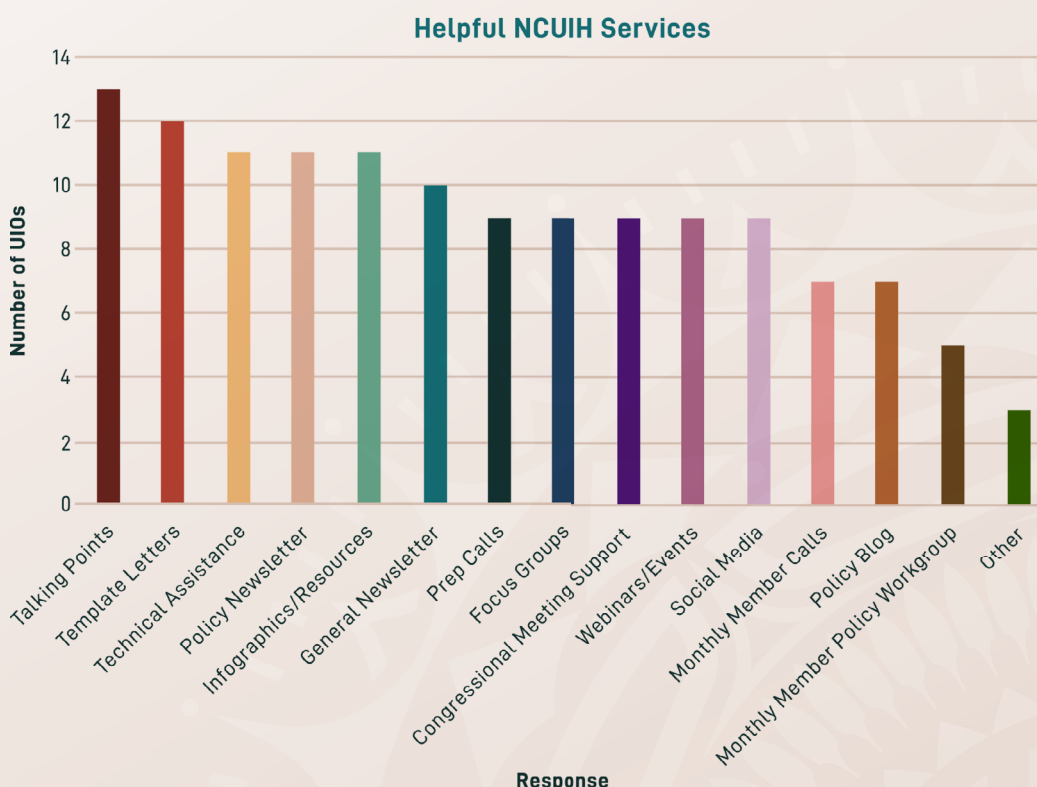
NCUIH has been a long-time supporter of the SDPI program. Recently, NCUIH worked closely with Senator Warren's (D-MA) office on the recent unveiling of the landmark bill Honoring Promises to Native Nations Act on December 05, 2022.⁵² This legislation would reauthorize SDPI at \$300,000,000 for each fiscal year beginning in 2023 through 2032. The proposal for this bill was first introduced in August 2019 by Congresswoman Deb Haaland (D-NM) and Senator Warren. Lawmakers then took feedback from tribal governments and citizens, tribal organizations, UIOs, experts, and other stakeholders which informed the development of this current legislation. NCUIH has also submitted several comments to federal agencies including IHS, HHS, and OMB, urging permanent reauthorization of the SDPI and increased funding, with built-in automatic annual medical inflationary increases.

The current SDPI is authorized through FY23 at \$150 million. During both focus groups and the survey, UIOs maintained that reauthorizing SDPI through 2025 and increasing funding to \$200 million annually is another high priority.

52 S.5186: Honoring Promises to Native Nations Act, S.5186, 117th Cong. (2022), <https://www.congress.gov/bills/117/congress/senate-bill/5186>

NCUIH provides a range of services such as a COVID-19 Resource Center, a Regulations Tracker, webinars, e-mail updates, calls, listening sessions, newsletters, toolkits, template comment letters, and technical assistance. UIOs have found these resources helpful in information dissemination and advocacy on behalf of UIOs. Focus group discussions were also mentioned as a beneficial way to communicate with other UIOs and hear about what they are experiencing.

The following graph shows a compilation of UIO rankings for NCUH services offered throughout the past year:



NCUIH is using this data to create an advocacy strategy to include federal and congressional policy priorities for 2023, design handouts and other informational resources for the identified issues and inform relevant agencies and Congress about the major issues impacting UIOs.

The goal of the assessment was to allow NCUIH to identify policy priorities for UIOs in 2023. Based on the focus group, questionnaire, and this policy assessment, the 2023 policy priorities will be the following:

- 1. Increase Funding for the Indian Health Service and the Urban Indian Line Item**
- 2. Permanent Full (100%) FMAP for Services Provided at UIOs**
- 3. Behavioral Health Funding**
- 4. Advance Appropriations to Insulate Indian Health Care Providers from Shutdowns and Exception Apportionment for Continuing Resolutions**
- 5. Reauthorize SDPI through 2025 and Increase Funding to \$250 million Annually**
- 6. Health IT/EHR Improvement and IHS National Data Warehouse Reporting**
- 7. Increase Traditional Healing Funding**
- 8. Establish an Urban Confer for HHS and the VA**
- 9. Inclusion of UIOs in Advisory Committees with Focus on Indian Health**
- 10. Improve Accuracy of UIO Data Reported by the IHS NDW**
- 11. Increase Innovative Resources to Reduce Stigma and Fear Around HIV in AI/AN Communities**
- 12. Increase Behavioral Health Support Resources at UIOs for AI/ANs Living with HIV**
- 13. Increase access to research describing past work on addressing HIV prevention, treatment, and care**

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