FIELD HEARING ON EMPOWERING NATIVE AMERICAN AND RURAL COMMUNITIES

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

MAY 10, 2024

Serial No. 118–FC27

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
57–012 WASHINGTON : 2024

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United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
May 3, 2024
No. FC-26

CONTACT: 202-225-3625

Chairman Smith Announces Field Hearing on Empowering Native American and Rural Communities

House Committee on Ways and Means Chairman Jason Smith (MO-08) announced today that the Committee will hold a hearing on adoption, foster care, and child support issues within the Native American and Rural Communities—in addition to exploring ways to enhance access to rural health care and discussing pro-growth tax policies. The hearing will take place at **9:00 AM (Mountain Time) on Friday, May 10, 2024, at Salt River Prima Maricopa Indian Community** in Scottsdale, Arizona.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Friday, May 24, 2024**. For questions, or if you encounter technical problems, please call (202) 225-3625.

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The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials

submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

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EMPOWERING NATIVE AMERICAN AND RURAL COMMUNITIES

FRIDAY, MAY 10, 2024

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 9:01 a.m. Mountain Time, at the Salt River Pima-Maricopa Indian Community, Community Council Chambers, 10091 East Osborn Road, Scottsdale, Arizona, Hon. Jason T. Smith [Chairman of the Committee] presiding.

Chairman SMITH. The committee will come to order. I want to first start off by thanking President Harvier, the Tribal Council, and the entire Salt River Pima-Maricopa Indian community for hosting the committee. And I want to thank Representative Schweikert for bringing us all to Arizona. The weather is just right.

I also want to wish a very happy birthday to the chairman of our tax subcommittee, Mr. Mike Kelly, who is here for his birthday. [Applause.]

So——

Mrs. FISCHBACH. Do we have cake?

Chairman SMITH. It is a surprise.

So this is the first Ways and Means hearing on sovereign tribal land in our committee's 235-year history. It is an honor to be able to make history in the chamber where this community exercises its self-governance.

We are here in Arizona to strengthen our government-to-government relationship, and affirm our commitment to help tribal communities prosper. Whether it is improving health care or making our economy more innovative, the policies we craft must include the voices and perspectives of Native Americans.

I have the honor of representing southern Missouri, which is one of the most rural areas in the entire country. It is a region filled with hard-working families who do right by their neighbors. It is also a region where many folks struggle to make ends meet. Though the experiences of rural communities and tribal communities are not the same, I see similarities between some of the broad challenges that they both face. Native American tribes face unfair double standards in solving those challenges.

The committee has been focused on policies aimed at strengthening tribal families, particularly in the areas of child welfare, adoption, and child support. Tribal child support agencies, unlike state agencies, are not allowed to garnish past-due child support

from tax refunds. As we heard at a committee hearing last fall, it makes it more difficult for parents to take care of their children.

Tribes face unique challenges when it comes to administering Federal child welfare programs. Native American children, constituting just one percent of the total child population in the United States, are disproportionately represented in foster care placements, accounting for 2.7 percent of placements. Collaboration between state agencies and Tribes is necessary to ensure culturally appropriate interventions and placements within their communities to protect vulnerable children and keep families together whenever possible.

One area that unites both rural and tribal communities is the health care crisis. There are simply not enough doctors or nurses or sites of service. As a result, rural Americans have a 43 percent higher mortality rate compared to Americans living in cities and suburbs, and Native Americans have a 33 percent higher mortality rate. Those are tragic facts that show more work needs to be done to solve this crisis.

The committee is focused on working toward a future where every individual can access health care in the community where they live and where they work. Part of the challenge is getting more doctors to practice in rural and Native American communities. When doctors complete their residency in a rural community, they are six times more likely to set down roots and practice. This week our committee voted to guarantee the recent Medicare-funded residency slots promised to rural hospitals are actually filled by truly rural hospitals. This is just a first step, and the committee will make further improvements to the Graduate Medical Education Program to secure the physician workforce for rural Americans.

At the same time, we should look at how to help grow the health care workforce serving Native American communities as well. Patients also need open hospitals and quick emergency services in their area. Your congressman, Mr. David Schweikert, has been a champion in Congress for preserving health care for every family. Just two days ago the committee passed his bill that allows Medicare patients to continue to use telehealth and provides critical funding for small hospitals and emergency services across the country, including right here in the East Valley.

Looking at the future, we must use every tool we have to end the health care crisis in underserved communities. For example, a competitive tax code will help businesses innovate and produce the next generation of lifesaving drugs and medical products. Next year, the tax cuts passed under President Trump that fueled innovation and made American businesses more competitive will expire. We must find ways to build on the successes of those tax cuts.

I want to thank the witnesses for taking time out of your busy schedules for being here today.

We also want to hear from everyone in the audience, as well. There will be clipboards that we will be passing out so that you can share with us any concerns or ideas. We will enter those comments and ideas into the official hearing record, and take those back with us to Washington as we consider how to empower Native American and rural communities.

Chairman SMITH. I am pleased to recognize the gentlelady from California, Ms. Chu, for her opening statement.

Ms. CHU. I want to begin by saying thank you to the Salt River Pima-Maricopa Indian community for welcoming us to this hearing today on this beautiful land. Thank you to tribal leadership, elected council members, and our distinguished witnesses for being here today.

I also want to thank our witnesses for joining us as we discuss challenges facing the American Indian population, as well as residents of Arizona regarding the issues under the jurisdiction of this committee, including health, workforce development, family support, and tax issues.

I am proud of the work that President Biden and Democrats in Congress have done to prioritize the needs of tribal nations and native communities. For instance, our American Rescue Plan included a $32 billion direct Federal investment in tribal nations, the largest in U.S. history, and the Bipartisan Infrastructure Law invested $13 billion in high-speed Internet, roads, bridges, public transit, clean water, and sanitation throughout tribal communities.

While I am proud of this progress, we know there is much work to be done to ensure we meet our commitments to tribal nation children and families who live both on and off tribal lands, and I am especially concerned about tribal children who come into contact with the child welfare system.

Before the Indian Child Welfare Act of 1978, or ICWA, as many as one-third of native children were forcibly removed from their homes by state child welfare and private adoption agencies, often without any justification, and the vast majority of these children were placed in White, Christian homes outside of the families and communities they knew best.

But the passage of ICWA set Federal requirements designed to provide culturally appropriate services and keep native children in their community whenever possible. For instance, agencies and courts must first consider placement with relatives or, if that is not possible, with other families within the tribal community, where they can remain connected to their culture and identity. The bill was under threat at the U.S. Supreme Court last year, but fortunately the court upheld ICWA.

But even with ICWA in place, we have to do more to meet these goals. Last year I was approached by Chairman Martin of the Morongo Tribe in southern California, who was concerned about California's disproportionate high rate of Native children entering the child welfare system. These children are 4.5 times more likely to enter care than their non-Native counterparts, and he explained to me that these children are still more likely to be placed outside of their own communities, away from tribal and cultural connections. That is why I introduced H.R. 3461, the Strengthening Tribal Families Act, along with representative Don Bacon. The bill would assist state child welfare agencies in implementing Federal protections for tribal children by strengthening the relationships between these agencies and the courts.

The bill directs the Department of Health and Human Services to assess the State's implementation of ICWA, so that we can know how ICWA is actually being implemented, state by state.

And as we discuss the importance of family-building and preservation today, I want to emphasize that this includes the ability of all parents, including Native parents, to decide when and whether to start or continue their family. To that end I want to thank our witness, Rachael Lorenzo, for being here, and recognize the work that they and their team do to provide reproductive freedom for Native people in both New Mexico and Arizona.

Like so many others, I was horrified when this Arizona Supreme Court upheld an abortion ban enacted before Arizona was a State, before women could even vote. And so I appreciate the work that you do at Indigenous Women Rising to ensure that women in your community retain the ability to make choices about their own bodies.

I additionally want to acknowledge and thank you and your team for the work that you do to support indigenous women through their pregnancies, should they choose to continue them, and to ensure that they have a supportive birth experience and a healthy delivery.

Ms. CHU. With that, I yield back.

Chairman SMITH. Thank you, Ms. Chu. I am pleased to recognize our generous host, Mr. Congressman Schweikert, for one minute. [Laughter.]

Mr. SCHWEIKERT. I will try to go quickly, Mr. Chairman.

And members, thank you for coming out here. I know it is a long flight. Now you sort of understand maybe why Western members are often cranky.

Also, to the community, thank you for letting us be here. I am blessed. My entire life I have lived alongside this community. When I am in Arizona, there is never a day I am not on your land, partially because I drive up and down the Beeline Highway.

But this is an important point I really want to make. There are a number of issues, whether it be child welfare, economic issues, to, you know, enterprises, to bonding, to tax issues that I will argue are inherently unique to tribal lands, and are not necessarily partisan. They are just trying to come up with what is moral and what is smart economics. And sometimes we get into a mindset that sometimes can be a bit outdated on how sophisticated so many of our tribal communities have become.

So, Mr. Chairman, thank you again. You did something unique also in the panels today, everything from issues on, you know, the child welfare all the way over to tax issues, to even some things that are incredibly hopeful of what the future of access to health care to, actually, the revolution of cures will be sitting in front of us right now. And with that, Mr. Chairman, thank you for being here. Let's have at it.

Chairman Smith. Thank you, Mr. Schweikert.

I will now introduce our witnesses. First we have Mikah Carlos, who is a council member of the Salt River Pima-Maricopa Indian Community. We have Elisia Manuel, who is the founder of Three Precious Miracles. We have Kenneth Kahn, who is chairman of the Santa Ynez Band of Chumash Indians. We have Dr. Michael Kupferman, who is senior vice president of Physician Enterprise and president of Banner University Medical Division. We have Richard Morello, who is chief executive officer of CND Life

Sciences. And we have Rachael Lorenzo, who is executive director of Indigenous Women Rising.

Thank you all so much for joining us today. Your written statements will be made part of the hearing record, and you each have five minutes to deliver remarks.

Mikah Carlos, you may begin when you are ready.

STATEMENT OF MIKAH CARLOS, COUNCIL MEMBER, SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY

Ms. CARLOS. [Speaking native language.] Good day. My name is Mikah Carlos. I am from the Salt River Pima-Maricopa Indian community, and I currently serve as a council member. I am also honored to serve as a board member for the National Indian Child Welfare Association. Thank you for the opportunity to provide testimony on tribal child welfare issues.

And I also want to thank you for holding this important hearing here in our tribal lands and in our council chambers.

I have had a long history of interactions with the child welfare system, both professionally and personally. As a child, when my parents divorced, both my mom—my non-Native mother was given primary custody of my siblings and I. She did not allow us to practice our culture because it went against her religious beliefs. While I was connected to my community through my grandparents and father, that connection slowly diminished over time.

As an adult, I can reflect back and now identify that, even though I wasn't cognizant of being disconnected, I was dealing with a direct impact of loss of culture and language on my well-being. There was always a sense of something was missing, and there was a void in my life that I tried to fill with decisions that I will admit were some bad choices that, thankfully, did not have lifelong consequences.

Fortunately, I had friends who were connected to the—through the community through our youth council, and it was through them that I started learning more about our himdag, which roughly translates to way of life. This is a main component of our culture, and it encompasses an array of things that does not easily translate into English. When you learn about the himdag in culture, you learn your connection to the community and our extended families. You learn and understand your role and purpose in the community. And finally, that piece that I felt like I was missing was falling into place.

It was those experiences that drove me to make culture a focal point of the work I do. We know that culture is prevention, and when it is incorporated holistically into services and programing for youth we see a reduction in risky behaviors because of the protective factors that are a part of our cultural practices. I have seen firsthand countless times that in one of my first jobs, working with Indian children who were placed outside of their communities, they often expressed interest in wanting to know more about being Indian, and felt ashamed that they didn't have a connection to their culture.

And when I later started working for my community, I managed programs that were tasked with reducing youth substance rates. I helped develop a program that focuses on teaching youth about our

himdag, which I directly saw change many of their point of views and increase their overall lifetime health outcomes.

As a tribal leader, this work is even more important because we are tasked with the overall well-being of our communities, and part of that is making sure that services are provided in a culturally significant and meaningful way. Through this I have come to appreciate the important role that Federal policy has in facilitating successful, culturally important programs and interventions that keep our families together and keep our youth connected to their culture.

Our child welfare department has more than 40 full-time employees, and offers a vast array of services to families and children. A hallmark of our child welfare services is a principle of intervening early, before crisis overwhelms our families. We work hard to build trust between our social services department and the community, so that families come to us and feel comfortable getting support and services. We know it is working because over the past 10 years we have reduced the number of children in out-of-home placement from 450 to just 99 today.

Annually to support these activities, approximately $2.7 million of our budget is funded by title 4(e), 4(b), and other Federal grants, while the remaining almost $7 million comes from our own tribal government funding. While we greatly appreciate and rely on these Federal funding streams, there are a number of barriers and limitations associated with them that make it difficult for us to provide the kinds of services that work for our community. And in some cases, reporting requirements can take so much time for staff that it is barely worth accepting the funding at all.

Additionally, our caseworkers have the added challenge of working with our citizens in child welfare systems beyond just our community and with the States—and other States, as well. Many of these jurisdictions lack experience with the Indian Child Welfare Act, which leads to miscommunication, delays, and direct barriers to serving our tribal citizens. To that end, we are supportive of several bills that would address these issues.

H.R. 2762, the Tribal Family Fairness Act, makes a number of technical fixes to the child welfare programs to reduce bureaucratic burdens and expand access to Title VI–B programs.

H.R. 3461, the Strengthening Tribal Families Act, which would help address the inconsistent application of ICWA in different states by directing HHS to provide evidence-based technical assistance to state child welfare agencies.

S. 1065, the Tribal Adoption Tax Parity Act, would provide parity for adoptions taking place in tribal court so that they are on the same footing as the state courts, and our citizens don't have to go through an unfamiliar court process just to get tax credits that intend to offset the expensive adoption process.

And lastly, H.R. 7906, Strengthening State and Tribal Child Support Enforcement Act, would give tribes access to the IRS Federal Tax Offset refund program, which states currently have access to.

Once again, I thank you for this opportunity to provide testimony to the committee, and I look forward to your questions. [Speaking native language.]

[The prepared statement of Ms. Carlos follows:]

STATEMENT OF MIKAH CARLOS
TRIBAL COUNCILMEMBER
SALT RIVER PIMA MARICOPA INDIAN COMMUNITY
TO THE U.S. HOUSE WAYS AND MEANS COMMITTEE
REGARDING TRIBAL CHILD WELFARE SERVICES AND THE TITLE IV-B PROGRAM

Skeg tas, ani ap cegig Mikah Carlos. Ciod onk Akimel amjed. Hello my name is Mikah Carlos and I am from the Salt River Pima Maricopa Indian Community (SRPMIC). I currently serve my community as a member of the tribal council, and I am honored to serve not only my community, but all of Indian Country as a Board Member of the National Indian Child Welfare Association. Chairman Smith, Ranking Member Neal, Congressman Schweikert, and members of the Committee thank you for the opportunity to provide testimony on tribal child welfare services, the federal adoption tax credit, and the Title IV-B Child Welfare Services and Promoting Safe and Stable Families programs. On behalf of our Community I want to thank you for holding this important hearing here on our land, in the first ever Ways & Means Committee field hearing on tribal land.

My family has had a long history of interactions with the child welfare system, from kinship and foster care placements in our home to the adoption of my sister. But there are some moments that stand out as pivotal in regards to the work I do with child welfare and culturally specific programming for youth.

As a child, when my parents divorced, my non-native mother was given primary custody of my siblings and I. She did not allow us to practice our culture because she felt like it went against her religious beliefs. While I was connected to my community through my grandparents and father, that connection slowly diminished over time as the relationship between my mother and father eroded.

As an adult who has and continues to make the effort to connect and embrace my culture, I can reflect back and now identify that, even though I wasn't cognizant of being disconnected, I was dealing with the direct impact of loss of culture and language on my well-being. There was always a sense of something missing and there was a void in my life that I tried to fill, with what I will admit, were some bad choices that thankfully did not have lifelong consequences.

Fortunately, I had friends who were engaged with the Community through the Tribe's youth council and it was there that I was able to start learning more about our himdag, which roughly translates to "way of life" in O'odham. This is a main component of our culture and it encompasses an array of things that are hard to translate into English. When you learn about the himdag and culture, you learn your connection to the community and our extended families. I began to understand the role and purpose I had in the community and finally that piece that felt like I was missing, started to fall in to place.

It was those experiences and my work in child welfare that drove me in my professional and personal life to make culture a focal point of the work I do. We know that culture is prevention and when it is incorporated holistically into services and programming for youth, we see a reduction in risky behaviors because of the protective factors that are incorporated into our cultural practices.

At the same time that I was on my journey to learn more about my culture and gaining an understanding of how impactful it is to be connected to your community, I began working for a foster care agency that contracted with my community and another tribe. Working with the Indian children who had been placed outside of their communities was again another reminder of how important it is for youth to be connected to their culture and communities. The children often expressed interest in wanting to know more about "being Indian" and sometimes they would even feel ashamed they didn't know about their culture. As much as SRPMIC makes efforts to connect youth placed outside of the community to our culture, there is nothing that can substitute for the lessons of himdag that you learn from being in community and with your community members.

Later, when I started working directly for my community, I managed programs that were tasked with reducing youth substance use rates. I learned more about the factors that contribute to substance using behavior, but more importantly, I began learning about how to prevent those behaviors before they start. I learned about protective factors and how when youth are connected to their culture and community, we saw lower rates of substance using behaviors and increased resiliency to adversity. Taking what I learned, I helped develop a program that focuses on teaching youth about our himdag that also serves a dual purpose of increasing the protective factors that will increase their overall lifetime health outcomes.

As a tribal leader, this work is even more important because we are tasked with the overall wellbeing of our community and part of that is making sure that services are provided in a culturally significant and meaningful way. When we intervene with youth and develop protective factors that will reduce certain behaviors and improve lifelong health and achievement outcomes. This is why it is so important that we keep our future, our children, connected to culture and our community because it means a healthy future of our people.

Salt River Pima Maricopa Indian Community and our Child Welfare Services

Established by Executive Order in 1879, our Community is home to the An Auk Akimel O'odham (Pima) and Xalychidom Piipaash (Maricopa) tribes. Located in the Phoenix metropolitan area, the Community spans 52,600 acres and has approximately 11,000 enrolled members that require significant government services to meet community needs.

SRPMIC operates a comprehensive array of child welfare services and adjudicates tribal juvenile matters involving our tribal member families within our tribal court. Our child welfare department has more than 40 full time employees including 28 caseworkers, 2 program administrators, 8 managers and 6 support staff. We are also fortunate to have a dedicated ICWA Court in Maricopa County with 1 dedicated ICWA judge who takes all ICWA or likely ICWA eligible cases. The ICWA Judge has a judicial assistant and courtroom assistant who help with data entry and tracking of ICWA cases. We also have 1 ICWA Court Coordinator.

We provide support and services to tribal nation children and families that live on and off our tribal lands and are involved in state child welfare systems. Our workforce has the added requirement and responsibility of working with our citizens in child welfare systems both in Arizona and many states beyond. This gives us a unique perspective on how other state child welfare systems operate, and the challenge of helping our children and families get the support and services they need in different jurisdictions.

We take great pride in how we have successfully designed and operate our child welfare program so that it can provide the support our children and families need in a timely and appropriate manner and avoid, whenever possible, the traumatic and costly removal of children from their homes and placement into foster care.

A hallmark of our child welfare services is the principle of intervening early before crisis overwhelms our families and we have little recourse to keep children safe other than removing them from their home. We work hard to create a positive relationship between our child welfare program and the community so that families will want to come see us to get support or services. We want our community to see the tribal child welfare program as a valuable partner in keeping children safe, not just a policing agent that monitors families or only helps after the crisis occurs. This means our program needs to look like our community so our families see themselves in our staff and how we work and know the program is serious about strengthening their capacity to help them keep their children safe.

Our programs are culturally based and always seek to strengthen our children and families connection to their tribal values, beliefs, and traditions. These tribal connections become protective factors that increase family and youth resilience and help them avoid risk taking behavior that can land them in child welfare, juvenile justice, or other systems. As an example of how our program has been successful, the tribe has lowered the foster care rates from 450 children in out of home care to 99 children in out of home care. The tribe is offering preventative services to address parenting, substance abuse, and mental health so children can safely remain in their homes or with family reducing the reentry of families into the child welfare system. Families are taking an active role in decision making and seeking supportive services from the Community.

Our child welfare services are funded by a blend of federal, state, and tribal government funding. One consistent challenge we face is finding federal funding that allows us to support services that align with tribal approaches. For example, we have an approved Title IV-E Foster Care, Relative Guardianship, and Adoption Assistance program and an approved Title IV-E Prevention Services program. While these HHS resources are very helpful, they are often more challenging to administer and have more narrow eligibility for what types of services, how long services can be provided, and who can receive the services than do Title IV-B funded services.

Conversely, our Title IV-B funds are the most flexible and best aligned to our community needs prevention funding we receive from HHS, but unfortunately, our Title IV-B funding allocation is also relatively small compared to other funding we receive. Between both Title IV-B programs we receive less than what it costs to fund two professional social workers who can provide the prevention services needed by our families ($130,000). Furthermore, despite this relatively small allocation, we are subject to administrative requirements that are similar to what a state has to conduct.

Our tribal court system is also a valuable partner in our efforts to keep our foster care rates low and strengthen our families, but there is a long line of tribes that are trying to access the funding under the Tribal Court Improvement Program that is currently funded at $1 million each year, so it could take years before we are able to receive a grant under this program, which makes integrating reform efforts with our tribal child welfare program much more challenging.

H.R. 2762, the Tribal Family Fairness Act

We think there are some common sense solutions to some these challenges in the Tribal Family Fairness Act (H.R. 2762), a bipartisan bill that would increase the tribal set-aside in Title IV-B, Subpart 2, so that more tribes would be eligible for the funding and existing tribal grantees would receive reasonable increases to their allocations, and streamline administrative burdens for tribes that receive smaller grants under the Title IV-B programs to be more realistic in proportion to the size of grant they receive. Currently, there are tribes that would like to receive Title IV-B funding, but are either ineligible because of the statutory funding formula, or the amount of funding they would receive under Title IV-B, Subpart 1 is so small that it doesn't even pay for the administrative costs to operate the program.

The bill would also increase the funding for the Tribal Court Improvement Program from $1 million to $5 million per year to expand the number of tribal courts that could access these funds. There are other provisions in the legislation that we also like that make it clear that tribal customary adoptions should be eligible for support under Title IV-B funds as they are with Title IV-E funds and clarify that tribes may use their federally-negotiated indirect rates in the administration of Title IV-B programs. The Salt River Pima Maricopa Indian Community supports this legislation.

The Indian Child Welfare Act & H.R. 3461, the Strengthening Tribal Families Act

SRPMIC children and families that are in the care of the State come under the requirements of the Indian Child Welfare Act (25 USC 1901 et seq.). The Indian Child Welfare Act (ICWA), which was recently upheld by the United States Supreme Court in a 7-2 decision in *Haaland v. Brackeen*, was enacted in 1978 to reduce the alarming number of Indian children being funneled into state foster care systems. Since then, it has been heralded by child welfare advocacy groups across the country as the "gold standard" in child welfare laws.

Over the years we have seen increasing collaboration between tribes and states in efforts to improve implementation of the law, such as we see here in Maricopa County, which has its own dedicated ICWA court, but there are still inconsistencies in how the law is implemented in different jurisdictions that deny Indian children of the protections the law provides and places unnecessary barriers to tribes that intervene in these cases that want to support their tribal citizens. We think these concerns could be more easily addressed if there was data to properly understand what the implementation concerns are and if there was supportive technical assistance for tribes and states to address implementation challenges. We also believe that the Department of Health and Human Services is in the best position to provide technical assistance to states and tribes to further their collaborative efforts to improve ICWA's implementation.

The Strengthening Tribal Family Act (H.R. 3461) provides clarity for HHS in their role with tribes and states to collect necessary data on ICWA's implementation and provide data-driven technical assistance to help states and tribes work together to improve ICWA's implementation. This legislation is bipartisan and directs HHS to collect targeted data on ICWA implementation that will support data-driven solutions to implementation concerns and promote collaboration between the Bureau of Indian Affairs and HHS in the process.

Salt River Pima Maricopa Indian Community supports this legislation and believes it will further our efforts to ensure our children and families receive the support and services they need regardless of where they live and work.

Tribal Adoption Tax Parity Act

Lastly, I want to share information related to the adoption of our tribal children and how federal law can get in the way of supporting adoption in tribal court, and is perpetuating a culture of inequity and disrespect for tribal governments. While I have shared with you how we strive to avoid out of home placements of our children whenever possible, there are some situations where the child can never be returned safely to their birth parents. In those situations, the tribe weighs carefully what type of placement will be in the best interest of the child. This can include a permanent guardianship home or an adoptive home.

When adoption is the best choice, many prospective adoptive parents, who are oftentimes who a relative of the child or a tribal member, prefer to perform the adoption in our tribal court where they feel more comfortable. The cost of adopting a child can contain significant costs, such as legal fees, and other new costs for the family, especially in the first year after placement. We strive to help our adoptive families as much as possible, but the adoptive family may need to bear the burden of some of these costs.

One of the barriers for families adopting in a tribal court is the Internal Revenue Code of 1986 only authorizes states to determine if a child being considered for adoption meets the requirements for the federal adoption tax credit. This tax credit of up to $10,000 can be very important to our families that want to adopt, so we support the Tribal Adoption Tax Parity Act (S. 1065), bipartisan legislation, which amends Internal Revenue Code to add tribal nations as eligible to make determinations for purposes of qualifying a child adopted in a tribal court for the federal adoption tax credit.

H.R. 7906, Strengthening State and Tribal Child Support Enforcement Act

While the Salt River Pima Maricopa Indian Community does not operate a child support enforcement program, many of the tribes we work with on a regular basis have robust programs that provide additional resources for children and helps tribal nations offset some of the costs of assistance they provide to children. Tribal nations that operate the program have designed their programs to maximize support for tribal children through innovative programs that use conventional cash methods to support children, as well as more innovative ways such as making home improvements, providing firewood for heating homes, or like we sometimes need here in Arizona, replacing critical air conditioning window units. Tribal child support programs are also using their funds to teach teens and young adults about the financial, legal, and emotional responsibilities of parenthood and improving intergovernmental case processing and collections from parents that live in other tribes or states.

While 60 tribes have approved plans to operate Title IV-D child support enforcement programs in their communities, there are many more tribes that would like to operate this program and do so without having to contract with a state to collect past-due payments. The Strengthening State and Tribal Child Support Enforcement Act (H.R. 7906) would authorize tribal nations to access the Federal Tax Offset Refund program directly to help secure collections from non-custodial parents through their federal tax refunds. This provides tribal nations with another tool to ensure that tribal children receive needed support they deserve.

This legislation is supported by the National Tribal Child Support Association and National Association of Tribal Child Support Directors.

Chairman Smith and members of the Committee thank you for the opportunity to provide testimony on these important issues and proposed legislation. It is my hope this hearing will provide a substantive record to move legislation forward.

Thank you.

Chairman SMITH. Thank you.
Elisia Manuel, you are now recognized.

STATEMENT OF ELISIA MANUEL, FOUNDER, THREE PRECIOUS MIRACLES

Ms. MANUEL. [Speaking native language.] Hello. Thank you, honorable Chairman Smith, Vice Ranking Member Chu, and all the members of the Ways and Means Committee, for this opportunity to speak before you today. My name is Elisia Manuel. My traditional Apache name is Beautiful Sunflower. And I am Mexican and Apache, born and raised here in Arizona.

I am the founder of Three Precious Miracles, a non-profit to support Native children affected by foster care. I work as a foster care recruitment manager. I lead two prevention councils, among many other things. I am married to my high school sweetheart, Tecumseh Running Deer Manuel, an enrolled member of Gila River Indian community. We are proud parents of three beautiful children who were once part of the child welfare system.

Our family is thankful for the Indian Child Welfare Act. ICWA was enacted in 1978, in the response of the large numbers of Native children being separated from their parents and communities, and it allows tribal governments to intervene in cases to work collaboratively with states. In January 2023 we became licensed foster parents and received our 2 foster children. The next month we were contacted that a baby boy needed a forever home. When we were at the hospital picking up our son, we were told that a baby girl needed a home, an ICWA-compliant home. She was placed into foster care by a non-ICWA case manager and into a non-Native family. That summer the judge ruled in our favor, and placed her with us, upholding ICWA the way Congress intended.

So in the matter of four months, we became parents to four children that were under the age of two years old. Our son, Micah, came to us about a year later. He was two days old and my son's biological brother. Tecumseh and I always tease that we have three children that are the same age for four days.

Our children became forever ours because of ICWA, that gold standard of keeping Indian children in Native homes. ICWA is important because it preserves culture and keeps tribal connections. But not all children are receiving the protections under the law. Despite ICWA being the gold standard, many states struggle to comply with the law and need support.

From a Federal level, I think you could encourage states and improve in implementation of ICWA through that Strengthening Tribal Families Act of 2023. This bill would help by giving states and—develop an ICWA plan and assess the strengths and improvements. We could help so many more families if tribal welfare had the same resources as state child welfare.

A month ago, there was approximately 9,000 kids in foster care, and 11 percent of them were Native children. Through my work I have found that we potentially have an additional 3,000 children, tribal children, in the foster—in foster care, and those children need supports, too.

We adopted through the state so our kids were eligible for adoption subsidy, child care assistance, and that adoption tax credit.

From my experience, a child who is under tribal social services are not eligible for those same benefits and resources. A few years ago we were asked if we would foster our daughter's sibling. We agreed only if she stayed in the state system so that she could receive those same benefits. We were never contacted back, even though we were willing to take her in.

Lack of resources also leads to more children coming into the system. Many provision resources are non-existent in tribal communities. In partnership with Prevent Child Abuse Arizona, we are working to implement family resource centers to fill in the gaps. I currently have a small warehouse of resources, and I try to support Native families statewide.

I strongly encourage you to reauthorize and strengthen the Title VI–B. The Federal program provides flexible funding for prevention of maltreatment for kinship, foster care, caregivers, and more, areas that are vital for tribal communities. With access to Title VI–B, tribes could accomplish a lot. We know, with our families, what our families need: resources, and culture. I wholeheartedly believe that culture is prevention, and feel empowered by the sense of belonging through my own cultural connections. Title VI–B is an opportunity for you to give more funding to tribes so that, in turn, we can provide support to our families.

I would like to thank the Committee for allowing me to share just a piece of my life through my testimony, and I will continue to be an advocate for Native children and families, child welfare, ICWA, as we will forever be blessed and we will bless others through creator. Thank you.

[The prepared statement of Ms. Manuel follows:]

Testimony of Elisia Manuel
Founder, Three Precious Miracles
Before the House Committee on Ways & Means
"Empowering Native American and Rural Communities"
Salt River Pima Maricopa Indian Community
Scottsdale, Arizona
May 10, 2024

Dagot'ee (hello in Apache). Thank you, Honorable Chairman Smith, Ranking Member Neal, and members of the Ways and Means Full Committee for this opportunity to appear before you today.

My name is Elisia Manuel and my traditional Apache name is Beautiful Sunflower. I'm Mexican and Apache born and raised in Arizona. I'm the founder of Three Precious Miracles, a nonprofit organization to support Native children affected by foster care. The organization has been thriving for just about ten years, providing basic resources and cultural opportunities to keep children connected to culture. I also currently work for StepStone Family Youth & Services as the Foster Care Recruitment Manager. I'm married to my high school sweetheart Tecumseh Running Deer Manuel, an enrolled member of Gila River Indian Community. We will be celebrating 20 years of marriage on June 3rd, 2024. We are proud parents of three beautiful children who were all once part of the Department Child Safety and Tribal Social Services system.

In addition to my regular job and running a nonprofit, I oversee two Prevention Councils with the Arizona Department of Child Safety (DCS), one in Pinal County in the Gila River Area and another in Apache County serving the White Mountain Apache Community. I also serve on the DCS Advisory Committee and am the Chair of the Phoenix Indian Center Urban Indian Coalition Indian Child Welfare Act (ICWA) Subcommittee. I am a board member of the First Things First Gila River Indian Community Partnership Council, serve on the Arizona Friends in Foster Care Scholarship Committee, the Johnson O'Malley Program committee in Casa Grande, and the Native American Women's Conference. My organization, Three Precious Miracles, is also a founding member with the National Youth Engagement Advisory Council, which works in collaboration with US Department of Health and Human Services Quality Improvement Center on Engaging Youth in Finding Permanency (QIC-EY). It is charged with advancing child welfare

programs and practice to ensure that they are authentically engaging and empowering children and youth in foster care throughout the U.S., especially in relation to permanency decisions. I'm proud to say that through my advocacy to get more Native communities involved, we have three Native American/ Hawaiian Natives groups represented in the QIC-EY pilot sites --The State of Hawaii, Oklahoma Southern Plains CPT Consortium, and Yakama Nation.

Our family has been very thankful for the Indian Child Welfare Act (ICWA). ICWA was enacted in 1978 in the response to the crisis affecting American Indian and Alaska Native children, families, and tribes. Large numbers of Native children were being separated from their parents, extended families, and communities by state child welfare and private adoption agencies. ICWA is an important protection for Native children and families. It allows tribal governments to intervene in these cases and work collaboratively with states to ensure that appropriate services and placements are available.

I became involved with the child welfare system when I started volunteering at the local Residential Youth Home on the Gila River Indian Community. In January 2013, we became licensed foster parents for the community and received our first two foster children the second week in January. On February 27th, 2013, Tribal Social Services contacted us that they had a baby boy that would need a forever home. His biological mother already had eight children in the system and his case plan would be adoption. He was identified as a failure to thrive preemie exposed to methamphetamines. We immediately agreed that that we would move forward with the adoption process.

When we were at the hospital for our son, we were told that a baby girl needed an ICWA-compliant home and asked if we would be willing to take her. She had been placed into foster care by a non-ICWA case manager and had been placed with a non-native family. We had several court hearings to request that the Department of Child Safety (DCS) transfer her case to the ICWA unit. On June 24th, 2013, the judge ruled in favor and placed her with us. I received a text message later that day from the foster mom and we met at a Walmart parking lot. The family handed our daughter to my husband with a few items – a baby blanket, two outfits, newborn pictures, a bottle, and a bottle of formula. And suddenly we were the parents of two babies only a week apart and two foster children. So, in the matter of four months we became parents to four children all under the age of two years old and all still wearing diapers.

Our son Micah came to us about a year later, on February 12th 2014. He was two days old, and it was just 2 days before our daughter's first birthday and 10 days before our son's first birthday. When the caseworker called to advise us that they had another baby that needed a forever home, I giggled and told her that I hoped she could find him a home. And then she told me he was my son's biological brother and mom had #10. So, we agreed with open arms although all our children haven't even turned 1 yet. Tecumseh and I always tease that we have three children that are the same age for four days every year. All my children were born in February, so we have a birthday party every week that month!

Our daughter became forever ours because of ICWA's "gold standard" of keeping Indian children in homes which reflect the unique values of Indian culture. I feel ICWA is so important because it helps preserve our culture, prevent the loss of tribal connections, and ensure our well-being within our communities. I believe that having a sense of where we come from through our cultural connections promotes a sense of purpose, belonging, and a healthier life. Honoring and preserving my own cultural heritage has been a powerful tool in promoting holistic health and addressing societal inequities. I'm still learning as an adult how culture makes me feel strength, resilience and lead a strong path for my ancestors. The adoption process for my family was amazing and I'm so thankful that we were blessed.

Across the country, Tribes and States are increasingly finding ways to improve ICWA's implementation. In Arizona, we have made progress by delivering ICWA trainings conducted by the ICWA unit liaison who provides information on child welfare systems. There was also an amazing ICWA conference hosted by Pascua Yaqui Tribe Office of the Attorney General that I personally enjoyed attending. On July 15th, 2023, I helped plan and facilitate an ICWA symposium at the Phoenix Indian School Memorial Hall to share information on ICWA, the court system, the Haaland v. Brackeen decision, and how to get licensed to become a foster parent. Cultural competency training has also been designed to support child welfare professionals to work with diverse families.

But there is still a need for more training specific to the implementation of ICWA. There are areas where implementation of ICWA is inconsistent and Native children are not receiving the protections under the law, such as placement with relatives or preventive efforts to avoid placement in foster care systems. As of a month ago, there are approximately 9,000 kids in foster care in Arizona and 11% are Native children. A rate that disproportionally higher than the

4.5% of Native Americans in Arizona's population, meaning Native children are at higher risk of coming to the attention of DCS. But there are also thousands more children in Tribal foster care that are not reported to our state system. For example, we have 22 beautiful tribes here in Arizona and we don't report tribal cases to the state because of sovereignty. Through my work and advocacy working with different tribal communities, I have found that we potentially have an additional 3,000 children in foster care.

Lack of data about ICWA implementation and lack of targeted assistance for states and tribes is a consistent barrier to improvements. From the federal level, I think you could encourage states to thoughtfully implement ICWA through the *Strengthening Tribal Families Act of 2023*. It would help by requiring states to develop an ICWA state plan and to regularly assess their strengths and areas for improvement. People want to understand the law and make it work, but we need more data, training, and consistent implementation. Native children across the country need to be protected, and they deserve our best efforts to keep them connected to their families and communities. I'm very thankful that my work has allowed me to teach a basic cultural training to staff and new foster parents to help them understand the importance of culture and ICWA.

We could help so many more families and Native children if tribal communities had some of the same resources as nontribal communities. My nonprofit scrambles every day to support tribal families taking in children. Too often our foster and kinship families don't have access to basic resources they need to take care for children, including beds, clothing, car seats, diapers, and more. But it's more than what our small nonprofit can provide through help from volunteers and donations. In our case, we were able to adopt our children because they came through the state child welfare system in conjunction with Tribal ICWA. As a result, they were eligible for the adoption subsidy and other resources such as childcare assistance and adoption tax credit. My husband and I work very hard to provide for three babies less than a year apart and thankful for the additional support we were offered, and it made a difference. However, from my experience, a child who is under Tribal Social Services and not the state system is not eligible for those same benefits and resources. A few years ago, we were called by the Tribal Social Services Department and asked if we would foster our daughter's little sister. I was the 18th person they called to find a placement. But, after talking to my husband, we agreed that we would take her only if she came through the state system so that she could receive the same benefits. We felt it was in the best interest for baby to be offered all resources to properly care for her. We never heard back and, last we heard, she is still in foster care, years later.

I believe that many more tribal families would be willing to care for children in foster care if the right support was in place. As my story demonstrates, there are inequities in who receives adoption subsidies, adoption tax credits, childcare resources, kinship support and more. If we want to deliver on the purpose of ICWA and have Native children stay in their communities, we need more equity between Tribal and non-Tribal child welfare. Right now, children have to stay in the state system to get these resources.

This lack of resources also leads to more Native children needlessly coming into child welfare. We need to give families what they need so they never encounter foster care. We need strategies and resources to address parental trauma and support parents who are facing a crisis. Many of the prevention resources available in nontribal communities are nonexistent in tribes. In partnership with Prevent Child Abuse Arizona, we are working to implement much-needed family resources centers statewide. In tribal communities, we would also need to make sure resource centers are equipped to address basic needs or be able to connect families to community-based services. To fill the gaps, I currently have a small warehouse in Sacaton and work with several community nonprofits to provide resources to Native families around the state.

To comprehensively support tribal families and children, I strongly encourage you to reauthorize and strengthen Title IV-B. This federal program provides flexible funding to prevent maltreatment, support kinship and foster caregivers, and strengthen families so children and youth can live safely at home -- three areas that are vital yet under-resourced in tribal communities. Tribes need more funding and fewer administrative burdens to access and maximize Title IV-B.

With greater and more equitable access to Title IV-B, Tribes could accomplish a lot. We know what our Native families and children need – resources and culturally attuned programs that prevent and heal maltreatment. Another example from my experience includes cultural sweat ceremonies and positive parenting workshops that we held for Native parents who are battling substance use and trauma and may have had their children removed. The parents have expressed feeling supported by their community brothers and sisters and culturally connected. This paves the pathway to recovery and for getting the help they need. I also volunteer in a local residential treatment center for youth, holding a culture group class for Native youth that are between the ages of 10 and 17. We provide invaluable emotional support and encouragement

during times of separation and loss while they are living away from tribal communities and family. We have a traditional facilitator who coordinates and incorporates cultural medicine to help preserve and honor ancestral knowledge and healing practices that have been passed down through generations. The clinician at the residential facility has witnessed firsthand the transformative power of embracing cultural medicine in promoting their well-being. I'm honored to work with Indian youth and parents and help them connect to their culture, begin to heal, and prevent any further involvement in child welfare. I wholeheartedly believe culture is prevention and can empower our life and belonging. Title IV-B is an opportunity for you to provide more equitable funding to Tribes so that, in turn, we can provide support for our families and children and prevent crises.

Embracing and celebrating my culture has not only enriched my life but has also empowered me to lead a more fulfilling and meaningful existence to help my children and others. I would like to thank the committee for allowing me to share a piece of my life through this testimony. I will continue to be an advocate for Native children and families, child welfare and ICWA as I feel our forever family has been blessed, and we will bless others.

Chairman SMITH. Thank you.
Mr. Kenneth Kahn, you are recognized.

STATEMENT OF KENNETH KAHN, CHAIRMAN, SANTA YNEZ BAND OF CHUMASH INDIANS

Mr. KAHN. Chairman Smith, Vice Ranking Member Chu, and members of the Ways and Means Committee, thank you for taking the time to hold a field hearing on Indian country, and for inviting me to testify as the chairman of the Santa Ynez Band of Chumash Indians located in Santa Barbara County, California. I am here today to ask the committee to address several tax parity issues that are creating barriers to economic development and self-determination across Indian country.

Generally speaking, tribal leaders all share the common goal of fostering economic activity to our lands so we might enhance services and employment opportunities for our citizens and neighbors. In this context I extend appreciation to Congresswoman Gwen Moore and Congressman David Schweikert for the introduction of the Tribal Tax and Investment Reform Act of 2024.

I would also like to thank Congressman Kelly for his leadership on similar bills in previous Congresses.

As I previously presented to this committee in 2020, tribal governments lack a fundamental tool available to state and municipal counterparts: full access to tax-exempt bond financing. From 1987 to 2010, Indian tribal governments issued an annual average of $157 million in tax-exempt bonds, totaling about $3.76 billion across 321 transactions. Although this appears substantial, it accounts for less than 1/10 of 1 percent of the total $6.6 trillion in tax-exempt municipal bonds issued during this period.

What explains this significant difference? Unlike state and local governments, tribal governments are subject to the essential government function test. Under this test, while it is possible for tribes to access tax-exempt bonds for schools, streets, or sewers, these activities do not generate revenue. In contrast, state and local governments have greater flexibility, being able to utilize tax-exempt bonds for wider—for a wider array of projects that generate revenue such as hotels and convention centers, sports stadiums, golf courses, and other common economic development activities.

Practically, this disparity translates to substantially higher financing costs for projects on tribal land compared to identical projects undertaken by state and municipal governments. Tribal governments' lack of access to tax-exempt bond financing inflates borrowing costs by approximately 25 percent for those projects undertaken by state and municipal governments, dissuading investment in tribal communities. To this end, I urge the Committee to take action to lift the restrictions imposed by the essential government function test as outlined in the Tribal Tax and Investment Reform Act.

Mr. Chairman, while each of the provisions found in the Tribal Tax and Investment Reform Act deserves attention by the committee, I want to bring sections 8, 10, and 13 of the bill to your attention.

Section 8 of the bill creates a new market tax credit tribal setaside, which would encourage needed private investment into tribal

areas. Even though much of Indian country qualifies as low-income, and such areas are the exact types of communities the program was designed to benefit, Native communities and tribally-focused community development enterprises have received very few allocations since the program's inception. And in most years they received none. We believe a set-aside would ensure this program starts to reach Indian country as needed.

Section 10 of the bill clarifies that the tribal general welfare benefits are not categorized as income related to supplemental social income eligibility benefit amounts. In 2014, Congress passed the General Welfare Exclusion Act, recognizing that an essential part of self-governance and self-determination is the ability to provide general welfare benefits to tribal citizens according to the unique circumstances, needs, customs, culture, traditions, and practices of tribal governments.

As such, while the General Welfare Exclusion Act exempted those benefits from taxation, it failed to clarify whether these benefits should count as resources for programs like Supplemental Social Income eligibility and HUD housing. The benefits provided by a tribe to its citizens should not be treated any differently than benefits provided to those in need by the Federal or state governments.

Lastly, section 13 of the bill would address an issue that makes it harder for tribes and the IHS to recruit health care providers. Under current law, the National Health Service Corps Loan Repayment Program offers loan repayment assistance to certain health providers who commit to serving in health professional shortage areas. For a specified period, benefits offered through this program are exempt from Federal taxation. However, the benefits provided by Indian Health Service Loan Repayment Program do not enjoy an exclusion from Federal taxation. This disparity in treatment of similar programs makes Indian country a less desirable location to practice, and further exacerbates health disparities found on most reservations.

Thank you for your attention and consideration to these crucial matters affecting tribal communities.

[The prepared statement of Mr. Kahn follows:]

Kenneth Kahn
Chairman, Santa Ynez Band of Chumash Indians
Written Testimony to the House Committee on Ways and Means
Friday, May 10 2024 – Salt River Pima Maricopa Indian Community

Chairman Smith, Vice Ranking Member Chu, and Members of the W&M Committee, thank you for taking the time to hold a field hearing in Indian Country and for inviting me to testify. As the elected chairman of the Santa Ynez Band of Chumash Indians, I am here today to ask the Committee to be mindful of the challenges facing Indian Country when developing tax policy.

In conversations with tribal leaders across Indian Country, a recurring concern emerges: the necessity of ensuring parity for tribal governments alongside state and municipal counterparts. All share the common objective of fostering economic activity to bolster services and employment for their constituents. In this context, I extend appreciation to Congresswoman Gwen Moore and Congressman David Schweikert for championing tax parity for tribes through the introduction of the Tribal Tax and Investment Reform Act of 2024.

As I previously presented to this Committee in 2020, tribal governments lack a fundamental tool available to state and municipal counterparts: full access to tax-exempt bond financing. From 1987 to 2010, Indian tribal governments issued an average of approximately $157 million annually in tax-exempt bonds, totaling about $3.76 billion across 321 transactions. Although this appears substantial, it accounts for less than one-tenth of one percent of the total $6.6 trillion in tax-exempt municipal bonds issued during this period.

What explains this significant difference? Unlike state and local governments, Tribal governments are governed by the Essential Government Function test (EGF. The EGF was initially introduced in 1982 as part of the Indian Tribal Government Tax Status Act, which included provisions for tax-exempt bonds, aiming to address concerns about tax parity for tribes. While this legislation represented progress, it fell short of achieving full equality with states and local governments. Private activity bonds, except for those relating to manufacturing plants on Indian lands, were not permitted.

In 1987, Congress further defined the EGF in the statute, limiting the use of tax-exempt bonds to functions typically undertaken by states and local governments. In practice, this constrained the use of tax-exempt bonds to specific functions, such as schools, streets, or sewers, which typically do not generate revenue. In contrast, state and local governments have greater flexibility, being able to utilize tax-exempt bonds for a wider array of projects that generate revenue, such as convention centers or commercial buildings.

Practically, this disparity translates to substantially higher financing costs for projects on tribal land compared to identical endeavors undertaken by state and municipal governments. Tribal governments' lack of access to tax-exempt financing inflates borrowing costs by approximately 25% than those of state and municipal governments, dissuading investment in tribal communities. I would also ask the Committee to consider the recently published report from

the Federal Reserve Bank of Minneapolis entitled "Tax code constraints limit tribal tax-exempt bonding".

I urge the Committee to take action to lift the restrictions imposed by the Essential Government Function test on tribal governments, as outlined in the Tribal Tax and Investment Reform Act.

Congress recognized the shortcomings of the EGF in 2009 by temporarily addressing the disparity through the Tribal Economic Development Bond program. This initiative authorized tribal governments to issue a combined $2 billion in tax-exempt bonds for eligible projects located on tribal land, excluding gaming facilities, with each allocation requiring Treasury approval.

Although the program demonstrated a strong demand for economic development in Indian Country, it had limitations. The $2 billion cap on tax-exempt bonds has been reached, limiting usage to tribes with approved projects over the past decade instead of benefiting all tribal governments. Moreover, initial regulations were overly prescriptive, hindering many tribes with shovel-ready projects from seizing the opportunity. Additionally, the issue of whether bonds maintained tax-exempt status when refinanced was unaddressed, jeopardizing project viability. Despite these challenges, the popularity of the program underscores the necessity for long-term access to tax-exempt financing in Indian Country. This sentiment is echoed by entities beyond Congress, including the Treasury Department, Government Accountability Office, and Joint Committee on Taxation, which identified the EGF as a barrier to tribal economic development.

While each of the provisions found in the Tribal Tax and Investment Reform Act of 2024 deserves attention by the Committee, I want to bring Sections 8, 10 and 13 of the bill to your attention. Section 8 of the bill creates a New Markets Tax Credit tribal set aside, which would encourage needed private investment into tribal areas. This provision, along with the tax-exempt bond provision, would be a game changer for economic growth in tribal areas and benefit the local, regional, and national economies.

Section 13 of the bill will provide for exclusion from gross income for payments under Indian health service loan repayment program and Indian health professions scholarships program. This section will make health professionals at the Indian Health Service eligible for recruitment and retention tax incentives available to other public sector health professionals. Under current law, the National Health Service Corps (NHSC) Loan Repayment Program offers loan repayment assistance to primary care medical, dental, and mental/behavioral health providers who commit to serving in Health Professional Shortage Areas (HPSAs) for a specified period. Benefits offered through this program are exempt from federal taxation. However, the benefits provided by Indian Health Service (IHS) Loan Repayment Program do not enjoy such an exclusion from federal taxation. This disparity in treatment of similar programs makes Indian Country a less desirable location to practice and further exacerbates health disparities found on most reservations.

Lastly, Section 10 of the bill clarifies that Tribal General Welfare Benefits (GWB) are not categorized as income related to Supplemental Social Income eligibility or benefit amounts. Championed by then Congressman Devin Nunes, the Tribal General Welfare Exclusion Act (TGWEA) excludes from gross income, for income tax purposes, the value of a tribal general welfare benefit. Unfortunately, ambiguity remains around this portion of the law. For example, various need-based programs like the Supplemental Social Income are defined by the Social Security Administration to include GWB as resources. Section 10 clarifies that these benefits from Supplemental Social Income eligibility and benefit amount determinations.

Thank you for your attention and consideration of these critical matters affecting tribal communities.

FEDERAL RESERVE BANK
OF MINNEAPOLIS

Tax code constraints limit tribal tax-exempt bonding

Legal barriers may contribute to tribal governments' lower usage of tax-exempt bonds

April 25, 2024

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Article Highlights

- Tribal citizen per capita tax-exempt bond proceeds fall below U.S. residents as a whole
- Legal constraints to issuing bonds and raising government revenue likely contribute to gap
- Further analysis requires more complete tribal bond data

Tax-exempt municipal[1] bonds play an important role in financing the construction of public purpose projects and supporting private development across the country. For a given level of risk, tax-exempt debt can offer a lower cost of capital than financing the same project using taxable debt.[2] Tribal governments, however, face both legal and debt service barriers to using this important financing mechanism available to state and local governments. These barriers can create challenges for tribes seeking to access the half-trillion-dollar annual tax-exempt municipal bond market for low-cost capital financing.

As part of our mission to advance the economic self-determination and prosperity of Native nations and Indigenous communities, the Center for Indian Country Development provides research and analysis on factors influencing access to capital in Native communities. To shed light on the barriers to tribes using tax-exempt bonding, we review the legal framework governing tribal tax-exempt bonding authority. We also provide an analysis of per capita tax-exempt bond financing. Our analysis spans 2003–2010—the most recent years for which both tribal-specific bond data are publicly available from the U.S. Department of the Treasury (Treasury) and annual municipal bond data are available from the Internal Revenue Service (IRS).

After accounting for differences in the target populations of both tribal governments and municipalities, we find that from 2003–2010, tribal governments' use of tax-exempt bonds falls below that of state and local governments. We also explore tribal-specific factors that may explain why we observe this large capital gap. More tribal tax-exempt bond data are needed to extend this analysis to recent years.

Tribal governments' disparate access to tax-exempt bonding dates back to the 1980s

Prior to 1983, federally recognized tribes (hereafter referred to as *tribes*) were not included as governmental entities eligible to issue tax-exempt bonds under Section 103 of the Internal Revenue Code (hereafter referred to simply as *tax code*). However, in 1983, Congress passed the Indian Tribal Governmental Tax Status Act, authorizing tribes to temporarily issue tax-exempt bonds under a

newly added Section 7871. While many of the provisions were set to sunset in 1985, this tribal authority was later made permanent in 1984. Despite the act's initial purpose of creating tax parity between tribal and state governments, tribal organizations have questioned the act's final text for failing to establish tax parity between tribal governments and other governments.

Section 7871 imposes two substantial restrictions on tribal tax-exempt bonding authority inapplicable to state and local governments: (1) tribal governments cannot issue tax-exempt qualified private activity bonds, with one narrow exception;[3] and (2) substantially all tribal governmental bond proceeds must finance an "essential government function." The qualified private activity bond restriction renders tribes ineligible to issue exempt facility bonds (the proceeds of which can be used to finance solid waste disposal and waste recycling facilities), small issue bonds (the proceeds of which can be used for manufacturing facilities and farm property), and redevelopment bonds (the proceeds of which can be used to improve blighted areas).[4]

The rationale for the "essential government function" restriction on tribal governmental bonding authority is explained in a 1982 Senate Finance Committee report often cited by the IRS. As articulated in this report, "These provisions do not permit an Indian tribal government (or subdivision) to issue tax-exempt bonds under circumstances where a corresponding issue by a State (or political subdivision) would not be tax-exempt."

In other words, the law prevented tribes from exploiting two tax exemptions—tax exemptions associated with bond financing as well as federal and state tax exemptions for project income—for a single project unless states could also do the same. To achieve tribal tax-exemption parity with states, Congress included the "essential government function" language appearing in Section 115 of the tax code. Section 115 exempts income derived from utilities or exercises of any "essential government function" performed by state and local governments from taxable gross income. In this way, Congress addressed the tax-exemption concern by limiting projects eligible for tribal tax-exempt bond financing to the class of projects capable of generating tax-exempt income for states.

Imposing an "essential government function" requirement for tribal bonds to ensure tribes cannot exploit tax exemptions unavailable to states achieves this outcome only if "essential government function" possesses the same meaning under Section 7871 as under Section 115. Consistent with the Senate Finance Committee report, the IRS initially interpreted "essential government function" under Section 7871 in line with Section 115 of the tax code. The IRS interpreted "essential government function" under Section 115 broadly to include income generated from essentially all government enterprises supporting government operations. The IRS' reconciliation of "essential government function" for both tribes and states was, however, short-lived.

In 1987, Congress amended Section 7871 to define "essential government function" as not including "any function which is not customarily performed by State and local governments with general taxing powers." Congress did not provide guidance as to the meaning of "customarily." Following the 1987 change, the IRS adopted a narrower view of "essential government function," interpreting "customarily" to exclude tax-exempt financing for all commercial or industrial activities.

In 2006, the IRS initiated a proposed rulemaking to recommend a three-pronged analysis for determining whether an "essential government function" was customarily performed: (1) the activity is not commercial or industrial, (2) numerous state and local governments have conducted and financed the activity with tax-exempt bonds, and (3) these governments have financed the activity for many years. The rule was never finalized, but the IRS adopted this standard in subsequent technical advice memos. This three-pronged analysis remains the standard by which the IRS evaluates the tax-exempt status of tribal bonds.

The evolution of the IRS' interpretation of "essential government function" under Section 7871 after 1987 departs from its interpretation of the same phrase under Section 115 of the tax code. This departure restricts the class of tribal projects eligible for tax-exempt financing while simultaneously maintaining the broad scope of the *state* income tax exemption. Removal of commercial and industrial activities from the meaning of "customarily" for the tribal-specific definition of "essential government function" eliminates an array of projects financeable with tax-exempt bonds in the state and local government context. These include, for example, hotels and convention centers, sports stadiums, golf courses, and other common economic development initiatives. State and local governments finance these projects to support economic development by directly generating revenue for the municipality, attracting private business activity, and supporting growth of a sustainable tax base.

The Great Recession drew attention to the need for less restrictive bonding authority for tribal governments. Responding to the economic crisis, Congress—as part of the American Recovery and Reinvestment Act—amended Section 7871 to pilot a special class of tribal tax-exempt bonds called Tribal Economic Development (TED) bonds. TED bonds were not subject to the prohibition against qualified private activity bonds or the "essential government function" test. Many tribes used these bonds to refinance taxable bonds,

finance tourism activities, and fund economic development projects similar to those of state and local governments. TED bonds were subject to a $2 billion volume cap, without increase or renewal. Although the volume cap has been reached, recent policy discussions reflect tribes' ongoing interest in tax-exempt economic development financing.

Measuring impacts of tribal tax-exempt bond restrictions

From 1987–2010, 17 percent of the 565 federally recognized tribes at the time[5] collectively issued an annual average of $159 million in tax-exempt governmental bonds for a total of roughly $3.81 billion, according to a 2013 Treasury analysis. Tribal participation in the overall tax-exempt bond market rarely surpassed *one-fifth of 1 percent* in any given year—well below what we would expect from a self-reported American Indian and Alaskan Native (AIAN) population of 1.5 percent of the U.S. population at that time.[6]

Recognizing challenges to quantifying the economic impacts of legal barriers to tribal bonding—including the lack of public data, inaccurate measures of tribal populations, and unique capital needs of tribes—the 2013 Treasury analysis shows the disparity in overall bond issuances between tribal and other governments. Recent research indicates this gap persists. While we would expect to see less use of bond financing by tribal governments than state and local governments given differences in the sizes of their service populations, the difference is better assessed on a per capita basis.

Our per capita analysis explores tribal and municipal bond data from 2003–2010. Specifically, we examine the per capita dollar value of long-term tax-exempt governmental bond issuances by all U.S. governments (the vast majority of which are state and local governments) and compare that to the per capita dollar value of long-term tribal tax-exempt bond issuances. Since tribal government services do not target a specific population, we define their target population as either (1) the overall AIAN population or (2) enrolled citizens of federally recognized tribes.[7] While there's no precise way to measure or compare the individual benefits of tax-exempt bonds, our analysis provides a way of thinking about an individual's share of the total dollar value of annual tax-exempt bond proceeds. Framing the disparity in terms of per capita investment allows for a more uniform comparison between tribal governments and municipalities.

We do not consider the per capita proceeds of tax-exempt qualified private activity bonds by state and local governments because tribes are unable, with one narrow exception,[8] to issue these bonds. Tribal access to the tax-exempt qualified private activity bond market could be meaningful to tribal economies. For context, the total proceeds of long-term tax-exempt qualified private activity bonds—which tribal governments cannot issue—exceeded $58 billion in 2020.

We focus our analysis on new long-term bond issuances because these figures generally exclude refinanced debt and, as a result, primarily represent new investment. The IRS designates long-term bond issuances to finance new projects as new tax-exempt bonds.

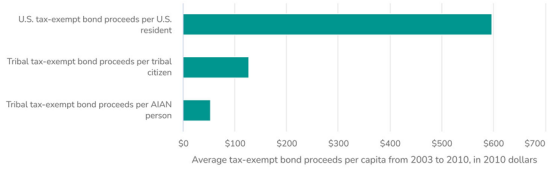
As shown in Figure 1, per capita tax-exempt bond proceeds are lower for tribal citizens and AIAN individuals than for U.S. residents as a whole.[9] Based on data from 2003–2010,[10] average per capita annual tax-exempt bond investments ranged from $127 in tribal bond proceeds per tribal citizen to $54 per AIAN individual. Over the same period, average per capita annual tax-exempt bond investments by all state and local governments were $597 per U.S. resident. This means that on average, annual per capita tax-exempt bond proceeds by state and local governments were roughly five times higher than annual per capita tax-exempt bond proceeds by tribal governments for tribal citizens.[11] While state and local government tax-exempt bond financing can create spillover benefits for AIAN individuals living within their jurisdictions, and tribal bond financing can create spillover benefits for non-tribal citizens in those areas, our analysis illuminates overarching differences in the usage of tax-exempt bond financing between tribal and municipal governments.

Potential reasons for the per capita tax-exempt bond disparity

The large gap in tribal and municipal governments' usage of tax-exempt bond financing is likely explained by, among other things, the legal constraints on tribal tax-exempt bonding authority.

1

Native Americans have lower per capita share of tax-exempt bond proceeds



Sources: Authors' calculations. Tax-exempt bond amounts are from the U.S. Department of Treasury's *Indian Tribal Government Access to Tax-Exempt Bond Financing* (Table 3) and the IRS' *New Money Long-term Tax-Exempt Governmental Bonds, by State of Issue and Bond Purpose* (Table 5). Population counts for AIAN individuals and the United States as a whole are from the 2000 Decennial Census. Tribal enrollment count is based on the U.S. Department of Housing and Urban Development's Indian Housing Block Grant Program's *Needs and Allocation* estimate for fiscal year 2000.

The "essential government function" test is likely one of the more significant reasons for the discrepancy due to its limitations on the scope of tribal activities eligible for tax-exempt financing. The test's prohibition on commercial or industrial activity renders ineligible a class of projects capable of servicing debt with project-generated revenue. State and local governments will often issue tax-exempt revenue bonds—that is, bonds for which debt service is covered by revenue of the financed project—to finance commercial, industrial, or other projects outside the scope of an "essential government function" under Section 7871. For example, a municipality could use a tax-exempt revenue bond to help support the construction of a multifamily housing development with some units reserved for lower-income households, but the "essential government function" test prohibits a tribe from funding this type of project with the same financing mechanism.

Because these project-specific revenue bonds can be unavailable to tribes, tribes have limited access to what can be an efficient way to service debt since the projects pay for themselves. Tribes can still issue taxable revenue bonds for projects outside the scope of the "essential government function" test. However, taxable revenue bonds with the same credit rating of tax-exempt revenue bonds demand a higher interest rate which increases the cost of capital[12]—potentially rendering a project prohibitively expensive.

The "essential government function" test may also indirectly create disparities in tax-exempt bond usage by amplifying differences in the tax base and tax authority between tribes and municipalities. In the absence of project-generated revenue, state and local governments rely on tax revenue to service tax-exempt bond debt. Tribes, however, cannot pledge property taxes, sales taxes, or other sources of government revenues in the same fashion. Instead, tribes must rely on existing sources of revenue—often from commercial enterprises—to service debt. Tribes could, in theory, finance utility projects such as sewage systems that generate revenue via customer fees, but many tribes do not charge their citizens fees. Likewise, many tribal communities do not possess sizable populations necessary to generate adequate fees to repay a large bond. In this way, the "essential government function" test limits the universe of eligible tax-exempt projects available to tribes. As a result, even when projects are eligible, differences in tax bases make it more difficult for tribes to service tax-exempt bond debt.

Considering tribal access to tax-exempt bonding

Expanding tribal tax-exempt bonding authority could increase access to capital in tribal communities, enhance tribal governments' ability to accelerate economic prosperity, and grow their private sectors. What might this cost? According to the Congressional Budget Office, increasing tax-exempt bond access for tribes would reduce federal tax revenue by an estimated $77 million over 10 years.[13] In comparison, the estimated total cost of the federal tax exemption for municipal bonds was $27 billion in fiscal year 2022.

Tribal organizations and Treasury have raised possibilities for increasing tribal tax-exempt bond parity. Possibilities for increasing tribal governmental bonding authority include (1) amending Section 7871 of the tax code to remove the "essential government function" test, or (2) removing the provision that financed projects be "customarily performed" by states and local governments and adding a provision defining "essential government function" under Section 7871 in line with Section 115. In a 2011 report, Treasury recommended granting tribes qualified private activity bonding authority with an accompanying volume cap similar to the cap imposed on states. Some tribal organizations have also recommended renewing or increasing the TED bond volume cap as a temporary solution.

Better data could inform policymaking

Policymakers and tribes need access to accurate, reliable, and robust data and research to render informed policy decisions regarding tribal governments' treatment in the tax-exempt bond arena. Our per capita analysis ends at 2010 due to a lack of available data for subsequent years. Although some more recent tribal tax-exempt bond data are available for publicly offered tribal bonds, such data represent a small portion of tribal bond issuances given that most occur in private markets. Analysis of tribal bonding data from 2011 to present would provide valuable information for understanding the economic impact of current tribal bonding policy.

Endnotes

1 References to "municipal" and "municipalities" throughout this article include state and local governments. Although states are not municipalities in the typical sense, "municipal bonds" are a class of government debt obligation generally understood within the finance industry to encompass bonds issued by both state and local governments.

2 Tax-exempt bonds bear the moniker "tax-exempt" because interest earned on the bonds is excluded from the bondholder's gross income for purposes of federal income tax and, in some cases, state income tax. The income tax exemption attracts investors to purchase lower-interest tax-exempt bonds because investors receive the same after-tax interest income as from bonds paying higher interest rates. The income tax exemption enables municipalities to reduce their capital costs since they pay interest at lower rates to finance infrastructure and development projects. In this way, the federal government supports infrastructure and development by foregoing the tax revenue that would otherwise have been payable absent the tax exemption.

3 The sole exception to the exclusion from tax exemption of tribal private activity bonds is for issuances where 95 percent or more of the net proceeds are to be used for the acquisition, construction, reconstruction, or improvement of certain manufacturing facilities subject to minimum employment requirements. 26 U.S.C. §7871(c)(3).

4 Interest on state and local bonds is generally excluded from the bondholder's gross income for federal income tax purposes. If a state or local bond is a private activity bond (PAB), however, the tax exemption does not apply unless the PAB is a qualified PAB (QPAB). The Internal Revenue Code's provisions defining PABs and QPABs are relatively complex. At a high level, PABs are bonds passing prescribed tests that measure the extent to which bond proceeds benefit nongovernmental persons. QPABs are PABs that meet certain requirements including that they be issued for qualifying purposes that create specific public benefits including qualified redevelopment bonds and 501(c)(3) bond issuances. See 26 U.S.C. §§141–145. Of note, while all states can issue qualified PABs, not all states choose to issue qualified PABs.

5 As of 2010, there were 575 federally recognized tribes. As of 2024, this number is 574.

6 The U.S. population in the 2000 Decennial Census was 281,421,906. The population identifying as AIAN alone or in combination with other races was 4,119,301.

7 We distinguish between the AIAN population and enrolled citizens of federally recognized tribes because they represent fundamentally different populations. We use U.S. Census data for the AIAN population. The U.S. Census Bureau relies on self-reported responses, and census respondents who self-identify as AIAN may not be citizens of tribal nations. Therefore, census data likely include individuals ineligible for tribal government services. For these reasons, census data for AIAN individuals represent the upper bound of the population benefitting from projects funded with tribal tax-exempt bonds. For a lower-bound population proxy, we rely on U.S. Department of Housing and Urban Development Indian Housing Block Grant Program (IHBG) tribal enrollment data. Federally recognized tribes report enrollment numbers to receive IHBG funds, but not all tribes receive IHBG funding and some tribes underreport tribal enrollment. Therefore, IHBG data represent a conservative estimate of the population benefitting from projects funded with tribal tax-exempt bonds.

8 As noted earlier, the sole exception to the exclusion from tax exemption of tribal private activity bonds is for issuances where 95 percent or more of the net proceeds are to be used for the acquisition, construction, reconstruction, or improvement of certain manufacturing facilities subject to minimum employment requirements. 26 U.S.C. §7871(c)(3).

9 AIAN individuals in our analysis include individuals self-identifying as AIAN alone or in combination with other races in the 2000 Decennial Census.

10 Data on tribal governmental tax-exempt bond issuances from 2003–2010 are available from IRS Form 8038-G, as reported in *New Money Long-term Tax-Exempt Governmental Bonds, by State of Issue and Bond Purpose* (Table 5).

11 Based on the same data, from 2003–2010 average annual per capita tax-exempt bond proceeds from state and local governments were two to nine times greater than annual tax-exempt tribal bond proceeds per tribal citizen. U.S. bond data include local, state, and tribal governments, although tribal government issuances represent a small fraction of these data.

12 Numerous variables influence bond yields and interest rates at any given time, but tax-exempt bond yields have been consistently lower than taxable bond yields over the last 10 years. For example, over a 10-year period beginning in February 2014, the average yield to maturity for tax-exempt A-rated bonds was 3.27 percent compared to 4.08 percent for taxable A-rated bonds, a difference of .86 percent percentage points (or 86 basis points). The yield spread concerning tribal taxable and tax-exempt bonds might differ, but even a small interest rate reduction could result in material savings over the life of a long-term bond.

13 The Congressional Budget Office (CBO) evaluated the cost of tribal tax-exempt bond parity in 2022. Tribal bond parity provisions were included in the Build Back Better Act. These provisions were removed before the law was eventually passed as the Inflation Reduction Act, but not before receiving a budget score from the CBO. The relevant tab within the score book is "Subtitle E. Infra. Financing"; the score for the tribal bond provisions of Section 13501 is under Part 3.

Matthew Gregg
Senior Economist, Center for Indian Country Development

Matthew Gregg is a senior economist in Community Development and Engagement, where he focuses on research for the Center for Indian Country Development. He has published work on historical development in Indian Country, Indian removal, land rights, and agricultural productivity.

John Morseau
Senior Policy Analyst, Center for Indian Country Development

John Morseau is a senior policy analyst for the Federal Reserve's Center for Indian Country Development, where he conducts research and provides policy insights on tribal taxation, access to capital and credit, and other Indian Country economic development issues.

Chairman SMITH. Thank you.

Dr. Kupferman, you are now recognized.

STATEMENT OF MICHAEL KUPFERMAN, MD, SENIOR VICE PRESIDENT OF PHYSICIAN ENTERPRISE, AND PRESIDENT OF BANNER, UNIVERSITY MEDICINE DIVISION

Dr. KUPFERMAN. Good morning, Chairman Smith and members of the House Ways and Means Committee. Thank you for inviting me to speak on the physician shortage. My name is Michael Kupferman, and I serve as Banner Health's senior vice president of physician enterprise and president of Banner University Medicine Division.

Banner Health is the state's largest private employer and the largest non-profit health care system. We are the primary clinical partner to the University of Arizona's medical schools in both Phoenix and Tucson. Of the more than 2,100 physician residents and fellows in the state, nearly half train at Banner Health across 91 programs. This training is supported by Medicare, Medicaid, and Banner Health.

Last year Banner spent more than $120 million on GME training. Many of these physicians will stay and practice medicine in Arizona upon graduation. Residents are essential for our medical workforce pipeline. They are also vital to many health care settings, ranging from rural clinics to community hospitals to large medical centers. Residents allow us to extend care into underserved communities, enabling our physician teams to serve Arizona's diverse veteran, Hispanic, Black, and Native American populations. Our residents deliver care at VA centers, rural hospitals, Indian Health Service facilities, and tribal clinics.

Last summer Banner Health and the University of Arizona announced an expansion of its GME programs by an additional 229 positions. The effort began this year with the goal of placing more than 140 of these positions in family medicine and internal medicine programs to help increase access to primary care physicians. We are making this investment because shortages contribute to a widening gap in care for our most vulnerable patients.

Arizona is the fourteenth most populous state, with more than seven million residents, and the sixth largest by size. This includes many remote rural areas and 22 Native American tribes. We are also one of the fastest-growing states. Our population has grown by 2 million people since 2000. With this growth, our senior population has been growing, too, up by 48 percent in the last decade. That means 17 percent of the state's population is on Medicare.

Arizona does a great job of retaining residents who train here. It is the pipeline, however, that has us very worried. Over the next 10 years, the country expects a shortage of 124,000 doctors. Arizona needs 3,600 physicians, including 2,000 in primary care alone. This is our biggest gap.

As I mentioned, Arizona has the fourteenth largest population, yet ranks thirty-seventh in resident physicians per capita. Arizona would have to add 1,100 GME slots to close this gap. This requires a significant investment at a time when hospitals and health systems have competing demands for finite resources.

On a Federal level, the current cap on Medicare funding for GME programs is a barrier to expanding the physician pipeline. The number of residency slots financed by Medicare was capped in 1996 for existing programs. In 2020 Congress passed a historic increase to Medicare GME programs by adding 1,000 new positions. This was the first increase in nearly 25 years, and a critical step toward addressing our country's workforce shortage.

As a result of this legislation, Banner was able to add 13 residency slots. As the head of Banner's Physician Enterprise, I want to say thank you. However, we still need more GME investment from our Federal and state partners. As the state's population grows, we encourage an adjustment to the fixed, five-year residency cap. This would help keep pace with the demographic changes and corresponding social determinants of health. Redistributing residency slots based on census tracks and programs with rural track positions should be taken into consideration, as well.

Lastly, continuing the expansion of positions would also bring relief to a program as diverse as ours. Nearly 70 percent of residents will practice in the communities where they complete their residency training. Developing robust training programs can help address geographic imbalances in our physician workforce. It also enables us to serve rural and underserved communities, including our tribal communities. As a result, this will increase the supply of doctors, which leads to increased access to health care services, resulting in a healthier population and ultimately leading to lower health care costs.

In closing, I applaud you, Mr. Chairman and members of the Ways and Means Committee, for your time and learning about Arizona's health care challenges. I am honored by the invitation to testify, and look forward to answering your questions. Thank you.

[The prepared statement of Dr. Kupferman follows:]

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Written Testimony

Michael Kupferman, MD, MBA
Senior Vice President of Banner Health's Physician Enterprise and President of Banner - University Medicine Division

before the
U.S. House of Representatives Committee on Ways & Means

Empowering Native American and Rural Communities
Salt River Pima-Maricopa Indian Community Council Chambers
Friday, May 10, 2024

Good morning, Chairman Smith and Members of the House Ways and Means Committee. Thank you for holding today's hearing, *Empowering Native American and Rural Communities*. Given the Committee's primary jurisdiction over the Medicare Graduate Medical Education ("GME") program, I appreciate your time in traveling out West to hear firsthand of the physician – and really, all health workforce – challenges we experience on a regular basis.

My name is Michael Kupferman, and I currently serve as Banner Health's senior vice president of physician enterprise and president of the Banner - University Medicine Division. In this role, I lead Banner's medical groups to advance value-based care, grow service lines and support academic medicine. I obtained my medical degree from the University of Pennsylvania and completed my residency in otolaryngology-head and neck surgery at the Hospital of the University of Pennsylvania and a fellowship in advanced head and neck surgical oncology at MD Anderson. I also received my MBA from the Kellogg School of Management at Northwestern University.

Banner Health is the state's largest private employer and largest nonprofit health care system. We are the primary clinical affiliate with the University of Arizona College of Medicine in Phoenix and the University of Arizona College of Medicine in Tucson. Of the 2,184 physician residents and fellows in the state, nearly 1,100, or 47 percent, train at Banner Health across 91 programs. This training is supported in part by Medicare, Medicaid and Banner Health. Last year, Banner spent more than $120 million on GME training. We invest in this space because we know it is critical for the state and the healthcare industry.

Many of these physicians will stay and practice medicine in Arizona upon graduation. Residents and fellows are not only important components of our medical workforce pipeline, but they also

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are vital to our healthcare delivery models in diverse environments. This includes rural clinics and large academic hospitals. Medical residents allow us to extend care into underserved communities, enabling our current physician teams to stretch even further and serve Arizona's diverse veteran, Hispanic, Black, and Native American populations. Our resident learners deliver care at our local VA centers, rural hospitals, Indian Health Service facilities and tribal clinics across six large western states as part of Banner's mission.

Last summer, Banner Health and the University of Arizona College of Medicine - Phoenix announced an expansion of its GME programs by an additional 229 residency and fellowship positions. The full-scale effort began this year with the goal of placing more than 140 of these positions in family medicine and internal medicine programs to help increase access to primary care physicians in the state. We are making this investment because shortages continue to contribute to a widening gap in care for our most vulnerable patients, the elderly and those living in remote areas designated as "Health Professional Shortage Areas," also commonly referred to as "HPSAs."

On a national scale, 10,000 Americans become eligible for Medicare each day. The US Census Bureau projects that by 2030, one in five Americans will be over the age of 65; and within the decade, older Americans will outnumber children for the first time in US history. This trend is driving up the demand for health care services. Those projections become even more alarming knowing that 74 million Americans currently live in HPSAs, according to the Health Resources and Services Administration ("HRSA").

On a smaller scale – but still vast for us – Arizona is the 14th most populous state with more than 7.4 million residents and the sixth largest by size. This includes many remote rural areas and 22 Native American Tribes. We also are one of the fastest growing states. Our population has grown by 2 million people since 2000. Commensurate with this growth, our senior population (age 65+) has been growing too – up by 48 percent in the past decade. That means 17 percent of the state's population is on Medicare.

Given these statistics and our terrain, our health systems must have more physical points of care and wider provider networks in place. Since Arizona has become a healthcare destination for world-class quality care, accounting for more than 20 percent of the state's economy, innovation is key to treating patients with complex needs as well as for reaching them. Banner's physician enterprise is a part of that equation.

Our residency programs train physicians to manage and treat patients in a rapidly changing environment. As the population ages, unfortunately, so does our health care workforce. For instance, 31 percent of our active physician workforce is age 60 or older, and soon will be retiring. Our experienced nursing staff is also facing similar retirement rates.

The state of Arizona does a great job retaining medical residents who train here. It is the pipeline, however, that has us worried.

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Over the next ten years, the country expects a shortage of 124,000 physicians. For Arizona, we estimate needing 3,600 physicians including 1,941 primary care physicians. This is our biggest gap, which we currently meet by 39 percent. Additional Arizona datapoints include:

- 42nd in the nation for active primary care physicians per capita;
- 31st in total active physicians per capita; and
- 43rd in active general surgeons per capita.

As previously mentioned, Arizona has the 14th largest population yet ranks 37th in resident physicians per capita. That's about 28.5 FTE per 100,000 population compared to the US rate of 43.8 per 100,000 population. Arizona would have to add 1,100 graduate medical education slots to attain a rank of 15th. Closing this gap requires significant financial investment.

This commitment is complicated by the fact that hospitals and health systems encounter additional challenges requiring resources. This includes rising operational expenses ranging from technology and IT equipment to pharmaceuticals, emergency readiness and much more. The challenges – along with a changing regulatory and payment landscape plus higher utilization rates due to longer life expectancy – make it difficult to hit our 2030 goal.

This is why a strong workforce pipeline is key. It is why I personally spend a lot of time concentrating on programs here in the state built around primary care to help our medical students transition into residency programs. Career development is one of the most successful paths for introducing the next generation of students to the field of medicine. We also are working with community leaders to increase our education capacity at our colleges of medicine. Last, but not least, we are increasing the capacity of our physician training programs. These are some of the steps that Banner pursues in developing its pipeline to meet projected demand.

On a federal level, the current cap on Medicare funding for GME programs is a barrier. The number of residency slots financed by Medicare was capped in 1996 for existing programs – but not for new programs. In 2020, Congress passed a historic increase to the Medicare graduate medical education program by adding 1,000 new Medicare-supported GME positions. These slots were prioritized for teaching hospitals in rural areas, hospitals training residents over their cap, hospitals in states with new medical schools and hospitals that care for underserved communities. It was the first increase in nearly 25 years and a critical first step toward addressing our country's physician workforce shortage. As the head of Banner's physician enterprise…I want to say, thank you.

We still need more GME investments, however. For example, we know that nearly 70 percent of residents will practice in the community where they completed their residency training.

Developing robust residency training programs can help address geographic imbalances in our physician workforce. It also enables us to serve rural and underserved communities throughout the state, including Arizona's tribal communities. The end result: increased supply of physicians leads to increased access to health care services, which reduces overall morbidity and mortality.

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At Banner, we take an "all-of-the-above" approach. From our vantage point it requires increased education capacity; simulation training; use of smart technology; rotation exposure and I will go one step further…developing value-based care models that incentivize primary care physicians to integrate with the communities that they serve. This is care coordination at its optimum and it is entrenched in Banner's patient centric mission.

From a federal policy perspective, we take an equally expansive view. As a state's population grows, we encourage an adjustment to the fixed 5-year residency cap. This would help keep pace with demographic changes and corresponding social determinants of health. Redistributing residency slots based on census tracks and rewarding rural track rotations should be taken into consideration, too. Last, continuing the gradual expansion of Medicare-supported medical residency positions would also bring much needed relief to a program as diverse as ours.

The bottom line is that Arizona confronts a growing disparate population. Large academic medical centers like ours are required to pursue new delivery methods of care; and if we are to successfully meet tomorrow's health care needs, they must first be rooted in training.

In closing, I applaud you, Mr. Chairman and members of the Ways & Means Committee for your time in learning more about Arizona's health care challenges. I am honored by the invitation to testify and look forward to answering your questions.

Chairman SMITH. Thank you.
Richard Morello, you are now recognized.

STATEMENT OF RICHARD MORELLO,
CHIEF EXECUTIVE OFFICER, CND LIFE SCIENCES

Mr. MORELLO. Thank you, Chairman Smith, Vice Ranking Member Chu, Congressman Schweikert, fellow members of the Ways and Means Committee, and the Salt River Pima Indian community, for inviting me to speak. My name is Rick Morello, and I serve as the chief executive officer of CND Life Sciences, an early stage neuro-diagnostics company based just a few miles from here at the Pima Center in Scottsdale.

Our mission is to transform the way neurodegenerative diseases like Parkinson's and dementia with Lewy bodies are diagnosed and treated so that patients and the entire family have a chance for better health outcomes, despite the severe challenges of these age-related disorders.

CND's three neurologist founders, one of whom continues to play a major role at the Neuroscience Institute at HonorHealth here in Scottsdale, knew that there was a more accurate, convenient, and cost effective way to diagnose these neurodegenerative disorders earlier in the disease process. These debilitating conditions take decades to develop, and are often misdiagnosed when the underlying pathology is unclear. But to CND's founders, a promising solution was very near: our skin.

Brain-based diseases like Parkinson's are systemic in nature, and involve many central and peripheral nerve structures. It was not a surprise to our founders that a precise laboratory method could be developed to detect, visualize, and quantify a key protein known to be the hallmark of these diseases by examining the nerves in our skin.

So this past March, the Journal of the American Medical Association, JAMA, published a ground-breaking, multi-center study demonstrating that CND's Sin-1 test detected the abnormal form of this alpha-synuclein protein over 92 percent of the time in small skin biopsies of patients with Parkinson's disease, dementia with Lewy bodies, and these other related disorders. Three tiny pieces of skin collected through a simple, 15-minute, office-based procedure could provide vital insights about the brain.

Experts in the field noted that Sin-1 could be part of something extremely exciting by offering an easier method to detect early signs of diseases and provide the means for emerging therapies to be delivered in clinical practice. I am humbled to say that CND, centered here in Arizona, has grown from 5 employees and a few customers in 2020 to a thriving life science firm with 100 employees, 1,300 clinician customers in 47 states who use Sin-1 as a standard practice.

But pursuing innovation is filled with obstacles and risks, and without the help of federally-supported mechanisms and numerous advantages here in Arizona, CND's mission may not have materialized. We made the crucial decision to call the greater Phoenix area our home, even though we license some of the technology from a Harvard-affiliated institution in Boston. The favorable economic climate in Arizona was clear. We had access to great talent, great

universities, attractive real estate we could afford and expand with growth. We have blossomed from our original 1,000 square feet of space to nearly 30,000 square feet of facilities at the Pima Center, and expect to develop and double in size in the next few years.

CND also greatly benefitted from the Federal grants that focused on small business innovation and health advancement. We have been awarded R&D-focused SBIR grants, with one grant supporting our key study that was published in JAMA. The next studies are focusing on earlier detection, the potential prevention of disease, and the funds that we were provided were not—transformational not just to CND, but the entire field of biomarker testing for these diseases.

Finally, CND continues to capture the amazing support from the local Arizona ecosystem, including being a member in AZBio, working collaboratively with the ASU Biodesign Institute, and expanding our footprint at the Pima Center.

As I conclude my opening remarks, I would like to underscore two key points from CND's experience as a small company.

First is the importance of the government's role in fostering a favorable economic ecosystem in which innovation can thrive. There is real hope for detecting conditions like Parkinson's and Alzheimer's before they manifest into debilitating stages that wreak havoc on patients, families, and the health care system. Veterans, farmers, and patients in tribal and rural communities are particularly vulnerable to these diseases, and often lack access to specialized care. The things that can be done, including R&D tax deductions, favorable capital purchase incentives, flexible Medicare reimbursement approaches, and efficient FDA review processes are some of those mechanisms.

Thank you again for allowing me to provide these perspectives to the committee today. On behalf of everyone at CND Life Sciences, we are truly humbled by these opportunities to turn innovation into something that all of us can benefit from now and in the future.

[The prepared statement of Mr. Morello follows:]

Testimony of Richard J. Morello

Chief Executive Officer, CND Life Sciences

Before the House Ways and Means Committee

"Fostering a Fiscal Environment for Healthcare Innovation: A Local Case Study with Global Impact"

May 10, 2024

Introduction

Good afternoon, Chairman Smith, Congressman Schweikert, Members of the Subcommittee, and Esteemed Members of the Salt River Pima-Maricopa Indian Community Council. Thank you for the opportunity to testify at this field hearing today. My name is Rick Morello and I serve as chief executive officer of CND Life Sciences, a fast-growing neurodiagnostics company founded in 2017 and based just a few miles from here at the Pima Center in Scottsdale.

Our mission is to transform the way neurodegenerative diseases like Parkinson's and dementia with Lewy bodies are diagnosed and ultimately treated so that patients and families across our vast population have a chance to experience better health outcomes despite the severe challenges of these age-related disorders.

After a decade of research, CND's three neurologist founders – two of whom are on faculty at Harvard Medical School and one who continues to play a major role at the Neuroscience Institute at HonorHealth in Scottsdale – knew that there was a more accurate, convenient, cost-effective, and potentially groundbreaking way for physicians to diagnose patients who exhibit signs and symptoms of these neurodegenerative disorders earlier in the disease process. These debilitating conditions take decades to develop and are often misdiagnosed when the underlying pathology is less clear. To the CND founders, there was a promising solution hiding in plain sight: our skin.

They understood that brain-based diseases like Parkinson's are systemic in nature and can implicate many different central and peripheral nerve structures and processes. Skin, of course, is filled with nerves and has close connections to biological pathways in our brains. Therefore, it was not a surprise to our founders that a precise laboratory method could be developed to detect, visualize, and quantify a protein known to be the pathological marker of these diseases by examining nerves in the skin.

On March 20, 2024, that vision became a solidified reality when the *Journal of the American Medical Association* (JAMA) published CND's groundbreaking, NIH-supported, multicenter study demonstrating that CND's Syn-One Test had a 95% positivity rate in detecting the abnormal form of the alpha-synuclein protein through small skin biopsy samples of patients diagnosed with Parkinson's disease, dementia with Lewy bodies, and related disorders. Three tiny pieces of skin collected through a simple 15-minute procedure in a neurologist or primary care office could provide incredibly important insights about the brain. The immediate media coverage and reaction by the scientific and patient communities were substantial. Many noted how the Syn-One Test could be part of something extremely exciting in the field by offering an easy method to detect early signs of these diseases and provide the means for emerging therapeutic interventions to be delivered in clinical practice.

Establishing great science, however, is just one critical path in the long journey of maximizing the impact and sustainability of healthcare innovation. Today, CND is humbled and fortunate to say that the Company has grown from 5 employees and a few customers in early 2020, when Covid was shutting many small businesses, to a thriving life sciences firm with over 100 employees and 1,300 clinician customers in 47 states, supported by loyal investors from everyday angels to organizations like HonorHealth here in Scottsdale. Growing from nothing to something while pursuing innovation is filled with uncertainties, challenges, and risks, and without the help of federally supported mechanisms and fiscally advantageous opportunities here in Arizona, CND's mission would have been in serious jeopardy.

Surviving the Start-up Gauntlet: Actualizing the Promise of Innovation

The statistics on innovation failures are stark. About 75% of start-ups backed by venture capital fail[1] and perhaps up to 90% of all entrepreneurial attempts end up closing, most within the first five years. In the world of healthcare and life sciences, actualizing innovation is a truly high risk, high reward endeavor affecting a broad array of stakeholders - from the patients who are the ultimate beneficiaries of breakthroughs, to the families that support them, to everyday people who take on sustainable jobs that deliver the products and services that innovation hatches. Founders and companies who accept the innovation challenge go into the often-treacherous journey with a lot to lose, but those who have conviction to address an unmet need with ingenuity and a plan to address the myriad of obstacles have a chance. Having the right economic and regulatory ecosystem supported by modern policies and programs that facilitate cost-effective healthcare innovation is absolutely essential.

[1] https://corpgov.law.harvard.edu/2023/09/29/startup-failure/

It is hard to imagine CND ascending to this stage in our evolution without the benefits of this supportive ecosystem. First, CND made the crucial but easy decision to call Arizona and the greater Phoenix area our home. While a good part of our Syn-One Test technology was licensed from a Harvard-affiliated health system in Boston, the favorable economic climate for life science companies in Arizona was clear. From our very beginnings, we had access to great talent, great universities, and real estate we could rely on, afford, and expand with growth. The cost difference on real estate alone was four times higher in Boston than here. We are proud to call the Pima Center our home and have blossomed from our original 1,000 square feet of lab space in Phoenix to nearly 30,000 square feet of facilities at Pima employing over 70 individuals in Arizona and countless service providers. Thank you to the Salt River Pima-Maricopa Indian Community for providing us this amazing location.

CND also benefitted greatly from federal grants that focused on small business innovation and health advancement. We applied for and were awarded over $10 million in R&D oriented funds over a two-year period, with one grant supporting our major clinical study demonstrating the validity of the Syn-One Test technology, and two others now catalyzing the exploration of early detection (and possible prevention) of Parkinson's disease and related disorders. These funds were truly transformational not just for CND but the entire field of diagnostics and biomarker testing for neurodegenerative diseases.

CND was also able to apply grant funds to support the acquisition of key capital equipment for our laboratory and be positioned for early growth. These are big-ticket item investments that would be extremely difficult to make at the beginning stages of a company like CND, which has a promising vision and foundational assets to solve a major unmet medical need but does not have straight-line access to private capital.

In considering the impact of the federal grant funding noted above, the return on investment to the government is already becoming apparent. As an accurate, convenient, and more cost-effective alternative to expensive imaging and other testing modalities, Syn-One is promoting easier access for patients and more definitive diagnostic evaluations. This utility often leads to the avoidance of unnecessary tests and office visits that can stem from diagnostic uncertainty. Additionally, by applying Syn-One earlier in the disease process, patients and families can take certain steps to decrease the likely costs and burdens of disease and be better positioned for future therapies that might alter its course.

Finally, CND also continues to capture the amazing support from the local Arizona ecosystem, including being a member of the Arizona Bioindustry Association (AZBio) and working collaboratively with the Arizona State University Biodesign Institute on discovery projects that could have major cost-efficiency and innovation returns for CND over the long

term. We are proud to say that CND's mission has truly arrived on a world stage with Arizona and the Pima Center being the foundational centers of everything we do.

Federal Footing: Fostering Innovation and a Path for Growth

As I conclude my remarks for the Committee, I would like to underscore some key learnings from CND's experience as a company striving to solve major medical challenges that could have far-reaching impact for millions of patients and the healthcare system as a whole. Our work has just begun and the road ahead is filled with both opportunities and risks.

I cannot say enough about the importance of the federal government's role in fostering and facilitating a favorable economic ecosystem in which innovation can emerge and thrive. Indeed, the private capital markets will continue to be a primary source of funds for good ideas and promising companies. But relying on those avenues alone is insufficient.

In the critical area of healthcare, the United States has both a major advantage and a major conundrum. We are a true mecca for breakthroughs, standout technology, world-class academic institutions, amazing clinicians and care centers, and intellectual vigor. But with these invaluable assets comes the undeniable barrier of cost. The next decades of healthcare innovation must move our treatment system to one that prioritizes prevention and suppression of serious illnesses for all patients across all communities. Innovation will seize opportunities in everything from telehealth to the application of actionable data at our fingertips so that care is delivered early, conveniently, and effectively for 350 million people. In the area of neurodegenerative diseases, we are on the cusp of transformation, where there is real hope for detecting conditions like Parkinson's and Alzheimer's before they manifest into debilitating stages that wreak havoc on patients, families, and the healthcare system at large. Precision diagnostics will play an important role, and having an ecosystem that supports policies and programs that encourage and facilitate innovations will be essential. Meaningful R&D incentives, favorable capital purchase structures, flexible Medicare reimbursement approaches, efficient FDA review processes, and other policy areas will all be essential. Ultimately, we are confident the country has the will and skill to allow innovation to be the driving force of thoughtful change and progress we have always relied on it to be.

Thank you again for allowing me to provide these perspectives to the Committee today.

Chairman SMITH. Thank you.
Rachael Lorenzo, you are now recognized.

STATEMENT OF RACHAEL LORENZO, EXECUTIVE DIRECTOR, INDIGENOUS WOMEN RISING

Ms. LORENZO. [Speaking native language.] And hello, everyone. Mr. Chair and members of the Committee, thank you for the invitation to speak before the Ways and Means Committee. My name is Rachael Lorenzo, and I am from the Mescalero Apache tribe and the Pueblo of Laguna in New Mexico.

So many thanks to the Salt River Pima-Maricopa Indian Community for hosting this historic hearing on your lands today.

I am the founder and executive director of Indigenous Women Rising, a Native-led-and-centered reproductive justice organization based in New Mexico that serves the entire United States, its territories, indigenous people from Mexico and Central America and Canada. We fund midwifery care, abortion care, menstrual hygiene, and anything our Native relatives need in the realm of sexual and reproductive health.

At IWR we believe all people should be able to make decisions about their bodies, including whether or not to have children and freedom to live in safe, sustainable communities. Our communities are entitled to continuing our cultural beliefs and our languages, managing our tribal lands, clean water, stable housing, paved roads, accessible childcare, well-paying jobs on and off our reservations, quality education, state-of-the-art health care that is culturally sensitive, consistent Internet access, affordable fresh food, safe communities from freedom—free from violence and addiction, and agricultural sovereignty.

While the work that we do may not be agreeable with everyone in our own communities, we remain respectful of tribal sovereignty and the role our elders and tribal leaders play in our daily lives, and we always pray for them, that they are guided by the needs of their people and the longevity of their cultures and languages.

Indigenous Women Rising does the work that Native folks across the country ask of us, funding and support. While our work may be considered controversial, the people who come to us who come from a variety of Christian faiths and traditional beliefs, we all have one thing in common: we need an auntie or cousin figure to help us talk through some of these taboo topics and know what our options are.

Not only do we have an abortion fund, but we have an emergency fund which funds pregnant people who decide to carry their pregnancies to term, to hire the doula or midwife of their choice without worrying about cost. The name of this fund comes from the Pueblo creation stories as the people's emergence into this world.

I want to ensure that I am very clear. Abortion has been here since time immemorial. Whether bands or groups of Native people faced war, famine, or migration, sex has never been an afterthought, and our ancestors knew the remedies to start our periods again, like the plants to use and how to use them, and the other plants used for breast milk production or easing postpartum bleeding. These stories have been passed down in many communities all over the world, including mine.

I want to emphasize that about one quarter of our callers come from Arizona, whether they are seeking abortion care in Arizona or traveling elsewhere. Our abortion fund started in 2018 because indigenous folks right here in the Grand Canyon State saw us in the media for a breastfeeding project in 2017, and asked if we could also help them seek abortion care.

We also assist our relatives with traditional needs, like compensating a medicine man or a medicine woman in their own tribe to help with a healing ceremony or funeral home expenses for burials. As Native people, we have a communal obligation to support each other, and that obligation is as old as my people. For me, this communal obligation is not just to Native people, but to all people. This means Indigenous Women Rising's work ensures that we can care for our reproductive and sexual health just as easily as it is to see the sky outside. [Speaking native language.] Thank you.

[The prepared statement of Ms. Lorenzo follows:]

Testimony of Rachael Lorenzo
Before the United States House Committee on Ways & Means
"Field Hearing on Empowering Native American and Rural Communities"
May 10, 2024

[Greeting in Keres] Gu'waa'tzee/hello.

Thank you for the invitation to speak before the House of Representatives Ways and Means Committee. My name is Rachael Lorenzo, and I am from the Mescalero Apache Tribe and the Pueblo of Laguna, in New Mexico. Many thanks to the Salt River Pima-Maricopa Indian Community for hosting this hearing on your lands today.

I am the founder and executive director of Indigenous Women Rising, a Native American- led and -centered reproductive justice organization based in New Mexico that serves the entire United States, its territories, Indigenous peoples from Mexico and Central America, and Canada. We fund midwifery care, abortion care, menstrual hygiene, and anything our Native relatives need in the realm of sexual and reproductive health.

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Indigenous Women Rising does the work that Native folks across the country ask of us- funding and support. While our work may be considered controversial, the people who come to us, who come from a variety of Christian faiths and traditional beliefs– we all have one thing in common: we need an auntie or cousin figure to help us talk through some of these taboo topics and know what our options are. Not only do we have an abortion fund, but we have an Emergence Fund, which funds pregnant people who decide to carry their pregnancies to term to hire the doula or midwife of their choice without worrying about cost. The name of this fund comes from the Pueblo creation stories as the people's emergence into this world.

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use and how to use them. Many of these plants also assisted with birthing the placenta, and other plants used for breastmilk production or easing postpartum bleeding. These stories have been passed down in Native and Indigenous communities all over the world, and my community included.

I want to emphasize that about one quarter of our callers come from Arizona, whether they are seeking abortion care in AZ or elsewhere. Our abortion fund started in 2018 because of Indigenous folks right here in the Grand Canyon State saw us in the media for a breastfeeding project in 2017 and asked if we would also help them seek abortion care. We also assist our relatives with traditional needs, like compensating a medicine man or woman in their own tribe to help with a healing ceremony or funeral home expenses for burials.

As Native peoples, we have a communal obligation to support each other and that obligation is as old as my people. For me, this communal obligation is not to just Native people but all people. This means Indigenous Women Rising's work ensures that we can care for our reproductive and sexual health, just as easily as it is to see the sky outside.

Da wa eh. Thank you.

Chairman SMITH. Thank you all for your testimony. We will now proceed to the question-and-answer session. We will start with Mr. Schweikert.

Mr. SCHWEIKERT. Thank you, Mr. Chairman. And everyone listening, you can see we are trying to cover a really broad breadth.

Ms. Manuel and Councilman Carlos, I want to do something because my wife and I actually care a lot about this. So, a decade-plus ago, we became foster parents. We did the classes. We also had a trainer come from Gila River to talk us through that if there was ever a child that was a Native American, that the tribe would have, you know, first rights to see if they could find an indigenous family to place them with. But then they also walked us through a program that they were testing, and I don't even know if it is still going on in Gila River, that if you were a non-Native family, to at least build a level of cultural training, cultural sensitivity, cultural relationships.

A, does that exist?

B, considering the scale of the number of foster kids, which rips my heart out, are there ways we can make sure that the relationship to your one's child's native culture is there? Is that a possibility? Have you heard of this? Help me, update me where the world is today.

Ms. CARLOS. Yes. So in Salt River we also do have non-Native families that take our children. And one thing that we provide is a robust opportunity to come back to the community. If they are still in the state, they can bring their children back and stay connected to the community, to the gardens, to the lands.

We offer multiple services where, before a child is even placed, we make sure that they have an understanding of the importance of the culture, and trying to again emphasize that the himdag—again, which is hard to explain, because it encompasses so much about their connection to the community, but also their role in the world—trying to give them an understanding of that. And it is hard to translate that when you can't even translate it into English, but we do our best to make sure that they understand that, at a bare minimum this is who they are. They are [speaking native language].

And so we do those services here, and we want to make sure that we emphasize it. And we understand that, you know, there is not always a possibility. Sometimes children are removed and placed outside, and——

Mr. SCHWEIKERT. If there is ever a chance, I would love to explore—and that is a much larger conversation of is that something we should honor and try to make sure that, if there is a Native child that—because of shortages and those things, that there is still—I mean, you know, you have seen, I bring my two little kids whenever you are having a festival here. One of them thinks she is Native, I think.

But help me on that, because I want to dive further into how available that type of cultural sensitivity training is for those who are providing foster care.

Ms. CARLOS. I mean, yes. Should it happen? Yes. The reality is, are the tribes able to support it? There are limitations on funding. Do they even have foster care people that are able to provide those

services if they are not already tasked with doing case management, intervening in child welfare situations?

Mr. SCHWEIKERT. Okay.

Ms. CARLOS. But yes, it should always happen. And it is a—it would be of benefit not only to the child, but also to the tribe to have that support, to make sure that those programs are able to be created either through Federal funding or any other set-asides.

Mr. SCHWEIKERT. Yes, and so we need to discuss if there are any barriers to that.

Ms. CARLOS. Yes.

Mr. SCHWEIKERT. And I know the tyranny of the clock. Chairman, you were kind enough to walk through a number of the provisions on sort of tax parity. Of those provisions, what do you think would have the most positive economic impact on tribal communities across the country for prosperity?

Mr. KAHN. Well, I mean, I think, from our perspective, just the challenges with the central government functions test. You know, our tribe, fortunately, we were able to take advantage of the program that was authorized in the 2009 American Recovery Act. Unfortunately, that had a $2 billion cap, and so we were able to take advantage of that. But that didn't have the essential government function test element in it.

Mr. SCHWEIKERT. Okay, look, one of our concerns—and you are going to see a broad base here—is we are sitting right now on the land of a very sophisticated community. Your tribe has a high degree of management expertise. How do we make sure that we are doing something for even some of our tribes that are on very difficult pieces of property, making prosperity much more universal for different tribal communities with some of these provisions?

You know, we have the legislation, but I want to make sure we are making it accessible and rational because we also don't want to create a debt spiral also. So, this is my way of saying help us make it work, and that is important.

Mr. KAHN. Yes. And as you know, many tribes are different. A lot have larger land bases. Some are in economic areas that they can take advantage of. And so I think we do have to think from a perspective of, you know, whether it is New Market Tax Credits, whether it is private equity bonds, whether it is the, you know, a smoother path to provide tribes on the same level playing field as states

Mr. SCHWEIKERT. Okay.

Mr. KAHN [continuing]. And local governments, I think there is a lot of those, but it depends on the tribe and where they are geographically.

Mr. SCHWEIKERT. Thank you.

And thank you, Mr. Chairman.

Chairman SMITH. Ms. Chu is recognized.

Ms. CHU. Ms. Carlos, thank you for your expert testimony related to the child welfare system and your specific understanding of the importance of Federal protections under the Indian Child Welfare Act, or ICWA. I am glad to see that we are in agreement that there is a need for clarity in the role that HHS plays in implementing ICWA. And as you say in your testimony, there are still inconsistencies in how the law is being implemented in different ju-

risdictions. That is exactly why I did introduce H.R. 3461, the Strengthening Tribal Families Act, along with Representative Bacon.

So, can you elaborate on your testimony by sharing some examples of the collaboration between tribes and states that you have seen in Maricopa County?

Do you think Congress should direct HHS to take a more active role in assessing states' compliance with ICWA? And why?

Ms. CARLOS. Yes. So the tribe, our tribe, has a unique relationship with Maricopa County. We have an MOU that allows us to intervene. And because of that, we can proactively participate in Indian child welfare. And it allows us to have a greater say in these very life-impacting decisions that are happening for our children.

It also allows us to connect with families that are outside of our reservation who are eligible for the services that we provide. And when you talk about HHS, yes, HHS does need to have a more direct role as data is needed to develop specific trainings and implementation programs. And if we don't have the data to show what is missing or what is working, it leaves us hanging and scrambling, trying to find out how can we better implement these services. And it is really just trying to figure this out on our own.

Ms. CHU. Thank you.

Ms. Lorenzo, can you discuss what it means for the community you serve to access reproductive health care, and what it has been like to serve Native patients in the southwest since the implementation of SB8, then Dobbs, and now Arizona's rapidly-changing legal landscape surrounding abortion?

Ms. LORENZO. Mr. Chairman, Representative, thank you for that question.

First I want to say it is an honor to be able to serve indigenous patients throughout the country, for them to be able to trust us with some of their most intimate and scary moments.

As the laws change, the—state by state—and I also want to remind the committee that in the states where there are bans, that is where the most need is. And even before SB8 in Texas, our callers still came from states with restrictions like Arizona, Oklahoma, the deep south, North Dakota and South Dakota.

So as the bans become more restrictive, there is a lot more misinformation. There is more opportunities for crisis pregnancy centers or CPCs to pop up and give medical misinformation. There is fear of criminalization. Even though the law says that providers are going to be the ones who are criminalized, there is still fear that a pregnant person would be criminalized for seeking abortion care.

Here in the southwest, again, Arizona makes up a quarter of those that we serve with our abortion fund and our midwifery fund. So I think that just goes to show the need that Native folks have, and it should be treated as any other kind of health care.

Ms. Chu. Thank you.

Ms. Carlos, Title VI–B, this committee is responsible for reauthorizing it before it expires in September of this year. And it is crucial that we take seriously the impact that inadequate funding has had on the people who are meant to be helped by these funds. Can you tell us how an increase in 4(b) funding would directly benefit the children and families in Maricopa County?

Ms. CARLOS. Yes, it would be hugely impactful. So Title VI–B is funding that the community utilizes, but we receive just under $135,000 of, again, the $2.7 million in grant funds, which is an even smaller fraction of the $7 million that the tribe puts up of its own funds to do these services. If we were to have an increase in Title VI–B, it would allow us to do more of the intensive prevention efforts that actually prevent families from entering into the child welfare system.

And so I think it is important that we are talking about also the shortage of health care right now, because when we see that children enter into the system and they have these adverse childhood experiences, or they have these traumatic experiences, it leads to lifelong health outcomes that are detrimental. And that also increases a burden on our health system, as well.

So if we were able to do more with the funding that is provided, we were able to do more intensive prevention services, it also allows us to create opportunities to have healthy communities, as well. So it is hugely impactful. It would allow us to do a lot more.

And the funding that we do receive isn't enough. We want to do more. We simply don't have the funding there.

Ms. CHU. Thank you.

I yield back.

Chairman SMITH. Mr. Kelly is recognized.

Mr. KELLY. Thank you, Chairman, and thank you for having this event today.

First of all, thank you all for allowing us to come here. I think that sometimes we forget, when we talk about different issues, this has nothing to do with Republicans and Democrats. And so I wish we wouldn't get wrapped around the axle on the politics of it, and just talk about the policy.

But sitting beside Mr. Schweikert when we have hearings and we have briefings and things, I become acutely——

Mr. SCHWEIKERT. Be nice.

Mr. KELLY. I am going to be nice. [Laughter.]

Mr. KELLY. I got more familiar with adoption, and the differences of where different benefits go to, and how we determine who gets what credits and where they go.

So everybody always uses a term that, you know, the youth are 25 percent of our population but 100 percent of our future. This is a great opportunity for all of us to be here, just as representatives from Congress, not as representing any particular party, because I am so fed up with the idea that it is either red or it is blue. It is—no, it is all red, white, and blue.

And certainly, for Native Americans, this is an issue that should have parity, and talking about being able to adopt, and being able—how did these tax credits work, and why is it one set for one group and not for another group? And so I marvel sometimes at how highly educated we are, and yet how stupid we are when it comes to treating everybody the same way.

So we just introduced another bill, and Ms. Moore would know about this. So this is taking place right now back in Washington, D.C., the Tribal Adoption Parity Act. And I just think, again, as I am saying, because sitting beside David all the time, we talk about this, and I have gotten to know or be around his children, and

there is no question about the amount of love that family has with children. And I think we are all fixated on our future with this.

But if you can, share some of the concerns you have. And what is it that we could do differently than what we are doing now?

And I think the big question is, okay, fine, you came to Arizona, you sat with us, you talked with us. You told us how much you appreciated having us here. And then, in hours from now we will be flying back to wherever it is that we started from, and next week we will be in Washington again.

So the question is how long does that passion stay? How long does that concern stay?

And looking into the future, you should have really great expectations. But the fact that we can come out of Washington, D.C.—I come from Pittsburgh, Pennsylvania. I came out here and my son actually went to school down south of here. He was bearing down at the University of Arizona. So if you can, share some of the frustrations you have of being treated different.

And so when we talk about parity, I am talking about true parity, not words, but actually actions that take place that show who we are as a nation, a complete nation. So any of you who don't want to weigh in, I can't imagine your frustration at sometimes of how long it has taken to get where you are today. And somehow do these words keep falling on deaf ears?

And when people make a commitment to you, does the commitment stay here when they fly back to wherever it is they come from, or do they take that commitment with them to the actual floors of Congress and try to get something accomplished?

Please.

Ms. MANUEL. Thank you so much for that wonderful question, and you have me kind of shivering because, as I stated in my testimony, I will continue to advocate. And when people tell me no, I am going to knock on the next door and the next door and the next door, I am not going to give up.

I am still learning my culture as an adult woman, and that is something that really makes me proud. I was recently given my traditional name just recently, and that power that I felt, that missing piece of my heart totally connected by just my godmother and my family coming down from White Mountain saying, "We accept you, and we are going to take you in, and we are going to give you what you need." And I felt so empowered for electrifying.

And so, knowing that and working with individuals that are in non-Native homes, feeling a sense of belonging, a sense of identity gives me strength to say I am going to keep moving forward when I see my daughter wanting to and my son wanting to learn more about their culture. And so we are getting books, and we are trying—I am asking questions to my family and to my in-laws. Like, how do I do this? What do I do? Because I am still learning, as an adult woman.

And I have been able to work in the residential treatment centers to go into the treatment centers for children that are 10 to 17 years old. And they ask me, "Auntie"—they call me auntie—"can you please come back?"

And I am like, "What do you want Auntie to bring?"

"Can you bring me some beans? Can you bring me Indian tacos? Can you bring me a Piccadilly slushie?" Like, those types of their culture that makes them feel a part of their community is something that I feel Three Precious Miracles and my team of volunteers and great partners that support me is what I am going to continue to do.

So I really do feel that the committee right now has the opportunity to say, "Let's make sure that they are provided what they deserve, so that they have that sense of belonging, their culture, their connections," and all of those. Thank you.

Mr. KELLY. Rachael.

Ms. LORENZO. Mr. Chairman, Representative, thank you for making that statement.

I firmly believe that tribal sovereignty should always be at the forefront of every decision that Congress makes. Tribes are sovereign entities, essentially. We are our own nations. We have our own chairmans here. And hearing about this economic—or this governance—essential government functions test is heartbreaking to hear. I think reevaluating that, because the nature of the relationship between tribes and the Federal Government is incredibly paternalistic, and those—it seems to be working as it was intended.

And so trying to go back and make sure that Native families have what they need, I really believe that less restrictions on funding and reevaluating the—what it means to be an essential government functioning is something that can only be done by tribes. Only tribes and the people in their communities have the answers to the solutions.

Mr. KELLY. Okay.

Ms. LORENZO. And so less red tape for tribal nations, I think, is——

Mr. KELLY. Okay.

Ms. LORENZO [continuing]. Should be one of the——

Mr. KELLY. One word of encouragement.

Ms. LORENZO. Yes.

Mr. KELLY. Okay. Refuse to lose. There is too many things that have been spoken for too long, and people leave with making promises that go to wherever it is they go, and forget about the promises that they made. I know people talk about they love to win. You have got to hate losing. And I think it is time to make sure that we stay the course of what it is we need to do.

I can't tell you how much I appreciate being with you all. Thank you so much. I wish we had more time, but God bless.

Thank you, Chair.

Ms. LORENZO. Thank you.

Chairman SMITH. Ms. Tenney.

Ms. TENNEY. Thank you so much, Mr. Chairman, and thank you to our host for this beautiful facility, and just to be able to share a little part of this beautiful part of the Earth with you.

I just want to say to Elisia, I love that your name is Beautiful Sunflower. And you absolutely live up to that.

But my first question I want to address to Mikah Carlos, and I want to say congratulations. Mr. Schweikert said today that you are the youngest tribal council member to serve. So congratulations. We love seeing that.

But I want to address a quick question—last November the Ways and Means Committee did a hearing on the Child Support Enforcement Program, and how a pending IRS rule would prohibit the states from using contractors and, you know, private contractors from accessing the Federal tax refund program.

If the Salt River Pima-Maricopa community were to lose access to vital resources like this Federal tax refund offset program for collecting past-due child support payments, what significant outcomes, if any, do you anticipate would happen to Native communities, particularly yours, if you were not able to access every everything that you could to make sure that you were to come up with the back child support due?

Ms. CARLOS. Thank you. And while Salt River does not operate the child support program, I do know that in instances where tribes lose access or they are not able to basically collect on the past-due child support that helps support their families, we see that they have to make up those funds in other ways. We see that they continue to struggle to make sure their basic needs are met.

And so when we lose access to those tools, it creates a bigger burden on the families that are already burdened. And so if they are already having a one-parent household, or they are already doing kinship placement, or there is other factors that are in play, you are increasing the burden that is put on those families that are already taking those children and making sure that they are trying to make their basic needs met.

I have friends that were directly impacted by the lack of having that child support payment come to them. And what ended up happening is that the parent was out of the house more because they had to pick up additional shifts or do an additional job. And so really, what that did is it increased the stress and it increased the burden in the household that really was detrimental to everybody, and it was because they simply didn't have the tools to collect those payments.

And so when we take away those tools from tribes, again, you are placing the burden back on them to figure out a way how to navigate the system that we have seen doesn't make it easy to navigate. And so really, it is putting the burden back on the tribe, which then burdens the family again. And we are back in this cycle of having inequities and having burdens placed on families that are already struggling.

Ms. TENNEY. Also, I just thank you for that, because I know you are trying to make up the shortfall, and we don't want to take any of those tools away from you.

And let me just, generally, I would like to ask you, can you share your firsthand experience of witnessing the implementation of the Indian Child Welfare Act within the Salt River Pima-Maricopa County community, and maybe give us some of your successes, the challenges?

What could we do to improve it? How could we help make this more effective in making sure that Native American children and families are helped, actually, under the guidelines and not hurt, as you sort of alluded to in your first answer?

Ms. CARLOS. Yes. So my family has a very personal connection to ICWA. My sister was an ICWA adoption, and she is my best

friend. Her adoption was actually finalized on my eighth birthday, and that is the greatest gift that I have ever been given.

So when we talk about the importance of ICWA, when we talk—I know I alluded to the importance of culture and making sure that children feel like they have a connection to their communities and the understanding of having—the difference that that makes in their lives—again, I grew up disconnected from my culture, and I didn't realize at the time that a lot of the decisions that I was making was trying to fill that gap, trying to figure out who I was and really aligning with whoever would take me in. And sometimes that led to bad decisions, and it led to bad friend groups.

And so really, when we talk about the importance of ICWA and making sure that children are remaining in their communities, we talk about the cultural importance, we talk about making sure that they are connected to their people, to their lands, and making sure that they have an understanding of their role in the greater picture of life.

And really, that is what ICWA does, is it makes sure that these children are connected, and makes sure that they remain tied to their communities. And when we talk about the importance of it, it really goes so much greater than that. Like we have talked about with health care, there is so many things that are tied into having traumatic experiences with children. And when children are disconnected, it is a traumatic experience. We saw that in boarding schools when they removed children from their families. We are now dealing with the generational trauma of that, the intergenerational things that are woven into our DNA because of traumatic events that happen to our grandparents, our great grandparents.

And so ICWA is that piece that it is supposed to bridge the gap, it is supposed to prevent those things from happening again. It allows us, as tribes, to have a chance to heal our communities. And if we keep removing our children, and if we don't have ICWA there to help prevent those things, again we are going back to a cycle of creating generations of trauma. And so ICWA allows us to have a chance at healing our communities.

Ms. TENNEY. Thank you so much for that.

My time has expired, Mr. Chairman, I yield back.

Chairman SMITH. Ms. Moore is recognized.

Ms. MOORE of Wisconsin. Thank you so much, Mr. Chairman, and thank you for convening this meeting in Phoenix, Arizona, and particularly at the Salt River Pima-Maricopa Indian Community Council Chambers.

I do want to thank President Harvier in his absence—he had to get off to another meeting—for hosting us. And I do want to salute the people who are here, and the ancestors, and grateful to them that they are extending the privilege to all of us to be here. I am so excited.

And as I have listened to the testimony today, and I just think back to just what I love talking about, taxes. [Laughter.]

Ms. MOORE of Wisconsin. And, you know, because a lot of people in my community of Milwaukee, Wisconsin wanted to know why in the heck did I want to be on the tax committee. And it is because—I don't know, if we are talking about adoption, if we are talking about general welfare, if we are talking about housing de-

velopment, if we are talking about economic development, we are talking about taxes. And, you know, and so I am really, really delighted to be here today. I am so delighted. And I am—just to be here with Mr. Schweikert.

Thank you for hosting us, as well.

And for those of you who may have had some contact with Mr. Schweikert, you know how persnickety he is. [Laughter.]

Ms. MOORE of Wisconsin. And so it has been great working with the last year-and-a-half on the Tribal Tax and Investment Reform Act that we introduced just yesterday, and it is to provide tax parity for Indian country. This is very exciting, because when we think about that—Mr. Kahn, and I am going to ask you some questions. I am so glad that Mr. Schweikert redirected you when you said the most important sections of our bill were section 8, the New Market Tax Credit, very important; clarification of the general welfare benefits so that they are not regarded as income; and section 12, so that we might feel some of the needs to provide medical education and provide more doctors in Indian country. I am glad that you circled back to section 3, the treatment of tribes as states with respect to bond issuance and excise tax.

The government, the essential government functions test, that seems to be sort of that string of inequity and lack of sovereignty that flows through a lot of what happens in Indian country. And I know Mr. Schweikert made a comment with regard to, you know, not wanting people to be in debt, and not going overboard, and blah, blah, blah. I get all that. But that will take care of itself by just removing this essential government test and letting the process work.

Let me just ask you, Mr. Kahn. Can you just give us some examples very quickly of what the tribe has been unable—what tribes—not necessarily your tribe—are unable to do because of this essential government function test?

Mr. KAHN. Thank you very much for your question.

You know, I see a theme here with health care, child welfare, and taxation, you know, the lack of parity. You know, there have been guardrails that have been put on tribes. And, you know, we would like to remove those so we can have the same opportunities to be able to prosper like states, local governments.

And so, when it comes to some of the challenges that we have, you know, lack of access to affordable financing, you know, is a big deal for a lot of us tribes.

Ms. MOORE of Wisconsin. Like for building hospitals or whatever?

Mr. KAHN. Hospitals, community centers. But also, you know, tribes don't have tax bases. And so we depend on economic development.

Ms. MOORE of Wisconsin. So sovereignty means treating you the same way they would a state or a city that wants to build a hospital, that government financing. I want to thank you for that.

I am very impressed by our witness—I can't read her name—Rachael. That is your name. And I wanted to ask you. We had a chance to chat in the back, and you said you were from New Mexico. So what interests do you have in Arizona, coming from New Mexico?

Ms. LORENZO. Mr. Chairman, Representative Moore, as I mentioned earlier, back in 2017, when we got some media coverage about a breastfeeding project, we had indigenous folks—mostly Hopi, Walapai, and Dine relatives—reach out to us and ask us if we could provide abortions. And I said, no, I am not a provider, but I can help you. I was just fresh out of grad school.

And so when I started helping them make appointments, then I started realizing there is a gap in funding, not every insurance plan will cover it. Medicaid in Arizona doesn't cover it. And so that is what inspired me to start the abortion fund that is still operating to this day.

And a huge chunk of the folks that we serve come to us for sexual and reproductive health. And we are in communication with local clinics like Dr. DeShawn Taylor, who owns the Desert Star Family Planning Clinic. And, you know, we do our best to make sure we are meeting all the needs on the spectrum for sexual——

Ms. MOORE of Wisconsin. Thank you so much for that.

Ms. LORENZO [continuing]. Reproductive health.

Ms. MOORE of Wisconsin. My time has expired.

Thank you, Mr. Chairman, I yield back.

Chairman SMITH. Thank you.

Mrs. Fischbach.

Mrs. FISCHBACH. Thank you, Mr. Chair.

And first of all, thank you all for being here, and thank you, Mr. Chair, for putting this together and to all of our hosts. I really appreciated the discussion on child welfare issues. And I will tell you I understand there is a unique and sometimes challenging relationship between the tribes and government entities, and so I appreciate that you recognize that, too. And we could have a whole hearing on that. So I won't go into it.

But I did have to sit down with Mr. Cole from Oklahoma and get a better understanding so I understood that better as we go through this legislation so that we are able to address the issues properly and not always be, "We are from the government, and we are here to help." So I try not to say that ever, unless I am joking.

But, you know, and I talked to a couple of folks. I represent a very rural district. And one of the things is that, you know, workforce is obviously a challenge. And I will just say that the health care workforce, in particular, is an issue.

And Dr. Kupferman, you mentioned in your testimony that you guys added 229 positions, residency positions, and so I am wondering if you could maybe talk a little bit about how can the GME program be improved to benefit the rural health care workforce, and why is it so important not only to those rural areas, but to the health care system in general, you know, and how it really does improve it?

Dr. KUPFERMAN. Thank you very much for that question. Certainly, challenges in rural health care are not germane specifically to physicians, but all health care providers: nurses, medical assistants, people who help run our hospitals. But more in particular, areas around being able to provide coverage in an emergency room, obstetrics, and gynecological services in our rural hospitals. EMS services in our hospitals continues to bedevil us in areas where we have our own rural hospitals.

And so expanding not just the number of trainees that we are bringing into these locations, but also continuing to invest in some of those incentives that will allow individuals to make that decision that they would like to live in those rural locations once they finish their training, and that is the pipeline that we are building and we continue to invest in.

We have just started a rural residency program in northern Arizona. We continue to plan on expanding on that because once a resident begins their training in a particular location, there is a very high likelihood that they are going to stay there. But we have got to get them into those locations. And so it is being able to expand not just new programs, but even currently existing programs.

As I mentioned in my testimony, there is a cap on currently existing programs. And so if there is opportunities to expand on those in areas where we know that there has been extensive population growth or there has perhaps been closure of other hospitals, and so increasing the radius from which someone in the community would need to travel, that is where we have great opportunities. It is incentives to those hospitals. It is incentives and opportunities for residents to go to those locations, and then also incentives to compel them and encourage them to live in those communities and be part of the fabric of those areas. And it works, but it takes time, and we are fully invested in that process.

Mrs. FISCHBACH. And I appreciate that, Doctor. And I recognize that it is not just the doctors, but there is a whole lot of pieces that have to fit together, and that is one of them.

But if you bring the doctors, will you get the nurses? If you have the nurses, will you get the doctors? So we have to look at all of the aspects of it. And so I appreciate that you are focusing on rural hospitals, because it is part of having those strong communities in rural areas, and it is a huge portion. Having that health care available is a huge portion of it. So I appreciate that.

And I just have a couple of seconds left, and I will just again say thank you to all of you because this has just been incredibly informative, and a great trip, and a great hearing. So thank you very much.

And I yield back.

Chairman SMITH. Thank you.

Mr. Moore is recognized.

Mr. MOORE of Utah. Thank you, Chairman. Most importantly, thank you for bringing us out West.

I represent Utah, the northern part. And Mr. Schweikert earlier stated that we are cranky when we are back in Washington, D.C., but it is not because of the flight, necessarily. It is more the humidity.

So it is great to be out here with this broad array of topics, and I may get to the point where the chairman has to cut me off, because if you are going to ask me to talk about adoption and Title VI–B, and then Title VI–B and E, and also medical innovation, I might struggle with that timeline.

But just before I don't get a chance to say it further, I have served as a board member for the Raise the Future organization. Wendy's has a focus on adoption for foster children, as well, with the Dave Thomas Foundation for adoption. It is near and dear to

my heart. But when I hear Representative Schweikert talk about actually going to a class, and actually putting his effort and doing what he is doing, and the action that he is taking is far more than a fundraiser, a board meeting that I have ever done.

And I am so just honored to be among so many folks that are really fighting for this issue, because when you have a child that times out of foster care, we are not just talking small percentages, four or five percent that go into homelessness, or drug addiction, or this or that, and we are talking 40, 50 percent. It is a really, really dangerous area. And I am so appreciative of those people that are really in this fight.

Jackie Walorski, the late Jackie Walorski, was a member of this committee, and this was her main issue, title 4(e) and (b). And as we come up on that reauthorization, it is going to take a whole committee to do the work that she would do. But on to—thanks for indulging me there.

Mr. Morello, I do have a few questions about the medical innovation side because it is so important to my district, it is so important to Mr. Schweikert. It is key to getting outside of that, getting—figuring out how to actually solve that debt, blah, blah, blah stuff, and it is the case——

[Laughter.]

Mr. MOORE of Utah. One concern I hear a lot from my medical innovators in Utah are the delays that they experience in obtaining Medicare reimbursements to bring these medical innovations to our seniors. Ultimately, that impedes patient access to care and reduces incentives to invest in these technologies. For example, the coverage with evidence development pathway at CMS was introduced in 2005 to bring innovative device to market quicker, but now it is a signal to innovators that their products will be restricted and they will never move off of that designation.

Since 2005, of the 27 devices with CED, only four have been given full national coverage. Can you speak to CND Life Sciences' experience with the Medicare reimbursement process?

Mr. MORELLO. Yes.

Mr. MOORE of Utah. Can you share with me just your experience with it, and also any suggestions you have for Congress or CMS that we could improve these processes to ensure that medical innovations get to patients quicker?

Mr. MORELLO. Yes. Thanks very much for that question.

So I think the first thing for us is we are serving patients with diseases like Parkinson's and Alzheimer's and so on. So about 65 percent of the patients we serve are of Medicare age today. And as you mentioned, the burden of creation of evidence should be the burden that we bear, and it is a massive investment to create the clinical studies, create the data to work with stakeholders across the landscape to show that our innovation deserves the attention of reimbursement by Medicare.

As you point out, the next step for us, the next step for a lot of other companies is, well, how do I bring that evidence in a way that Medicare can have a conversation and make decisions on appropriate reimbursement? It is not as transparent of a process. And as you point out, the intention of having coverage with evidence in

some cases has created sort of the fear and the burden of can we get there.

And so I think, for us, as we look at the next months ahead of us, we are going to do everything we can to continue to build the evidence, to make that conversation as easy as possible. I do think there are some structures that even FDA has adopted on things like having device companies sit down in what is called a pre-submission meeting and a pre-submission process, which should be a little bit more of a handshake between sort of the innovators and, in this case, the regulators.

And so we would agree that there is probably more work to be done to allow reimbursement mechanisms, particularly for a population of patients who are at a stage of their lives that, hopefully, they have put in the investment to be able to access some of these innovations. I think there are a number of things that can happen to—again, it starts with sort of the transparency and the mentality of being open and flexible.

We will bear the burden of bringing the evidence, absolutely, but I think that is crucial for the future.

Mr. MOORE of Utah. Thank you, sir.

Chairman, my time has run up, as I predicted it would. Thank you.

Chairman SMITH. Thank you.

Ms. Carlos, Ms. Manuel, child welfare is very important to this committee, as you have seen with our members, and we have the sole jurisdiction for Title VI–B child welfare program, which is currently due for reauthorization. Given your knowledge and expertise, I wanted to ask you both what Congress should do to ensure that reauthorizing is supportive of tribal child welfare programs and the relationship between tribes and states when it comes to addressing issues of child abuse or neglect.

Ms. CARLOS. Yes. And like I had stated, you know, IV–B is complicated in tribal access, as we have heard so much. There is no parity to the states. So our access is often overburdened with the bureaucratic process. And so to make these things equitable to tribes, there has to be an increase of funding, but you also have to make the process easier and accessible to tribes.

We see that—again, going back to prevention—prevention is intensive. And so the funds are insufficient to make sure that we can prevent families from even entering into the child welfare system.

And so when we ask Congress, what can you do, you can increase the funding that is available to tribes. You can increase the ease of access and make sure that there is parity from the tribes, that tribes have access to the same tools that the states would, as well. And so those are some of the most critically important things that are important, are critical to us.

Because, really, what we are trying to do is create healthy communities. And when we don't have access to funding or when we are prevented from using funds in an efficient manner where sometimes, even if it is too burdensome for our staff, we will just withgo funding and—because of—we need our staff to actually focus on the important things that are, you know, helping our families versus trying to bury them in paperwork.

So those are the two things that I can say are really important, especially about Title IV–B.

Chairman SMITH. Ms. Manuel.

Ms. MANUEL. Yes. So I would like to say that just to be able to collaboratively work together and promote, like, accountability with the state and community resources at that level, and then have some, like, public ICWA plan to create more transparency of what is happening—like I stated in my statement earlier, like, we have more than what you see with the state level. There is three times that amount. There is more like 3,000 Native children in foster care that you don't see. And so having that transparency to realize that there is such a huge need, and offering the resources of Title B–VI [sic] funding can help deal with some of the things that we see in communities like the housing issue that provide funding there. It could provide assistance through the lack of child care that is in tribal communities.

And then also, with mental health, you know, dealing with mental health issues and providing that funding to support those families, through my work and really advocating for ICWA, we have been able to make some great progress from what I have seen with the symposium that I helped facilitate last year with the Phoenix Urban Indian Coalition which—I sit as their chair. Pascua Yaqui offers a annual conference for their ICWA families to do more teachings, but more understanding of culture, the sensitivity of all of us.

We are in the beautiful State of Arizona, where there is 22 tribes here. And so we need to be more aware of where you are, and how can we educate more individuals on ICWA and the Title—how Title IV–B can make a difference.

Chairman SMITH. Thank you.

The committee is looking into barriers for tribes in administering their own tribal child support programs. Ms. Carlos, in your written testimony, in your public testimony, you describe challenges that tribes face in accessing the same enforcement tools as states. Can you explain how direct access to tools such as the Federal tax refund offset program would benefit tribal nations in securing child support payments for tribal families?

Ms. CARLOS. Thank you. So again, going back to the lack of parity, there is tools that the states have that tribes do not have access to. And really, what it tells us is that there is an underlying message of inequity, of—that our tribes are not legitimate, that we have to go through these extra steps in order to access the same tools that the states would. And really, what that does is it perpetuates the paternalism that exists in the Federal and tribal relationship.

And so, if we have access to these tools without the burden of having to prove that we are legitimate governments, that we are to be trusted the same as the states would, that would also allow us to better service our communities and allow us to create programs and do things, again, to exercise our sovereignty, to find the solutions that work best for our communities.

Chairman SMITH. Thank you.

Dr. Kupferman, one of the biggest challenges we face when it comes to health care access in our Native American and rural com-

munities is a basic lack of personnel to provide that care. As we continue to explore ways to increase the health care workforce in rural, underserved, and tribal communities, we also recognize the value of rural training programs.

How effectively have you seen the rural training programs work in your health system to ensure these communities have the health care personnel needed to provide timely access to care?

Dr. KUPFERMAN. Thank you for that question, Mr. Chairman.

Indeed, this is a multi-dimensional challenge that we are addressing at a variety of points along the education pipeline. We have medical students who are rotating in rural and Native American locations to expose them to that type of work, those types of environments, and then that perpetuates a stronger interest to undertake residency training programs in those environments, as well.

The more we continue to invest in training and education in these locations and building that pipeline, we see those successes. We have individuals who have done some of our training programs that have perhaps a rural track, such as in surgery or family medicine, and people who do those tracks, they stay there. They really enjoy living in those communities. They become deeply part of the fabric of those communities, unlike being in a large city.

And so these training programs work. We need to expand them. We need to continue to grow them. We need to partner with communities who are also investing alongside us to provide lower-cost housing, making the rotations and those experiences far more hospitable, and allowing people to be part of those communities. So we are deeply invested in continuing on that pathway, and I think we broadly have to continue to support them financially, as well, through expanding residency programs.

Chairman SMITH. Thank you.

Mr. Morello, there are proactive things that Congress can do to help facilitate greater innovation, including when it comes to our health care system and making new technologies and new avenues of care affordable. What actions could Congress take at the Federal level to help drive health care innovation?

And what would be the downstream benefit to access to care in rural, underserved, and tribal communities with those changes?

Mr. MORELLO. Yes, thank you, Chairman, for that question.

I think the first thing that we experienced in just taking what is a scientific idea and innovation, and building the research and development capability was we did apply for and had access to some grants that were very specific around translation. How do we take an idea, but put forward a compelling plan that would include rigorous studies, and to do that as fast as we can, but using the sort of hard and true methods of demonstrating that evidence?

So continuing to find ways where—and I am sure there are a variety of mechanisms—where the investment in R&D is something that the Federal Government can encourage in the right ways, I think part of that trust in giving any company those types of opportunities is we have to have a plan to demonstrate that it can be cost effective, it focuses on broad access.

So in our case, as that example, we knew that being able to have diagnostics that could be done in pretty much any community set-

ting in a 15-minute procedure, it could be done by a nurse practitioner, those are the sorts of things that, in our opinion, innovation just can't be shooting for the moon. It has to have a clever plan that focuses on cost effectiveness and access for all patients. That is, again, going back to the burden that companies like ours have to demonstrate, so that if the government says we are going to provide those incentives and grants and whatnot, that is part of the plan that we put forward. I would say that is absolutely front and center.

Chairman SMITH. Thank you. I want to thank each and every one of you all for your time, for being here, and for sharing such great information.

I want to thank the members of our committee for taking the time to make sure that you made it down to Scottsdale. It is not easy whenever we all come from numerous other states, and so I appreciate the commitment that you all have.

Please be advised that members have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the committee stands adjourned.

[Whereupon, at 10:36 a.m. Mountain Time, the committee was adjourned.]

LOCAL SUBMISSIONS FOR THE RECORD

Date	May 10, 2024
Name (Print)	Leland Fulwilder
Company	Tribal Member SRPMIC

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Empowering Native American and Rural Communities

We want to hear your story. Below please provide any personal experiences or general comments about empowering Native American and rural communities that you wish to be included in the official hearing record.

Our children receive minors trust fund payments at the age of 18. In 2017 the Tax Cuts and Jobs Act increased the tax rate on those trust fund distributions. Children are seeing a higher effective tax rate that is pegged to the rate applicable to estates and trusts. To remedy this, the "kiddie tax" should be amended to exempt these distributions.

Many of our community members receive lease payments for their land leases of allotted land. At the current time the tribal government does not offer any documentation of the lease payments because the income is not taxed. The income is not taxed because it derives from trust land owned by noncompetent Indians. Since no documentation occurs for this income, it reduces documented income for community members reducing their ability to get loans or qualify for income-based programs.

**The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/*

Date	May 10, 2024
Name (Print)	Joseph Manuel Baag' Ibidga'
Company	Eagleheart Entertainment Services

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Empowering Native American and Rural Communities

We want to hear your story. Below please provide any personal experiences or general comments about empowering Native American and rural communities that you wish to be included in the official hearing record.

Taxes --

1. 100 million indigenous people were killed.
2. All this US Land is stolen land.
3. All resources have been stolen from Indigenous people and continue to be used and taken.

This country could never begin to payback all of this. My solution, which should be your solution is: STOP taxing indigenous people in every way. Employment, food, land, autos, ALL TAXATION. That's how you can start repaying indigenous people for all it has sacrificed to these United States.

Joe Manuel
eagleheartofaz@gmail.com
520-610-3291
Former: Lt. Governor, Chief Judge, Associate Judge, Councilman.

**The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/*

PUBLIC SUBMISSIONS FOR THE RECORD

American Academy of PAs

AAPA Statement for the Record Submitted to the House Ways and Means Committee Field Hearing: "Empowering Native American and Rural Communities"

May 10, 2024

Dear Chairman Smith, Ranking Member Neal and members of the committee:

On behalf of the more than 168,000 physician associates/physician assistants (PAs) throughout the United States, the American Academy of Physician Associates (AAPA) thanks the committee for your ongoing commitment to ensuring all Americans have access to high-quality healthcare. AAPA appreciates the opportunity to submit comments for the record with respect to the committee's May 10, 2024, Field Hearing on Empowering Native American and Rural Communities.

AAPA recognizes the complex and multifaceted issues and challenges facing the healthcare workforce in the United States, especially on the heels of a global pandemic and record levels of burnout. As our nation's population continues to age and additional factors, such as rising chronic disease, increase demand for healthcare services, we are confident that PAs are an integral part of the solution. The PA profession was established in the 1960s at a time when the nation was facing a primary care shortage and was founded to improve access, especially in rural and underserved communities.[1] Today, PAs remain ready to respond to the national demand for greater access to high-quality healthcare services. PAs already possess the medical education, training, and experience to do so.

As Congress considers policies to ensure timely access to high-quality care for all patients, AAPA encourages the committee to embrace opportunities to reduce provider barriers and burdens wherever they interfere with optimizing patient care and access. AAPA also encourages the committee to reauthorize current programs to address workforce challenges and enact legislation to ensure all providers can practice to the top of their license and education. Although PAs are already providing high-quality care across the nation and in all medical specialties, outdated barriers to practice remain. AAPA stands ready to work with the committee as you consider new ideas to ensure quality care is available to all Americans, particularly those in rural and underserved communities.

[1] Cawley JF, Cawthon E, Hooker RS. Origins of the physician assistant movement in the United States. JAAPA. 2012 Dec;25(12):36-40, 42.

Background: What is a PA?
PAs are medical professionals who diagnose illness, develop, and manage treatment plans, prescribe medications, and are often a patient's primary healthcare provider. PAs are highly trained professionals with thousands of hours of medical education and training who practice in all medical and surgical specialties in all 50 states, the District of Columbia, U.S. territories, and in the uniformed services. Additionally, PAs are one of three healthcare professions, including physicians and advanced practice registered nurses (APRN), who are recognized in Medicare to provide both primary and mental health medical care in the United States. The typical PA education program provides students with an intensive, master's degree level, medical education over approximately three academic years, or 27 continuous months.[2] However, PA education does not end with graduation. To practice, PAs must pass the PA National Certifying Examination and obtain state licensure. To maintain certification, PAs must also complete 100 hours of continuing medical education (CME) every two years and pass a comprehensive examination every ten years.[3] Many PAs seek additional educational opportunities following graduation and throughout the duration of their careers.

For more than 50 years, PAs have provided high-quality, cost-effective healthcare services to patients across the nation. However, several barriers remain at the state and federal levels that prevent PAs from practicing to the full extent of their education, training, and license. These barriers diminish the value PAs can bring to rural communities suffering from ongoing shortages of qualified healthcare providers.

According to the Health Resources and Services Administration (HRSA), more than 15% of Americans live in rural areas, but only 10% of physicians practice in those communities.[4] About 16% of all clinically practicing PAs are located in a rural county, with more than 1 in 3 practicing much needed primary care in rural locations. Removing barriers to ensure PAs can practice to the top of their license should be viewed as an important solution to the shortage of providers along with adequate access to primary care in rural and underserved areas.

Diabetic Shoes
PAs diagnose and treat illnesses, manage complex conditions, prescribe medications in all 50 states, and assist in surgery – but the current statute governing Medicare does not authorize PAs to complete the simple task of ordering diabetic shoes. With the aging U.S. population and increasing prevalence of diabetes, it is absurd that a PA can manage a patient's diabetes and other complex chronic conditions but is not authorized to order diabetic shoes. *The Promoting Access to Diabetic Shoes Act (H.R. 618/S.131)* will modernize current Medicare policy and authorize PAs to certify a patient's need for diabetic shoes.

A study published in the American Journal of Medicine in 2018 found that PAs perform as well as physicians in the management of diabetes at diagnosis and during four years of follow-up care. PAs are federally recognized primary care providers and frequently manage care for diabetics who may have multiple comorbidities. Outside of the Medicare program, PAs can certify the need for diabetic shoes for their patients. This is an example of the Medicare statute not making common sense or keeping up with how medicine is practiced today.

Diabetic foot complications are directly related to poor clinical outcomes and substantial cost, especially among rural Medicare patients. Compared to urban populations, rural populations have a 16 percent higher prevalence of type 2 diabetes, a 20 percent higher type 2 diabetes-related hospital mortality, and smaller improvements in overall mortality rates in the past two decades. [5] It is further estimated that rural patients face a nearly 35 percent increase in major amputation following diabetic foot ulcers as compared to patients living in urban areas.[6]

[2] PAEA. Program report 35, Table 6, page 7

[3] NCCPA. Certified PAs: Improving health, saving lives, making a difference.

[4] HRSA. Designated HPSAs as of March 31, 2024.

[5] Dugani, Sagar et al. Diabetes Metab Res Rev. Burden and Management of Type 2 Diabetes Mellitus in Rural United States.

Often referred to among providers as the 'diabetic amputation loop', 19 percent of diabetic patients will then face a second amputation within one year and more than 37 percent within the first five years.[7] The cost of a lower extremity amputation (LEA) among Medicare beneficiaries is substantial and growing. It has been estimated that the mean annual reimbursement of all services for diabetic Medicare patients with an LEA was more than $49,000 in 2006, more than $51,000 in 2007, and more than $54,000 in 2008.[8]

Modernizing Medicare to authorize PAs to certify a patient's need for diabetic shoes, consistent with state law, will improve the quality and continuity of care available to diabetic patients, especially for those living in rural and medically underserved areas experiencing critical access issues and physician shortages.

Mental and Behavioral Healthcare Access

Our nation is currently facing a significant shortage of mental healthcare providers, and unfortunately this shortage is only projected to grow in the coming years. As front-line providers, PAs are recognized across the nation as high-need providers in mental health who play a critical role in expanding psychiatric care.[9] While some PAs practice in mental and behavioral health specialties including psychiatry, currently more than 30,000 PAs practice in primary care and *routinely provide mental healthcare to their patients*.[10] PAs in emergency and hospital medicine also treat patients with psychiatric symptoms and are often a first line provider for patients to access mental or behavioral health services. PAs also serve an essential role providing high-quality mental health services to veterans across the Department of Veterans Affairs (VA) system. It is imperative that PAs are authorized to practice to the full extent of their education, training, and experience to confront the growing need for behavioral and mental healthcare services.

As highly educated and qualified medical professionals, PAs practice in behavioral health facilities, hospitals, private practice, rural health clinics, community health centers, and prisons across the United States. With clinical expertise, medical training, and the initiative to help, PAs are on the ground in local communities. In 2018, the PA Foundation launched an inaugural *Mental Health Outreach Fellowship.*[11] This profession-driven initiative was the first phase of a wider mental health outreach effort that sought to connect PAs with community mental health needs.[12] In 2019, the first PA fellows reported training more than 1,500 people across the United States to recognize and respond to mental health needs in their communities.

Recognized in federal law as providers in opioid treatment programs, PAs are also instrumental in providing care for patients with substance use disorder (SUD) and surrounding mental, physical, and behavioral health concerns. Effective treatments for substance use disorders are available, but few patients receive the treatment they need. In 2019, only 12.1% of individuals with a SUD received treatment.[13]

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[6] Krepnek GH, Mills JL, Armstrong DG. A diabetic emergency one million feet long: disparities and burdens of illness among diabetic foot ulcer cases within emergency departments in the United States, 2006-2010.

[7] Liu R, Petersen BJ, Rothenberg GM, et al. Lower extremity reamputation in people with diabetes: a systematic review and meta- analysis. BMJ Open Diab Res Care 2021;9:e002325. doi:10.1136/ bmjdrc-2021-002325

[8] Margolis DJ, Malay DS, Hoffstad OJ, et al. Economic burden of diabetic foot ulcers and amputations: Data Points #3. 2011 Mar 8. In: Data Points Publication Series [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2011-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK65152/

[9] Medical Director Institute. The psychiatric shortage: Causes and solutions. National Council for Behavioral Health. March 28, 2017. Washington, DC. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_NationalCouncil-.pdf

[10] AAPA. 2020 PA Data Book

[11] https://pa-foundation.org/mental-health-outreach-reflecting-and-forging-ahead/

[12] https://pa-foundation.org/our-programs/mental-health-outreach-fellowship/

[13] https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/increase-proportion-people-substance-use-disorder-who-got-treatment-past-year-su-01/data

While rural and urban areas alike are dealing with an overdose crisis, 56 percent of rural counties lack access to a provider who can prescribe treatment.[14] PAs are authorized to prescribe controlled medications in all 50 states. Once granted, no state has ever rescinded PA authority to prescribe controlled medications. There has been no record of increased liability or malpractice claims due to PA prescribing of scheduled drugs, and professional liability insurers have not increased premiums when PAs have been granted authority to prescribe controlled medications.

Healthcare in the United States continues to evolve from a traditional, physician-centric model to a more streamlined, efficient, and patient-centric model and PAs are evolving with it. As our nation faces a severe shortage of behavioral health providers, including physicians, it is imperative that PAs and other qualified mental health providers are appropriately utilized to provide this necessary care. The COVID-19 pandemic and public health emergency (PHE) highlight just how critical a robust and secure healthcare workforce is to our nation's security and overall wellbeing. Access to high-quality, evidence-based healthcare is critical for positive patient outcomes and healthy communities. PAs and other providers throughout the United States have faced increased stress, high rates of burnout and challenges to their own mental health. PAs must also confront an increasing demand to provide critical healthcare services while physician shortages, especially in rural and low-income areas, continue to grow.[15]

Medicare Shared Savings Accountable Care Organization (ACO)
PAs are recognized in the Medicare Shared Savings Program (MSSP) as "ACO professionals," yet their patients cannot be assigned as beneficiaries in that program. Under current law, Medicare fee-for-service beneficiaries are assigned to an ACO based on their utilization of primary care services furnished by a physician. However, individuals in rural and underserved communities often rely on PAs and other advanced practitioners. As a result, the physician requirement prevents Medicare fee-for-service beneficiaries in these communities from accessing the coordinated care provided by ACOs. It is essential that primary care services furnished by PAs and other advanced care providers count for purposes of ACO assignment. This encourages ACO formation in rural and underserved areas and allows healthcare providers to attain enough ACO beneficiaries to participate in the Medicare Shared Savings Program. Through these changes, ACO assignments will be more effective for beneficiaries and providers in rural communities that suffer from acute physician shortages and encourage the adoption of value-based care principles such as care coordination and population health.

The ACO Assignment Improvement Act (H.R. 7665/S.3939) will improve the way beneficiaries are assigned under the MSSP by also basing such assignment on primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists.

Cardiac and Pulmonary Rehabilitation (CR/PR)
Current law arbitrarily restricts the ordering and supervision of cardiac and pulmonary rehabilitation in Medicare. In 2018, Congress rightfully authorized PAs and other advanced practice providers to **supervise** cardiac and pulmonary (CR/PR) services but with a delayed implementation until 2024. However, PAs are still not authorized to **order** this critical service for their patients.

CR/PR services are an essential and proven tool in the management of patients with chronic respiratory conditions, those who have survived myocardial infarction (heart attack) as well as patients fighting chronic obstructive pulmonary disease (COPD.) CR/PR services have also been used to treat patients recovering from an active SARS-COV-2 infection. Despite the clinical implications and critical importance of this treatment, CR/PR services remain severely underutilized, especially among high-risk populations in rural areas.[16]

[14] AIR, Exploring Urban-Rural Disparities in Accessing Treatment for Opioid Use Disorder, November 19, 2021.

[15] https://www.aamc.org/media/45976/download?attachment

[16] Fleg JL, Keteyian SJ, et al. Increasing Use of Cardiac and Pulmonary Rehabilitation in Traditional and Community Settings: OPPORTUNITIES TO REDUCE HEALTH CARE DISPARITIES. J Cardiopulm Rehabil Prev. 2020 Nov;40(6):350-355. doi: 10.1097/HCR.0000000000000527. PMID: 33074849; PMCID: PMC7644593.

CR/PR services are offered through medically directed and supervised programs designed to improve a patient's physical, psychological, and social functioning. Both programs utilize supervised exercise, risk factor modification, education, counseling, behavioral modification, psychosocial assessment, and outcomes assessment.

PAs are routinely on the front line in critical care environments, such as in hospitals, clinics, emergency rooms, and intensive care units. They are highly trained providers, qualified to order and supervise critical medical services. However, under current law only physicians may order and supervise CR/PR programs in Medicare. CR/PR services are proven to improve health outcomes for patients who have survived a heart attack and/or have chronic obstructive pulmonary disease (COPD) and can treat patients recovering from other chronic diseases, including COVID-19. However, this life-saving treatment is underutilized, especially in rural and medically underserved areas, because qualified providers such as PAs are unnecessarily and arbitrarily prevented from ordering and supervising CR/PR. Patients deserve the highest- care available; outdated restrictions like this only compound the challenge in areas where access issues and care disparities are particularly acute. *The Increasing Access to Quality Cardiac Rehabilitation Care Act (H.R. 2583/S.3481)* would authorize PAs to order this critical service for Medicare patients, especially those in rural areas.

Hospice and Palliative Care

In 2018, *the Medicare Patient Access to Hospice Act* was included in *the Bipartisan Budget Act of 2018* and broadened the Medicare definition of hospice "attending physician" to include PAs. This inclusion took effect in January of 2019 and was a necessary step in ensuring adequate access to hospice care for Medicare patients, especially those in rural and underserved areas.

PAs regularly function as a patient's primary healthcare provider. Frequently, it is the primary provider, acting in the role of a Medicare hospice attending physician, who helps with a patient's transition to hospice and subsequently assists in facilitating care received. However, PAs may not certify or re-certify terminal illness. PAs are highly qualified health professionals and should be authorized to perform these functions, consistent with state law, under Medicare. Further, PAs need to be authorized to perform the face-to-face encounter that is required prior to recertification after a patient has been under the hospice benefit for 180 days. NPs, however, *are* authorized to perform this face -to-face visit that is then used by a physician to determine a patient's eligibility for recertification. These arbitrary restrictions on PAs remain a significant barrier to care for patients needing hospice services and are amplified in their detrimental effects by ongoing provider shortages. Our rural communities are facing a significant hospice workforce shortage that Congress could help alleviate. Authorizing PAs to certify and recertify terminal illness, in addition to perform face- to-face visits required for recertifications, something well within their scope and education, would significantly increase the number of highly qualified providers in the hospice workforce.

AAPA requests that Congress 1) modify 42 U.S.C. 1395f(a)(7)(A) to authorize PAs to certify and recertify terminal illness, and 2) modify 42 U.S.C. 1395f(a)(7)(D)(il) to authorize PAs to perform the face-to-face encounter prior to recertification after a patient has been under the hospice benefit for 180 days.

Federal Workers Compensation

Currently, all US federal and postal employees receive workers compensation coverage for employment-related injuries and disease through the Federal Employees Compensation Act (FECA). However, FECA does not cover medical care provided by PAs (or nurse practitioners [NPs]) within the current definition of *"medical, surgical, and hospital services...,"* meaning once a federal or postal employee is injured on the job, they can no longer receive

healthcare from a PA, even if that PA is their primary care provider (PCP) through their federal health insurance program. This undue and unnecessary restriction negatively impacts our federal workforce, especially those in rural areas where access to any provider, not just physicians, can be challenging.

PAs provide high-quality healthcare and are recognized providers in Medicare, Medicaid, and nearly every state and federal healthcare program, including state workers' compensation programs. PAs are included in the definition of an *"acceptable medical source"* by the Social Security Administration and thousands of PAs are federal employees themselves and practice within the Department of Veterans Affairs, the Department of Defense, the Public Health Service, and Indian Health Services. FECA is the outlying federal program that does not recognize the critical role PAs play in our healthcare system. The *Improving Access to Workers' Compensation for Injured Federal Workers Act (H.R. 704/S.260)* would authorize PAs to treat their federally employed patients in accordance with state law.

Conclusion

In 2021, an AAPA Practice Survey[17] found that approximately half of the PAs who responded were already working in or interested in moving to practice in, a rural location, health professional shortage area, or medically underserved area. PAs are practicing in rural areas across the nation and while interest remains high, barriers and recruitment challenges remain. While PAs increase access to healthcare in rural areas, they also increase economic benefits in the same communities.[18] AAPA urges the committee to consider the vital role that PAs and other providers play in communities across the nation, specifically in rural and underserved areas, and ensure that they can provide the care that is so critically needed.

AAPA thanks the committee for the opportunity to submit these recommendations and for your ongoing dedication to our nation's healthcare systems. We are committed to working with Congress to advance our shared mission of improving access to healthcare in the United States. If we can be of assistance on this or any issue, please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at theuer@aapa.org.

[17] https://www.aapa.org/download/103451/

[18] Eilrich FC. The economic effect of a physician assistant or nurse practitioner in rural America. JAAPA. 2016;29(10):44-48. doi:10.1097/01.JAA.0000496956.02958.dd

ICBA
One Mission. Community Banks.

May 10, 2024

ACRE Act Essential to the Prosperity of Rural Communities

The Independent Community Bankers of America, representing community banks across the nation with nearly 50,000 locations, appreciates the opportunity to provide this statement for the record for today's hearing in Scottsdale, Arizona: "Empowering Native American and Rural Communities."

Among the topics to be discussed today are rural health care and pro-growth tax policies. ICBA urges this committee's consideration of the Access to Credit for our Rural Economy (ACRE) Act (H.R. 3139), bipartisan legislation sponsored by Reps. Randy Feenstra and Wiley Nickel, as a critical component of the solution to these challenges. ACRE, with 63 bipartisan cosponsors to date, will promote the availability of affordable homes in rural Native American and other communities for healthcare workers and other essential workers.

ACRE provides that interest on single-family mortgages in communities of less than 2,500 in population is exempt from taxation, provided the home is a principal residence and the principal value of the loan (together with all other loans secured by the home) does not exceed $750,000. This interest exclusion will allow community banks to offer lower interest rates on rural homes, providing critical relief at a time of historically high interest rates.

In addition, ACRE provides that interest earned on loans secured by agricultural land is exempt from taxation. Many rural economies are centered on agriculture, and loan interest rate relief provided by the ACRE Act is a pro-growth tax policy. We urge the Ways and Means Committee to ensure ACRE is included in future tax reform or tax extension legislation to help ensure the prosperity it would promote in rural America.

Thank you for convening today's hearing. We appreciate this committee's focus on health care and economic growth in Native American and Rural Communities.

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