AMERICAN INDIAN
MEDICAL EDUCATION STRATEGIES ALLIANCE

Response to the Senate Finance Bipartisan Medicare GME Working Group

Background

Tribal Affairs Generally

9.7 million American Indians and Alaska Natives (AI/ANs) live in the United States, comprising 574 federally recognized tribes spread across the country.[1] While it may be assumed that most AI/ANs live on one of the 324 designated Tribal reservations and trust lands, or 221 Alaska Native village statistical areas, only 22 percent of AI/ANs live on reservations.[2] More than 70 percent of AI/ANs live in urban and metropolitan areas.[3] 25 percent of AI/ANs live in poverty, proportionately more than any other group, and more than double the rate of 11.5 percent of Americans generally.[4]

As noted in the National Indian Health Board's *Health Equity in Indian Country*:

> *"American Indian and Alaska Native" is first and foremost a unique political status, and is only secondarily, and in specific contexts, a racial identity.*

The United States has recognized the sovereign status of AI/AN Tribes since the writing of the Constitution, and this status has been reaffirmed in court.[5] Because of their sovereign status, Tribes are often listed as the *third* sovereign in the United States, standing with the federal and state governments.[6]

Despite their sovereign status, Tribes rely upon the federal government to provide certain services.[7] This agreement has been enshrined in various treaties between Tribal nations and the federal government and is referred to as the federal Indian trust responsibility. That trust obligation has been described as "the unique and moral duty of the United States to assist Indians in the protection of their property

---

[1] Census Bureau 2023: Facts for Features: American Indian and Alaska Native Heritage Month: November 2023; https://www.census.gov/newsroom/facts-for-features/2023/aian-month.html

[2] *Id.*

[3] National Council of Urban Indian Health. "Urban Indian Health Facts." https://ncuih.org/about/urban-indian-health-facts/. *See also* HHS Office of Minority Health; American Indian/Alaska Native Health; https://minorityhealth.hhs.gov/american-indianalaska-native-health

[4] Emily A. Shrider and John Creamer, U.S. Census Bureau, Current Population Reports, P60-280, Poverty in the United States: 2022, U.S. Government Publishing Office, Washington, DC, September 2023. https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-280.pdf

[5] The Constitution mentions Native American tribes in the context of being sovereigns in U.S. CONST. art. I, § 2, cl. 3; U.S. CONST. art. I, § 8; and U.S. CONST. amend. XIV, § 8. *See* Johnson v. M'Intosh, 21 U.S. 543, (1823); Cherokee Nation v. Georgia, 30 U.S. 1, (1831); Worcester v. State of Ga., 31 U.S. 515, (1832).

[6] Sibyl Diver, Native Water Protection Flows Through Self-Determination: Understanding Tribal Water Quality Standards and "Treatment as a State." 163 J. Contemp. Water Res. Educ.7, 11 (2018).

[7] DAVID EUGENE WILKINS & K. TSIANINA LOMAWAIMA. UNEVEN GROUND. AMERICAN INDIAN SOVEREIGNTY AND FEDERAL LAW 5. (UNIVERSITY OF OKLAHOMA PRESS, EDS., 2001). *SEE* DAVID F. COURSEN, *TRIBES AS STATES: INDIAN TRIBAL AUTHORITY TO REGULATE AND ENFORCE FEDERAL ENVIRONMENTAL LAWS AND REGULATIONS*. 23 ELR 10579; 11 (1993) . *See* Diver *supra* at 24.

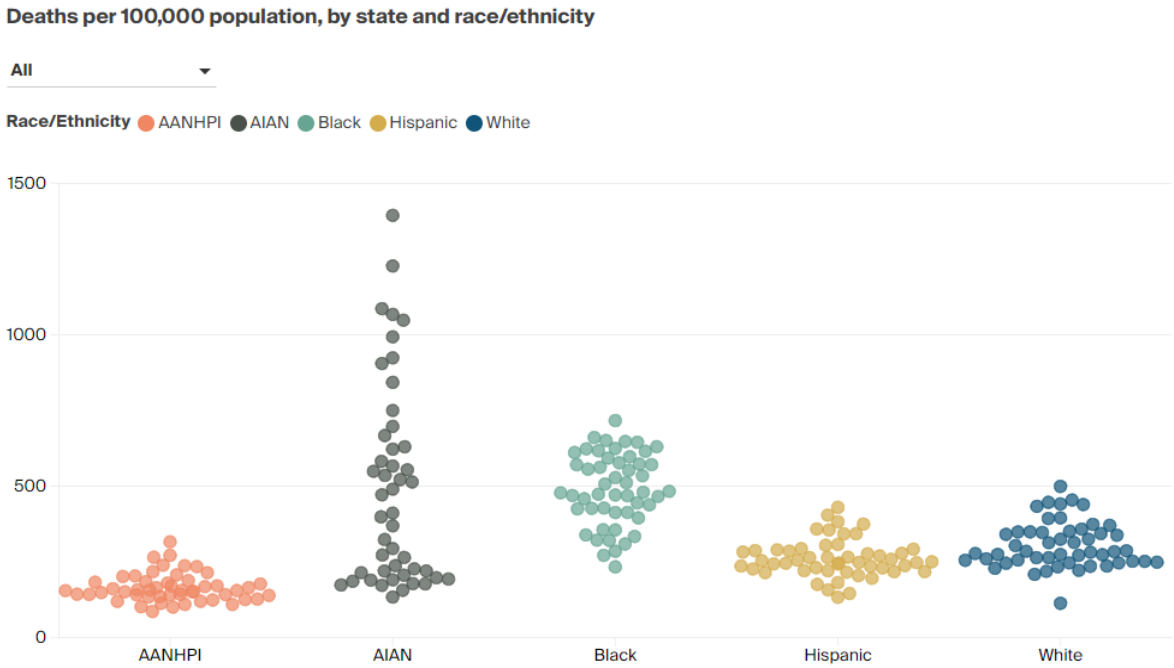
and rights."[8] Simply put, the trust is viewed as a fiduciary obligation held by the federal government to provide specific services (including health care and education) and protect Tribal lands.[9]

Tribal Health Generally

AI/ANs experience higher rates of chronic diseases and worse health outcomes compared to the overall United States population. AI/ANs are disproportionately affected by many chronic conditions, including heart disease, cancer, diabetes, and stroke, as well as unintentional injuries (accidents).[10] AI/ANs are three times as likely as Caucasian individuals to be diagnosed with diabetes and to receive late or no prenatal care.[11] Additionally, AI/ANs have a lower life expectancy than their White counterparts (65.2 years vs 76.4 years), with AI/AN communities experiencing a 6.6-year decline between 2019 and 2021.[12]

Furthermore, AI/ANs suffer from some of the highest rates of avoidable deaths from preventable and treatable causes. For example, in 2020-2021, the U.S. rate of deaths before age 75 from preventable causes per 100,000 population was 231.9. For AI/AN individuals, however, that rate was more than double the national rate at 478.9. In one state, the rate of preventable deaths was more than 4.5 times the national rate at 1,394 deaths from preventable causes per 100,000 population.[13]

[8] KIRKE KICKINGBIRD, ALEXANDER T. SKIBINE, LYNN KICKINGBIRD. INDIAN JURISDICTION. (Institute for the Development of Indian Law, eds., 1983).
[9] Diver *supra* at 11
[10] Indian Health Service; Disparities; https://www.ihs.gov/newsroom/factsheets/disparities/
[11] HHS Office of Minority Health; Infant Mortality and American Indians/Alaska Natives; https://minorityhealth.hhs.gov/infant-mortality-and-american-indiansalaska-natives
[12] Hill, L. and Artiga, S. Kaiser Family Foundation. "What is Driving Widening Racial Disparities in Life Expectancy?" https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-is-driving-widening-racial-disparities-in-life-expectancy/
[13] David C. Radley et al., *Advancing Racial Equity in U.S. Health Care: The Commonwealth Fund 2024 State Health Disparities Report* (Commonwealth Fund, Apr. 2024). https://doi.org/10.26099/vw02-fa96



David C. Radley et al., *Advancing Racial Equity in U.S. Health Care: The Commonwealth Fund 2024 State Health Disparities Report* (Commonwealth Fund, Apr. 2024). https://doi.org/10.26099/vw02-fa96

In addition, AI/AN medical facilities often suffer from high physician staffing vacancy rates, contributing to negative outcomes. For example, in IHS medical facilities (excluding Tribal-operated and urban Indian organizations) the physician vacancy rate is 60 percent in the Bemidji IHS Area, 51 percent in the Billings Area, 50 percent in the California Area, 50 percent in the Portland Area, and 38 percent in the Great Plain Area.[14] If Tribally-operated programs or urban Indian organizations were included, then the number of vacancies and vacancy rates would be even higher. The issue of high physician vacancy rates in IHS medical facilities was noted in the 2018 GAO report "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies."[15]

Congress has taken note of I/T/U staffing vacancy rates in the past. In 1976, Congress wanted IHS to create workforce partnerships with teaching hospitals in the *Indian Health Care Improvement Act.* However, Congress has yet to appropriate funds for the IHS to create these partnerships.[16]

[14] HHS Assistant Secretary for Planning and Evaluation; Office of Health Policy; " How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives." https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihs-funding-disparities-report.pdf

[15] GAO-18-580

[16] Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. JAMA. 2022;328(4):327–328. doi:10.1001/jama.2022.10359

Overview of the Indian Health System

The *Indian Health Care Improvement Act* (IHCIA), along with the *Snyder Act of 1921*, forms the statutory basis for the delivery of federally funded health care and the direct delivery of care to AI/ANs. Since its passage in 1976, and its permanent authorization in 2010, the IHCIA has provided the programmatic and legal framework for carrying out the federal government's medicine and health care trust responsibility.[17]

To accomplish this goal, the federal government created the Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), whose sole mission is to deliver health care to AI/ANs. IHS provides medical care to 2.6 million AI/AN individuals who belong to 574 federally recognized tribes.

While IHS-operated medical facilities are frequently viewed by non-Tribal individuals as the most visible medical care provider in Indian Country, IHS is only part of the greater system that provides medical care to AI/ANs. This system is referred to as the **I/T/U**, in reference to the three categories of participating facilities: **I** for IHS, **T** for Tribal-operated, and **U** for urban Indian organizations (UIOs).

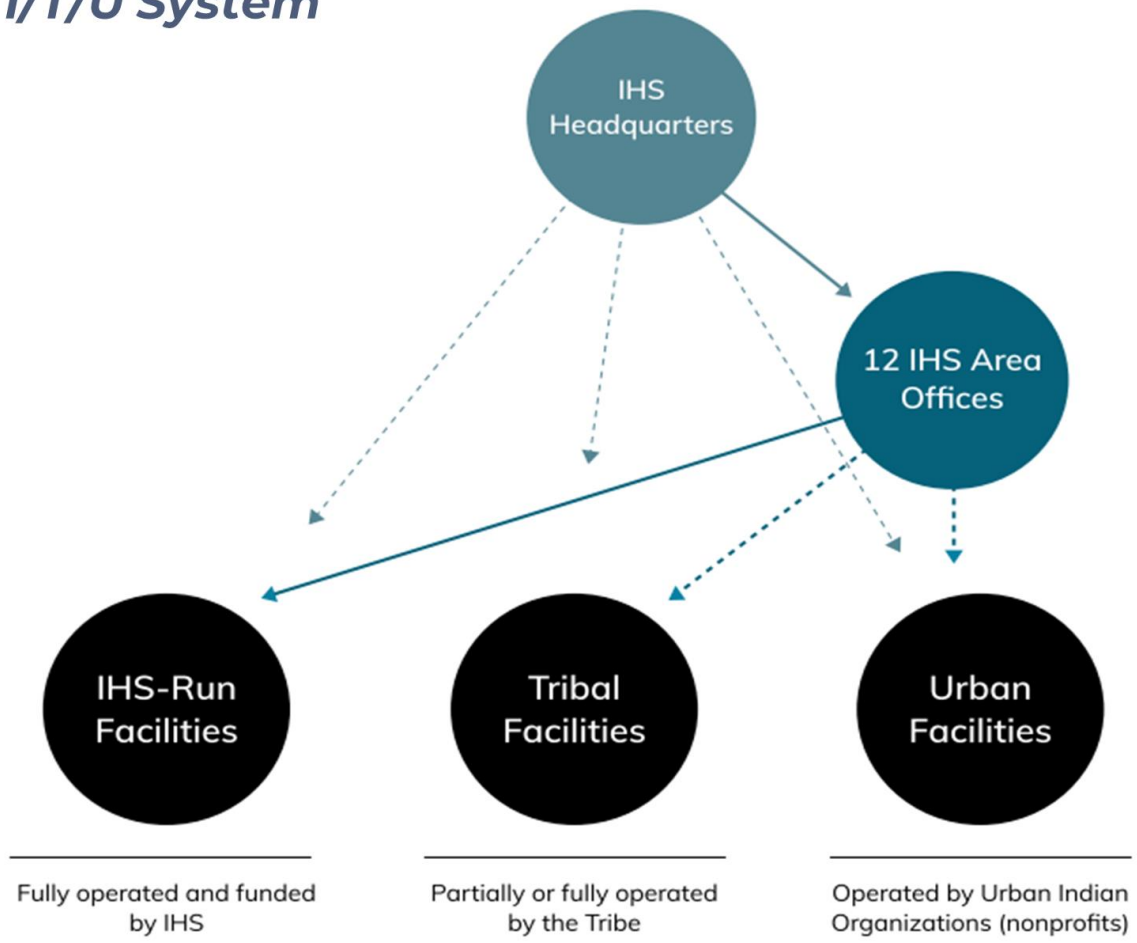
- Indian Health Service
    - These facilities provide direct care to AI/ANs in medical hospitals and clinics owned and operated by the IHS.
    - Funding comes from congressional appropriations and billing Medicare, Medicaid, VA, and 3rd party insurance.
    - Examples
        - Phoenix Indian Medical Center (Phoenix, AZ)
        - Cass Lake Hospital (Cass Lake, MN)
        - Not-Tsoo Gah-Nee Indian Health Center (Fort Hall, ID)
        - Catawba Health Service (Rock Hill, SC)
        - Northern Navajo Medical Center (Shiprock, NM)
        - Elko Health Center (Elko, NV)
        - Chemawa Indian Health Center (Salem, OR)
        - Lockport Health Center (Lockport, NY)
        - Micmac Health Services (Presque Isle, ME)
- Tribal operated
    - Tribal operated facilities are medical hospitals and clinics purpose-built by Tribes, or former IHS medical hospitals or clinics that are now operated by a Tribe.
    - Funding comes from IHS, Tribal funds, and billing Medicare, Medicaid, VA, and 3rd party insurance.
    - Examples
        - Cherokee Indian Hospital - *Eastern Band of Cherokee Indians* (Cherokee, NC)

[17] National Indian Health Board. "Indian Health 101." https://www.nihb.org/tribal_resources/indian_health_101.php

        - Yellowhawk Tribal Health Center – *Cayuse, Umatilla, and Walla Walla* [Confederated Tribes of the Umatilla Indian Reservation] (Chiloquin, OR)
        - Choctaw Health Center – *Mississippi Band of Choctaw Indians* (Choctaw, MS)
        - Marimn Health – *Coeur d'Alene Tribe* (Plummer, ID)
        - Tribal Health Services - *Mashantucket Pequot Tribal Nation* (Mashantucket, CT)
        - Reno-Sparks Indian Colony Tribal Health Clinic –*Numa, Washeshu,* & *Newe* [Reno-Sparks Indian Colony] (Reno, NV)
        - W. W. Hastings Hospital – *Cherokee Nation* (Tahlequah, OK)
        - Tséhootsooí Medical Center – *Navajo* (Ft. Defiance, AZ)
        - Little Traverse Bay Bands of Odawa Indians Health Clinic – *Little Traverse Bay Bands of Odawa Indians* (Petoskey, MI)
- Urban Indian Organizations (UIOs)
    - UIOs are nonprofit organizations in an urban center governed by a board of directors of whom at least 51 percent are AI/ANs and dedicated to establishing and administering an urban Indian health program and related activities as described in the *Indian Health Care Improvement Act*.[18]
    - Funding comes from grants, IHS, and billing Medicare, Medicaid, VA, and 3rd party insurance.
    - Examples
        - Seattle Indian Health Board (Seattle, WA)
        - Native American LifeLines of Baltimore (Baltimore, MD)
        - Nebraska Urban Indian Health Coalition, Inc. (Omaha, NE)
        - Nevada Urban Indians, Inc. (Reno, NV)
        - Texas Native Health (Dallas, TX)
        - Native American Rehabilitation Association of the Northwest, Inc (Portland, OR)
        - Hunter Health (Wichita, KS)
        - Denver Indian Health and Family Services (Denver, CO)
        - American Indian Health & Family Services (Detroit, MI)

[18] National Council of Urban Indian Health. "Urban Indian Health Facts." https://ncuih.org/about/urban-indian-health-facts/

I/T/U System



See: HHS Indian Health Services Health IT Modernization; 2019

Current State of GME in Indian Country

Unlike the Veterans Health Administration (VHA) which, for over 75 years, has operated a highly successful GME program that has encouraged and funded partnerships with medical schools and teaching hospitals, the IHS does not have a dedicated GME funding stream and partnership program.[19] I/T/U facilities that have established GME programs have primarily done so through HRSA grants (which must be reauthorized) and internal Tribal funds.

Agency	Full-time GME trainees or rotation slots	Annual GME budget line	Annual funded trainees located at or partnered with IHS, Tribal-operated, or urban Indian organizations (I/T/U)
Indian Health Service	0	$0	1 (receives funding from Medicaid, not IHS)
HRSA: THCGME	932 (AY22)	$119 million (FY23)	69 (6 programs)
HRSA: CH-GME	8,224 (FY21)	$385 million (FY23)	0
VHA	12,000 slots with 6 rotators per year [75,000 trainees]	$874 million (FY23)	0 (the 2018 *VA MISSION Act* PPGMER is set to train 100 individuals)

[19] Since its establishment, overseen by its Office of Academic Affiliations and strengthened with a dedicated budget line, it is estimated that 120,000 trainees rotate annually through the VA system and 70 percent of all U.S. medical trainees have rotated through the VA system. Given the success of the VA's efforts, it serves as a useful model that can be duplicated in Indian Health Service and other urban and rural Tribal facilities.

See Petrakis, Ismene L. MD1; Kozal, Michael MD2. Academic Medical Centers and the U.S. Department of Veterans Affairs: A 75-Year Partnership Influences Medical Education, Scientific Discovery, and Clinical Care. Academic Medicine 97(8):p 1110-1113, August 2022. | DOI: 10.1097/ACM.0000000000004734; *See also* Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. JAMA. 2022 Jul 26;328(4):327-328. doi: 10.1001/jama.2022.10359. PMID: 35816350.

CMS: Medicare	98,542 (FY20)	$16.2 billion (FY20)	6 (1 program)
44 states: Medicaid	No exact figure	$7.39 billion (2022)	2 (1 program rotating through an IHS facility)
DOD	1,455 (FY17)	No exact figure	0
National Total	*144,660 (2021)*	*$25 billion*	*77 (8 programs)*

There are currently eight residency programs located in federally recognized Tribal clinics.

Residency (3-year) programs	Est.	Res/yr	Funding sources	I/T/U	Location
Seattle Indian Health Board (Family Medicine)	1994	2	Self-funded & Medicare (external hospital partner)	Urban	Seattle, WA
Cherokee Nation (Family Medicine)	2009	8	HRSA RRPD to THCGME	Tribal	Tahlequah, OK
Puyallup Tribal Health Authority (Family Medicine)	2011	4	HRSA THCGME	Tribal	Tacoma, WA
Choctaw Nation (Family Medicine)	2012	5	HRSA THCGME	Tribal	Talihina, OK
Chickasaw Nation (Family Medicine)	2018	4	HRSA THCGME	Tribal	Ada, OK
Sierra Nevada - Chapa De Indian Health (Family Medicine)	2022	2	HRSA RRPD to Medicare (external hospital partner)	Tribal	Grass Valley, CA

Cherokee Nation (Pediatrics)	2022	3	HRSA RRPD to THCGME	Tribal	Tahlequah, OK
UNM - Northern Navajo Medical Center (Family Medicine)	2022	2	HRSA PCTE, Medicaid in PGY-1 Hospital in 2/3	IHS	Shiprock, NM

Responses to Workgroup Questions

How can Congress help incentivize Medicare GME in IHS facilities?

The AIMES Alliance is grateful to the Workgroup for including a question on the connection between IHS and Medicare GME. I/T/U facilities currently have little to no participation in the Medicare-GME program, but it is essential that they be allowed to participate. Participating in the Medicare-GME program provides two key elements: quality care and sustainable staffing.

First, academic medical centers with training programs have been documented to have better outcomes among patients.[20] This quality care also has a spillover effect on hospitals near training institutions. Quality care can be difficult to measure in the short term but should be part of the measurable outcomes in the first 5-10 years. This necessitates a consistent, dedicated funding source that Medicare can provide.

Secondly, multiple sources, including the GAO, have noted that physicians are likely to stay and practice medicine in the area where they completed their residency training.[21] The Alliance encourages the Workgroup to take advantage of this knowledge and provide the authorities and resources needed to train physicians where they are most needed, knowing that they are more likely to stay and continue serving in those communities.

Based on the outline provided by the Workgroup, the AIMES Alliance recommends that the Workgroup consider the following:

- Expand its thinking to include Tribal-operated and urban Indian programs, in addition to IHS facilities.
- Dedicate a specific number of Medicare GME slots for I/T/U facilities.
- Permit I/T/U facilities to use Medicare GME funds for residency development costs and partnerships with academic institutions.

Expand Thinking to Include all Tribal Facilities.

The Alliance appreciates that the Workgroup has noted the disconnect between Tribal health services and its well-known physician shortage issues, and the Medicare-GME program. While the Workgroup specifically called out IHS facilities,

[20] Burke LG, Burke RC, Orav EJ, Duggan CE, Figueroa JF, Jha AK. Association of Academic Medical Center Presence With Clinical Outcomes at Neighboring Community Hospitals Among Medicare Beneficiaries. JAMA Netw Open. 2023 Feb 1;6(2):e2254559. doi: 10.1001/jamanetworkopen.2022.54559. PMID: 36723939; PMCID: PMC9892959

[21] GAO-17-411

the Alliance encourages members to expand their thinking to also include Tribally operated and urban Indian organizations when discussing Medicare GME expansion. The three pillars of the I/T/U system (IHS, Tribal, and urban Indian) support each other and provide essential medical care to AI/ANs. They also suffer from physician shortages. Excluding one or more of these categories of Tribal medical facilities from these discussions and any future legislation would be a disservice to the Workgroup's goal of expanding access to care through Medicare GME.

Dedicated Specific GME Slots for I/T/U Facilities.

The Medicare program is the largest source of GME funding, providing far more funding to GME programs than any other program including Medicaid, the VA, the Department of Defense, the Children's Hospital GME program, and the Teaching Health Center GME (THCGME) program. However, despite the large amount of funds distributed across the country, most funding goes to large, urban hospital systems located on the East and West coasts, not to small hospitals that provide care to underserved populations and struggle with staffing shortages.[22] The way that the Medicare-GME program is currently structured, I/T/U medical facilities do not have the capacity, resources, and time to compete with large, urban hospitals for Medicare-GME slots even though the communities the I/T/U facilities serve would greatly benefit from GME slots. If physician shortages are truly going to be reduced in the communities with the greatest need, it is essential that I/T/U facilities be given the chance to hold Medicare-GME slots.

This can be accomplished in several different ways:

1. Add criteria that allows for increased Medicare-GME slots for hospitals with partnerships with I/T/U medical facilities, similar to dental and podiatry positions across the country.[23]

This option would incentivize hospitals to form mutually beneficial partnerships with I/T/U facilities and allow physician residents to perform rotations in those facilities. This funding could be provided to hospital systems, but only if they demonstrate that they establish a continuity clinic partnership with an I/T/U clinic. That would mean the residents would be in those clinics for most of the 2nd and 3rd years of residency (as opposed to simply doing shorter duration rotations).

While these rotations would not be the full-time residency slots that build trust between physicians and communities and increase the likelihood of the resident continuing to work at the I/T/U in the future, it would bring needed staffing to I/T/Us. Hospitals that receive Medicare-GME funding that partner with an I/T/U should also be required to share a proportional amount of funding with the partner I/T/U to help that facility cover its associated GME costs.

---

[22] GAO-17-411

[23] Dental and podiatry positions are not subject to the federal funding cap and always have funding available due to the critical shortage across the country.

If criteria like these are added, participating hospitals must be required to truly partner with the I/T/U and not simply dominate a relationship. This may include adapting training curricula to incorporate traditional healing practices, Tribal terminology, and other adjustments to ensure the highest and most culturally appropriate care is being provided to Tribal members, and is taught to rotating physicians serving in the participating I/T/U.

2. Amend the existing Medicare-GME authorities and statutes to carve out a specific number of Medicare GME slots that must be allocated by HHS to I/T/U facilities or to accredited medical schools to establish residency programs jointly with I/T/U clinics.

Congress has the authority to direct federal spending where it wishes it to go. Considering the benefits of GME in reducing physician shortages, Congress should assign GME slots where they will have the greatest impact in expanding access to care. To that end, the Workgroup should consider amending the existing Medicare-GME authorities and direct HHS to set aside no fewer than 200 GME slots for I/T/U facilities or to accredited medical schools to establish residency programs jointly with I/T/U clinics. This adjustment would directly send Medicare-GME funding to where it is needed most, ensuring that large, urban hospital systems or others would not be able to take those slots at the detriment of I/T/Us. These slots would also provide stable, full-time residents the opportunity to serve in I/T/Us, thus providing sustainable staffing relief to Tribes.

Since some I/T/U clinics may not have the capacity to sponsor a residency at this time, allowing Tribal facilities to enter into mutually agreed to partnerships with accredited medical schools would be another way to bring Medicare-GME residents to I/T/U facilities. The medical school would be the sponsor and provide academic support, but the program would be coordinated under contract with the I/T/U.

In contrast to a rotation partnership (see point 1), establishing full time residencies with Medicare-GME slots would unleash the full benefits of physician GME. The physicians would be able to invest in the communities, build trust with community members, and provide patient-centered, culturally appropriate care while honing their skills and learning high quality medical care.

3. Under the auspices of the Medicare-GME program, establish a dedicated but separate pilot program where a specific number of Medicare-GME funded slots are provided to I/T/U facilities for a set period with concurrent evaluation provided by the HHS Office of the Assistant Secretary of Planning and Evaluation and the GAO.

Pilot programs allow for flexibility and innovation to help find the best solutions to the most complex problems. Since a dedicated I/T/U GME program does not exist, the Workgroup can “test-drive” novel ideas before enacting them at a larger scale.

The Alliance recommends that the Workgroup establish a pilot program where a specific number of Medicare-GME slots are provided to I/T/U facilities to allow them

to establish and/or operate residency programs. The awarded slots could be contingent upon the I/T/U facility having an academic partnership with one or more medical schools or existing sponsoring institution, thus ensuring that the awarded slots will have partners who can provide preceptors and instructors.

To ensure that IHS, Tribal-operated, and urban Indian programs are fully represented, and that multiple regions across the country receive slots, it is recommended that any pilot created start with 50 annual residency slots. This would ensure appropriate distribution across different facilities and locations. It is also recommended that any pilot created last for no shorter than six years, ensuring that multiple classes of residents can perform their work.

Not all I/T/U medical facilities are ready to operate physician residencies. By operating a pilot program, Congress could direct CMS (after formal consultation with Tribal nations) to select the facilities that have the greatest capabilities, desire to operate a GME program, or need. Tribal consultation is the best way for the pilot to be inclusive of all I/T/U facilities. Other criteria in selecting facilities could include, but not be limited to:

- Distance from the nearest Tribal medical facility.
- Distance from the nearest traditional medical facility.
- Active partnerships with academic medical institutions.
- Active partnerships with other teaching hospitals.
- Number of services rendered.
- Current staffing numbers.
- Location within the U.S.

Evaluation is an essential aspect of pilots to ensure that the program operates properly and generates a positive return on investment. Annual reports should be submitted to Congress and provide an accounting of the program. The reports could include information such as:

- The number of eligible patients who received care from residents under the pilot program.
- The number of eligible patients who received care from each resident per position under the pilot program.
- The number of eligible patients who received care from residents under the pilot program expressed as a percentage of all individuals who received care from such residents.
- The number of clinical appointments for eligible patients conducted by each resident under the pilot program.
- The number of clinical appointments for eligible patients conducted by residents per position under the pilot program.

- The number of clinical appointments for eligible patients expressed as a percentage of all clinical appointments conducted by residents under the pilot program.
- The number of GME positions at each I/T/U facility under the pilot program.
- Retention information of the residents after graduation and documentation as to where they practiced.
- The cost to the Department of Health and Human Services under the pilot program in the year immediately preceding the report and since the beginning of the pilot program.
- The cost to the Department of Health and Human Services per resident placed under the pilot program at each covered facility.
- The number of residents under the pilot program hired by the Secretary to work in I/T/U facilities after completion of residency in the year immediately preceding the report and since the beginning of the pilot program.
- The medical specialties pursued by residents under the pilot program.
- An analysis of health outcomes of eligible patients attending the covered facilities over the course of the pilot program.
- An analysis of the geographic distribution of the residents under the pilot program.

Congress could also request that the GAO and HHS Office of the Assistant Secretary of Planning and Evaluation evaluate the pilot during its implementation. The information provided by the evaluations would provide Congress with data that could be used to adjust and expand the program.

Considering the success of the VA's long-running GME program, which has been described as "remarkably successful…, perhaps more so than the [program creators] could have anticipated," we are confident that a dedicated I/T/U GME program would also generate a positive return and be viewed as "remarkably successful."[24]

4. In conjunction with the Senate Indian Affairs, HELP, and Appropriations Committees, authorize and fund an Office of Tribal Health Workforce and Academic Partnerships within HHS that would work with IHS, CMS, and HRSA to oversee and implement GME programs and partnerships within I/T/U facilities.

The Alliance recognizes that the Senate Finance Committee does not have jurisdiction over all health, GME, Tribal, or spending programs. However, the

[24] *See* Petrakis, Ismene L. MD1; Kozal, Michael MD2. Academic Medical Centers and the U.S. Department of Veterans Affairs: A 75-Year Partnership Influences Medical Education, Scientific Discovery, and Clinical Care. Academic Medicine 97(8):p 1110-1113, August 2022. | DOI: 10.1097/ACM.0000000000004734; *See also* Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. JAMA. 2022 Jul 26;328(4):327-328. doi: 10.1001/jama.2022.10359. PMID: 35816350.

committee does have jurisdiction over many associated parts and its input would be essential to creating a dedicated Tribal-physician GME office and program. A dedicated program could either be the permanent result of a Medicare-GME in I/T/U facility pilot program (see point 3) or it could be a standalone legislative product.

The benefits of a fully authorized and funded I/T/U GME office and program is clear. Much like the very successful Office of Academic Affiliations at the Veterans Health Administration, an I/T/U GME office would provide clear leadership, guidance, and oversight in establishing fruitful partnerships between I/T/U medical facilities and M.D. and D.O.-granting academic institutions. This office could help I/T/U facilities and its partners navigate CMS (Medicare), HRSA (THCGME, CHGME), and other GME programs to ensure they are being properly used and are maximizing access to care in their communities.

Authorization from Congress would be essential for this office to succeed. The office would need clear directives from Congress to ensure that urban and rural Tribal members are being served, physician shortages are being reduced, partnerships are being created, and GME funds are being used appropriately.

AIMES Alliance member and longtime I/T/U workforce advocate Partners in Health has provided background on what a dedicated I/T/U GME office could do with $42 million in annual appropriations. With that amount, the I/T/U office could help provide dedicated GME coordination, fund 16 programs and 62 residents while providing technical assistance, and additional short-term rotations and fellowships. That would create a comprehensive GME ecosystem that currently does not exist in the I/T/U system right now.

Purpose	**Example Budget**	**Example Outcomes**	***Program Model / Cost basis***
1) Coordinate programs across I/T/Us	$1 million	National, regional, local coordination	*VHA OAA*
2) Fund residency planning and development (with TA)	$16 million	$1,000,000 per program = 16 programs per year	*HRSA RRPD + TA* *HRSA THCPD + TA*
3) Fund full-time residency positions at I/T/Us	$10 million	$160,000 per slot = 62 residents per year	*HRSA THCGME* *CMS*

4) Fund VA-style residency rotations	$5 million	$70,000 per slot * 6 rotations = 426 trainees per year	*VHA OAA*
5) Fund fellowship positions	$10 million	$200,000 per fellow = 50 fellows per year	*UCSF, MGH, UW, Utah, Sinai*

Permit I/T/U Facilities to Use Medicare GME Funds for Residency Program and Partnership Development.

Since many I/T/U facilities do not currently have a residency program in place, they would need to build the program before accepting residents. One of the primary barriers to I/T/U medical facilities establishing GME programs is the lack of funding to cover residency startup costs. It can take between 1 – 2 years and between $1-2 million to set up a successful GME program, all of which involves significant investment. Startup costs may include:

- ACGME accreditation costs
- Curriculum development
- Recruitment and retention of faculty
- Faculty salary

Limited funding is available through the HRSA Rural Residency Planning and Development (RRPD) Program to provide funding to cover residency startup costs, but that does not apply to non-rural facilities such as urban Indian organizations and numerous IHS and Tribal-operated facilities. IHS has no funding to support the development of GME programs. Some tribes have been able to cover the costs of GME development through their general fund, but most cannot.

Permitting I/T/U facilities to utilize Medicare GME funding for residency program and partnership development would remove one of the primary barriers to I/T/U facilities not having GME programs. This allowance could also be expanded to other rural clinics or medical facilities that serve underserved populations to help them cover the cost to start up a residency program.

Conclusion

Expanding GME opportunities to not just IHS, but also Tribal-operated and urban Indian medical facilities is a clear way to reduce physician shortages, improve health outcomes, and expand access to care to those that need it most. It also helps to contribute to the equitable growth of the health care workforce in our I/T/U communities, with an impact through generations. We need to change our mindset to train residents where we need them. It is important for many patients in I/T/U communities to have a racially, ethnically, and/or culturally concordant physician

providing care for them, as it honors many Tribal members' unique Indigenous health beliefs and helps to build trusting patient-physician relationships. The few I/T/U residencies in existence are already starting to reap the benefits from their hard work. The Choctaw Family Medicine Residency has reported that 70 percent of residents are retained in their health care system. Puyallup Tribal Health Authority and Seattle Indian Health Board residencies report 55 percent and 45 percent of their residency graduates, respectively, are recruited to I/T/Us after residency. These are prime examples of what can be accomplished through I/T/Us, health care systems, medical academic institutions, and government partnerships. The AIMES Alliance encourages the Workgroup to train physicians where they are needed and expand GME to Tribal medical facilities.