November 10, 2026

The Honorable John Thune
Senate Majority Leader
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Chuck Schumer
Senate Minority Leader
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Mike Johnson
Speaker of the US House of Representatives
H-232 US Capitol Building
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
2267 Rayburn House Office Building
Washington, DC 20515

Re: Indian Health Priorities for the Remainder of the 119th Congress

Dear Majority Leader Thune, Minority Leader Schumer, Speaker Johnson, and Minority Leader Jeffries:

On behalf of the undersigned national organizations collectively serving all 575+ federally recognized Tribal Nations and all 41 urban Indian organizations (UIOs), we urge you to take immediate action on critical health priorities during the remainder of the 119th Congress. Together, our organizations represent American Indian and Alaska Native (AI/AN) people across the Indian Health Service, Tribal, and Urban Indian (I/T/U) system. Tribal Nations have a unique legal and political relationship with the United States. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal Nations, recognizing a trust relationship to safeguard Tribal rights, lands, and resources.[1] In fulfillment of this trust relationship, the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal Nations.[2] Congress affirmed this duty through the Indian Health Care Improvement Act (IHCIA), declaring that, "in fulfillment of its special trust responsibilities and legal obligations to Indians," it is the policy of this Nation "to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy"[3]

Fulfilling that obligation requires continuous funding for the Indian Health Service and the extension of public health provisions that are lifelines in AI/AN communities. We urge you to include the following bipartisan Indian health priorities as you negotiate the December 11, 2026, funding deadline and the year-end legislative package.

[1] Worcester v. Georgia, 31 U.S. 515 (1832).
[2] Seminole Nation v. United States, 316 U.S. 286, 296-97 (1942).
[3] 25 U.S.C. § 1602(1)

Fiscal Year 2027 Appropriations Priorities

- **Indian Health Service (IHS) Advance Appropriations for FY2028**– Congress must provide advance appropriations for FY 2028 across all IHS accounts to ensure continuity of clinical care across IHS, Tribal, and urban Indian health programs. Without advance appropriations, a federal government shutdown would devastate healthcare services to millions of American Indian and Alaska Native people.

- **Extend the Moratorium on the OMB Proposed Rule "Regulation for Federal Financial Assistance (OMB-2026-0034)**–Congress must extend the moratorium on the proposed OMB rule to revise Guidance for Federal Financial Assistance (Uniform Guidance) to prevent political interference in federal financial awards. The proposed rule would convert the Uniform Guidance into a binding government-wide regulation and allow agencies to terminate awards based on shifting agency priorities or the "national interest." The OMB Uniform Guidance proposed rule interferes with Congress' constitutional appropriations authority and risks the funds Congress appropriates to carry out the federal trust responsibility.

- **Reclassify Contract Support Costs (CSC) and Section 105(l) as Mandatory**–We urge Congress to reclassify the required CSC and 105(l) line items as mandatory appropriations. The Indian Self-Determination and Education Assistance Act (ISDEAA) requires IHS to fully fund CSC and Section 105(l) lease payments, making these payments legally mandatory. Because these payments are currently provided through discretionary spending, annual increases mostly go to these line items, leaving all other IHS programs flat-funded. In FY 2027, these costs rose to $1.731 billion for CSC and $720 million for Section 105(l) lease payments, accounting for 28.2% of the total IHS budget.

Year-End Tribal Health Extenders and Reauthorizations

- **Reauthorize the Special Diabetes Program for Indians for at least two years at no less than $200 million per year**–We request that Congress enact a multi-year reauthorization of SDPI before funding expires on December 31, 2026. The Special Diabetes Program for Indians serves more than 982,000 AI/AN people across 310 programs in 36 states and remains the nation's most effective federal initiative for combating diabetes in Indian Country. SDPI has helped cut end-stage renal disease among AI/AN people by more than half. SDPI focuses on a culturally informed and community-directed approach to treat and prevent Type 2 diabetes in Tribal communities.

- **Exempt Tribal health organizations and urban Indian organizations from 340B rebate models**–Under the 340B Rebate Model Pilot Program, the Health Resources and Services Administration requires participating Tribal health organizations and urban Indian organizations to purchase drugs at full price and wait to receive a rebate. Many Tribal and urban Indian health programs

operate on tight budgets and lack the capital to cover upfront costs that can be up to 100 times the 340B price or to absorb the cash flow delays built into a rebate model, diverting resources away from patient care. We urge Congress to follow the calls from Tribal leaders to pass legislation exempting Tribal health and urban Indian organizations from 340B rebate-based pilot models.[4]

- **Extend Controlled Substance Telehealth Prescription Flexibilities**– Enact a multi-year extension of the Drug Enforcement Administration (DEA) and Department of Health and Human Services (HHS) telemedicine prescribing flexibilities for Schedule II-V controlled substances via audio-video telemedicine, and audio-only prescribing of Schedule III-V narcotics before the December 31, 2026, expiration. Tribal leaders have also recommended extending these flexibilities directly to the DEA in a Tribal consultation letter in May 2026. Allowing these flexibilities to lapse would immediately harm Tribal patients, particularly those in remote and roadless communities, by cutting access to life-saving medication-assisted treatment and behavioral health care.

Bipartisan Indian Health Service Legislation

- **Pass the IHS Emergency Claims Parity Act**–Enact H.R. 8658, the *Indian Health Service Emergency Claims Parity Act*, to extend the Purchased/Referred Care (PRC) emergency notification window from 72 hours to at least 15 days, protecting AI/AN patients from surprise medical bills following emergency care. We greatly appreciate that the House of Representatives and Senate passed their respective bills, H.R. 8658 and S. 1055, in September 2026. As Congress works to reconcile the two versions for final passage, we urge the passage of the House version to extend the PRC emergency notification window to *at least* 15 days, allowing IHS to determine the best timeline through Tribal consultation and the rule making process.

- **Pass the IHS Workforce Parity Act**–Enact the *IHS Workforce Parity Act*, S. 632/H.R. 10956, to allow IHS Scholarship and Loan Repayment Program recipients to fulfill their service obligations through half-time clinical practice. This bipartisan legislation was passed out of the Senate Committee on Indian Affairs and awaits a hearing in the House of Representatives. The legislative fix provides essential flexibility to recruit and retain physicians and nurses at rural I/T/U facilities and should be passed into law before the end of the year.

- **Pass the Urban Indian Health Parity Act** – Enact H.R. 4722, the *Urban Indian Health Parity Act*, to extend 100% Federal Medical Assistance Percentage (FMAP) to Medicaid services provided at urban Indian organizations (UIOs). When Congress authorized 100% FMAP for the Indian health system in 1976, it recognized that the federal government, not the states, bears the trust and treaty

[4] National Congress of American Indians (Oct. 2026). NCAI Resolution #PSC-26-011, Urging HRSA to Exempt Indian Health Care Providers from the 340B Rebate Model Pilot Program, https://ncai.assetbank-server.com/assetbank-ncai/action/viewAsset?id=6091.

obligation to provide health care to American Indian and Alaska Native people. Indian Country has sought 100% FMAP for UIOs since 1999 and now is the time to bring UIOs into parity with the rest of the Indian health system.

Indian Country stands united in calling on Congress to enact these time-sensitive priorities before the conclusion of the 119th Congress. Thank you for your continued bipartisan commitment to upholding the federal trust responsibility. For any questions or additional information, please direct all communication to Emily Larsen, Congressional Analyst at the National Indian Health Board, via email at elarsen@nihb.org.

Respectfully,

National Congress of American Indians
National Council of Urban Indian Health
National Indian Health Board

Cc: The Honorable Susan Collins, Chair, Senate Committee on Appropriations
The Honorable Patty Murray, Vice Chair, Senate Committee on Appropriations
The Honorable Tom Cole, Chair, House Committee on Appropriations
The Honorable Rosa DeLauro, Ranking Member, House Committee on Appropriations
The Honorable Lisa Murkowski, Chair, Senate Committee on Indian Affairs
The Honorable Brian Schatz, Vice Chair, Senate Committee on Indian Affairs
The Honorable Mike Crapo, Chair, Senate Finance Committee
The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Bill Cassidy, Chair, Senate Health, Education, Labor, and Pensions Committee
The Honorable Bernie Sanders, Ranking Member, Senate Health, Education, Labor, and Pensions Committee
The Honorable Bruce Westerman, Chair, House Committee on Natural Resources
The Honorable Jared Huffman, Ranking Member, House Committee on Natural Resources
The Honorable Brett Guthrie, Chair, House Energy and Commerce Committee
The Honorable Frank Pallone, Ranking Member, House Energy and Commerce Committee