Draft date: 11/4/24

2024 Fall National Meeting
Denver, Colorado

JOINT DIVERSITY, EQUITY, AND INCLUSION MEMBER DIVERSITY LEADERSHIP BREAKFAST FORUM AND NAIC/AMERICAN INDIAN AND ALASKA NATIVE LIAISON COMMITTEE
Monday, November 18, 2024
7:30 – 8:00 a.m. Breakfast
8:00 – 9:00 a.m. Liaison Committee Meeting
Gaylord Rockies Hotel—Juniper Ballroom—Level 1

ROLL CALL

Glen Mulready, Chair	Oklahoma	Alice T. Kane	New Mexico
Trinidad Navarro, Vice Chair	Delaware	Mike Causey	North Carolina
Lori K. Wing-Heier	Alaska	Jon Godfread	North Dakota
Peni Itula Sapini Teo	American Samoa	Andrew R. Stolfi	Oregon
Barbara D. Richardson	Arizona	Larry D. Deiter	South Dakota
Dean L. Cameron	Idaho	Jon Pike	Utah
Grace Arnold	Minnesota	Mike Kreidler	Washington
Chlora Lindley-Myers	Missouri	Nathan Houdek	Wisconsin
Scott Kipper	Nevada	Jeff Rude	Wyoming

NAIC Support Staff: Lois E. Alexander

AGENDA

1. Consider Adoption of its Summer National Meeting Minutes —*Commissioner Glen Mulready (OK)* — Attachment One

2. Hear a Presentation on the American Indian Medical Education Strategies (AIMES) Alliance Regarding Medical Access for American Indians and Alaska Natives—*Bill Snyder (Leavitt Partners) and Dr. LeeAnna Muzquiz (American Indian Family Physician and Associate Dean of Admissions at the University of Washington School of Medicine)*

3. Hear a Presentation on Producer Outreach to Tribal Members Providing Access to Affordable Insurance Products—*Brendan McKenna (Vice President, Tribal First)*

4. Hear a Panel Discussion on How Regulators Support Tribal Communities and Answer any Questions from Attendees—*Director Lori K. Wing-Heier*

(AK), Commissioner Glen Mulready (OK), Bill Snyder, Dr. LeeAnna Muzquiz, and Brendan McKenna)

5. Discuss Any Other Matters Brought Before the Liaison Committee —*Commissioner Glen Mulready (OK)*

6. Adjournment

Draft Pending Adoption

Draft: 8/26/24 (revised 10/8/24)

NAIC/American Indian and Alaska Native Liaison Committee
Chicago, Illinois
August 14, 2024

The NAIC/American Indian and Alaska Native Liaison Committee met in Chicago, IL, Aug. 14, 2024. The following Liaison Committee members participated: Glen Mulready, Chair (OK); Lori K. Wing-Heier (AK); Barbara D. Richardson (AZ); Dean L. Cameron represented by Shannon Hohl (ID); Grace Arnold represented by Peter Brickwedde (MN); Chlora Lindley-Myers represented by Jo LeDuc (MO); Scott Kipper represented by Nick Stosic (NV); Mike Causey represented by Angela Hatchell (NC); Jon Godfread represented by John Arnold (ND); Andrew R. Stolfi represented by Alex Cheng (OR); Larry D. Deiter represented by Frank Marnell and Tony Dorschner (SD); Jon Pike represented by Ryan Jubber (UT); Mike Kreidler represented by Todd Dixon (WA); Nathan Houdek represented by Andrea Davenport (WI); and Jeff Rude (WY).

1. Adopted its Spring National Meeting Minutes

Cabinet Executive Officer Richardson made a motion, seconded by Commissioner Rude, to adopt the Liaison Committee's March 17 minutes (*see NAIC Proceedings – Spring 2024, American Indian and Alaska Native Liaison Committee*). The motion passed unanimously.

2. Heard a Presentation on the AIMES Alliance

Robert M. Dorrell (Blue Cross Blue Shield of Oklahoma—BCBSOK) introduced Spencer Davis (Leavitt Partners) and said that the American Indian Medical Education Strategies (AIMES) Alliance is managed by Leavitt Partners. The Alliance brings together voices from all sectors to collaboratively drive solutions forward that will bring graduate medical education (GME) to Tribal communities. He said there are numerous founding members that include health plans, associations, universities, health systems and tribes. Davis said this program is collaboratively advancing federal and Tribal solutions that expand graduate medical education (GME) opportunities in Indian Country through communications, outreach, and policy development to reduce physician shortages in Tribal medical facilities. He said the goal is to keep up to date on the latest policies, activities, and developments focused on reducing physician shortages and expanding GME in Tribal medical facilities by joining the AIMES Alliance community.

Davis said the diversity of the AIMES Alliance membership is its strength. He said AIMES Alliance members include those from Tribal nations, urban and rural Tribal organizations, medical institutions that grant Doctor of Medicine (MDs) and Doctor of Osteopathic Medicine (DOs), teaching hospitals, residency programs, and physician and workforce advocates. He said the Alliance brings together voices from all sectors to collaboratively drive solutions forward that will bring GME to Tribal communities.

Davis said that despite the billions of dollars put toward training physicians, hardly any money goes to Tribal medical facilities even though they could benefit the most from improved staffing. He said American Indians and Alaska Natives (AI/ANs) suffer from some of the highest rates of avoidable deaths from preventable and treatable causes. For example, from 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. He also said the mission of the AIMES Alliance is to advance AI/AN access to care, reduce physician shortages, and expand opportunities for training physicians to benefit communities by collaboratively advancing federal and Tribal solutions that expand GME in Tribal communities. The AIMES Alliance is working to accomplish its mission through communications, outreach, and policy

development. Davis said the AIMES Alliance envisions an environment where urban and rural Tribal members benefit from access to fully staffed medical facilities filled with physicians who provide high-quality and culturally appropriate care and invest in the communities they serve. He said the Alliance also envisions a medical education and training environment where allopathic and osteopathic physicians have extensive opportunities to benefit communities and further their education and training in urban and rural Indian Health Service (IHS), Tribal-administered, and other Indigenous clinics and facilities.

Davis said Dr. Donald Warne leads the AIMES Alliance as its convener and is currently serving as co-director of the Johns Hopkins Center for Indigenous Health. Davis said Warne is an acclaimed physician, one of the world's preeminent scholars in Indigenous health, health education, policy, and equity, as well as a member of the Oglala Lakota Tribe from Pine Ridge, South Dakota. He said Warne will also serve as Johns Hopkins University's new Provost Fellow for Indigenous Health Policy. Davis said that because Warne comes from a long line of traditional healers and medicine men and is a celebrated researcher of chronic health inequities, he is also an educational leader. Warne created the first Indigenous health-focused Master of Public Health (MPH) and Doctor of Philosophy (PhD) programs in the U.S. or Canada at North Dakota State University and the University of North Dakota, respectively. He said Warne previously served at the University of North Dakota as a professor of Family and Community Medicine and associate dean of diversity, equity, and inclusion (DE&I), as well as director of the Indians into Medicine and Public Health programs at the University of North Dakota School of Medicine and Health Sciences.

Davis said Dr. Michael Toedt serves as the AIMES Alliance's senior advisor and is the founder and chief executive officer (CEO) of Toedt Health Solutions. He said Toedt is a North Carolina-licensed and board-certified family physician and the former chief medical officer (CMO) of the IHS, as well as their chief medical informatics officer (CMIO). Davis said Toedt is a retired rear admiral with over 30 years of experience as a physician executive, public health expert, health information and technology expert, and flag officer in the U.S. Public Health Service Commissioned Corps. Davis said that Toedt, as a Uniformed Services University of the Health Sciences graduate, has first-hand experience serving in IHS, Tribal, U.S. Department of Defense (DoD), and U.S. Department of Veterans Affairs (VA) health care facilities. He has served on numerous U.S. Department of Health and Human Services (HHS) committees. He said Toedt has extensive experience working with local, regional, Tribal, state, and federal governments, emphasizing eliminating health inequity and improving health outcomes for vulnerable and underserved populations.

Davis said GME is the period of training performed after medical school where physicians gain specific skills and experiences in a particular medical specialty (residency) or subspecialty (fellowship). He said GME is primarily funded by four federal programs and agencies (Medicare, the Health Resources and Services Administration (HRSA), the VA, and the DoD) and one joint federal-state program (Medicaid). Davis said GME residents and fellows in Tribal medical facilities create an ecosystem of sustainable, high-quality care locally, reducing the need for travel, long waits, and paying for high-cost locum tenens positions (a locum, or locum tenens, is a person who temporarily fulfills the duties of another; the term is especially used for physicians. For example, a locum tenens physician is a physician who works in the place of the regular physician). He said physicians invested in the community are more likely to provide consistent, accessible, and culturally appropriate care to Tribal members. Davis said that 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: IHS, Tribal-operated, and Urban Indian Organizations (UIOs).

Director Wing-Heier asked what the AIMES Alliance is doing in Alaska. Davis said it reached out to several programs in Alaska but was told that due to funding restrictions, the organizations were not able to participate. Director Wing-Heier asked Davis to call her so she could help arrange a meeting, as funding is not the problem currently. She said the Alaska Division of Insurance (DOI) would be a better resource for AIMES at this time. Marnell asked

Davis if the AIMES Alliance was able to utilize student loan forgiveness to attract new physicians. Davis said he had heard nothing about expanding in this area. Cabinet Executive Officer Richardson said Arizona has many Tribes, but the AIMES Alliance map had none listed in Arizona. Davis said the map listed the organizations' headquarters locations, so they reached out to Arizona through their home office in Minnesota and had good conversations with the University of Arizona. Commissioner Mulready said Oklahoma was a notable example of the launch phase and asked where the AIMES Alliance is heading next. Davis said it was investigating how to use this program to benefit Tribal organizations. He said that historically, Oklahoma had incredible leaders in this space and that they meet monthly about how to take all these ideas forward. He said they are now in implementation mode for four major categories and plan to accelerate over the coming year.

Commissioner Mulready introduced Bill Snyder (Leavitt Partners) and asked about funding, specifically, what meaningful contributions from non-Tribal organizations meant. Davis said the AIMES Alliance has no set dues but encourages participation. He said the Bush Foundation has a focused Commonwealth Fund with listening sessions regarding funding. He also said the AIMES Alliance did not want to place any undue burden of funding on membership entry. Commissioner Mulready said there was a lack of physicians; and that U.S. Representative Tom Cole (R-OK) is the Chair of Appropriations and is a tribal member who could be very helpful in securing funding. He also asked why the AIMES Alliance was not pursuing physician assistants (PAs). Davis said that the AIMES Alliance is trying to be as specific as possible to get the biggest bang for its buck. It is not saying no to PAs but not saying yes yet.

3. Heard Updates from States on Native Community Outreach

Director Wing-Heier said health care accessibility is a huge challenge in Anchorage and other rural areas, as the cost is excessive, and the governor is working with HHS and the DOI on potential solutions.

Dixon said Washington is publishing a 12-page document that provides insurers with a handbook to meet the requirements of federal Tribal rules about networks, care, medical practice, etc. He suggested it might be a good topic for a future NAIC meeting.

Commissioner Mulready said members have not heard from agents/producers who are actively engaged in the tribal communities at this Liaison Committee but would like to in the future.

Having no further business, the NAIC/American Indian and Alaska Native Liaison Committee adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Consumer/AIAN/2024 Summer/Minutes_SNM_AIAN CMTE

Draft Pending Adoption

Draft: 11/5/24

American Indian and Alaska Native Liaison Committee
E-vote
November 15, 2024

The American Indian and Alaska Native Liaison Committee held an E-vote to affirm its 2024 Mission Statement for 2025 on Oct. 15, 2024. The following Committee members participated: Glen Mulready, Chair (OK); Trinidad Navarro, Vice Chair (DE); Lori K. Wing-Heier (AK); Barbara Richardson (AZ); Dean L. Cameron (ID); Grace Arnold (MN); Mike Causey (NC); Jon Godfread (ND); Larry Deiter (SD); Mike Kreidler (WA); and Nathan Houdek (WI).

1. Reaffirmed its 2024 Mission Statement for 2025

Commissioner Mulready said the Liaison Committee met via E-vote to reaffirm its 2024 Mission Statement for 2025.

The motion passed unanimously Oct. 15, 2024.

Having no further business, the Sample (S) Task Force adjourned.

SharePoint/NAIC Support Staff Hub/Committees/Consumer Committee/AIAN/2024 Fall/Reaffirm E-vote Min

AMERICAN INDIAN

MEDICAL EDUCATION STRATEGIES ALLIANCE

AIMES Members as of November 2024

Seattle Indian Health Board
For the Love of Native People

Partners In Health

College of Human Medicine
MICHIGAN STATE UNIVERSITY

Arkansas College of Osteopathic Medicine

ACPM
American College of Preventive Medicine

ROCKY VISTA UNIVERSITY
UTAH

SANFORD HEALTH

ROCKY VISTA UNIVERSITY
COLLEGE OF OSTEOPATHIC MEDICINE

MAYO CLINIC

RuralGME

OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES

HCSC Health Care Service Corporation

DENVER HEALTH ACADEMIC AFFAIRS
OFFICE OF EDUCATION

THCGME

AACOM
American Association of Colleges of Osteopathic Medicine

TOURO COLLEGE OF OSTEOPATHIC MEDICINE
Harlem, NY | Middletown, NY | Great Falls, MT

TOURO UNIVERSITY CALIFORNIA

Germane SOLUTIONS

Mount Sinai

MONTANA STATE UNIVERSITY
Office of Rural Health
Area Health Education Center

WCRGME
WISCONSIN COLLABORATIVE for RURAL GME

ROCKY VISTA UNIVERSITY
MONTANA COLLEGE OF OSTEOPATHIC MEDICINE

CENTER FOR INDIGENOUS HEALTH

UW Medicine
UW SCHOOL OF MEDICINE

CHAPA-DE
INDIAN HEALTH

ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

FAMILY MEDICINE RESIDENCY OF WESTERN MONTANA

GREAT PLAINS TRIBAL LEADERS HEALTH BOARD

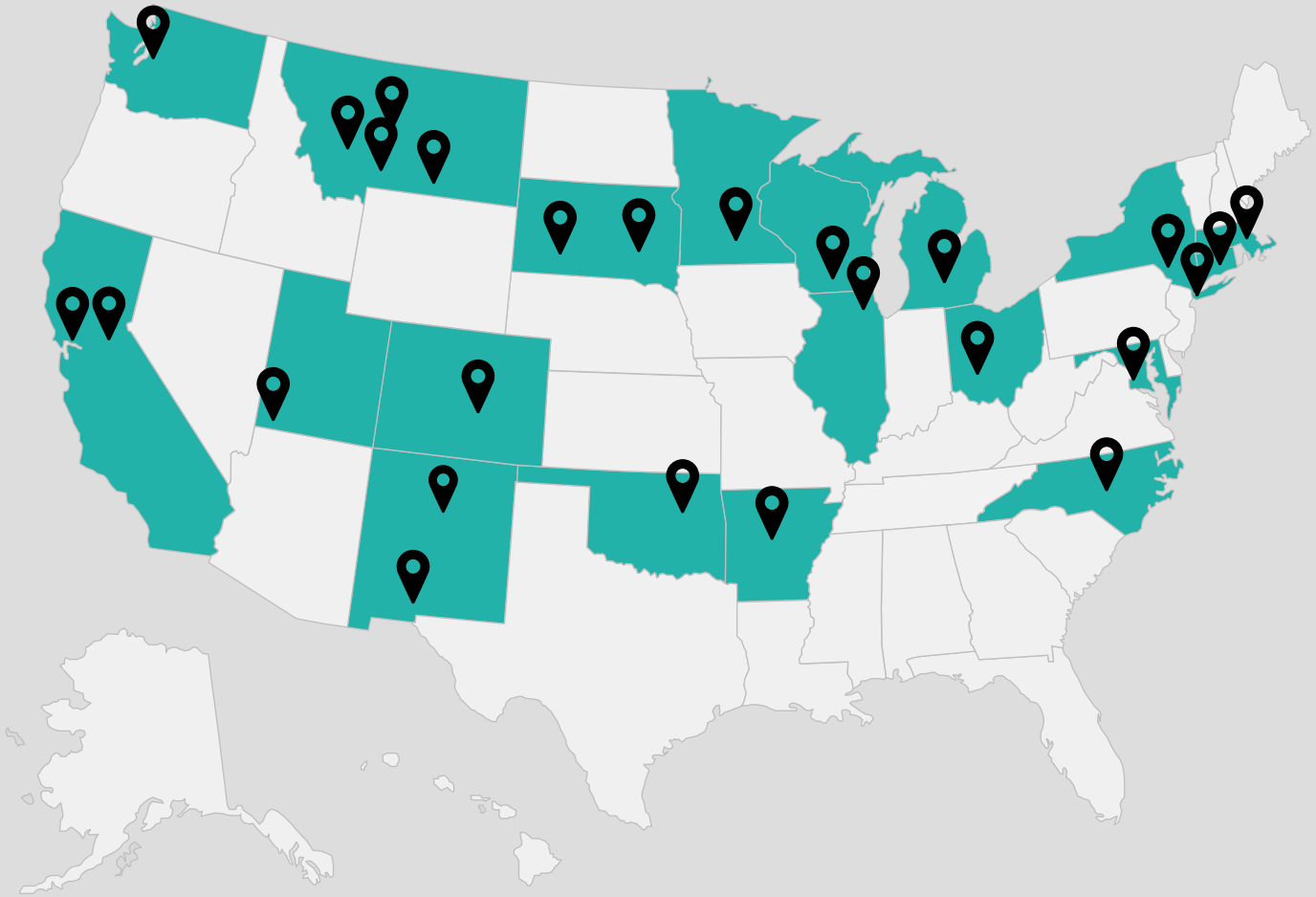
ASSOCIATION OF NATIVE AMERICAN MEDICAL STUDENTS

BURRELL COLLEGE OF OSTEOPATHIC MEDICINE

Albuquerque Area Indian Health Board Inc.
Est. February 4,1980

Mashantucket Pequot Tribal Nation

AIMES Members Span the Country



19 States

Seven Tribal Partners

14 Medical Schools
- 10 Osteopathic
- 4 Allopathic

4 Teaching Hospital Systems

1 Health Plan

1 Residency Program

5 Physician and Medical Education Advocates

Who Are Our Leaders?

Dr. Donald Warne: Alliance Convener

- Oglala Lakota tribe from Pine Ridge, South Dakota
- Co-Director of the Johns Hopkins Center for Indigenous Health.
- One of the world's preeminent scholars in Indigenous health, health education, policy and equity.

Dr. Michael Toedt: Senior Advisor

- Retired Assistant Surgeon General and USPHS Rear Admiral (Lower Half)
- Former Chief Medical Officer and acting Chief Medical Informatics Officer of the Indian Health Service.

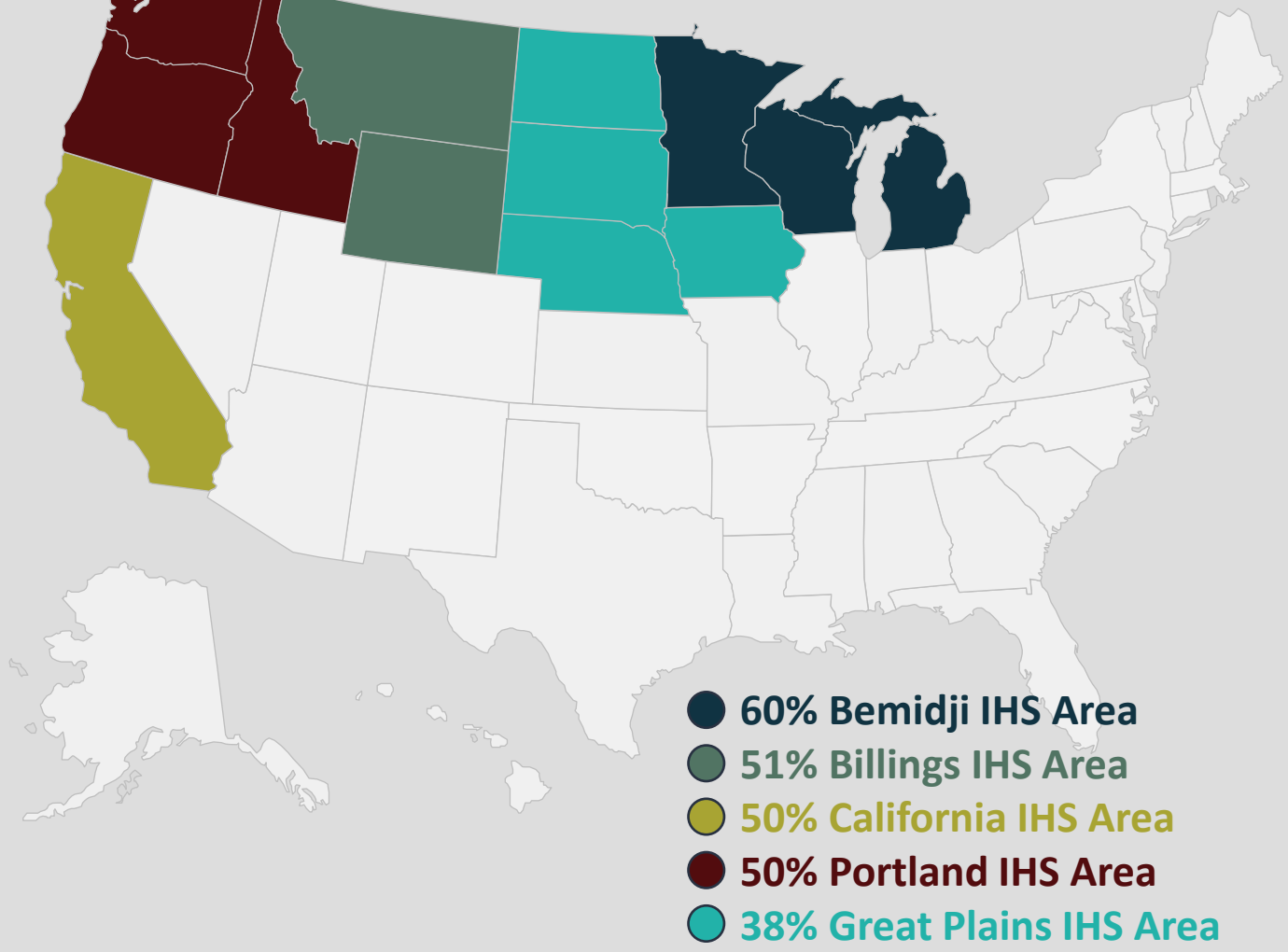
What Brought the Alliance Together?

- **There are not enough physicians and other healthcare providers serving and staying in Indian Country.**
  - The IHS vacancy rate averages about 26% overall but exceeds 50% in some areas.

- **AI/AN individuals are dying younger and at higher rates of avoidable causes of death than other groups.**

- **With the AI/AN life expectancy now down to 65 years, an AI/AN child born today won't live long enough on average, to use Medicare.**

Select Physician Vacancy Rates at Indian Health Service Facilities.



Why Now?

There are several indicators that show why *now* is the time to push for physician-GME in Tribal community policy changes.

1. In the *Consolidated Appropriations Act, FY2023* (2022), Congress included a historic provision providing advance appropriations for the Indian Health Service (IHS).

2. Congress protected and kept in place the IHS advance appropriations when leaders negotiated and passed the *Fiscal Responsibility Act* in 2023.

3. Congress is deeply concerned over ongoing physician shortages, particularly among underserved populations and locations.

4. Congress is open to new ideas, new funding, and ensuring that existing GME funding is going to where it is needed most.

Indian Health 101

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).

GME Background

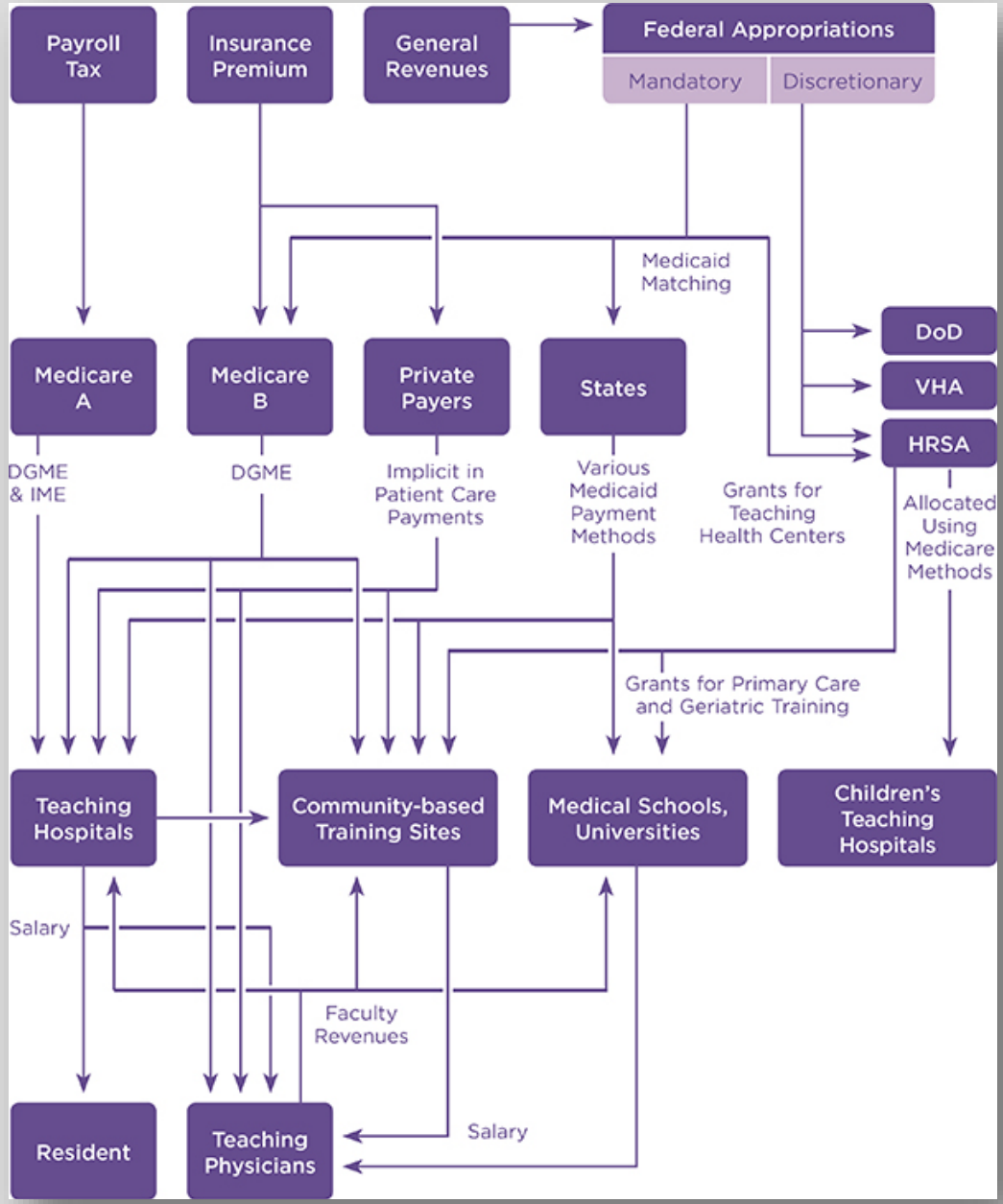
What is Graduate Medical Education (GME)?

- GME is the period of education that physicians do after medical school where physicians gain specific skills and experiences in a particular medical specialty (residency) or subspecialty (fellowship).

GME Background

How can GME impact Tribal communities?

- Having GME (residents and fellows) provide care in Tribal medical facilities is an important and sustainable way to ensure there are enough medical providers.
- Training physicians (unlike traveling or locum tenens physicians) are more likely to continue practicing in the communities where they train and invest in those communities.
- Having physicians live in the community where they serve helps to create a more stable provider pipeline that will offer consistent, accessible, and culturally appropriate care to Tribal members.



What We're Accomplishing

Alliance members are hard at work collaborating and thinking of ways to advance GME in Tribal facilities.

- Established a formal, governing Charter.
- Continue to hold regular, monthly Alliance strategy meetings.
- Visited Washington DC on June 12-13 and had meetings with Congressional and Administration policymakers.
- Responded to the Senate Finance Committee's Medicare-GME RFI.
- Continue to generate a strong social media presence to draw attention to Tribal workforce issues.
- Currently working on constructive approaches to improve current GME programs, and advance opportunities for new I/T/U programs.

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

Tribal GME at Work: The University of Washington School of Medicine

The UW School of Medicine operates WWAMI a multi-state medical education program in Washington, Wyoming, Alaska, Montana, and Idaho.

- UWSOM WWAMI is focused on increasing the number of primary care physicians, especially in underserved areas throughout WWAMI, by providing community-based medical education, expanding graduate medical education and continuing medical education.
- Each year, 275 students make up the first-year class.
- There are 33 programs across the five-state region in the UW Family Medicine Residency Network.
- There are more than 200 clinical sites throughout WWAMI.
- More than 50% of WWAMI graduates become primary care physicians.

LeeAnna Muzquiz (*Confederated Salish and Kootenai*), MD
Associate Dean for Admissions, University of Washington School of Medicine

Invitation

Proactively engage with the Tribal nations and urban and rural Tribal organizations in your states.

Check out the Tribal GME Opportunities tool on the AIMES alliance website and share it with interested individuals and organizations in your networks.

Let policymakers know that GME Opportunities in Tribal communities are important to you and the organizations you represent!

Organizations interested in joining the AIMES Alliance should contact Dr. Muzquiz or Bill Snyder.

AMERICAN INDIAN
MEDICAL EDUCATION STRATEGIES ALLIANCE

Working Together to Expand GME in Tribal Communities

aimesalliance.org

aimesalliance@leavittpartners.com

@AIMES Alliance

Exercising Self-Governance to Deliver Health Care

NAIC DEI Leadership and AI/AN Liaison Committee

Annual Fall Meeting, 11.08.2024

TRIBAL FIRST®

DISCUSSION POINTS

- U.S. POLICY TIMELINE
- LAWS STRENGTHENING SOVERNGTY
- PROMOTING SELF-GOVERNANCE
- COST MANAGEMENT
- RESOURCE INTEGRATION

U.S. GOV. POLICY: SYSTEMATIC FAILURE

1800 → 1850 → 1900 → 1950 → 2000

Treaty-Making

1800 60M buffalo roamed
1800 600K American Indians
1803 Jefferson's Letter
1830 Indian Removal Act
1831 Cherokee Nation v GA
1834 Indian Commerce Act
1838 Trail of Tears
1849 US War Depart. → BIA

Assimilation

1861 Homestead Act
1862 Dakota Conflict Trials
1869 Transcontinental RR
1871 Indian Appropriations Act
1876 Battle of Little Big Horn
1877 Sell or Starve Campaign
1887 Dawes Act
1890 Battle of Wounded Knee

Reorganization

1900 5K buffalo roamed
1900 250K American Indians
1921 Snyder Act
1924 Indian Citizenship Act
1924 Racial Integrity Act
1928 Meriam Report
1934 Indian Reorganization Act
1950 IHS created

Self-Determination

1953 Termination Policy
1954 Transfer Act
1956 Relocation Program
1971 A/N Claims Settlement Act
1972 Trail of Broken Treaties
1975 AIPRC
1975 ISDEAA
1976 IHCIA

Self-Governance

1994 Tribal Self-Governance Act
2003 MMA
2010 PPACA
2010 Tribal Health Model
2016 PRC Rates Rule
2017 Redding Rancheria v IHS

STRENGTHENING SOVERGNTY → EXERCISING POLICY

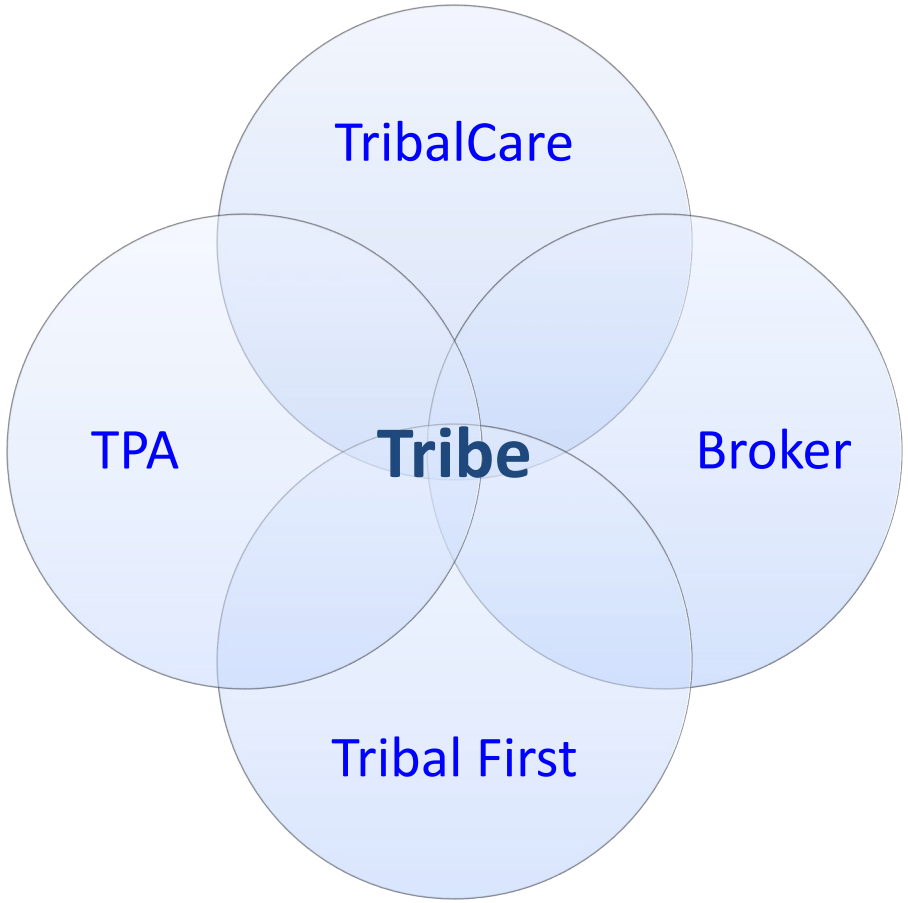
Unique Laws Specific to Tribal Health Plans

- Indian Self Determination & Education Assistance Act
- Indian Health Care Improvement Act
- Medicare Prescription Drug, Improvement and Modernization Act
- Patient Protection and Affordable Care Act
- Public Health Service Act

TRIBAL PARTNER → SELF-GOVERNANCE

Opportunity to Promote:

- ✓ Tribal Sovereignty
  - Ø IHS oversight
  - Ø State oversight
  - Serve the needs of Plan participants
  - Serve generations to follow
- ✓ Secure PRC Program Authorities
  - Collaborate across Stakeholders
  - Continue to pool appropriations
  - Exercise PRC authorities to:
    - → purchase health care services
    - → deliver health care services
    - → enforce Payor of Last Resort rules
- ✓ Strength in Numbers
  - Align efforts to serve Tribes/Pueblos across Indian Country
  - Best practices shared by all



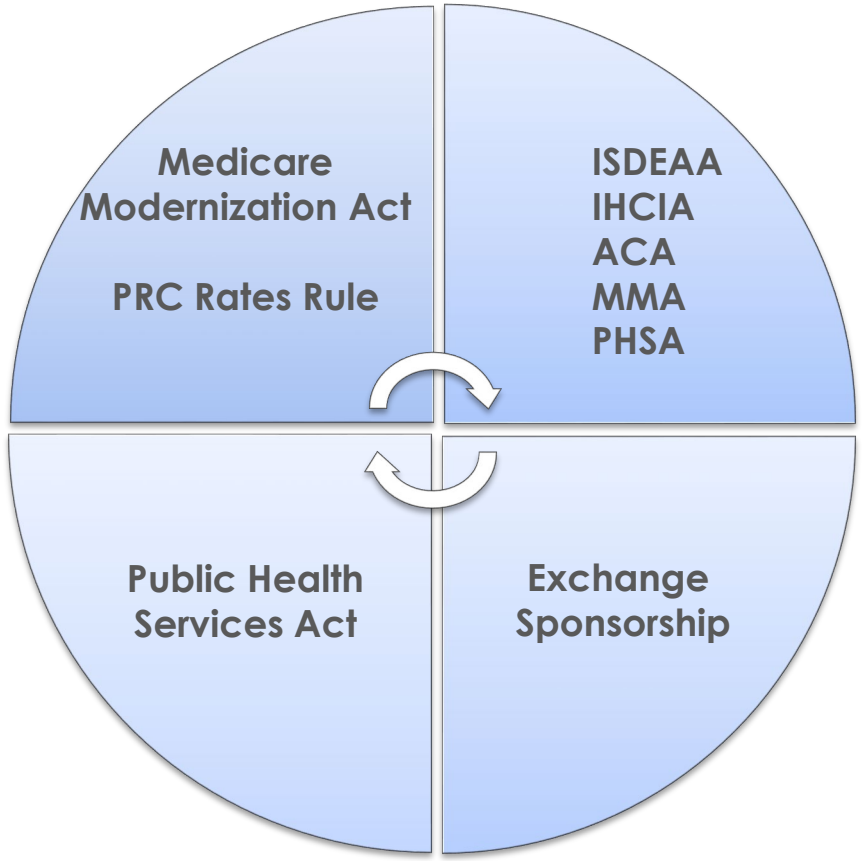
TRIBAL COST MANAGEMENT RESOURCES

Medicare-like Rates

Saves ~ 75% of billed charges on hospital-based / professional medical claims

340B Drug Purchasing

Saves ~ 50% compared to the traditional PBM model; **all** Plan participants eligible



Authority

Sovereignty / self-governance for the purchase & delivery of health services

POLR → Redding Rancheria

CHEF Submissions

State Exchange Plans

Tribes may purchase fully-insured plans for their members on a monthly basis

RESOURCE INTEGRATION

Plan Administration	➢ Preferred TPA Partner ➢ PRC Program Coordination ➢ SPD Compliance ➢ Reporting
Stop Loss	➢ Preferred Carrier Partners ➢ Premium Reward Program ➢ SPD Compliance ➢ Reporting
Broker Support	➢ Account Support Services ➢ Vendor Partner Relations ➢ Reporting