National Indian Health Board

Testimony of the National Indian Health Board
Legislative Hearing to receive testimony on S. 3126, S. 3264, S. 3937, S. 4079, & S. 4556
Senate Committee on Indian Affairs
September 23, 2020

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, thank you for holding a legislative hearing on September 23, 2020 to receive testimony on S. 3126, S. 3264, S. 3937, S. 4079, and S. 4556. On behalf of the National Indian Health Board and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, we submit this testimony for the record.

S. 3937

NIHB strongly supports S.3937, the Special Diabetes Program for Indians (SDPI) Reauthorization Act of 2020, introduced by Senator McSally and supported by Senator(s) Murkowski and Sinema. The bipartisan S. 3937 would provide five years of guaranteed funding for SDPI at an increased funding authorization level of $200 million annually. This represents the first increase to SDPI's funding level in sixteen years, and the longest reauthorization of the program in more than a decade. Significantly, S. 3937 would also authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 self-determination and self-governance contracting and compacting agreements. In short, self-determination and self-governance reinforce inherent Tribal sovereignty, and impart greater local Tribal control over programming to ensure maximize effectiveness.

As NIHB has shared with the Committee in prior testimony, Tribes are requesting technical changes to the introduced text in S. 3937 to clarify the intent of the "Delivery of Funds" language in order to ensure proper implementation of the new 638 authority. Specifically, we urge the Committee to pass S.3937 with the requested changes to the Delivery of Funds section outlined below:

''(2) DELIVERY OF FUNDS.— On request from an Indian tribe or tribal organization, the Secretary shall award diabetes program funds made available to the requesting tribe or tribal organization under this section as amounts provided under Subsections 106(a)(1) and Subsection 508(c) of the Indian Self-Determination Act, 25 U.S.C. § 5325(a)(1) and § 5388(c), as appropriate."

During the Committee's legislative hearing in September, Rear Admiral (RADM) Weahkee stated that Title V self-governance Tribes already have the authority to add their SDPI awards to their annual funding agreements (AFAs) while Title I self-determination Tribes do not. We believe this statement requires further context and explanation. While Title V self-governance Tribes *may* currently "add" their SDPI awards to their AFAs, they are restricted from accessing the full scope of authorities established under Title V of the Indian Self-Determination and Education Assistance

Act (ISDEAA) to support their SDPI operations. For example, Title V Tribes who have elected to add their SDPI funds to their AFAs are not currently entitled to Contract Support Costs (CSCs) for their SDPI programs, nor are they able to streamline diabetes data reporting. Authority for Tribes to receive CSCs and other ISDEAA related provisions specifically for SDPI would require a statutory change. Tribes drafted the legislative language shared earlier in this section precisely to achieve that goal.

Moreover, the intent of the Tribes in pushing for this structural 638 change to SDPI's governing statute is not simply to ensure both Title I and Title V Tribes can simply "add" SDPI funds to their AFAs – it is to ensure Tribes who choose to receive their SDPI funds through the 638 mechanism are entitled the corresponding statutory provisions, such as CSCs and streamlined data reporting.

Not only would S. 3937 further reinforce Tribal self-determination and self-governance, but it would also finally insulate the program from its recent string of destabilizing short-term extensions. SDPI is currently slated to expire on December 11, 2020. Its most recent extension, under H.R. 8337, Continuing Appropriations Act, 2021 and Other Extensions Act, lasts for only eleven days – ***SDPI's shortest extension on record and its fifth short-term extension since September 2019 alone***. In her opening remarks during the legislative hearing in September, Senator McSally stated that "*SDPI has suffered from a series of short-term reauthorizations, and stagnant funding, that's hindered the program's full potential*." Similarly, Senator Murkowski brought attention to the mere eleven day extension of SDPI in her opening comments, and discussed how short-term extensions hurt the programs and "do nothing to increase any level of certainty" for Tribal SDPI grantees. The Senator also acknowledged that diabetes is a leading risk factor for a more serious COVID-19 illness according to the Centers for Disease Control and Prevention (CDC), as Tribes and NIHB have repeatedly referenced as clear evidence of the need for long-term reauthorization of this life-saving program.

As NIHB reported in prior testimony, a national survey of SDPI grantees conducted by NIHB found that nearly 1 in 5 Tribal SDPI grantees reported employee furloughs, including for healthcare providers, with 81% of SDPI furloughs directly linked to the economic impacts of COVID-19 in Tribal communities. Roughly 1 in 4 programs have reported delaying essential purchases of medical equipment to treat and monitor diabetes due to funding uncertainty, and nearly half of all programs are experiencing or anticipating cutbacks in the availability of diabetes program services – all under the backdrop of a pandemic that continues to overwhelm the Indian health system.

We appreciate this Committee's bipartisan commitment to SDPI, but Tribes need Congress to collectively act on long-term reauthorization to ensure Tribes and Tribal citizens can continue to benefit from this indispensable public health program.

S. 3126

AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before this public health emergency began, and many of these challenges have only worsened under the pandemic. This is especially true for Native youth. A 2018 study found that AIAN youth in 8th, 10th, and 12th grades were significantly more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days.[1] According to the Centers for Disease Control and Prevention, suicide rates for AIANs across 18 states were reported at 21.5 per 100,000 – 3.5 times higher than demographics with the lowest rates.[2]

To that end, **NIHB supports S. 3126, the Native Behavioral Health Access Improvement Act of 2019.** The concept of a special behavioral health program modeled on SDPI to address chronic and pervasive behavioral health challenges in Indian Country was first presented by a cohort of NIHB's Native Youth fellows. In May 2017, the NIHB Board of Directors passed a resolution formally requesting funds be allocated toward substance abuse prevention and intervention programs for AI/AN Youth that promotes high self-esteem and resilience through cultural enrichment. We greatly appreciate Senator Smith's leadership in introducing S. 3126, and thank Vice Chair Udall, Senator Tester, Senator Cortez Masto, and Senator Warren for supporting this critical legislation.

S. 4556

We support the passage of S. 4556 for the Director of IHS to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California. Currently, IHS does not have the authority to acquire and/or improve Best Road. The legislation would authorize the Director of IHS to acquire and improve Best Road to provide safe access to the Desert Sage facility for staff and emergency vehicles. Desert Sage is the first Youth Regional Treatment Center in CA to provide culturally-sensitive substance use treatment for AIAN youth. Previously, AIAN youth attended out-of-state treatment facilities that inconveniently removed them from their critical support systems during recovery. AI/AN youth are disproportionately impacted by substance use, addiction, overdose, and suicide. A 2018 study found that AIAN youth in 8th, 10th, and 12th grades were significantly more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days.[3] For California Native youth, access to Desert Sage is critical to address these disparities.

Conclusion

[1] Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open.* 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

[2] Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242. DOI: http://dx.doi.org/10.15585/mmwr.mm6708a1

[3] Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open.* 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

We thank the Senate Committee on Indian Affairs for holding this hearing on important legislation, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for all AI/ANs, and raises health outcomes.