National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD FOR THE U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES 23RD ANNUAL TRIBAL BUDGET AND POLICY CONSULTATION

Wednesday, April 7, 2021

On behalf of the National Indian Health Board (NIHB)[1] and the more than 574 federally recognized Tribal Nations we serve, NIHB submits this testimony for the record on FY 2023 Tribal budget priorities.

Over the course of a Century, sovereign Tribal Nations and the United States signed over 300 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises – which exist in perpetuity - collectively form the basis for what we now refer to as the federal trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared within the law that, "…*it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy*.[2]

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[3] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people." This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

---

[1] The National Health Board (NIHB) is a 501(c) 3 not for profit organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. Because the NIHB serves all federally-recognized Tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. The NIHB is governed by a Board of Directors consisting of representatives elected by the Tribes in each of the twelve IHS Areas. Each Area Health Board elects a representative and an alternate to sit on the NIHB Board of Directors.

[2] 25 U.S.C. § 1602

[3] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

Importantly, the Federal Government has a unique legal and political government-to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[4]

The trust responsibility establishes a clear relationship between Tribes and the federal government.[5] The Constitution's Indian Commerce Clause, Treaty Clause and Supremacy clause, among others, provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs and support for the Indian health system that provides their care.

The Indian Health Service (IHS) is the principal federal entity charged with fulfilling the federal trust responsibility for healthcare; however, every branch and agency of the federal government is required to honor and uphold the trust obligations for health and public health to sovereign American Indian and Alaska Native (AI/AN) Tribal Nations and Peoples. These trust obligations are owed to American Indian and Alaska Native peoples and do not have an expiration date.

AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.[6]

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.[7] In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)[8]; higher prevalence of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of type II diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

CDC reported that the presence of underlying health conditions such as type II diabetes, obesity, cardiovascular disease, and chronic kidney disease significantly increase one's risk for a severe COVID-19 illness. AI/AN populations are disproportionately impacted by each of these chronic health conditions. For instance, type II diabetes incidence and death rates are three times and 2.5 times higher, respectively, for AI/ANs than for non-Hispanic Whites. Despite significant improvements in rates of End Stage Renal

[4] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html
[5] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.
[6] South Dakota Department of Health. Mortality Overview. Retrieved from https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf
[7] Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.
[8] Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

Disease (ESRD) as the result of the highly successful Special Diabetes Program for Indians (SDPI), AI/AN communities continue to experience the highest incidence and prevalence of ESRD.

At the core of the federal trust responsibility to Tribal Nations is the fact that the federal government is supposed to ensure the health and welfare of Native peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold its contract or responsibility in a way that is perhaps unparalleled in modern American history. However, Tribes are increasingly confronted with systemic barriers that impede their ability to actually receive help from the federal government and this is slowing or even outright denying access to aid.

During the last year, the COVID-19 funding enacted by Congress created a vast amount of public health aid for Indian Country. However, against recommendations from Tribes, the federal government chose to use a competitive grant making process as a means for distributing funds to Tribes. Many Tribal offices and programs limited by personnel due to COVID-19, were forced to use a skeleton staff to apply for these competitive grants and within very tight timeframes. If Tribes could not pull together staff and other needed resources, they were simply unable to apply for these pots of money to provide care for their people. Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the quality of a grant application – yet that is the construct that the federal government has forced Tribes to operate under. That is unacceptable.

While Tribes may be eligible for competitive grants addressing public health and other issues, many of these programs have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to apply and/or compete for the grants. Moreover, **Tribal eligibility for funding does not equate to Tribal access,** especially when Tribes are forced to compete with states, cities, and other governments that are generally higher resourced. In short, the federal government must cease using the competitive grant mechanism to try to fulfill its trust obligations to Tribal Nations. It is essential that HHS make a major commitment to creating set-asides for direct funding to Tribal governments and organizations in a streamlined, non-competitive, sustainable, and equitable fashion.

As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were largely left behind during the nation's development of its public health infrastructure and systems continue to be chronically underfunded. As a result, many Tribal public health systems remain far behind those of most state, territorial, and even city and county public health entities in terms of their capacity. This includes core services; such as disease surveillance and reporting; emergency preparedness and response; public health law and policy development; and public health service delivery. Additionally, HHS must commit the resources and CDC must continue its meaningful and sustainable direct investments into Tribal communities for public health if we are ever to close the gap in the disparities of lower health status, and lower life expectancy of AI/AN Peoples compared to the general population.

The Administration, with the support of Congress, must devise a plan to appropriate funds that goes beyond just sustaining maintenance-level services which have been essential to cover expenses related to population growth and legal obligations for full funding of Contract Support Costs (CSC). Leaders of our

Tribal Nations strongly urge that this Administration to fulfill the historic agreements, which were essential to the power and growth of these United States, by putting forth a real budget that will finally eradicate the persistent health disparities that have impacted every age group in Tribal communities and for generations. It takes a committed partnership between the United States and Tribal Nation leadership to honor these agreements. And it takes decisive action by this Administration to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States.

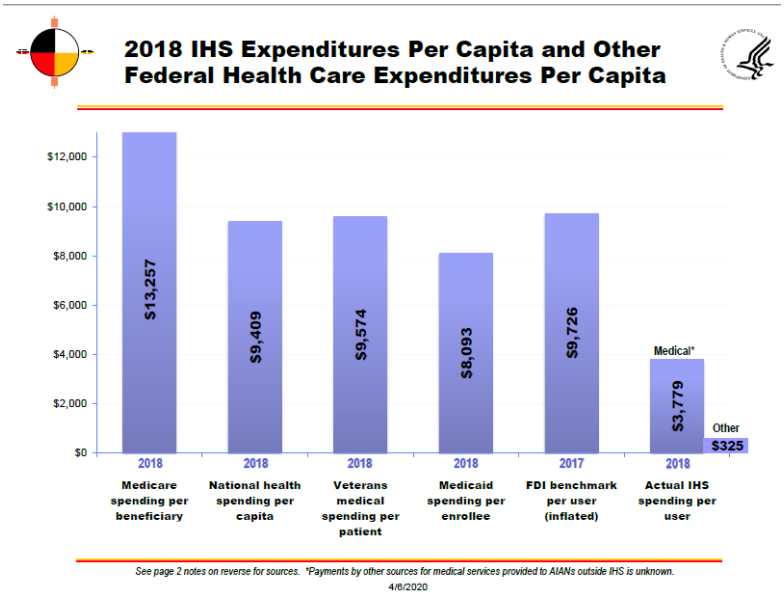
NIHB looks to the Administration to propose a FY 2023 budget that reflects its commitment to upholding the federal Trust responsibility. Do this by committing to bold increases for Indian health programs across HHS and full funding for at the IHS. NIHB is grateful for the opportunity to offer testimony and for the modest increase in the HIS budget (when weighed against need), but it is imperative to remind HHS and the Office of Management and Budget (OMB) to continue to engage with Tribes during the budget process to guarantee that any proposals or funding determinations are in line with Tribal priorities. By standing on the binding government-to-government relationship, HHS and Tribal Nations can forge a new and viable pathway to finally fulfill the federal trust responsibility for health.

The following testimony provides input on budget requests for:

- Indian Health Service (IHS)
- Centers for Medicare and Medicaid Services (CMS)
- Centers for Disease Control and Prevention (CDC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- National Institutes of Health (NIH)
- Health Resources and Services Administration (HRSA)
- and the Office of Minority Health (OMH).

THE INDIAN HEALTH SERVICE

The Indian healthcare and public health delivery system faces chronic and significant funding disparities, most notably in per capita spending between the IHS and other federal healthcare programs. In 2018, the IHS per capita expenditures for patient health services were just $3,779, compared to an estimated $9,409 per person for healthcare spending nationally. Lack of adequate investment into Indian Country's healthcare and public health delivery systems have been major contributing factors to the poor health status of AI/ANs.



In its annual recommendations to the Indian Health Service, the Tribal Budget Formulation Workgroup (TBFWG) proposed a FY 2022 budget of $12.579 billion. with. The TBFWG expressed optimism that the Biden Administration intends to work with all Tribes in a meaningful way to full the Trust and treaty responsibilities to America's First Peoples. With a commitment from the Biden Administration, this year the TBFWG chose to put forward a budget request for full and mandatory funding for the Indian Health Service – **a minimum of $49.8 billion for FY 2023.**

This serves as a departure from previous requests that asked for conservative percentage increases to be phased in over 10-12 years.

It is more apparent than ever that our Tribal Nations will never achieve a fully funding, needs-based budget unless we boldly stand up for the true need to address the ever-growing health disparities in Indian Country.

Asking for a percentage increase based on a fiscal year budget that is so inadequately funded from the outset allows the realization of only marginal increases for Tribes to work. In reality, this means we can never make any substantial improvements to our health status, health systems or public health systems.

Since the start of the COVID-19 pandemic, just over year ago, the need for full and mandatory funding has become more and more urgent to Tribal leaders and the Indian health system. The gross inequities that AI/ANs experience continue to be revealed. The lack of public health infrastructure, the chronic underfunding of our health delivery systems, and the disproportionate numbers of our people with serious, underlying health conditions, created the perfect storm for our communities to be ravaged by this virus.

While the long-term effects of the virus are still unknown, **Indian Country NEEDS to be prepared to respond.** Tribes need the public health infrastructure and resources to protect and care for their people,

which includes adequate funding for chronic disease prevention programs that can reduce risks when facing future pandemics.

Tribes strongly advocated for and welcomed the supplemental funds for Indian health through the various COVID-19 relief legislative packages over the past year; however, so much work left to be done. Tribes stand with President Biden that these funds only serve as a down payment for the true funding needed to meet the Treaty and Trust responsibilities. The Tribes have repeatedly and thoughtfully stated true Tribal health funding needs for decades through this very budget formulation process. The Tribal Budget Formulation Workgroup (TBFWG) identified the top six areas that have the highest funding need:

1. Hospitals and Clinics
2. Purchased/Referred Care
3. Health Care Facilities Construction
4. Sanitation and Water
5. Mental Health
6. Alcohol and Substance Abuse

Treatment of chronic diseases like diabetes, auto-immune deficiencies, cancer, and heart disease quickly erode our limited resources leaving very few dollars for upstream prevention and health promotion. Aging facilities and lack of resources to modernize equipment and health information technology contribute to the low quality of care afforded to AI/ANs. In 2016, IHS reported to Congress that the average age of IHS hospitals are nearly four times older than mainstream hospitals, at 40 years compared to 10.6 nationally.[9] Similarly, space capacity at IHS facilities is severely limited, able to accommodate only about 52% of the AI/AN service population. Limited funding also impacts efforts for health workforce recruitment and retention. IHS and Tribal health systems are unable to make a notable difference in reducing chronic health workforce shortages because they lack the resources to offer doctors and other types of providers with competitive salaries, housing, and other incentives to join their teams.

FY 2023 IHS Tribal Budget Formulation Workgroup Request (TBFWG)

NIHB fully supports the testimony of the TBFWG, which was submitted separately.

The NIHB and the TBFWG continue to advocate for fulfilment of the Trust responsibility for health through the enactment of a true fully funded IHS budget. This includes amounts for personal health services, wrap-around community health services, and facility investments. Top priorities include:

- Urge the Administration to take immediate steps to address unfulfilled Trust and Treaty obligations with Tribal Nations by putting in place a strategy to finally end unacceptable health disparities and urgent life safety issues at IHS and Tribal Health facilities by implementing a budget which fully funds IHS at $49.8 billion.

- Increase the Tribal Budget Formulation Workgroup Recommendations to a total of $49.8 billion for the IHS in FY 2023 by adding *at a minimum*:

[9] Indian Health Service. 2016. The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress. Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

- +$197.1 million for full funding of current services
- +$303.1 million for binding fiscal obligations[10]
- +$36.57 billion for program increases for the most critical health issues (~287% above FY 2022 Budget Recommendations). Top priorities for program expansion include:

1. Hospital and Clinics	+$8.65 Billion
2. Purchased/Referred Care	+$5.22 Billion
3. Health Care Facilities Construction/Other Authorities	+$3.59 Billion
4. Mental Health	+$3.23 Billion
5. Alcohol and Substance Abuse	+$2.31 Billion
6. Indian Health Care Improvement Fund	+$2.16 Billion
7. Maintenance and Improvement	+$2.27 Billion
8. Dental Services	+$2.49 Billion
9. Sanitation Facilities Construction	+$1.88 Billion
10. Community Health Representatives	+$1.17 Billion
11. Equipment	+$726.8 Million
12. Health Education	+$646.0 Million
13. Public Health Nursing	+$627.5 Million
14. Urban Indian Health	+$749.3 Million
15. Electronic Health Record	+$355.8 Million
16. Community Health	+$153.9 Million
17. Indian Health Professions	+$195.7 Million
18. Facilities and Environmental Health Support	+$141.6 Million
19. Self-Governance	+$43.9 Million
20. Tribal Management Grants	+$23.7 Million
21. Direct Operations	+$19.6 Million
22. Alaska Immunization	+$1.000 Thousand

❖ Support the preservation of Medicaid, the Indian Health Care Improvement Act, and other Indian-specific provisions in the Patient Protection and Affordable Care Act (P.L. 111-148), or any subsequent replacement bill, and provide dedicated funding to begin implementing the new authorities and provisions of the Indian Health Care Improvement Act (IHCIA), which have not yet been implemented and funded (~$100 million in FY 2023).

❖ Take immediate action on repeated requests to allow the IHS to fully fund critical infrastructure investments which directly impact patient care and safety, similar to that afforded to the VA and DoD, specific to:
- Health IT for full implementation of interoperable EHR systems and telehealth capacity at ~$3 billion over 10 years.
- Funds should be provided outside of the discretionary budget and sequestered from the operating budget of health services.

[10] *Includes placeholder estimates for Contract Support Costs (CSC), 105(l) leases, and staffing for new facilities and newly recognized Tribes*

- Health Facilities Construction Funding and Equipment (~$21 billion over 10 years)

❖ Advocate that Tribes and Tribal programs be permanently exempt from sequestration and rescissions.

❖ Support Advance Appropriations for the Indian Health Service.

❖ Allow federally operated health facilities and IHS headquarters the same flexibility to adjust programmatic funds across accounts to maximize efficient use of federal dollars at the local level

❖ Request mandatory funding for Contract Support Costs (CSC) and 105(l) lease agreements, separate from the IHS annual operating discretionary budget.

❖ Oppose IHS action to unilaterally restrict ISDEAA authorities in the absence of Tribal consultation and devised a mechanism to ensure that funding is transferred to IHS in a timely manner.

❖ Recommend that the Special Diabetes Program for Indians be permanently reauthorized and increase funding to $250 million per year plus annual inflationary increases and authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 contracts and compacts.

❖ Expand the model of IHS as a jurisdiction for COVID-19 vaccines to future activities and providing Tribes the opportunity to become jurisdictions as well.

❖ Facilitate interagency agreements between IHS and HHS operating divisions.

❖ Seat Tribal representatives in all HHS operating divisions.

❖ Appoint a Tribal Senior Counselor position as a political appointee in the HHS immediate Office of the Secretary.

❖ Set a federal Indian law expert in the HHS Office of General Counsel.

❖ Elevate the Director of Indian Health Service to Assistant Secretary of Health and Human Services.

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Unfortunately, the 2-5% incremental increases to the IHS budget over the past decade have not adequately kept pace with expenses related to population growth and medical and non-medical inflation. Leaders of Tribal Nations insist that a true and meaningful investment be made to finally eradicate the pervasive health disparities which has overwhelmed Indian Country for years. It takes a true commitment between the United States and Tribal Nation leadership to put a strategy and budget in place. AI/AN Tribes have put their best strategy and budget together in this FY 2023 Budget Request; it is time for the United States to also put forward their best strategy and budget and honor the Trust responsibilities. Decisive action by this Administration must occur to prioritize department resources to bring the health of AI/AN citizens closer to parity with the rest

of the citizens of the United States. We must rise above just settling for maintenance funding to sustain what has proven to be an unacceptable level of health care in Tribal reservations and villages.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

The Centers for Medicare and Medicaid Services (CMS) plays a critical role in the Indian health care delivery system. CMS third-party billing collected by the Indian Health Service (IHS), Tribes, Tribal organizations, and urban Indian health centers (the I/T/U) provides crucial financial support for the Indian health care system and supports the federal government's trust responsibility. These vital funds must be protected and strengthened in Tribal communities by ensuring that all eligible users enroll in these programs. CMS and Tribes must continue to engage and work to serve the needs of American Indians and Alaska Natives (AI/ANs). The following recommendations describe budget and policy priorities for Tribes and the National Indian Health Board (NIHB) for this Administration.

CMS Administrator and Senior Leadership Must Commit to Tribal Consultation

CMS programs offers American Indians and Alaska Natives who are eligible for its programs access to healthcare services and provides revenue to the I/T/Us through third-party billing – for these reasons it is imperative that the CMS follow the HHS Tribal Consultation Policy and the Biden Administration's *Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships* and actively engage with Tribes during regularly scheduled Tribal Consultation sessions. CMS and HHS leadership can benefit from robust and meaningful Tribal consultation which is intended to provide a platform for Tribes to share vital input, feedback, and recommendations throughout the entire process of developing policies, regulations, and budgets.

NIHB is concerned about the lack of engagement of CMS leadership with Tribal Nations. During the last Administration, the CMS Administrator did not attend one CMS Tribal Technical Advisory Group (TTAG) meeting and rarely attended Secretary's Tribal Advisory Committee (STAC) meetings during her tenure. Often Tribes and the TTAG were relegated to discussing issues with subordinate CMS leadership or programmatic staff who were not empowered to have substantive policy discussion or make critical decisions during Tribal consultation. **If this Administration's goal is to improve and strengthen Tribal Consultation as discussed in the President's Memorandum on Tribal Consultation, CMS, as well as all HHS Operating Divisions must have its most senior leadership participate in Tribal consultation sessions.**

Facilitate Meaningful Tribal Consultation at the Federal and State Level

Many Tribes have good working relationships and partnerships with their State Medicaid programs. Tribes have worked with their State programs to implement Medicaid expansion, support waivers, including Indian-specific waivers, and to create positive open consultation policies. The best results are achieved through open and early dialogue, so that Tribal programs can weigh in on State plans and priorities at the outset, rather than being forced to adapt at the last minute. The issues that have arisen between States and Tribes regarding Section 1115 waivers or State Plan Amendment (SPA) approvals have occurred when States develop their proposals without careful consideration for how they will impact AI/AN access to the

Medicaid program. As discussed above, many of these proposals may be beneficial to the State but would inadvertently hurt Tribal programs.

Early and meaningful consultation is key to avoiding such conflicts, and CMS can play a key role in ensuring this consultation takes place and fully benefits the development of proposed policy. CMS not only has the ability to exercise this authority, doing so respects the Nation-to-Nation relationship between the United States and Tribes. The ongoing COVID-19 pandemic has required quick action, but consultation with Tribes will ensure these actions benefit all communities including Tribal communities.

NIHB acknowledges CMS's commitment to seek Tribal participation in the development of policies and programs that have Tribal impacts. Based on President Biden's Memorandum on Tribal Consultation and Honoring Nation to Nation Relationships, each of the HHS operating divisions were asked to review and revise their Tribal Consultation Policies this year. In conjunction with the HHS Tribal Consultation Policy (which is currently under review), but with special attention to Tribal-state relations, the 2015 CMS Tribal Consultation Policy outlines best practices for Indian Tribes to raise issues with CMS, establishes a minimum set of requirements for CMS engagement with Tribes, and facilitates coordination between CMS, IHS, and other HHS divisions of concern. The Tribal Consultation Policy continues to be an important tool to initiate and maintain an open line of communication with Tribal Nations. CMS should build upon the best practices from its current Tribal Consultation Policy and use its authorities to strengthen state-Tribal relations.

Many Tribes have successfully worked with their States and CMS to submit Indian specific waivers that have been incredibly successful in Indian Country. These waivers, which provide facility-based reimbursement for IHS and Tribal health care facilities, were approved in Arizona, Oregon, California, and Utah. The States of Wyoming, Mississippi, and Oklahoma currently have similar waivers pending with CMS for approval. We encourage CMS to approve these waivers, as they reflect the ability of States and Tribes to work together to adapt State programs to meet the critical needs of Indian people. We also encourage CMS to look at the impact that Medicaid expansion has had in Indian Country. Medicaid expansion has been transformative in Indian Country. Tribal programs that would routinely run out of funds to make referrals for needed care halfway through the year are now able to pay for this care. Preventive care has dramatically improved health outcomes for our people and is a more efficient use of federal health care resources.

We ask that CMS ensure that Medicaid expansion is maintained as an option for AI/ANs. We understand that States have been seeking additional flexibilities regarding federal requirements. Tribes have the same motivation regarding State requirements that do not fit well with the Indian health care delivery system. We encourage CMS to work with states and the Tribes to explore ways to create Tribal specific provisions (in some cases, needed exemptions) in the Medicaid program, through waivers and encourage that policy development to ensure that the Indian health system is not damaged as part of the agency's push toward greater flexibilities for states. Doing so will impose no additional costs on the States and will allow Tribes to tailor the Medicaid program to their needs, all while allowing the States to develop their own approaches in an expeditious manner.

Fully Fund the Administration and Operation of CMS TTAG and its Subcommittee Activities

CMS and Tribes established the Tribal Technical Advisory Group (TTAG) to CMS in 2004 to enhance the government-to-government relationship between Tribal Nations and the United States. The TTAG

serves as an advisory group to CMS on policies and programmatic issues impacting AI/ANs served by Medicare, Medicaid, the Federally Facilitated Marketplace, and the Children's Health Insurance Program (CHIP). CMS is an integral part of the Indian health care delivery system and is critical to honoring the federal trust responsibility to provide health care to AI/ANs.

In December 2020, the CMS TTAG approved a new five-year strategic plan with an annual budget request for $5,738,000 to fully fund TTAG's goals and objectives. However, in March 2021, the CMS Division of Tribal Affairs (DTA) presented a budget that was only $3,467,000, a difference of $2,271,000. This work is critically important, and we recommend CMS work with the TTAG to understand the impact of these issues so the budget can be restored to what it was in FY 2019, which included funding as follows:

- $2.74 million for Federal Administrative Funding (Fed-Admin)
- $2.1 million for Indian health care related funding
- $360,000 CHIPRA National Education tribal set-aside.

NIHB recommends that CMS/HHS restore the TTAG recommended funding to at least the amount of the FY 2019 budget; or full funding of TTAG Strategic Plan priorities $5.7 million.

We thank HHS and CMS for the level of support directed to the CMS-TTAG Strategic Plan activities. But we also want to stress that the CMS Strategic Plan has never been fully funded and many of the TTAG recommendations have not been implemented or accomplished because of this. In FY 2020, for example, CMS funded the TTAG recommendations at approximately $3.7 million, despite TTAG requesting up to $5.2 million to fully fund its recommendations. For the objectives of the Strategic Plan to be implemented in FY 2022, the TTAG recommends that CMS increase the TTAG budget by least $1.5 million, which will allow CMS and the TTAG to fully fund all activities in the draft 2020-2025 Strategic Plan, which accurately reflects long term goals within the Indian health system. In addition, given this Administration's priority in granting more flexibility to States, Tribes will need more technical assistance to ensure that States are meaningfully consulting with Tribes in the operation of their Medicaid programs as required by the CMS Tribal Consultation Policy. This work is crucial to help AI/AN and Indian health providers participate in CMS programs, and AI/AN CMS-eligible beneficiaries to attain greater access and participation in quality health care in the I/T/U system.

Support Funding for Medicaid and CHIP Outreach and Education

Over 40 years ago, Congress amended the Social Security Act to authorize Medicaid reimbursement for services rendered to eligible AI/ANs through an IHS or Tribal health program facility. In 1976, a House of Representatives report explained that "These Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian…" As a result, Medicaid reimbursement to IHS and Tribal health program facilities is considered part of the trust responsibility. Today, Medicaid represents 67% of third-party revenue at the IHS, and 13% of overall IHS spending. It is likely that together with Medicare over $1 billion in CMS funding supports Indian Health Programs.

Because Medicaid is so critical to fulfilling the United States trust responsibility and is an important supplement to the underfunded Indian health care delivery system, more targeted resources are needed to ensure that Medicaid eligible AI/ANs are enrolling in health programs. This additional funding would be used to conduct training and host webinars in Indian Country in order to provide information on enrolling in Medicaid and the Children's Health Insurance Program (CHIP). CMS could also consider alternative sources of funding for the I/T/U to assist AI/ANs to enroll in CMS funded programs, including Medicaid,

Medicare, and dual eligibility enrollment. Increased enrollment in these programs means fewer dollars expended by the Indian Health Service to provide services. More dollars for the Indian Health Service mean more and higher quality care received by AI/ANs and less pressure on the limited resources of the Indian Health Service.

Support the Role of Medicare in Indian Country

Through meaningful partnerships with HHS, Tribes have produced innovative programs to achieve and maintain healthy lifestyles while also improving access to health resources and services as promised under the federal trust responsibility. For example, Tribal communities in the lower 48 are repeating the successes achieved by Alaskan Native communities with programs such as the Dental Health Aid Therapy (DHAT) program and the Community Health Aide Program (CHAP), both of which provide solutions to health care shortages in rural areas. Additionally, the remarkable success of the Special Diabetes Program for Indians in reducing the incidence of type II diabetes and ESRD paved the path for implementation of the Medicare Diabetes Prevention Program (MDPP).

Medicare is a vital part of fulfilling the federal trust responsibility. About 138,000 patients have Medicare. While most Medicare funds are received through mandatory appropriations, there are still portions within the discretionary budget that directly impact the Indian healthcare system. The President's Budget proposals to change Medicare Outreach and Education (O&E) would have varying degrees of impact, depending on its implementation. If changes are made to the Medicare beneficiary education requirement, they should also include consideration for Tribal communities who greatly benefit from printed materials, especially in rural areas of Indian Country where limited access to broadband reduces the effectiveness of electronic versions. Proposals to rebase the National Medicare Education (NME) User Fee could have potential benefits if user fees from Medicare Advantage (MA) and Part D plans "equitably support" outreach and education that is best for the beneficiary.

CMS has cited its support for MA plans because they promote "provider choice" but have been unable to meet the needs of AI/AN beneficiaries as adequately as original Medicare plans. Many IHS and Tribal healthcare facilities are located in counties that do not have MA plans. In addition, many MA plans do not have agreements to pay Indian Health Programs when an MA patient is seen at these programs. Support should be given to work out a method to ensure IHPs are paid when they see an AI/AN patient. Outreach and education materials need to clearly state that AI/ANs have the opportunity to choose their I/T/U provider and that provider will receive payment. As national spending for entitlement programs like Medicare and Medicaid continues to increase, the agency's budget falls under immense scrutiny. Any budget recommendations to decrease, flat fund or nominally increase the discretionary portions of the CMS budget have deep impacts for Tribal communities who have come to depend on enrollments in and payments from CMS programs. It should also be mentioned that flat funding requests operate in essence, as decreases, as operations costs continue to increase and as more people access the programs.

Maintain 100% FMAP and Give Full Effect to CMS's 2016 State Health Official (SHO) Letter

In February 2016, CMS issued a State Health Official (SHO) Letter extending 100% Federal Medical Assistance Percentage (FMAP) to services rendered by a provider that is not an Indian Health Service or Tribal provider so long as certain requirements are met. 100% FMAP ensures that the responsibility to pay for Medicaid services to AI/ANs remains with the federal government and is not shifted to the states. However, since the release of the SHO letter in 2016, CMS has not provided adequate technical assistance and guidance for Tribes to take advantage of this policy. While CMS did issue a Frequently Asked

Questions (FAQs) document on January 18, 2017, clarifying the scope of the "clinic services," it recognized that it had "not given tribal-specific guidance" or outreach on the issue, which resulted in varied practices and policies. CMS further recognized the need for some states and Tribes to "make legislative or regulatory policy changes, provide public notice, define services, make systems changes, and potentially make programmatic and staffing changes." Where this is required, we ask for the agency to provide technical assistance to make changes in law that will better support Tribes to benefit from 100% FMAP.

Expanding 100% FMAP to cover Purchased and Referred Care (PRC) services benefits IHS and Tribal health programs by allowing States to expand coverage for AI/ANs, either by covering additional population groups or additional services. PRC funds are used to secure essential health care services from private sector providers when such services are not available within the Indian Health Care delivery system. However, payment for services under PRC is limited by what is appropriated by Congress. Therefore, it is a substantial benefit to have Medicaid reimbursement expanded to cover PRC services received outside of IHS and Tribal facilities so that more PRC dollars are available to cover those AI/ANs that are not Medicaid eligible. Tribes also support extending the 100% FMAP to Urban Indian Health Programs also increases access to and provides additional resources for much needed care for Indians living in urban areas.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The COVID-19 pandemic brought with it a disproportionate impact on AI/AN people and illuminated many of the disparities Tribes experience, particularly in the public health arena. These have contributed to disproportionately poorer COVID-19-related health outcomes experienced by AI/ANs. It has never been more important to increase the resources flowing to Indian Country. Now is the time to adjust the funding and policy landscapes to better support Tribal public health infrastructure, the societal realities Tribes experience associated with poverty, remoteness, and lack of investment into Tribal public health systems.

According to the latest data from the CDC, American Indian and Alaska Native (AI/AN) people are 1.6 times (60%) more likely to be diagnosed with COVID-19[11], 3.5 times (350%) more likely to require hospitalization[12] and 2.4 times (240%) more likely to die from COVID-19-related infection when compared to non-Hispanic white people[13]. However, these disparities in COVID-19-related death rates are not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the largest disparities.

[11] Data reported by state and territorial jurisdictions (accessed 03/10/2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US intercensal population estimate. Calculations use only the 53% of case reports that have race and ethnicity data available; this can result in inaccurate estimates of the relative risk among groups.
[12] COVID-NET (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covid-net/purpose-methods.html, accessed March 1, 2020, through February 27, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US standard COVID-NET catchment population.
[13] NCHS provisional death counts (https://data.cdc.gov/NCHS/Deaths-involving-coronavirus-disease-2019-COVID-19/ks3g-spdg, data through March 6, 2021). Numbers are ratios of age-adjusted rates standardized to the 2019 US intercensal population estimate.

Among AI/ANs aged 20-29 years, 30-39 years, and 40-49 years, the COVID-19-related mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts[14].

AI/ANs continue to face significant chronic health disparities, especially for conditions like diabetes and respiratory illnesses, which increase the risk of a poor COVID-19 health outcome, including death. These disparities will continue to go unaddressed without a bold and substantive IHS budget. A weak budget would leave Indian Country more vulnerable to COVID-19 outbreaks. It is imperative to prioritize Tribal public health infrastructure and capacity for Tribes to see meaningful decreases in these disparities. **NIHB fully supports the Biden Administration's call for increased health and public health equity.**

Unfortunately, because of high rates of misclassification and under-sampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the impact of COVID-19 in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID-19, however, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities. Multiple states with large AI/AN populations including but not limited to Minnesota, Michigan, New York, and California continue to report thousands of COVID-19 cases without any information on patient race/ethnicity or categorizing cases as "other" on demographic forms. In California, for instance, the state noted they lack race/ethnicity data for nearly 30% of reported cases. Multiple studies demonstrate that surveillance systems frequently misclassify AI/ANs or omit them from surveillance systems entirely. These issues continue exacerbate health disparities including those from COVID-19.

The CDC must work with state and local health departments, community-based organizations (CBOs), Federally Qualified Health Centers (FQHCs), IHS facilities, Tribally-run health facilities, and Tribal Epidemiology Centers (TECs) **to ensure that complete and accurate data is captured and shared with Tribes** so they can effectively respond and recover from COVID-19, and other similar public health emergencies. Timely and accurate data play a vital role in public health decision-making, and would allow for better, data-driven Tribal public health policy, which would better protect Tribal members.

Expand and Strengthen the Government-to-Government / Expand Self-Governance.

The Tribes and CDC established the CDC TAC in 2005 to improve the government-to-government relationship. The TAC serves as an advisory body to CDC on policies, programs, and funding opportunities that impact Tribes but does not supplant formal Tribal consultation. Meaningful and robust Tribal consultation must continue. Tribal leaders know best how to care for their people; therefore it benefits the CDC to implement and incorporate Tribal leader recommendations into every aspect of the CDC that impacts AI/ANs. Tribes and the TAC have repeatedly called upon the federal government to expand self-determination and self-governance authority across all of HHS. In the interim, the CDC should work closely with Tribes to obtain a complete understanding of the current public health needs and allow for maximum flexibility in the administration of funded Tribal public health programs.

Remove Barriers that Inhibit Adoption of Traditional Practices

[14] Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3

Recognizing Tribal sovereignty means recognizing the sovereign right of Tribal nations to utilize traditional practices to provide for the health and public health of their people. Traditional medicine is central to many Tribal cultures and is effective at treating and preventing many chronic health issues facing AI/AN people. **Tribal Nations continue to experience many barriers when implementing or incorporating traditional and cultural practices as grant activities because it is not supported by CDC even though such practices have been supporting Tribal health and wellness for time immemorial.** The CDC could and should support Tribal models of health and healing that may not fit well into standard Western approaches by including language in their funding opportunity announcements that recognize the value and applicability of cultural and traditional practices as viable Tribal grantee activities.

New CDC-Wide Requirement

The Consolidated Appropriations Act of 2021 directed each Center, Institute, and Office (CIO) within the CDC to create written guidelines to integrate Tribal public health priorities and needs across the entire agency. These written guidelines are to be developed in consultation with the CDC TAC and will establish best practices around the delivery of Tribal technical assistance, as well as the consideration of cultural and traditional Tribal public health practices. Because the CDC is required to work with the TAC to develop these guidelines, the Tribes are afforded an unprecedented opportunity to create a new, more inclusive path forward for working with CDC. **However, consultation with the CDC TAC does not supplant Tribal consultation. NIHB requests that the agency engages in meaningful and robust Tribal consultation throughout the development process.**

Create Set-Aside Funding for Tribes Throughout the CDC and Invest in Tribal Public Health Systems

Tribes interact with the CDC on a regular basis and there should be funding dedicated to ensuring that the agencies can meet unique Tribal needs. Unfortunately, the status quo often prevents the fulfillment of Tribal needs. For example, CDC frequently distributes funding via competitive grants and conducts programming aimed at strengthening Tribal public health infrastructure and systems, but these methods of funding do not allow for equitable funding across all Tribal public health systems.

Dedicated funding for Tribes and Tribal organizations is the most effective way to ensure that adequate resources are reaching Indian Country, while also furthering the fulfillment of the federal government's trust responsibility for health. With Good Health and Wellness in Indian Country (GHWIC) as a potential model, CDC should consult with Tribes to design and fund Tribal public health infrastructure and capacity development initiative in Indian Country with the flexibility to permit Tribes to tailor programs to their unique community priorities. The CDC must commit to these direct Tribal investments that support Tribes in addressing public health development and other issues. **There should be a minimum of 5% set-aside for Tribes across all CDC Centers, Institutes, and Offices (CIOs) to meaningfully begin to build equitable Tribal public health systems, compared to states and local health departments**. This funding will help integrate Tribal public health needs and priorities across the entire CDC and all CDC programs. For those CDC CIOs that do not send funding out as grants, **at least 5% of funding resources for internal activities should be directed and dedicated to Tribal support**.

Ensure Tribal Access to Data and Support Tribal Data Sovereignty

Recent federal scientific initiatives throughs the National Institutes of Health (NIH) and the Food and Drug Administration (FDA), have sought Tribal leaders' endorsement of their projects in Indian Country. While Tribal advocates support the development of scientific initiatives to prevent and cure diseases,

Tribes are sovereign nations and are the ultimate stewards and owners of the data collected on their Tribal citizens.

The CDC must work collaboratively with Tribes to ensure that Tribes have access to their Tribal data. Understanding and honoring Tribal data sovereignty must be the cornerstone of all CDC Tribal data collection efforts. Doing so will improve overall public health data reporting and provide the most accurate information for developing budget and public health priorities, while allowing Tribal leaders and administrators the most accurate data in determining resource allocation and program development and evaluation.

Structural challenges in data reporting only serve to render invisible the disparate impact of COVID-19 in Indian Country. For example, TECs continue to face significant barriers in exercising their statutory public health authorities by facing major hurdles in accessing federal and state public health surveillance systems, including for COVID-19, which often has incomplete or inaccurate race/ethnicity data. In addition, not every state, city and county jurisdiction include AI/AN as a distinct demographic on health assessment and surveillance forms, often lumping them under "other." These race/ethnicity data gaps contribute to ongoing underestimates that only further obscure the true burden of COVID-19 and other diseases for AI/ANs. Furthermore, Tribes often experience significant barriers in accessing the patchwork of state infectious disease tracking and reporting systems. This must be corrected to allow the Tribes access to their own data in a timely manner.

While available data demonstrates higher rates of health disparities among AI/ANs in a variety of health conditions, **estimates of disease prevalence and incidence for AI/ANs are likely to be underestimates due to high rates of racial misclassification and undercounting of AI/AN populations in state and federal surveillance systems**. A comprehensive plan to address the gaps in data collection across these surveillance systems is drastically needed to improve the information readily available to Tribal leaders to better inform their public health policies and programs.

<u>Promote and Sustain Environmental Health Improvements in Indian Country</u>

The health of the environment directly impacts public health in Indian Country. Contaminated drinking water, harmful air pollutants, destruction of natural habitats, climate change, extreme weather, and exposure to toxic heavy metals are issues that Tribal communities struggle to prevent, often with little or no support from the federal government. Twenty-five percent of the nation's 1,300 Superfund sites are located in or near Indian Country, even though Indian County is, tragically, only approximately 2.3% of the national land area. **Lack of access to clean water, pollution, and insufficient sanitation infrastructures impact the physical and mental health as well as emotional and spiritual wellness for AI/AN communities and individuals.** Without proper access to clean water and adequate sanitation infrastructure it is hard – if not impossible – for Tribal citizens to be healthy and for Tribes to adhere to CDC recommendations and guidelines for COVID-19 mitigation and control, which further propagates COVID-19 infections across Indian Country. The CDC must establish Tribal sanitation and clean water infrastructure as a public health priority.

<u>Prioritize Indian Country in the Ending the HIV Epidemic: A Plan for America</u>

The rate of HIV infection among AI/ANs in 2016 was 10.2 per 100,000 – the fourth highest among other racial/ethnic groups. Furthermore, the frequency of HIV diagnoses among AI/AN persons continues to rise. The current national plan does not address the unique prevention and care realities of Indian Country. There must be specific language to discuss American Indians and Alaska Natives as a population that is

statistically at higher risk for acquiring or passing away from HIV or viral hepatitis. The CDC should continue to engage with Tribes through formal consultation to incorporate Tribes in all the federal government's HIV response activities, including how best to capture AI/AN data in an accurate and respectful manner.

Linkage to care has been proven to be one of the most effective and simple interventions that can be undertaken with a person newly diagnosed with HIV or a person that has fallen out of care. However, only a handful of providers across the entire I/T/U healthcare system are trained to provide HIV specialty care for American Indians and Alaska Natives. Therefore, many AI/ANs are required to rely upon referral care to providers outsides the Indian health system, and outside of their own communities – often traveling hours to make appointments. These providers, while technically knowledgeable, may not have experience or the cultural knowledge to provide comprehensive, competent care to AI/AN people living with HIV. The lack of local providers, distance to HIV specialists, and absence of culturally competency serve as deterrents for many AI/AN seeking ongoing care and monitoring. HHS and the CDC should, as integral components of its national HIV response, direct funding to support Tribal-specific training, technical and capacity building assistance, and materials dissemination.

SUBSTANCE ABUSE MENTAL HEALTH SERVICES ADMINISTRATION

Increased physical distancing and isolation under the COVID-19 pandemic have led to recent and alarming spikes in drug overdose deaths, suicides, and other mental and behavioral health challenges. Population-specific data on increased drug overdose and suicide deaths during the pandemic are currently unavailable; yet if trends prior to the rise of COVID-19 are any indicator of risk, it is safe to assume that AI/AN people are experiencing serious challenges. One of the major drivers of increased mortality rates among AI/ANs overall has been significantly higher rates of drug overdose and suicide deaths than the general population.

AI/ANs are disproportionately impacted by mental and behavioral health issues including substance use disorders, overdose, mental illness, historical and intergenerational trauma, and suicide. Tribal communities also lack dedicated and sufficient behavioral health providers contributing to high rates of inaccessibility of care. For example, in some Tribal communities, the closest substance use treatment facility can be upwards of 100 miles away, while other Tribes may only have one or two behavioral health specialists who are largely under resourced to meet demand for services. For instance, non-metro AI/ANs experienced the highest percentage increase in drug overdose deaths from 1999-2015 at 519%[15], while experiencing the second highest overall opioid overdose death rate, second highest heroin overdose death rate, and highest prescription opioid overdose death rate nationwide in 2016[16].

[15] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12

[16] Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. DOI: http://dx.doi.org/10.15585/mmwr.mm675152e1

AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before the COVID-19 pandemic began, and many of these challenges have been exacerbated, especially for Native youth. A 2018 study found that AI/AN youth in 8th, 10th, and 12th grades were statistically significantly more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days. Further, according to the CDC, suicide rates for AI/ANs across 18 states were reported at 21.5 per 100,000 – 3.5 times higher than demographic groups with the lowest rates. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma, alongside contemporary trauma.

Suicide prevention and postvention are also top priorities for Tribal communities. In 2016, AI/ANs had the highest overall suicide death rate at 21.39 deaths per 100,000[17]. According to National Violent Death Reporting System data analyzed by CDC across 18 states, AI/AN suicide rates in those states were at 21.5 per 100,000 – more than 3.5 times the rate among demographics with the lowest rates[18].
It is imperative to prioritize Tribal mental and behavioral health programs for Tribes to see meaningful decreases in these disparities. The Biden Administration called for increased health and public health equity and SAMHSA should takes steps to ensure equity is achieved.

Substance Abuse and the Opioid Epidemic
AI/ANs have been particularly impacted by the intensifying opioid epidemic. A national study looking at death certificate data reported that AI/AN experienced the highest prescription opioid death rate of any demographic in 2017 at 7.2 deaths per 100,000, and the highest percentage increase in prescription opioid deaths between 2016 and 2017 at 10.8%. Overall opioid overdose death rates in 2017 were at 15.7 per 100,000 while heroin overdose death rates among AI/ANs were at 5.2 deaths per 100,000 – the second highest rates of any demographic nationwide. Starting in FY 2018, and again in FY 2019, Congress enacted 5% set asides in opioid response grants for Tribes and Tribal organizations and a 10% set aside for medication-assisted treatment. According to SAMHSA, 164 Tribes and Tribal organizations received Tribal Opioid Response (TOR) grants in FY 2019.

For FY 2023, SAMHSA should maintain the Tribal set aside of opioid monies so Tribes can continue to build their prevention, treatment and recovery infrastructure and capacity. However, **the set aside should be increased to 10% to allow for more Tribes to enter the program, and for existing Tribal grantees to be able to expand the range and quality of services available to their communities.** If needed, the agency should request a statutory change to allow Tribes to access these funds.

SAMHSA should **also maintain the $10 million set aside for medication-assisted treatment (MAT) for Tribes and Tribal organizations**. MAT access in Tribal communities is highly fragmented, and there are very few IHS and Tribal providers that have the necessary training and certification to prescribe MAT. However, SAMHSA's FY 2020 Congressional Justification did not mention this $10 million Tribal set aside. It is essential that these funds are maintained and expanded.

[17] Suicide Prevention Resource Center. Racial and Ethnic Disparities. Retrieved from http://www.sprc.org/racial-ethnic-disparities
[18]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

SAMHSA should provide set aside funding in FY 2023 for Tribes for first responder trainings for opioid overdose reversal drugs such as naloxone. Tribal communities, like many throughout the country, are in desperate need of training for first responders and other health professionals. In many Tribal communities, access to naloxone is highly limited due to the rural nature of these communities. This also makes timely access to first responders more difficult and reduces response times for an overdose. Expanding availability of trainings can help Tribes recruit more local first responders and train community members on how to administer life-saving drugs like naloxone.

SAMHSA should double funding for Tribal Behavioral Health Grants for substance use prevention to $40 million and expand program flexibility to permit Tribes to implement projects that are uniquely tailored to meet their community needs. In addition, **SAMHSA should engage in meaningful and robust Tribal consultation to discuss opportunities and strategies for restructuring the program as formula-based**, which many Tribes prefer.

Tribal communities face significant challenges in curbing new HIV infections and expanding access and linkage to care for HIV positive individuals. The Indian health system currently does not receive dedicated funding for HIV prevention and treatment, contributing to a paucity of Tribal programs in this arena. **While Tribes are eligible for Minority AIDS Initiative funds, no Tribes or Tribal organizations received this funding in FY 2016, 2017, or 2018**. Thus, NIHB requests that SAMHSA **enact a 5% set aside in Minority AIDS Initiative funds for Tribes and Tribal organizations**.

Rates of neonatal abstinence syndrome and maternal opioid use disorder have increased significantly in recent years in Indian Country, largely driven by the opioid epidemic. However, SAMHSA did not fund any Tribes or Tribal organizations for pregnant and postpartum women grants in FY 2018. NIHB requests that **SAMHSA enact a 5% set aside so Tribes can improve maternal and child health and behavioral health outcomes**.

Peer recovery programs are effective mechanisms for increasing access to health services in underserved areas, especially for individuals who face shame and stigma for behavioral health issues. Expanding Tribal access to Recovery Community Services Program can help address these issues in Tribal communities. NIHB requests that **SAMHSA create and pilot a program specifically for Tribes to develop culturally appropriate peer recovery initiatives** utilizing the Tribal Behavioral Health Agenda as a blueprint.

The President's 2021 budget request discontinued the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. SBIRT is a highly effective program at both IHS, and SAMHSA must be renewed for FY 2023 and beyond.

<u>Mental Health and Suicide Prevention</u>

Suicide is primary concern for many Tribal communities, especially as it relates to Native youth. Suicide rates among AI/ANs overall have consistently been either the highest or second highest of all demographics from 2000-2016. Among Native youth, average suicide rates among 15–19-year-olds from 2000-2016 were almost quadruple the national rate, more than double the national average for 20-24-year-olds. In fact, AI/ANs under the age of 44 are significantly higher than any other racial demographic. Multiple factors including exposure to violence and trauma, mental health disorders, alcohol

and drug misuse, low rates of access to mental health services, and a higher prevalence of experiences with discrimination and alienation all contribute to the higher rates of suicide within AI/AN youth.

SAMHSA should increase its support for the AI/AN Suicide Prevention Initiative by requesting $15 million for this initiative for FY 2023 and continue expanding Tribal access to the Garrett Lee Smith suicide prevention grant program.

For FY 2023, SAMHSA should double Tribal Behavioral Health Grants for mental health to $40 million and expand program flexibility to permit Tribes to implement projects that are uniquely tailored to meet their community needs. In addition, **SAMHSA should engage in meaningful and robust Tribal consultation to discuss opportunities and strategies for restructuring the program as formula-based**, which many Tribes prefer.

SAMHSA should continue its support for the Circles of Care program funding to Tribes and increase funding to at least $8.5 million. The Circles of Care Program offers three-year infrastructure/planning grants which seeks to eliminate mental health disparities by providing AI/AN communities with tools and resources to design and sustain their own culturally competent system of care approach for children. Behavioral health infrastructure is one of the key challenges for many Tribal communities when it comes to creating sustainable change for their communities. Circles of Care represents a critical part of this work.

Project LAUNCH grants promote the wellness of young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Given its focus on younger children, this program can help reduce future mental health issues and suicide risk. We request that **SAMHSA expand the program's reach into Indian Country and explore opportunities to designate funding under this field for Tribes** specifically so that they can develop more uniquely tailored and culturally appropriate initiatives.

Political Appointees

President Biden called for his Administration to be more representative of the people they serve. NIHB believes that Indian Country inform each decision made by federal agencies that impacts Tribes and fulfills the federal trust responsibility.

SAMHSA should create senior level AI/AN political appointee positions in each of the offices and centers that constitute SAMHSA.

Expand Self-Governance

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. Self-governance represents efficiency, accountability, and best practices in managing and operating Tribal programs and administering federal funds at the local level. Expanding self-governance translates to greater flexibility for Tribes to provide critical substance misuse and mental health services and allow for greater autonomy for Tribes to expand those services to best serve their people. Allowing Tribes to enter self-governance compacts with SAMHSA would mean that federal dollars are used more efficiently because resources in Tribal communities, which are often small, could be more easily pooled and would allow Tribes to organize comprehensive substance misuse and mental health services to better serve those who have the greatest need.

SAMHSA should fully support the expansion of self-determination contracting and self-governance compacting across the agency.

End Competitive Grant Processes for Tribes

The competitive grant process pits Tribes against each other for vital substance misuse and mental health funding, which does not honor the US Trust obligation to the Tribes. Further, Tribes often must compete against more established mental and behavioral health entities for significant federal dollars and often lose out on those opportunities.

SAMHSA should create Tribal set-asides, non-competitive funding for Tribes in all funding opportunities across

OFFICE OF MINORITY HEALTH

American Indians and Alaska Native (AI/AN) people occupy a unique space in the landscape of the American public life. Although many AI/AN individuals would be considered to be part of minority populations, many if not most of these same individuals hold membership as part of their Tribal nations, which accords them a special and significant political status, separate and unique from their status as minority group members.

The federal trust responsibility extends to every branch of the federal government and to every Executive Department and agency.

Tribal citizens are due services that will advance the trust responsibility of the federal government to ensure that Tribal Nations and Tribal populations people achieve the highest health status possible. The OMH should recognize and address the unique needs of Indian Country through its programing, while also answering the special duties it has to AI/AN people as a result of the trust responsibility – a responsibility it does not have to any other minority group in the United States.

To carry out these solemn responsibilities, **OMH should work to increase funding that is specific to Tribal populations.** It should **ensure that OMH staff are educated about the government-to-government relationship and the unique political status of American Indians and Alaska Natives,** and furthermore the Office can take a lead role in educating partner agencies/operating divisions in HHS.

NIHB also requests that **OMH engage in meaningful Tribal consultation on restoring the OMH AI/AN Health Research Advisory Council** which was dissolved earlier this year. While engagement with Tribal advisory committees does not substitute for consultation, advisory committees provide an effective built-in process for regular engagement with Tribal leaders and technical experts who can inform the agency about Tribal priorities and challenges.

Center for Indigenous Innovation and Health Equity

We are concerned about the proposed Center for Indigenous Innovation and Health Equity. While we appreciate the interest in addressing health equity issues in our communities, we do not feel that the current proposal considers the unique political status of Tribes and the importance of engaging with Tribal nations

as initiatives are being enacted. **We want to emphasize that Tribes are sovereign nations and that any initiative that seeks to benefit AI/AN people should be mindful of this.** Tribal governments are the oldest governments in North America and their existence predates the United States.

This was recognized in Article I, Section 8, Clause 3 of the U.S. Constitution, which states that the United States Congress shall have power "*[t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes*." The sovereignty of Tribes within the framework of the United States government was further clarified in *Cherokee Nation v. Georgia,*[19] which states that Tribes occupy a unique area within the American political framework as "domestic dependent nations."

The distinctive nature of Tribal Nations has consistently been recognized in American law and jurisprudence. Many AI/ANs were not even United States citizens until the passage of the Indian Citizenship Act of 1924. Today however, AI/ANs are dual citizens, of their Tribe and the United States government, and this reality should inform any work being done to address long-standing concerns in our communities. **Being AI/AN is not merely a racial classification but also an indicator of citizenship in a sovereign entity**. As previously stated, the United States has a unique trust responsibility to Tribal Nations, which has repeatedly been invoked in statutes, regulations, agency guidance, and court decisions. It would be improper for the United States to undertake this initiative without working closely with Tribal Nations. The agency ***must*** keep these considerations in mind as they work to address the long-standing health issues that have plagued our communities. ***We believe that the proposal, as constructed, does not honor Tribal sovereignty and fails to acknowledge the existence of Tribes as distinct political entities.***

NATIONAL INSTITUTES OF HEALTH

AI/AN communities have experienced historic and current ethical violations when receiving healthcare from IHS and participating in medical research.[20] For example, 3,406 AI/AN women were sterilized without their permission between 1973 and 1976 by the federal government. The pervasive and historical atrocities committed by the United States against the AI/AN people is the root cause of current Tribal distrust. In addition, there are continued perceptions around the lack of acknowledgment and inclusion of Tribal research evidence and practices. Moreover, Tribes have expressed how intergenerational Indigenous knowledge, wisdom, and evidence is not accepted as "evidence-based" as it is defined in Western research circles which contributes to the lack of tailored, culturally appropriate, and practice-based programs implemented in Tribal communities.

There exists an inherent bias against indigenous knowledge and funding Tribal-centric research projects at NIH, which could begin to be remedied by ensuring grant reviewers are educated around their inherent biases and increasing the number of AI/AN reviewers. By prioritizing Tribes for R21 funding opportunities (exploratory and developmental research grants), a body of evidence can begin to be established for culturally appropriate, indigenous-focused traditional practices that would better serve the AI/AN people.

---

[19] 30 U.S. 1 (1831)

[20] NCAI Policy Research Center and MSU Center for Native Health Partnerships. (2012). 'Walk softly and listen carefully': Building research relationships with tribal communities. Washington, DC, and Bozeman, MT: Authors.

Although ongoing research abuses and violations have resulted in a general mistrust of research; Tribal leaders acknowledge the need to address AI/AN health disparities as well as the benefits research can yield as a tool for Tribal sovereignty. To bring benefits to Tribal communities, and minimize risk, meaningful research partnerships must be created and must include open communication, trust, and reciprocity between researchers and Tribal communities. For example, community-based participatory research (CBPR) has been cited as an effective model for research practice with Tribal communities as it honors Tribal sovereignty, includes frequent and meaningful consultation, and ensures community leaders have decision-making authority throughout research development, implementation, and evaluation. **Ethical and meaningful inclusion of AI/ANs should be prioritized in NIH research efforts, which can be achieved through continued robust and regular Tribal Consultation.**

There exist a couple factors that are regarded as barriers by NIH in studying Tribal citizens: 1) population size, and 2) Tribes are sovereign nations. These barriers can be easily overcome, however, by effectively engaging and involving Tribes at the beginning of a potential research project. Tribes should have a voice in crafting the research protocol, including operational aspects along with the storage and access to the collected data. The NIH, if it would choose to do so, could work *with* Tribes to establish Memorandums of Understanding (MOUs) to solve these operational details.

Tribal Health Research Office

The NIH is the national agency advancing medical research. NIH's mission is to "seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability." The NIH should work to ensure the AI/AN people have *equitable* opportunities to participate in achieving that mission.

Since its establishment in 2015, the Tribal Health Research Office (THRO) has been integral in ensuring meaningful input from and collaboration with Tribal Nations on NIH programs and policies. The NIH TAC has tried to educate NIH officials around the importance of obtaining the Tribe's consent to enroll Tribal citizens into research programs. The agency has historically had difficulty appreciating the significance of Tribal consent, but the Tribes persist in their education efforts. To better recognize this concept, explore a potential NIH research project that would take place in France – on French citizens. The federal government would be required to obtain explicit consent from the French government before proceeding. Research on Tribal citizens is no different – the Tribal government must consent.

The NIH should continue funding and supporting the NIH TAC and dedicate additional resources to support a standing work group of Tribal technical experts, with subject matter expertise and experience in the areas most needed by the NIH TAC. This work group would create knowledge products on those areas for the Tribal leaders appointed to the TAC, and help the TAC prepare for the TAC meetings. Furthermore, to the extent possible, NIH needs set aside funding to support additional Tribal Liaison staffing in NIH institutes, to advance the work of the THRO and NIH TAC to ensure that Tribal input is received and implemented at every level of the Agency.

All of Us Research Program

The NIH started enrolling Tribal citizens into the All of Us research program without Tribal input or consent. It was only after significant concerns were raised by the NIH TAC and several Tribes that the agency embargoed the Tribal data collected, without prior Tribal government consent. **The All of Us**

Research Program should take meaningful steps to ensure the ethical and appropriate inclusion of AI/ANs. NIHB submitted written comments for the record in October 2019 to NIH expressing disappointment in the lack of transparency, slowness of pace, and the overall piecemeal approach to Tribal Consultation with which the agency has adopted Tribal suggestions. Additionally, the NIHB Board of Directors passed a resolution calling for specific action to ensure Tribal leaders are engaged in a meaningful and robust way about the recruitment of their Tribal citizens. The NIH should take steps to implement the recommendations contained within that resolution.

NIH should work closely with the NIH TAC to assess consultation input to date and immediately develop clear processes and guidelines that ask individual sovereign Tribal Nations to provide prior consent before collecting data and specimens from their Tribal members, and provide Tribal Nations oversight, including local control and storage of any data or biospecimens that are associated with or identified to be from a citizen of their Tribal Nation. The NIH TAC is made up of Tribal experts around research. The agency should recognize that wealth of Tribal expertise on the TAC and allow for the results of the consultation to be synthesized and drafted into a report for review by Tribal leadership.

Tribal Research Opportunities

Research with minority groups, including AI/AN Tribes, is important to ensure that research conclusions are accurate and inclusive of different types of populations. However, when studying AI/AN populations, you are not only studying a minority population but also citizens of sovereign nations. Further, like all parts of the federal government, NIH has a special duty to AI/AN Tribes to ensure the fulfillment of the federal government's trust responsibility. Medical research is critical because the AI/AN population experiences significant health disparities – including diabetes, HIV, infant mortality, mental health, substance abuse, and other significant health issues. Despite these challenges, there are few opportunities available for Tribes to receive direct funding from NIH. This is particularly significant as research can be a sensitive issue in Tribal communities due to issues such as past abuses and harmful processes or conclusions. Consequently, providing direct funding to Tribal communities allows Tribes to take control of research affecting them and may lead to increased participation and effectiveness.

More Tribal control over research in their communities will ensure the principles of CBPR are followed and would allow for the discovery of new evidence-based practices. Additionally, the community-based approach would allow for real-time adjustments to the study if issues were to arise. As communities, we understand the benefits from the research – potential harms – and it informs the study through data collection. NIH currently offers two funding opportunities for AI/AN populations which provide direct funding to Tribes: Interventions for Health Promotion and Disease prevention in Native American Populations; and Native American Research Centers for Health (NARCH), which particularly supports collaboration between Tribes or Tribal organizations and academic institutions on projects that Tribes have identified and prioritized. This opportunity allows increased partnership, with potential benefits beyond one single project, and gives Tribes' agency in determining their own priorities. The NARCH program needs to be expanded beyond the traditional western framework and incorporate AI/AN traditional ways. Furthermore, the NARCH reviewers need to have a baseline knowledge around what they are reviewing from Tribes and AI/AN researchers. The NIH funding announcements are catered to large, research universities, which gives them an advantage over Tribes. **Clear set-asides must be made to specifically fund Tribal research, conducted by or with Tribes.**

Often, NIH will award university medical centers funds to conduct research on American Indians and Alaska Natives, but Tribes in the area are rarely engaged with or alerted to this fact until long after projects commence. This practice can mean including a Tribal citizen in research programs without the consent of their Tribal Nation in order to feign "tribal" engagement without achieving it. This practice must stop, and Tribal Colleges and Universities should be afforded the opportunity to receive these awards to conduct research on their people.

Tribal Data Sovereignty

The rights and responsibilities surrounding ownership, access and retention of data as well as the definition of research data may vary based upon the funding of the project, nature of the award, and general context of each situation. For the purposes of a specific research agreement, the investigator and Tribe should review the funders' expectations. The use, ownership, and stewardship of data is determined by the Tribes when conducting research in their communities. Clear parameters must be set around data access and publication plans. The NIH TAC should be involved in developing best practices for Tribal research that each Institute and Center within the NIH would honor and adhere to. With over 574 federally recognized Tribes, there will never be a one-size fits all approach. But best practices can be and should be developed to ensure individual Tribes can govern their data as they see fit.

Tribal Engagement and the Director of Health Equity

The recent announcement to improve tribal engagement efforts is encouraging. It is vitally important for the NIH to ensure the perspectives and needs of AI/AN communities are integrated into the agency's research priorities, and ongoing support for engagement activities with Tribal Nations must continue. Also, the recent announcement about the search for a Director of Health Equity for the All of Us Research Program provides the NIH with a unique opportunity to make a significant effort to increase trust among Tribes. **NIH should meaningfully consider and prioritize AI/AN candidates for the Director position, which will be a major step towards ethical and equitable inclusion of AI/ANs.**

End Competitive Grant Processes for Tribes

The competitive grant process pits Tribes against each other for essential health research funding, which does not honor the US Trust obligation to the Tribes. Further, Tribes often must compete against more established research entities for significant federal dollars and often lose out on those opportunities. **NIH should create Tribal set asides, non-competitive funding for Tribes in all funding opportunities across NIH and streamline reporting requirements to reduce burdens on Tribal Nations receiving federal health research funding.**

Political Appointees

We also believe that the agency could improve how it engages with Tribes more broadly. President Biden called for his administration to be more representative of the people they serve. We believe that the NIH would benefit from having leadership that understands Indian Country. **In order for NIH to fully honor its mission and the trust responsibility, there must be a Tribally informed voice in a political leadership position, with actual decision-making authority in every Institute and Center within the NIH.**

HEALTH RESOURCES AND SERVICES ADMINISTRATION

It is no secret that the Indian health system faces chronic and pervasive health workforce shortages that limit the continuity, quality and accessibility of care. According to a 2018 report from the Government Accountability Office, the overall provider vacancy rate across eight IHS areas with substantial direct patient care responsibilities was 25%, but reached as has as 31% in some areas.[21] Tribal and IHS health systems have long faced difficulties in recruiting and retaining quality providers including primary care physicians, public health practitioners, medical specialists, nurses, nurse practitioners, dentists, pharmacists, and physician assistants. As reported in the FY 2021 IHS Congressional Justification, there are approximately 1,330 provider vacancies within the IHS system.

The Health Resources and Services Administration (HRSA) is tasked with increasing access to effective and quality health care for individuals living in medically underserved areas, with the mission to "*…enhance the health and well-being of Americans by providing effective health and human services."*

HRSA also holds the responsibility for administering the Federal Office of Rural Health Policy (FORHP), which administers several programs that directly benefit geographically isolated rural communities. American Indians and Alaska Natives are the most rural population in the country. In fact, 46.1% of AI/ANs live in rural communities, a rate which is over twice the percentage of the rest of the population.[22] **No community is more affected by rural health policy than American Indians and Alaskan Natives.** The duty to help Tribal communities is furthered by the trust responsibility, which places a duty on the federal government to remedy these issues. Tribal communities have long been neglected and provided with little investment or assistance to grow or develop their public health infrastructure that is vital to combat the health inequities that our communities face.

NIHB is pleased that HRSA is in the process of establishing a TAC. This will create a mechanism for ongoing Tribal input in and the opportunity to convey Tribal priorities on an ongoing basis. We hope that HRSA will utilize TAC input to advance progress in honoring the trust responsibility to Tribes for healthcare and public health services. This is in addition to engaging in regular and meaningful government to-government consultation with Tribal leaders and representatives before, during, and after development and implementation of agency policies and programs. HRSA's mission and principal duties are of particular significance to Indian Country given the historic and present-day challenges in healthcare, public health and behavioral health workforce and capacity, public health infrastructure, availability of clinical and preventative services, and other needs.

Health Workforce

Chronic and pervasive health staffing shortages–from physicians to nurses to behavioral health practitioners–stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies

[21] Government Accountability Office. 2018. Indian Health Service: Agency Faces Ongoing Challenges Filing Provider Vacancies. Retrieved from https://www.gao.gov/assets/700/693940.pdf

[22] Janice C. Probst, Fozia Ajmal, "Social Determinants of Health among Rural American Indian and Alaska Native Populations," Univ. of S.C. Rural and Minority Health Research Center, July 2019 https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf

documented as of 2016. Further, a 2018 GAO report found **an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas** (GAO 18-580). Lack of providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective, and culturally indifferent, at best – inept at worst. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that – at 37 years.[23] In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care.

We request that for **HRSA continue its support for National Health Service Corps (NHSC) placements within I/T/U facilities and work to expand the reach and penetration of the program into Indian Country**. IHS and Tribal facilities are heavily reliant on NHSC placements to compensate for perennial health workforce shortages, and any reductions to placements would be devastating to the Indian health system. **We request an increase in funding in the FY 2023 to support additional placements in the Indian health system.**

NHSC placements are largely dictated by Health Professional Shortage Area (HPSA) scores for medical, behavioral and dental care accessibility. In general, the higher the score, the higher the need for more providers and services. Previously, when the agency underwent a restructuring of HPSA scoring mechanisms, Tribes expressed how there was not adequate and meaningful consultation with Tribes despite the fact that any changes can have substantial impacts on the IHS and Tribal workforce. While existing statute and regulations ensure that I/T/U facilities qualify for automatic HPSA designation, it is still crucial that robust consultation inform any proposed changes to the scoring process. Thus, **we request that HRSA engage in meaningful Tribal consultation before proposing any changes to the HPSA scoring mechanisms and throughout the regulatory process and follow the Department of Health and Human Service's consultation guidelines for reference**.

In 2018, Congress provided funding to the agency to expand the NHSC Loan Repayment Program for Substance Use Disorder (SUD) providers. Tribal communities are disproportionately impacted by substance use disorders and drug overdose. In addition, there is a scarcity of behavioral health providers within the Indian health system. We **request that HRSA designate 5% of funds from the loan repayment program for SUD providers specifically for IHS and Tribal behavioral health providers** to expand recruitment and retention of quality practitioners serving AI/AN populations. We also **request that HRSA designate health workforce development grant funding for I/T/U facilities including under programs such as the Public Health and Preventive Medicine Training Grants, Preventive Medicine Residency Program, Nursing Workforce Development, Teaching Health Center Graduate Medical Education Program, and Telehealth Network Grant Programs.**

Health Centers

One of HRSA's primary duties is to improve delivery and access of quality primary care and other health services through its health center funding programs. The program offers comprehensive medical care including preventive services, mental health and behavioral health services, patient management and

[23] *See* https://www.ihs.gov/newsroom/factsheets/healthfacilitiesconstruction/

referrals, and some emergency medical services and pharmaceutical services for communities living in medically underserved areas. Given ongoing issues around inaccessibility of care in Indian Country, we **request that HRSA designate flagship funding specifically for Tribes and Tribal organizations in health center grant programs** to improve primary care and behavioral health outcomes.

Maternal and Child Health

As of FY 2019, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) supports 29 Tribal entities for voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. We request that **HRSA continue its support for the important MIECHV program in Indian Country**.

Ryan White HIV/AIDS Program

From 2010-2016, AI/ANs experienced a 46% increase in HIV diagnoses overall and an 81% increase among Native men who have sex with men. The Ryan White program is one of the most reputable and successful HIV prevention and treatment programs ever implemented, but it has very limited reach into Indian Country. While there are statutory restrictions to Tribal eligibility for Parts A and B, Tribes are eligible for Part C Early Intervention Strategies grants but receive very little direct funding. NIHB **requests that HRSA engage in Tribal consultation to explore strategies and receive recommendations for increasing direct Tribal access to Part C program dollars**.

Rural Health Policy

HRSA's rural programs provide resources and funding to rural and underserved areas to improve healthcare access and quality, and to address health threats like the opioid crisis. While Tribes are eligible for grants such as the Rural Health Care Services Outreach, Rural Health Opioid Program, Rural Health Network Planning and Development, Rural Communities Opioid Response, and Telehealth Network Program, these grants have very little penetration into Indian Country. While many Tribes are located in rural areas, the majority of rural funding tends to go to non-Tribal communities. NIHB requests that **HRSA designate a 5% set-aside of rural health program dollars for Tribes and Tribal organizations**. **We also request that the agency dedicate additional funding to outreach and education, so Tribes are aware of these opportunities. We ask HRSA to provide technical assistance to Tribes, so that they have the resources necessary to apply for and administer the funds.**

NIHB also requests that FORHP work directly with the Indian Health Service to address workforce shortages in Indian Country and that funding be appropriated to support these issues.

CONCLUSION

The social determinants of health and poor health status of health and poor health status for AI/ANs could be dramatically improved with adequate investment into the health, public health and health delivery systems in Indian Country. Funding must be identified to actually realize marked improvements in health outcomes and to build public health infrastructure for all AI/ANs.

While incremental increases are much needed to sustain the historical level of services, they do little to address the disparate health conditions of AI/AN communities. Leaders of our Tribal Nations insist that a true and meaningful investment be made to finally eradicate the pervasive health disparities which has overwhelmed Indian Country for years. It will take a true commitment between the United States and Tribal Nation Leadership to put a strategy and budget in place. Decisive action by this Administration must occur to prioritize department resources to bring the health of AI/AN citizens closer to parity with the rest of the citizens of the United States. We must rise above just settling for maintenance funding to sustain what has proven to be an unacceptable level of health care in Tribal reservations and villages.

NIHB implores the Administration to work with Congress in FY 2023 to enact a serious investment in Indian health that will honor and fulfill the promises made to our ancestors. Time and again, Congress and the courts have affirmed this federal trust responsibility. This Administration must take actionable steps to fulfill this promise by putting forward a true and impactful budget proposal. Our proud Nations continue to suffer from preventable or treatable diseases and our citizens die younger than other Americans.

In closing, we thank the Administration for the continued commitment to Indian Country and urge it to further prioritize Indian Country through the end of COVID-19 pandemic and beyond.