**TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD FOR THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES**
**FISCAL YEAR 2024 TRIBAL BUDGET AND POLICY CONSULTATION**
**April 6-7, 2022**

# Contents



# Introduction

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 2024 U.S. Department of Health and Human Services (HHS) 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 affect that policy.[2]

## Federal Trust Responsibility

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 2022-2026:

> Of noted significance, the federal government has a unique government to government relationship with Tribal nations and must establish regular and meaningful consultation and collaboration with Tribal officials in the development of federal policies that have Tribal implications, as outlined in Executive Order 13175: Consultation and Coordination with Indian Tribal Governments and carried out through the HHS Tribal Consultation Policy.[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 American Indians and Alaska Natives (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 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.

## Health Disparities and the Impact of COVID-19

On average, according to 2019 data from the Centers for Disease Control and Prevention (CDC), AI/ANs born today have a life expectancy that is 7 years less than the national average, with some Tribal communities experiencing even lower life expectancy.[6] COVID-19 has only added to this disparity. Recent data from the CDC shows AI/ANs had the highest rate of all races, compared to white, for COVID-19 cases, hospitalizations, and deaths. In fact, AI/ANs were 3.1 times more likely to be hospitalized from COVID-19, 2.1 times more likely to die from COVID-19 and 1.6 times more likely to contract COVID-19 compared to a white person. And no other race has higher rates than AI/AN. [7]

Given the statistics on the impact of COVID-19 on AI/ANs, it has never been more important to increase the resources flowing to Indian Country and to break barriers that have prevented Tribes from having direct access to data and resources. 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 the long-term lack of investment in Tribal health and public health systems.

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. Resilience is a key component of mental health and wellness; however, its development is necessitated by experiences

of trauma and adversity. The enduring spirit of American Indian and Alaska Native (AI/AN) communities is a prime example of resilience. The painful wounds of historical and intergenerational trauma manifest in several behavioral health-related symptoms, like substance misuse, suicide, stress-related disorders, and interpersonal violence. The American Indian boarding schools is a one-hundred-year trauma caused by federal programs designed to eradicate AI/AN culture, language, and identity through forced assimilation. The link between the historical trauma and disparities in physical and behavioral health is well documented.[8] These inequities will continue to go unaddressed without full funding of Indian Health Service and federal public health programs for AI/ANs..

## Direct Grant Funding to Tribes

The COVID-19 pandemic has required the federal government to uphold its obligation in a way that is perhaps unparalleled in modern American history. However, Tribes continually encounter systemic barriers that impede their ability to receive funds from the federal government, and this is slowing or even outright denying access. During the last two years, the COVID-19 funding enacted by Congress created not before seen investments into AI/AN public health . However, against recommendations from Tribes, the federal government chose to use a competitive grant-making process to distribute funds to Tribes. Many Tribal offices and programs had limited personnel due to COVID-19 and were forced to use a skeleton staff to apply for these competitive grants within very tight timeframes. If Tribes could not pull together staff and other needed resources, they were unable to apply for these pots of money to provide care for their people. Grants do not meet the federal trust obligation.

Tribes are eligible for numerous competitive grants that provide funding to address public health and other health-related issues. This is counter to the federal trust responsibility and undermines self-determination tenets. In general, Tribes have difficulty meeting the service population requirements, administrative and reporting requirements, or are under-resourced to apply and compete for the grants. Current grant structures tend to favor larger Tribes with the capacity and infrastructure to deliver intended services in the brief grant timeline. Tribal eligibility for funding does not equate to Tribal access; especially when the grant program requires Tribes to compete with states, cities, and other governments that are generally higher resourced.

The federal government must cease using the competitive grant mechanism to fulfill its trust obligations to Tribal Nations. By their very design, competitive grants exacerbate an already an inequitable system of winners and losers. The federal obligation to fully fund Indian country's health services was never meant to be contingent upon the quality of a grant application. Yet that is the construct under which the federal government has forced Tribes to operate. All divisions within HHS must make a significant commitment to creating set asides for direct funding to Tribal governments and organizations in a streamlined, non-competitive, sustainable, and equitable fashion.

## Prioritize the Health of American Indians and Alaska Natives

As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. 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. The nation left Tribes 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 most state, territorial, and even city and county public health entities in terms of their capacity.

If we are ever to address AI/AN health disparities and lower life expectancy, HHS, CDC, IHS and other agencies must commit the resources and continue their meaningful and sustainable direct investments into Tribal communities for health and public health.

## Fund Health Centers Using Traditional Healing and Cultural Practices

A significant increase in funding is needed to allow Tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that build upon the culture and tradition, inherent strengths already existing in Tribal communities. Traditional medicine is central to many Tribal cultures and is effective in treating and preventing many chronic health issues facing AI/AN people. AI/AN people continue to demonstrate alarming rates of psychological distress throughout the nation. Inadequate funding resources limit Tribes from implementing cultural and asset-based approaches to address these issues. Recognizing Tribal sovereignty means recognizing the sovereign right of Tribal nations to utilize Native intelligence, traditional and cultural practices as a means of achieving health.

Programs with treatment approaches for alcohol and substance abuse that include traditional healing and cultural practices are more successful with the AI/AN population. However, due to lack of funding available and the challenges with the grant-funded model, several culturally responsive in-patient treatment centers have closed their doors leaving major gaps in the availability of detox beds with the rising number of opioid and/or other addictions. HHS agencies should recognize the value and applicability of cultural and traditional practices as viable Tribal grantee activities and encourage the implementation of Tribal traditional practices into healing practices for all areas of health: mental and physical.

## Focus on Health Equity

Health equity is a cornerstone of the President's policy agenda, as demonstrated and explained in his Executive Order. A vital component of that Executive Order is its proposal to allocate resources to address the historic failure to invest sufficiently, justly, and equally in underserved communities. Investing resources alone will not eliminate unequal treatment or health outcomes.

Equity does not mean equality. **Equality** provides an individual or group with the same resources or opportunities. **Equity** generally recognizes that each person or group has different circumstances and allocates the resources and opportunities according to **need** to reach an equal outcome. However, there must be a discussion about what equity means for Indian Country. All

the HHS operating divisions must examine how they can dismantle access barriers for AI/AN people and fully finance the Indian health care system that provides their care.

### FY 2024 Budget Request

NIHB looks to the Administration to propose a FY 2024 Budget that reflects its commitment to upholding the federal trust responsibility. We recommend doing this by committing to bold increases for Indian health programs across HHS and full funding for IHS. We thank HHS and the Office of Management and Budget (OMB) for continuing 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 fulfill the federal trust responsibility for Native health.

The testimony below focuses on the budget priorities relating to each of the agencies. See NIHB's full legislative and policy agenda for additional priorities.[9] 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
- Immediate Office of the Secretary (IOS)

## Indian Health Service

In its annual recommendations to the Indian Health Service (IHS), the National Tribal Budget Formulation Workgroup (hereafter called "the workgroup") proposed a FY 2022 budget of $49.8 billion. The workgroup expressed optimism that the Biden Administration intends to work with all Tribes in a meaningful way to fulfill the Trust responsibility and treaty obligations to America's First Peoples. With a commitment from the Biden Administration, this year the workgroup chose to put forward a budget request for full and mandatory funding for the Indian Health Service – **a minimum of $51.416 billion for FY 2024.**

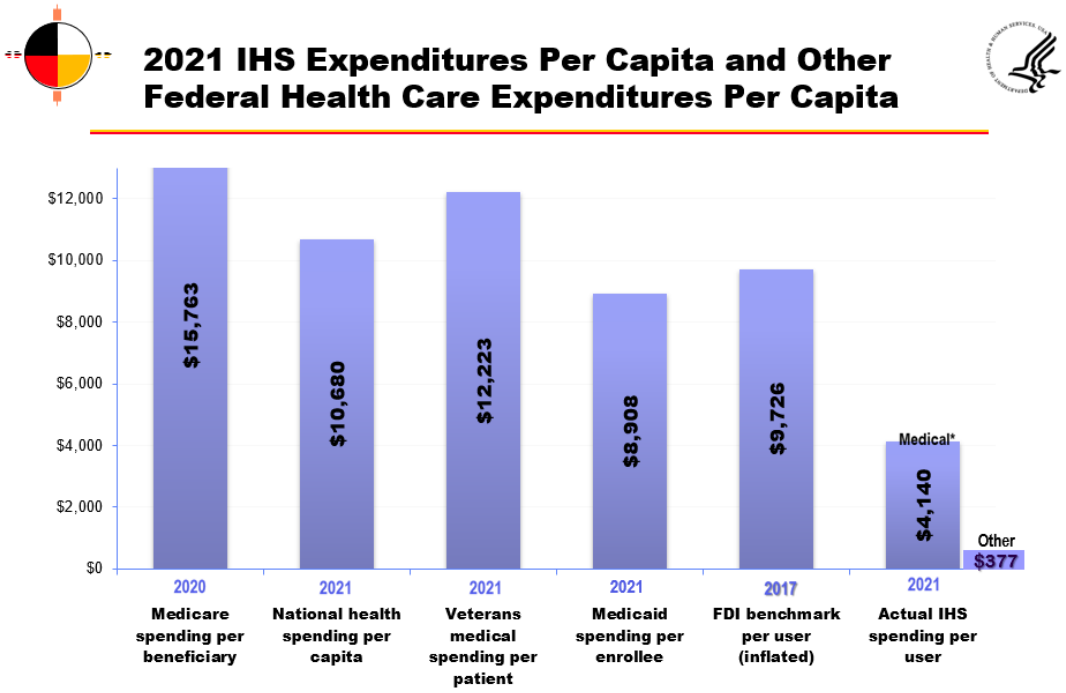
This request serves as a departure from previous requests that asked for conservative percentage increases to be phased in over 10-12 years. The small percentage increases started from an inadequately funded budget and did not give Tribes the funding they need to make any substantial improvements to our health status, health systems or public health systems. IHS must reinstate funding of public health work. It is more apparent than ever that our **Tribal Nations will never achieve a fully funded needs-based budget unless we boldly stand up for the true need to address the ever-growing health disparities in Indian Country.**

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. The 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 2021, the IHS per capita expenditures for patient health services were just $4,140, compared to an estimated $10,680 per person for healthcare spending nationally.

The chart below provides the comparisons of expenditure in the Veteran's Administration, Medicaid, and Medicare. As you can see, IHS per capita spending is almost ¼ of per capita spending on Medicare, more than 60 percent lower than National health spending per capita, approximately 1/3 of healthcare spending on Veterans, and less than 1/2 of per capita Medicaid spending. The most enlightening statistic might be the **2021** Actual IHS medical expenditures per user are 57 percent lower than the **2017** Federal Disparity Index benchmark spending per user. Once medical inflation is taken into account, this incredible mismatch between spending is even more exacerbated.[10]




## FY 2024 IHS Tribal Budget Formulation Workgroup Request

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

The NIHB and the workgroup continue to advocate for fulfilment of the Trust responsibility for health through the enactment of a true fully funded IHS budget. This is the only way to end recissions and sequestration for all Tribal health programs. Mandatory funding will protect all clinical line items to ensure that health providers can rely on funded levels. The TBFWG recommends that the Administration 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 $51.416 billion**. Top full funding priorities include:[11]

| Rank | Program Expansion | Funding Amount |
|---|---|---|
| 1 | Hospital & Clinics | $12.388 Billion |
| 2 | Purchased/Referred Care | $8.303 Billion |
| 3 | Indian Health Care Improvement Fund | $3.972 Billion |
| 4 | Dental Services | $3.572 Billion |
| 5 | Alcohol and Substance Abuse | $3.481 Billion |
| 6 | Mental Health | $3.461 Billion |
| 7 | Health Care Facilities Construction/Other Authorities | $3.220 Billion |
| 8 | Maintenance & Improvement | $3.139 Billion |
| 9 | Sanitation Facilities Construction | $2.287 Billion |
| 10 | Community Health Representatives | $1.247 Billion |
| 11 | Urban Indian Health | $973.59 Million |
| 12 | Public Health Nursing | $958.71 Million |
| 13 | Health Education | $678.04 Million |
| 14 | Equipment | $546.16 Million |
| 15 | Electronic Health Record | $491.97 Million |
| 16 | Facilities & Environmental Support | $441.56 Million |
| 17 | Indian Health Professions | $335.27 Million |
| 18 | Direct Operations | $101.87 Million |
| 19 | Self-Governance | $55.89 Million |
| 20 | Alaska Immunization | $42.54 Million |
| 21 | Tribal Management Grants | $15.78 Million |

The chart above shows the rankings of the areas that have the highest funding need. NIHB fully supports all recommendations provided by the workgroup in the National Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2024 Budget book. The top six funding areas are highlighted in the testimony of the workgroup with rationale for the funding requests.

# 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 system) provides crucial financial support for the Indian healthcare system and supports the federal government's trust responsibility to Tribal citizens. In FY 2019, the third-party collections for Federal facilities only accounted for $1.14 billion.[12] 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 priorities for Tribes and the National Indian Health Board (NIHB) for CMS:

## Fully Fund 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.[13] 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 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 for 2020-2025 with long-term goals for the Indian health system.[14] CMS TTAG requested $5.74 million to fund their strategic goals and objectives fully. However, in March 2021, the CMS Division of Tribal Affairs (DTA) presented a budget almost 40 percent lower of $3.47 million. This work is critically important and was funded in FY 2019 at $5.2 million. NIHB recommends that CMS, and HHS, restore the TTAG recommended funding to full funding of **TTAG Strategic Plan priorities at $5.7 million.** In addition, NIHB recommends that the agency commit to funding new TTAG-recommended activities to address health equity policy in CMS programs.

## Support Funding for 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…"[15] As a result, Medicaid reimbursement to IHS and Tribal health program facilities is considered part of the trust responsibility. In FY 2019, Medicaid represented 63.5 percent of third-party revenue at the IHS, and 12.5 percent of overall IHS spending.[16] In 2020, 32 percent of American Indians/Alaska Natives were enrolled in Medicaid and an additional 13 percent were enrolled in Medicare.[17]

Medicaid, Medicare, and Children's Health Insurance Program (CHIP) are important additions to the underfunded Indian health care delivery system and more targeted resources are needed to ensure that eligible AI/ANs are enrolling in health programs. With the unwinding of the public health emergency and many AI/ANs potentially falling off Medicaid, this funding is more important than ever. NIHB requests **CMS restore its Outreach and Education funding to $20 million (FY 2021 level) and set aside a large proportion of that to help with enrollment education during the unwinding period.**

# Centers for Disease Control and Prevention

NIHB acknowledges that Tribal set-asides, non-competitive funding streams, and expansion of Self-Determination across the Centers for Disease Control and Prevention (CDC), have been top Tribal priorities for the agency. Unfortunately, CDC administrative requests went largely unanswered during 2021. We hope the Administration will continue to champion these Tribal needs and priorities again. We were disheartened to see, for example, that the FY2023 Budget Request for CDC to the Congress included total funding of $10.675 billion (an increase of $2.8 billion) in discretionary budget authority, Public Health Service evaluation funds, and the Affordable Care Act Prevention and Public Health Fund with nothing designated for Tribes. Instead, there is more direct funding for states, territories, and major metropolitan cities. **We need direct funding as well.**

The CDC must invest to ensure that Tribes are provided equitable access to non-competitive funding streams to build their public health capacity, allowing maximum flexibility and sustainability. To achieve equitable and stable funding to support Tribal public health infrastructure, CDC must exhaust all administrative powers and work with Congress, to establish a minimum five percent set-aside across all Centers, Institutes, and Offices (CIOs) for Tribes and Tribal organizations to integrate Tribal public health needs and priorities across the entire CDC and its programs. NIHB asks that CDC pursue the following budget priorities:

## Provide Access to COVID-19 Resources

The decision to create the IHS/Sovereign Nation Jurisdiction/Allocation for COVID-19 vaccine distribution per Tribal input has been critical to shatter historical experiences of the gross inequities of prior pandemics. **CDC must allow COVID-19 funding to be used to improve IHS and Tribes' data capacity for public health activities related to surveillance, reporting, data flow, and protection of sensitive Tribal, patient, and employee data.** CDC should also provide technical assistance if its Vaccine Administration Management System portal is utilized until IHS public health data capacity can be improved.

## Research to Determine Native Determinants of Health

In addition to investments in Public Health Data, there must also be an investment in researching and addressing the social determinants of health that impact Tribal communities. These social determinants of health are void of Native voice and are not inclusive of or responsive to Indigenous determinants of health. Funds must be invested into identifying and determining Indigenous or Tribal determinants of health to reduce the burden of disease, disability, and death in Indian Country. If you can't measure it, you can't manage it. To improve the health, well-being, and quality of life for American Indian and Alaska Natives across Indian Country, significant and sustained investment, and recognition of social determinants of health that impact Tribal communities is vital. In addition to the traditional social determinants such as housing, food, water, education, jobs, and transportation, the research must have a Native lens and include addressing the impact of culture, traditional healing practices, spiritual vitality, Indigenous knowledge, and historical trauma, to improve health and well-being long-term. The FY 2022 appropriation does

not explicitly mention Tribes or Tribal organizations as eligible for social determinants of health funding, even though decades of research have documented health inequities experienced by American Indian and Alaska Native communities. **We ask for a five percent set-aside for Tribes.**

## Invest in Tribal Public Health Systems

Tribes interact with CDC on a regular basis and there should be funding dedicated to ensuring that the agencies can meet unique Tribal needs and that Tribes and the organizations that serve and support them are funded to provide technical assistance to Tribes. 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 initiatives 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.**

## Promote and Sustain Environmental Health Improvements

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 among the 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 only approximately 2.3 percent of the national land area.[18] 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. This has been shown to further propagate COVID-19 infections across Indian Country. Lack of drinking water is a public health issue. In 2021, Senate Bill 421 was introduced to fund clean drinking water and sanitation facilities.[19] The estimated cost to repair the public water systems on reservations was $150 million.[20] **We ask that the CDC request $150 million to address the issue of clean drinking water on reservations and establish Tribal sanitation and clean water infrastructure as a public health priority.**

## Address Climate Change

Addressing the impacts of climate change is also a critical priority for Tribal nations. Climate-related disasters like wildfires and floods have been devastating for many Tribal communities, and the effects of climate change continue to worsen. According to the Intergovernmental Panel on Climate Change and reported on the National Congress of American Indians website:

> "Indigenous peoples of North America are disproportionately vulnerable to climate change. The most vulnerable industries, settlements, and societies are generally those in coastal and river flood plains; those whose economies are closely linked with climate-sensitive resources; and those in areas prone to extreme weather events. Nearly all tribes fit into one of those categories, and most Alaska Native communities fit into all three."[21]

Approximately 86 percent of Alaska Native villages are prone to flooding with 31 qualifying for permanent relocation. The decrease in the population of salmon and trout has an economic and cultural impact on Alaska Natives. **The FY 2024 Budget must include $2 billion to begin to address the issue of climate change on reservations and in Alaska.** Funding must be prioritized for climate resilience, including climate adaptation work, first responders training, and community education.

## Fund Emergency Preparedness

Another priority is to increase funding for emergency preparedness and response activities. The FY 2023 Budget Request for Public health preparedness and response activities is $842 million. The majority of these funds are distributed through the Public Health Emergency Preparedness (PHEP) cooperative agreement. PHEP funding is for state, local, and territorial (SLT) health departments to improve planning and response to public health emergencies and natural or man-made disasters. No Tribal health departments (THDs) receive this funding. This blatantly ignores Tribes are sovereign nations with inherent public health authority and have a responsibility to maintain the safety and wellbeing of their citizens. **The FY 2024 Budget must include $1 billion to assist Tribes in increasing their emergency preparedness capacity to plan for, respond to, and recover from disasters and emergencies in Tribal communities.** Direct funding is needed to ensure Tribes have sufficient staff, training, and equipment to plan and respond to disasters and public health emergencies. We need access to Public Health Emergency Preparedness Funds plus $1 billion for current need and to help achieve equity!

## Prioritize Injury & Violence Prevention

Another priority for Indian Country is injury and violence prevention – a category where the Federal government can begin to make amends for the historical trauma that has occurred and the continued impact it has on health and wellbeing of AI/ANs. A May 2021 report by the National Native Children's Trauma Center summarized the research on adverse childhood experience (ACE) with national representative AI/AN samples.[22] One such study showed that AI/AN children were up to 3 times more likely to experience an ACE, with almost 10 percent of AI/AN children experiences five or more ACEs compared to non-Hispanic White children". Another study found that the average number of childhood traumas experienced for AI/AN participants was 2.32, approximately 40 percent higher than for individuals who identify as Black or Hispanic and over 50 percent higher than for individuals who identify as White. This is a problem that will not go away without substantial commitment of funds to address the underlying reasons for the occurrence of violence and injury. **NIHB requests the President to include $500 million for**

**Tribes to being to address this important issue.** With the expansion of the Violence Against Women Act and the Missing and Murdered Indigenous Persons (MMIP) concerns, Tribes must be prioritized in FY 2024 funding for Injury and Violence Prevention.

## End the HIV Epidemic

The President's FY 2023 Budget allows for $1.47 billion in HIV/AIDS, STI funding. The current national plan for HIV 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 dying from HIV or viral hepatitis. 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. 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. Tribes are ineligible for Ryan White program funding. **Therefore, NIHB asks the President to include $200 million for HIV/AIDS in Tribal Nations.** HHS and 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

While the pandemic has elevated many of the issues AI/AN people face, it has also exacerbated behavioral health crisis in Indian Country. To reduce AI/AN behavioral health inequity and improve health outcomes, a deliberate, multi-agency collaborative effort must elevate Tribal sovereignty and allow Tribes to direct their behavioral health initiatives with minimal administrative burden or restriction. The Biden Administration's historic investment in addressing AI/AN behavioral health disparities is a promising first step. However, to improve Tribal behavioral health, Substance Abuse Mental Health Services Administration (SAMHSA) must make a more significant investment in Tribal behavioral health programs and address current structural barriers.

To reduce AI/AN behavioral health inequity and improve health outcomes, NIHB asks that CDC pursue the following budget priorities:

## Strengthen Behavioral and Mental Health Systems

This Administration's promise of hope and investment in behavioral and mental health is clear. The President's FY2023 budget request for SAMHSA is $10.7 billion, an increase of $4.2 billion from the FY2022 enacted appropriations level. While the overall increase is promising, Tribes need expanded, direct funding and Tribal set-asides to address the severe behavioral and mental health disparities we continue to experience in Tribal nations and communities.

Tribes currently receive approximately $120 million in direct SAMHSA funding and are eligible to apply for an additional $158.8 million in competitive funding for their behavioral health systems and programs. This direct funding for Tribes accounts for only 1.9 percent of SAMHSA's total budget, which is neither an equitable nor proportional level of direct funding. **We request a 5 percent Tribal set aside of all SAMHSA funds in the President's Budget.**

## Address Substance Abuse and the Opioid Epidemic

The pandemic has intensified the occurrence of substance use disorders (SUDs) and drug overdose deaths. In 2020, AI/ANs had the highest age-adjusted drug overdose death rate of any demographic group. Additionally, drug overdose was the leading cause of death for AI/ANs aged 25-44 and was in the top four leading causes of death for all AI/ANs aged 45 and older—eclipsed only by COVID-19 and age-related illnesses.[23]

The COVID-19 pandemic has presented significant challenges to ensuring access to comprehensive prevention, treatment, and recovery services for AI/ANs with SUDs. Tribes responded to these challenges by expanding telehealth and prioritizing care coordination. However, due to inadequate funding, Tribes do not have the resources necessary to provide their communities with a continuum of care that ensures all patients have access to wraparound SUD services. Tribes also need robust funding to address a full spectrum of SUD services, including the construction of residential treatment facilities and the provision of transitional housing; culturally appropriate peer recovery support; and investment in the intersection between SUD prevention, treatment, and recovery and social determinants of health. For FY 2024, SAMHSA should

maintain the Tribal set aside of opioid monies. **We request the President set aside a total of $500 million to address substance abuse concerns and the opioid epidemic in Indian country.**

## Mental Health and Suicide Prevention

At first glance, the 2020 suicide data is hopeful: the provisional age-adjusted suicide rate was three percent lower in 2020 than in 2019 for the general population. However, this decline was not true for all demographics. In 2020 AI/AN males saw an increase in suicide, while AI/AN persons experienced the highest suicide rates of any population: 23.6 per 100,00—nearly 40 percent higher than non-Hispanic white persons.[24] Suicide was the leading cause of death for AI/ANs aged 10-14, and the second leading cause of death for ages 15-24.[25]

Appropriations for FY 2022 saw increases in key competitive grants for Tribes. Project AWARE increased by $1.8 million to $23.6 million. The Garrett Lee Smith Youth Suicide Prevention Grants increased by $2.3 million to $38.8 million. The President's FY 2023 budget request shows investment in suicide prevention and mental health services. The Tribal Behavioral Health Grant Program (Native Connections) increased by $2.9 million to $23.7 million.

SAMHSA should expand Tribal access to grants such as Project AWARE and the Garrett Lee Smith Youth Suicide Prevention Grants and reduce the competitive burden placed on Tribes to receive these much-needed funds. At minimum, SAMHSA should maintain the Tribal set-asides for the Tribal Behavioral Health Grant Program. **We request that SAMSHA set aside 5 percent of their budget for Tribes across SAMSHA's budget.**

# National Institutes of Health

To advance research on AI/AN, NIHB asks that National Institutes of Health (NIH) pursue the following budget priorities:

## Build Capacity for Tribal Epidemiology Centers (TECs)

NIHB is pleased to see an increase of 90.7 percent to $217 million in the category of Community Health and Population Sciences, partly to establish a Resource Center for the Tribal Epidemiology Centers (TECs). As mentioned in the Introduction, the TECs have had difficulty getting data from HHS agencies. A center to help support capacity for research is welcome.

## Invest in Tribal Research Capacity

NIHB encourages NIH to utilize its $88 million in funding on minority health to advocate for and provide grants for more research that will inform the AI/AN population around health outcomes. Research with minority groups is important to ensure that research conclusions are accurate and inclusive of different types of populations. However, AI/AN are not considered minorities due to their political status as 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.

NIH should expand the Native American Research Centers for Health (NARCH) program to incorporate AI/AN traditional ways of healing. NIH should support holistic and Tribal approaches to research and to prioritize Tribal healing traditions. NIH must continue to support research of relevance to AI/AN populations and to prioritize projects highlighted by Tribes as most important. Clear set-asides must be made to specifically fund Tribal research, conducted by or with Tribes. Part of this spending should be to ensure that NARCH reviewers have a baseline knowledge about Tribal culture and health. **We request that NIH appropriate $20 million towards these goals.**

To address the workforce shortages, especially as it relates to rural communities, NIHB asks that HRSA pursue the following budget priorities:

## Increase the Health Workforce

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. 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. 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 percent and reached 31 percent in some areas.[26]

A lack of health care providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective, and culturally indifferent. Depending on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in the community, and are unlikely to be available for subsequent patient visits. Along with the lack of competitive salary options, many IHS facilities are in severe states of disrepair, which can be a significant disincentive to potential new hires. While the average age of hospital facilities nationwide is about ten years, the average age of IHS hospitals is nearly four times that – at 37 years.[27]As the IHS eligible user population grows, it imposes an even more considerable strain on the availability of direct care.

We request that HRSA continue its support for National Health Service Corps (NHSC) placements within Indian, Tribal, and Urban Indian Health (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 FY 2024 to support additional placements in the Indian health system.

In 2018, Congress provided funding to the agency to expand the NHSC Loan Repayment Program for Substance Use Disorder (SUD) providers. **We request that HRSA designate in the FY 2024 Budget Request five percent of funds from the loan repayment program for SUD providers,** specifically for IHS and Tribal behavioral health providers, to expand the 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.

Graduate Medical Education (GME) Residency Training programs built in Indian country represent our current best hope for fulfilling physician and health care provider shortages. **Tribes need $15 million to establish residency training programs in Indian Country.** The location

where physicians do their post-doctoral training is a fundamental deciding factor on where they will practice. Between 2011 and 2020, 57.1 percent of individuals who completed a residency training are practicing in the state where they trained.[28] Chickasaw Nation has had some success with a residency training program and can serve as a model for Tribes developing such a program.

## Improve Health Centers

One of HRSA's primary duties is improving delivery and access to 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 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 $20 million in flagship funding specifically for Tribes and Tribal organizations in health center grant programs to improve primary care and behavioral health outcomes.**

## Support Maternal and Child Health

As of FY 2019, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) support 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 vital MIECHV program in Indian Country.

Further, AI/AN are 2.9% of the population and yet we have the second highest maternal mortality rate.[29] The pregnancy related maternal mortality rate is 28.3 deaths per 100,000 live births compared to 13.4 deaths per 100,000 live births for non-Hispanic white women.[30] One of the most effective ways to overcome this is to move toward a midwifery model of care. This perspective can make a tremendous difference in ALL lives: mothers and babies in prenatal and postnatal care. In 2019, AI/AN mothers were almost three times as likely to receive late or no prenatal compared to non-Hispanic white women.[31] And the year following birth can be fraught with dangerous complications.

The 2023 HRSA Congressional Budget justification states that only 48 students received loans to become certified nurse midwifes. That is not even one per state let alone a number sufficient to address the urgent needs or AI/AN mothers. **NIHB requests the President's FY 2024 Budget includes $15 million for scholarships to train 200 nurse midwives to practice in Indian Country. We further request $30 million for a culturally competent nurse midwife training program to be established at a Tribal college or university.**

## Continue the Ryan White HIV/AIDS Program

The Ryan White program is one of the most reputable and successful HIV prevention and treatment programs ever implemented, but it has minimal reach into Indian Country. Tribes are eligible for Part C Early Intervention Strategies grants but receive very little direct funding. NIHB requests

that the **President's 2024 Budget include $200 million in Tribal set aside** (note this amount was also addressed in the CDC portion of this testimony).

## Invest in Dental Health

The agency's Alternative Dental Care Provider Program is authorized to provide $60 million in grant funding to states and Tribes exploring alternative dental workforce models. While Congress has blocked HRSA from funding the program, should Congress fund it in 2024, we request HRSA prioritize Tribes wishing to use the program to **support dental therapy at $60 million**, as these Tribes have been planning and waiting for years for this funding to materialize.

HRSA's *National Health Service Corps Loan Repayment Program* and the *Scholarship Program* offer a critical incentive for providers in underserved communities, including some in Indian Country. HRSA should make these programs available for dental therapists to receive the same incentive dentists, and dental hygienists do to work in underserved communities. **We ask that scholarships increase by 300 percent.**

## Prioritize Rural Health Policy

HRSA is also home to the Federal Office of Rural Health Policy (FORHP), which administers several programs directly benefiting geographically isolated rural communities. American Indians and Alaska Natives (AI/AN) are the most rural population. 46.1 percent of AI/ANs live in rural communities, a rate over twice the percentage of the rest of the population.[32]

**NIHB requests that HRSA designate a five percent 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. NIHB also requests that FORHP work directly with the Indian Health Service to address workforce shortages in Indian Country and that **$12 million in funding be included in the President's FY 2024 budget for this purpose.**

# Immediate Office of the Secretary

To remain informed on the issues facing Indian Country, NIHB asks that The Immediate Office of the Secretary (IOS) pursue the following budget priorities:

## Appoint a Counselor to the Secretary

The COVID-19 pandemic has shown the importance of a strong partnership with HHS and the need for a Tribally informed voice within the Department's upper echelons. HHS must prioritize this request to ensure that AI/AN representatives are always at the table.

For FY 2024, HHS and IOS should prioritize funding a Counselor to the Secretary for AI/AN Health Law and Policy position. The FY 2023 request for IOS is $15.8 million, an increase of $3.06 million above the FY 2022 enacted budget. In the FY 2023 funding request, IOS noted that the increased funds were to "increase staffing to support ongoing and emerging health care issues and to focus on new Presidential and Secretarial priorities, especially health equity, and mental health treatment." **A similar request should be made for FY 2024 to ensure sufficient funding for the Counselor to the Secretary for AI/AN Health Law and Policy position.** This position is supported by Tribal leaders, who believe for HHS to make informed policy decisions, the Secretary needs a Counselor with an extensive background in federal Indian law and policy, including a deep understanding of Tribal nations and the relationship with the federal government. The appointment of such a Counselor is entirely feasible by creating a Schedule C position, which, by definition, works directly for a presidential appointee within a federal department.

# Conclusion

The Administration, with the support of Congress, must devise a plan to appropriate funds that surpasses sustaining maintenance-level services. The NIHB strongly urges the Administration to fulfill the federal government's duty to AI/AN people by putting forth a budget that will finally eradicate the persistent health disparities that have impacted every age group in Tribal communities for generations. This Administration must take decisive action to prioritize department resources to bring AI/AN health closer to parity with the rest of the citizens of the United States.

Tribes strongly advocated for and welcomed the supplemental funds for Indian health through the various COVID-19 relief legislative packages over the past two years; however, there is 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 President’s FY 2023 budget provides a bold and substantive step towards meeting this need by moving IHS to mandatory funding and putting forward an unprecedented 10-year budget plan. Full funding prioritizes Tribal public health infrastructure and capacity for Tribes to achieve meaningful decreases in these disparities. Mandatory funding will allow the Indian health care delivery system to continue to serve its people during times of government shutdowns or budgetary uncertainty. NIHB fully supports the Biden Administration’s call for increased health and public health equity.

# ENDNOTES and CITATIONS

[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).

[4] HHS Strategic Plan Cross-Cutting Principles, HHS Strategic Plan, FY 2022-2026, https://www.hhs.gov/about/strategic-plan/2022-2026/overview/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] https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-19.pdf

[7] "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity", Centers for Disease Control and Prevention, April 29, 2022, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[8] For one example, see: Bear, Ursula Running et al. (2019) "The impact of individual and parental American Indian boarding school attendance on chronic physical health of Northern Plains Tribes, Fam Community Health, 42(1): 1-7, accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6241300.

[9] See: https://www.nihb.org/Tribalhealthreform/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf

[10] The chart was provided to NIHB by Indian Health Service.

[11] The table includes the budgetary requests inclusive of staffing costs and current services.

[12] https://www.ihs.gov/newsroom/factsheets/ihsprofile/

[13] https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Tribal-Technical-Advisory-Group

[14] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

[15] https://www.ncai.org/07_NCAI-FY20-Healthcare.pdf

[16] https://www.ihs.gov/newsroom/factsheets/ihsprofile/

[17] 2020 American Community Survey (ACS), 5-year estimates, U.S. Census Bureau.

[18] https://indiancountrytoday.com/archive/kill-the-land-kill-the-people-there-are-532-superfund-sites-in-indian-country

[19] https://www.congress.gov/bill/117th-congress/senate-bill/421/actions

[20] https://www.latimes.com/world-nation/story/2021-06-26/native-americans-clean-water

[21] https://www.ncai.org/policy-issues/land-natural-resources/climate-change

[22] https://static1.squarespace.com/static/5859aae1ff7c503bc4a5a155/t/6089ab127add03492ac1a345/1619634963501/NNCTC+Fact+Sheet+Trauma.pdf

[23] https://www.cdc.gov/nchs/products/databriefs/db428.htm

[24] https://www.cdc.gov/nchs/data/vsrr/VSRR016.pdf

[25] https://wisqars.cdc.gov/cgi-bin/broker.exe

[26] https://www.gao.gov/products/gao-18-580

[27] https://www.ihs.gov/newsroom/factsheets/healthfacilitiesconstruction/

[28] https://www.aamc.org/news-insights/america-s-medical-residents-numbers-0

[29] https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm

[30] https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm
[31] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=38
[32] https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf