National Indian Health Board

Written Testimony of the National Indian Health Board

For the 27th Annual Tribal Budget Consultation
April 21, 2025

Introduction

On behalf of the National Indian Health Board (NIHB) and the 574+ sovereign, federally recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, thank you for the opportunity to provide written comment in formulation of the President's FY 2027 Budget Request to Congress. The NIHB Board of Directors sets an annual Legislative and Policy Agenda[1] to advance the organization's mission and vision. Our objectives are to educate policymakers about Tribal priorities, advocate for and secure resources, build Tribal health and public health capacity, and support Tribally led efforts to strengthen Tribal health and public health systems.

We sincerely appreciate the support Secretary Kennedy has shown for Tribal Nations, and the many times he has spoken of his commitment to Tribes and Tribal health. Designing the President's Budget for FY 2026 and FY 2027 will be a powerful opportunity for demonstrating how the Secretary intends to make good on his promises and commitments to Tribes.

As the U.S. Department of Health and Human Services (HHS) works to break down policy silos that trap American taxpayer resources behind inefficiency and waste, this is a prime opportunity to revolutionize HHS's entire model of grant-making and U.S.-Tribal relations. Too often, Tribal Nations are trapped in a federal funding structure operating on the assumption that only state governments are worthy of base funding, ignoring the reality that Tribes exist as jurisdictional sovereigns with the same needs as other governments in the United States. HHS budget proposals tend to only think in terms of the status quo – a status quo that has resulted in AI/AN communities with some of the worst health outcomes of any U.S. population.

Tribes share the vision for a Healthy America and a more efficient HHS, but Tribes must be active in discussions about changes in programs, services, and organizational structure, as these changes have significant implications for Tribal economies, Indian healthcare services, and the federal trust responsibility. These federal programs and personnel are not only operational necessities to our Indian health systems, they are part of the federal government's legal and moral obligation to Tribal nations.

The Secretary has identified Indian health as a top priority for his tenure as the HHS Secretary. He has prioritized meeting with Tribal leaders and visiting Indian Country. We deeply thank the Secretary for the meaningful steps he has taken to protect Indian health staff, programs, services, and buildings, and we ask that he ensure those steps are not undone and that no harm is caused to Tribes in the making of the President's budget. Indian Country needs a strong ally now. We stand ready to support the Secretary to stand up for Indian

[1] National Indian Health Board. (2025). 2025 Legislative and Policy Agenda for Indian Health. Retrieved from: https://www.nihb.org/resource/2025-legislative-and-policy-agenda-for-indian-health/

Country and Indian health. We thank you for the opportunity to provide testimony and look forward to working with leadership across HHS for the betterment of Tribal Nations.

Current Health Status

Today, AI/ANs collectively face the lowest health status of any group of Americans. The CDC reported in 2021 that life expectancy for AI/ANs has ***declined by nearly 7 years***, to just 65 expected years of life —nearly 11 years less than the national average, and equivalent to the nationwide average in 1944.[2] Native Americans die at higher rates than those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.[3] Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.[4] The CDC also found that, between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.[5] Native Americans are also more likely than people in other U.S. demographics to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.[6] According to a 2020 study by SAMHSA, AI/ANs experience the highest rates of suicide,[7] with a recent February 2023 CDC report finding that teen girls are experiencing record high levels of violence, sadness, and suicide risk.[8]

According to the CDC, AI/AN rate for congenital syphilis in 2012 was **5** cases for every 100,000 infants born. Reports released in January of 2023 show that 10 years later, the rate is now **645/100,000 for AI/ANs.** The national rates overall in 2022 are just 102. Failure to honor Tribal data requests, lack of investment in public health efforts, and lack of engagement with Tribal communities in the public health space have all contributed to this crisis we are seeing across Indian Country. This is just one example among many in which rurality, barriers to care, limited Tribal access to public health data, and limited public health

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[2] U.S. Department of Health and Human Services, Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021 (hereinafter, "Provisional Life Expectancy Estimates"), Report No. 23, August 2022, available at: https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf, accessed on: March 20, 2023 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).

[3] *See* U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter *"Broken Promises"*), 65, available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf, accessed on: March 20, 2023.

[4] Broken Promises at 65.

[5] Broken Promises at 65.

[6] Broken Promises at 79-84.

[7] Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States, Results from the 2020 National Survey on Drug Use and Health, available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf, accessed on: March 22, 2023.

[8] Centers for Disease Control and Prevention, *PRESS RELEASE: U.S. Teen Girls Experiencing Increased Sadness and Violence*, available at: https://www.cdc.gov/media/releases/2023/p0213-yrbs.html, accessed on: March 22, 2023.

infrastructure continue to contribute to health crises in Indian Country. HHS, can and must, do better.

American Indians and Alaska Natives experience some of the highest rates of behavioral health maladies; this has been attributed, in part, to the ongoing impacts of historical trauma.[9,10] AI/ANs have suffered physical, mental, emotional, and spiritual harms resulting from historical and intergenerational trauma that began with colonization and extended through the 1960s with the federal Indian Boarding School Policy. Over 100 years of cultural genocide at Indian Boarding Schools is not relegated to distant memory but exists in the living memory of many Tribal citizens today, and the legacy of unresolved historical and intergenerational trauma caused by the schools and other historic harms has created health disparities, detrimental physical and behavioral health outcomes, and lack of meaningful connection to Native identity for many Tribal citizens. Research links AI/AN historical and intergenerational trauma to increased rates of depression, suicidal ideation, substance use disorders, domestic violence and sexual assault, and a lower life expectancy than any other group in the United States.

The Trust Obligation

Tribal Nations have a unique legal and political relationship with the United States. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal Nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.[11] In fulfillment of this relationship, the Supreme Court declared in 1832 that the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal Nations.[12] In 1976, Congress reaffirmed its duty to provide for Indian health care when it enacted the *Indian Health Care Improvement Act* (25 U.S.C. § 1602), declaring 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 to provide all resources necessary to effect that policy." While IHS is one way that the federal government fulfills the trust responsibility for health, it is not the only way. Other agencies across HHS and the rest of the federal government must also uphold this sacred promise and legal obligation to Tribal Nations.

The United States' provision of AI/AN health programs and healthcare services are based on the unique political status of AI/AN and relationship between Tribal Nations and the United

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[9] Walls, et al., *Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest*, COMMUNITY MENTAL HEALTH J., Vol. 42, No. 6 (2006) at 522, https://link.springer.com/content/pdf/10.1007%2Fs10597-006-9054-7.pdf, accessed on: March 20, 2023.
[10] Kathleen Brown-Rice, *Examining the Theory of Historical Trauma Among Native Americans*, PROF'L COUNS, available at: http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/, accessed on: March 20, 2023.
[11] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[12] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).

States. Our healthcare programs and services must not be interrupted or reduced— the public safety of our people depends on them. Our political status has been further recognized through U.S. Department of Health and Human Services (HHS) Advisory Opinion 25-01, which reaffirms the distinct nature of our political status by making it clear that three recent Executive Orders targeting diversity, equity, and inclusion initiatives do not apply to or diminish HHS's legal obligation to provide health services to Tribes and their citizens. As changes to HHS and its programs and services arise, the federal trust and treaty responsibilities must continue to be met, and the government-to-government relationship must be upheld.

Chronic Underfunding

In December 2018, the U.S. Commission on Civil Rights' *Broken Promises* report found that Tribal Nations face an ongoing health crisis that is a direct result of the United States' chronic underfunding of Indian health care for decades, which contributes to vast health disparities between Native Americans and other U.S. population groups.[13]

According to IHS data from April 2022, actual IHS spending per user remains at a level equating to less than half of Medicaid spending per enrollee, less than half of Veterans medical spending per patient, and less than one-third of Medicare spending per beneficiary – even after including third-party revenue received by IHS.[14] The Federal Disparity Index Benchmark, which assumes IHS users are provided services similar to those available to the U.S. population, recommends more than twice the investment per user than IHS receives[15] – an estimate that excludes approximately two-thirds of the population that an appropriately funded IHS could serve.[16]

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 documented as of 2016. Further, IHS has reported a a 2018 U.S. Government Accountability Office (GAO) report found an average of 25 percent 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, or 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 the lack of competitive

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[13] Broken Promises at 65.
[14] Indian Health Service, email correspondence to the National Tribal Budget Formulation Workgroup, attachment "2021 IHS Expenditures Per Capital and other Federal Care Expenditures Per Capita – 4-27-2022," dated February 14, 2023.
[15] *Id*.
[16] The Indian Health Service estimates the population served as of January 2020 at 2.56 million; The U.S. Census Bureau estimates the AI/AN population as of July 2021 at 7.2 million.

salary options, many IHS facilities are in a serious state 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 39 years. In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. Need for healthcare services continues to grow, imposing an even more significant strain on the Indian health system.

Tribal Nations are also severely underfunded for public health and were largely left behind during the nation's development of its public health infrastructure. As a result, large swaths of Tribal lands lack basic emergency preparedness and response infrastructure, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response. Worse, funding which was made available has been taken back by Congress repeatedly because agencies are not obligating it to improve public health capacity in Indian Country quickly enough. The Administration must develop a plan to quickly obligate any remaining funding for Tribal public health infrastructure provided during COVID-19 response legislation. Losing almost $800 million in federal appropriations when IHS is so underfunded is just unacceptable.

We cannot expect the health of Tribal Nations to improve when they are consistently starved of resources and denied their full rights as sovereigns.

Basic Funding Principles

Nearly five decades of Tribal self-determination and self-governance policy have clearly demonstrated that empowering Tribes is the best policy to improve programmatic efficiency and meaningful health outcomes. In simple terms, good governance. As a contracting and compacting mechanism, self-governance agreements under the Indian Self-Determination and Education Assistance Act (ISDEAA) empower Tribes and Tribal organizations to design and operate federal programs within the scope of the law, with streamlined and consistent reporting and accountability. Self-governance exercise recognizes the inherent sovereign rights of Tribal Nations to exercise jurisdiction over their lands, citizens, resources, infrastructure, and affairs. Self-governance agreements promote the highest and best use of the taxpayers' resources by empowering those with a vested interest in their people's health, safety, and well-being to implement the program. Self-governance agreements also reduce duplicative administrative costs associated with program implementation, resulting in a more efficient federal government that invests in outcomes, not paperwork. However, the option to contract or compact is currently only available for select programs under the Indian Health Service.

Most federal agencies rely on grants to distribute funding to Tribes. Structural barriers inherent in the grants process create, in effect, two classes of government-to-government relationships: those who can afford to compete for grants, and those who cannot. While Tribal Nations continue to rebuild, grow, and thrive, some Tribal Nations do not have the capacity and resources they need to access Federal funds—and even for those that do, having

to repeatedly navigate Federal processes often unnecessarily drains those resources, creating waste and inefficiency.

Further still, Office of Management and Budget (OMB) funding data compared to actual program funding indicates that even where Tribes can afford to compete, the opportunities are effectively illusory. Competitive grants are incongruent with the treaty and trust obligations owed by the United States to Tribal Nations. However, the authorities establishing programs and eligibility throughout the federal government, including the amount of funding provided by Congress, create policy barriers in affecting change. Now is the time to propose systemic change in the FY 2026 and 2027 President's Budget: change that empowers Tribes and does not deprive them of resources.

For decades, Tribal leaders have consistently asked HHS to work with us to develop a proposal on expanding self-governance at HHS outside of the IHS. We know that self-governance would break down funding barriers, improve program efficiency and functionality, and provide much needed relief to Tribes when it comes to bureaucratic grant management. However, we have had limited progress with previous HHS leadership on this matter.

The Administration must work collaboratively with Tribal Nations to develop policy solutions and proposals to Congress to fix these systemic inefficiencies, but there are certain basic funding principles that HHS should keep in mind as it develops its annual budget request to Congress:

- Establish a 10 percent across-the-board set-aside of HHS resources for Tribal Nations.
- Provide formula-based, annual, recurring funding for programs that fulfill the treaty and trust obligations of the United States.
- Develop methodologies for program increases and funds distribution collaboratively with Tribal Nations to achieve their free, prior, and informed consent.
- Until such time that spending is mandatory, provide advance appropriations for programs that fulfill the treaty and trust obligations of the United States.
- If mandatory or advance appropriations are not enacted, provide full year, excepted Continuing Resolution (CR) durations (known as a CR "anomaly") for programs that fulfill the treaty and trust obligations of the United States.
- Provide full-year exception apportionment for programs that fulfill the treaty and trust obligations of the United States as part of OMB apportionment under any continuing resolution providing partial-year funding for such programs.
- Provide funding directly to Tribal Nations and not as pass-through funding through the states or another entity.
- Exempt Tribal funding from the outsized and harmful effects of sequestration, rescissions, and obligation limitation deductions on Tribal Nations.

- Support expansion of Tribal self-governance at HHS and engage in multi-agency compacting, contracting, and grant award agreements with Tribal Nations that reduce or eliminate cost barriers to program application, operation, and reporting.
- Eliminate barriers to program access such as dollar matching requirements, onerous asset collateralization, waivers of sovereign rights, and project size/parameters that favor projects that are illogical for Tribal applicants and communities.
- Provide Tribal Nations with the maximum flexibility possible in their use of federal funds.
- Reduce, unify, simplify, and streamline program *application requirements* and *reporting requirements* to the greatest extent possible to maximize federal investment in outcomes instead of record keeping.
- Provide increased, HHS-wide internal and external technical assistance and training to support the effective use of existing program resources. Agencies have a duty to provide assistance even when funds are transferred to another agency for administration.
- Require all federal departments or agencies with Tribal programs to develop an annual estimate of the cost to fully fund the responsibilities of each Tribal program within the department or agency.
- Put strict and consistent confidentiality requirements on all Tribal data collected by the federal government, including restrictions on internal use and transfer of Tribal data between agencies and penalties for misuse.

HHS Reorganization & OMB Passback For President's Budget FY 2026

Overall Comments

While Tribes support efforts to improve efficiency within HHS, any reorganization and reduction in force must be conducted in a manner that upholds the federal trust and treaty obligations to Tribal Nations. The current lack of information of changes and plans being made impinges on the Government-to-Government relationship and we respectfully request transparency and accountability of the Administration's actions – by hosting a Tribal Consultation. It is imperative that the Administration adheres to the legal trust relationship between our sovereign Tribal Nations and the federal government by allowing federal programs, set-asides, and staff to continue serving Tribal governments. Changes of the magnitude laid out in the FY 2026 Office of Management and Budget (OMB) budget passback[17] will require consistent and on-going consultation with Tribal Nations as the plan is developed and implemented. As you prepare the President's budget for FY 2026, we hope that you will consider legal obligations owed to Tribal Nations by preserving Tribal health programs.

[17] "New: A 64-page HHS restructuring proposal outlines sweeping cuts to US public health.", *Inside Medicine*, April 16, 2025. Accessed: https://insidemedicine.substack.com/p/new-a-64-page-hhs-restructuring-proposal

Preservation of Life-Saving Programs and Funding

Indian Health Service

We are deeply concerned regarding the proposed budget cuts to the Indian Health Service (IHS) in the OMB passback on HHS agencies and programs. The cuts proposed represent a nearly 30% reduction to the IHS base allocation from FY 2025 estimates. This would devastate Indian health. We urge you to immediately appeal the proposed reductions to IHS and Tribal programs outlined in the OMB HHS passback. Similar cuts were proposed to Indian programs within the Department of Interior, and Secretary Burgum took decisive action to appeal those proposed reductions for Tribal nations.

Among the proposed reductions included in the now public document, the Administration proposes to end IHS advance appropriations, stop funding to water and sanitation facilities and health care facilities construction, limit the ability of new Tribes to take on self-governance of IHS programs, and reduce the IHS services and facilities level by nearly $900 million in FY 2026. The OMB HHS budget passback for FY 2026 also includes the elimination of preventive health care within IHS, and the end of Tribal Management Grants and the Tribal Self-Governance Cooperative Agreements which are specifically designed to support Tribal Nations taking the first steps toward self-determination and self-governance of their health care programs. Tribal Self-Governance is an efficiency to the federal government, and reducing the opportunities for Tribes to engage in self-determination and self-governance is short-sighted to achieving the Administration's broader goals and priorities. Further, the impact of the changes laid out regarding reorganization in the OMB passback would be wholly devastating to our communities and our people and would ensure hundreds to thousands of otherwise preventable deaths in Indian Country.

The funding to the IHS is not an arbitrary budget number; these figures represent funding to keep doctors and nurses in our facilities nationwide. The IHS already operates with a 30% vacancy rate and is woefully and chronically underfunded by tens of billions of dollars annually. Many IHS clinics already operate on significant understaffing; if each facility across the IHS lost just one physician-level provider, 43% of those facilities would have to close their doors entirely. This loss of funding will lead to deaths in our communities from preventable medical incidents, such as precipitous births, cardiac events, untreated diabetes complications, and preventable suicides. We know these impacts because we have lived these outcomes. Before IHS had advance appropriations, during previous government shutdowns, members of our families died from these exact types of preventable emergencies when funding ran out.

We seek further dialogue through a formal Tribal Consultation to discuss the preservation of trust and treaty obligations and to safeguard the health and well-being of Tribal Nations. The livelihood and public health of Indian Country now rely on the Secretary's leadership to immediately appeal these proposed reductions before the President's Budget is finalized and to schedule recurring Tribal Consultation.

Chronic Disease

The changes planned in the OMB passback will also have an extremely negative impact for chronic disease in the United States. CDC's Center for Chronic Disease Prevention and Health Promotion has been targeted for wholesale elimination. This center is one of the country's best resources for addressing the chronic disease crisis and achieving the aims of the Make America Healthy Again initiative, so eliminating the Center in its entirety runs wholly counter to the Secretary's stated goals. Furthermore, the Chronic Disease Center houses three of the four CDC programs specifically designated for Tribes – a recognition of the urgency of addressing chronic diseases in Indian Country, as Secretary Kennedy has also remarked on multiple occasions. As all the programs under the Chronic Disease Center are also planned to be eliminated according to the passback, these vital Tribal programs would be lost. Tribes already receive less than one percent of CDC's funding – the loss of these programs would have a drastic and disproportionate impact on Tribal communities.

Other programs listed for elimination are also important for addressing chronic disease and continuing them would directly support the Make America Healthy Again initiative. These include programs like the Food as Medicine program, Chronic Disease Self-Management Education for elders under the Administration for Community Living, and nutrition programs.

Maternal and Child Health

On the world stage, the United States falls tragically behind peer countries when comparing trends in rates of maternal deaths and infant deaths. Preventable maternal and infant deaths remain inexcusably high in the United States. Many of the proposed cuts across HHS would cancel successful programs that have effectively helped to improve health for moms and babies. These programs need substantially increased investment if we are going to improve nationwide health outcomes; eliminating these programs will be catastrophic and undermine any goals to Make America Healthy Again. For example, the entire Maternal and Infant Health Branch within the CDC is slotted for elimination, as it falls under the Center for Chronic Disease Prevention and Health Promotion. Along with it, we would lose vital support for Perinatal Quality Collaboratives across the country, critical data systems for tracking causes of maternal mortality and pregnancy risks, and essential sources of information for prospective parents on sudden unexpected infant death and urgent warning signs during pregnancy. CDC is also working with partners to update resources for the Healthy Native Babies project, which helps local programs address safe infant sleep among American Indian and Alaska Native communities. Several of these programs provide funding that Tribal organizations rely on to protect moms and babies in their communities.

Other programs that provide necessary resources for ensuring healthier pregnancies and babies are also listed as targets for elimination. These include Healthy Start, which provides Tribes and other entities with funding to improve health outcomes before, during, and after pregnancy through better care coordination, community health education, and solutions

tailored to each community's specific needs. Programs that focus on reproductive health and preventing teen pregnancy also play an important role in improving maternal and child health outcomes by ensuring potential parents can wait until they and their families are healthy and prepared for bringing another life into the world. Other necessary maternal and child health programs at risk include newborn screenings, EMS for children, Infant and Early Childhood Mental Health, Children and Family Programs under SAMHSA, substance abuse treatment programs for pregnant and post-partum women, substance abuse prevention and recovery for youth, childhood lead poisoning prevention, youth violence prevention, Adverse Childhood Experiences (ACES) programs, prevention of injuries from firearms, drowning, and traumatic brain injury, and more.

Maternal and infant health will also be jeopardized by the elimination of HIV/AIDS funding. Not only does the risk of babies being born HIV+ substantially increase if we roll back our efforts and allow HIV rates to increase across the country, but prevention and treatment of other potentially deadly sexually transmitted infections (STIs) also relies on this funding. The United States is currently facing STI rates unprecedented in the modern era, including a tragic epidemic of syphilis that has resulted in far too many preventable deaths of infants, particularly in Tribal communities. These STI epidemics will grow out of control if funding is scaled back. In his first Administration, Trump made a significant milestone in establishing the Ending the HIV Epidemic Initiative; if we turn back now before the epidemic is fully resolved, we risk losing all progress made already under this promising Trump initiative.

Preventive Health Services

The Secretary has emphasized that his goals for HHS are to 'Make America Healthy Again,' support Tribes, and reduce chronic disease; the most efficient way to accomplish those goals is to invest in public health and preventive services. It is shocking, then, to see so many essential preventive health programs marked for elimination. Within IHS specifically, all programs under Preventive Health have a proposed budget of $0. This would include all funding for public health nurses, community health representatives, health education, and the Alaska immunization program. These are all vital components of the Indian health system, made even more necessary by the underfunding and inaccessibility of many healthcare treatment services. Also alarming is the planned elimination of Tribal Behavioral Health grants for substance abuse prevention and mental health.

Other concerning proposed program cancellations include the Prevention and Public Health Fund, preventive health services for elders, elder falls prevention, most other injury prevention, overdose prevention, oral health, and all prevention resources under CDC's Center for Chronic Disease Prevention and Health Promotion (like those related to cancer, diabetes, nutrition, obesity, reproductive health, smoking, heart disease and stroke, and school-based preventive health services).

Eliminating prevention programs is the fastest way to *increase* rates of disease and injury across the country, along with corresponding national expenditures on healthcare. This

increased burden of disease, injury, and expense is likely to fall most heavily on resource-constrained communities with limited healthcare access, like many Tribes.

Behavioral Health

The proposed budget cuts will eliminate nearly 92 percent of funding for substance use prevention, approximately 25 percent of mental health services, and approximately 13 percent of substance use treatment. This includes the elimination of SAMHSA's Circles of Care program that strengthens mental health care services for Tribal communication. During a time of rising opioid rates and related overdose deaths, the U.S. cannot afford to reduce prevention, intervention, and treatment efforts. Indian Country is disproportionately impacted by substance use rates and the reduction in funds will destabilize resources available to Tribal mental and behavioral health services.

Rural Health

American Indians and Alaska Native are more heavily concentrated in rural areas than other populations. Many Tribal communities are located in extremely rural and remote areas of the country. Keeping rural hospitals open is critical for everyone who does not live near a metropolitan center. Concerningly, many of the programs that help rural hospitals keep their doors open and their facilities staffed are listed for elimination.

Services for People with Disabilities

The gutting of programs serving people with disabilities across HHS will harm every demographic group in every region of every state across the country, including across Tribal communities. Like all others in our communities, people with disabilities deserve to live with dignity, make their own choices, and participate fully in society. These programs are necessary to achieving these goals. Any ethical vision of a future where we have 'Made America Healthy Again' will include the necessary resources and changes to allow people with disabilities to thrive.

Head Start and Support for Families

Elimination of programs like Head Start will have a disproportionate impact on Tribes. Head Start has been shown to improve not only short- and long- term education outcomes, but also significant positive impact for social, emotional, and behavioral development,[18] which contribute towards improved long-term health outcomes. Access to consistent quality early childhood education for families also means that parents are free to work, so Head Start families are better able to achieve economic stability. Programs like Head Start and the Low

[18] Brookings. (2016). The long-term impact of the Head Start program. Retrieved from: https://www.brookings.edu/articles/the-long-term-impact-of-the-head-start-program/

Income Home Energy Assistance Program (LIHEAP) provide essential support to families who need a hand up as they work to support their families.

While the Administration's stated goal in eliminating the federal Head Start program is to put education back in the hands of States, Tribes also depend on Head Start early childhood education programs and do not have the ability to tax and raise revenue the way states do to run such programs. Moreover, both health and education are tied to the federal trust responsibility for American Indians and Alaska Natives. Head Start and other similar programs must be preserved for Tribes.

HHS Staffing

Recent Administrative actions have also dramatically impacted staffing at the Indian Health Service and across HHS, even when staff have not been laid off. We are concerned about the short- and long-term impacts to the federal workforce at IHS and other HHS Tribal programs. Even when limited exemptions have been provided for IHS, there has been significant damage to support the staff workforce necessary for billing, administration, scheduling, and oversight. The constant and continual messaging is also impacting staff morale more generally, which is creating anxiety and driving providers and other staff to look for employment outside the Indian health system. The IHS already has a 30 percent provider vacancy rate, and the Indian health system cannot sustain significant loss of staffing while maintaining current level of services and accreditation for facilities. We urge the Secretary to exercise his authority to immediately exempt IHS from the Hiring Freeze to allow all necessary staff to be hired that are critical to maintain facility accreditation. Even restoring the exemptions for the Hiring Freeze adopted in 2017[19] would be broader than the currently available exemption.

Our Direct Service Tribes are some of the most impacted by these staffing reduction activities. A Tribal government's decision to receive health care directly from the IHS is an action based on Tribal sovereignty and self-determination. Direct Service Tribes have exercised their self-determination right for IHS to provide some or all health services to their Tribal citizens, covering activities and programs from delivery of care to billing. This is all done by federal IHS employees. The choice to retain Tribal shares with IHS and cover the costs of full-time employees (FTEs) is an act of Tribal sovereignty made by the Direct Service Tribes. Any reductions in staff of the federal workforce on Indian programs, including the termination of certain probationary employees and deferred resignations, will reduce

[19] Letter from Chris Buchanan, Acting Dir., Indian Health Service, to Tribal Leaders and Urban Indian Organization Letters. (Feb. 10, 2017). Retrieved from: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2017_Letters/DTLL_UIOLL-HiringFreeze_02102017.pdf; *see also* U.S. Department of Health and Human Services. Re: 2017 HHS Hiring Freeze Exemptions, published February 6, 2017, available at: https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:7300b189-a51d-4b5e-acc7-80f391f08fa3?viewer%21megaVerb=group-discover, accessed on April 21, 2025.

resources for Direct Service Tribes. This is grossly unfair and penalizes Direct Service Tribes for exercising their Tribal sovereignty and self-determination rights.

If a Tribe elected to contract all IHS functions under the Indian Self-Determination and Education Assistance Act (ISDEAA), they would be entitled to those shares and FTEs which they chose to retain at IHS. Staffing and funding reductions limit the available resources which Tribes may be currently, or in the future, looking to self-govern through ISDEAA. We can already see that Tribes which have self-governance have been buffered from the worst of these hiring freezes and reduction in force (RIF) activities. The recent developments may inspire more Tribes to move towards self-governance. The resources associated with any FTEs will be lost and unavailable to an ISDEAA contract unless reinstated by a future administration or Congress. Tribes should not see programs that they may one day intend to contract gutted in the interim. These impacts are why it is so critically important for the Administration to consult with Tribes before developing or enacting a policy, including for staffing.

IHS Advance Appropriations

After more than a decade of tireless advocacy by Tribes, Tribal organizations, and champions for Indian Country, in 2022, Congress enacted a Fiscal Year (FY) 2023 omnibus spending package, including FY 2024 advance appropriations for the Indian Health Service (IHS). Advance appropriations help protect the Indian health system from the harmful impacts of a continuing resolution (CR) or shutdown by authorizing the next fiscal year of funding now (essentially covering that CR or shutdown period). The enactment of advance appropriations for IHS marked a historic paradigm shift in the nation-to-nation relationship between Tribal Nations and the United States by providing certainty and stability in the provision of the United States' trust and treaty obligations to provide for AI/AN health care. However, the OMB Passback for FY 2026 indicates that the Administration seeks to now end advance appropriations for the IHS.

Before receiving advance appropriations, IHS was the only federal healthcare provider without basic certainty of funding from one year to the next. When CRs or shutdowns occurred, IHS and Tribes could not receive their full year of funding. Instead, they might only receive a portion of the funding, or none at all. As a result, funding was not available to pay critical health care staff, cover purchased/referred care, purchase essential medical equipment, or pay for utilities and other necessary expenses. Healthcare organizations cannot function efficiently or effectively in an environment with such extreme budget uncertainty. Without advance appropriations, American Indians and Alaska Natives are uniquely at risk of death or serious harm caused by delays in the annual appropriations process.

The treaty and trust obligations of the United States to provide for Indian health care are duties that should be mandatory direct appropriations; but until such time, advance

appropriations are an interim step that saves lives. It is critical that advance appropriations for IHS are preserved.

Expansion of Self-Governance

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. A self-governance program model promotes efficiency, accountability, and best practices in managing Tribal programs and administering federal funds at the Tribal level. Because Tribes can tailor programs according to the communities' needs, self-governance results in more responsive and effective programs. The Indian Self-Determination and Education Assistance Act (ISDEAA) provides the mechanisms to achieve this. However, ISDEAA is not currently applied to all IHS programs or applicable throughout the HHS. Additional legislation and administrative action are needed to expand and strengthen Tribal self-determination and self-governance in HHS health programs. The President's budget for FY 2026 can revolutionize efficiency in Indian health programs by including expansion of self-governance across HHS and all of IHS.

Recommendations for the President's FY 2027 Budget Request

Overall Comments

The Trump Administration can play an important role in the historic advancement of U.S.-Tribal relations through the President's Budget. The Administration should maximize the value of advisory committees and Tribal consultation procedures it has in place to advance outcomes that will improve efficiency, invest in health of Tribal communities, and support Tribal sovereignty and self-determination. Further, the Administration's departments and agencies should work to identify the gaps in their funding and programs to meet the treaty and trust obligations they have to Tribes. In terms of efficiency and good governance, a strong collaborative relationship throughout the Administration can help rapidly advance policy proposals that meet the promises and goals of the Administration.

Office of the Secretary – General Departmental Management

Within the Office of the Secretary, General Department Management are several accounts that benefit Tribes and Tribal organizations. Tribes receive $2 million set-aside from the Minority HIV/AIDS Fund, and the Office of Minority Health provides grants and education and outreach to Tribal communities, including funds for the Center for Indigenous Innovation and Health. The Center for Indigenous Innovation and Health (CIIH) was created at the direction of Congress to implement innovative and culturally appropriate frameworks to prevent and improve disparities in chronic diseases, such as obesity, hypertension, and diabetes, that are prevalent in Native communities. The President's FY 2027 Budget Request must continue these important resources in Indian Country.

Additionally, the Office of the Secretary administers the Nonrecurring Expenses Fund (NEF). We encourage HHS to continue to ensure that IHS receives support from the NEF for infrastructure improvements, as it has in recent years. This support is necessary as IHS's ability to provide quality care suffers from hundreds of dilapidated buildings with outdated systems and equipment.

HHS should also support funding for technical support for Tribal Advisory Committees (TACs), including the Secretary's Tribal Advisory Committee (STAC). Currently, NIHB provides significant technical support to the STAC, but does not receive any funding from HHS to do this important work. As part of our support, NIHB staff invest well over 150 hours in advance, during, and after each STAC meeting to help coordinate technical advisors, develop talking points for Tribal leaders, track issues, host Tribal caucuses, and conduct follow up with agency officials. This work is all critical to ensure STAC continues to foster meaningful engagement between Tribal leaders and HHS. Other federal agencies have provided funding to NIHB for our work to support other TACs, and Tribal leaders continue to request our support for the STAC. HHS officials during TAC meetings have a myriad of technical staff present; Tribal leaders deserve the same opportunity to provide meaningful input. Please include this as a priority in your upcoming budget.

Additionally, NIHB reiterates our request for the appointment of a Counselor to the Secretary for AI/AN Health Law and Policy as a political appointee within the HHS Immediate Office of the Secretary (IOS). Too often, it seems the Department relies only on IHS staff to provide a perspective for Indian Country on key policy issues and initiatives. Yet, HHS is one of the most far-reaching organizations in the federal government. The issues facing Indian Country are far broader than the direct services that are provided by IHS. Federal Indian law and policy is a unique area of law in which an expert is needed. To make informed policy decisions, the Secretary needs a Counselor who is both Native and possesses an extensive background in federal Indian law and policy, including a deep understanding of Tribal Nations and their relationship with the federal government. We have seen where this investment pays off. When a Tribal Advisor was appointed to OMB in the Office of the Director, OMB's policies engaged Tribes fully and we saw important, cross-cutting policy decisions, meaningful OMB Tribal consultations, and overall beneficial engagement from OMB with Tribal Nations.

<u>Administration for Community Living (ACL)</u>

The Administration for Community Living (ACL) exists to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. The array of programs under this small agency aim to ensure that all people, regardless of age and disability, are able to live with dignity, make their own choices, and participate fully in society. Since elders and people with disabilities are vital and valued citizens within their Tribes who make irreplaceable contributions to the wellbeing of their communities, these ACL programs meaningfully promote the flourishing of Tribal communities.

ACL is responsible for carrying out almost all the programs of the Older Americans Act. Health-related social services funded under that act include supportive services such as personal care, chore services, and transportation, congregate nutrition services (meals served at group sites such as senior centers, churches, or senior housing complexes), home-delivered nutrition services, family caregiver support, community service employment, the long-term care ombudsman program, and services to prevent the abuse, neglect, and exploitation of older persons. In 1978, the Older Americans Act (OAA) was amended to include Title VI which established programs for the provision of nutrition and supportive services for Native Americans. Today, this program also includes caregiver support services. Most of the funding is provided through the "grants for Native Americans" line item in annual appropriations, with the expanded caregiver support services funded in a separate line item titled, "Native American Caregivers Support." The ACL also provides funding for resource centers and competitive grants that may make up the extremely small remainder of the grants received by Tribes from ACL.

As an authorized but unfunded program in the *Indian Health Care Improvement Act* (IHCIA), elder care and long-term service care resources are extremely strained in Tribal communities. Tribal programs at ACL provide critical resources toward addressing this immense and growing need as our communities continue to age. However, these ACL programs are still severely under-resourced. Funding for ACL should be increased to close this gap in health and wrap-around services for the aging population.

The President's FY 2027 Budget Request for ACL must continue to ensure sustained and increased funding for Tribal programs under the OAA, including funding for Adult Protective Services, as well as for other vital resources for supporting elders and people with disabilities.

<u>Administration for Strategic Preparedness and Response (ASPR)</u>

The HHS Administration for Strategic Preparedness and Response (ASPR) leads the nation's medical and public health preparedness for, response to, and recovery from disasters and other public health emergencies. ASPR collaborates with Tribal, state, local, and territorial governments, as well as hospitals, healthcare coalitions, biotech firms, community members, and other partners across the country to improve readiness and response capabilities.

Tribal governments have faced significant challenges in responding to public health emergencies, including pandemics and other all-hazards events. These challenges include limited access to resources and funding, lack of infrastructure and equipment, limited access to timely and accurate information, complex grant application and reporting requirements, inadequate federal technical assistance and support, and inadequate communication and coordination from federal, state, and local partners. The COVID-19 pandemic exposed significant gaps in pandemic and all-hazards preparedness, particularly in the areas of Tribal public health infrastructure and emergency response coordination. Fortunately, the Pandemic and All-Hazards Preparedness Act (PAHPA) is still up for reauthorization in the

119th Congress, which means that HHS can propose changes and provide technical assistance to Congress to update the U.S. Code to address disproportionately low investment in Indian Country for pandemic and all-hazards response and include changes that improve the efficiency and effectiveness of HHS programs for Tribes and Tribal organizations.

Administered by the ASPR, the Hospital Preparedness Program (HPP) provides leadership and funding through cooperative agreements to states, territories, and eligible metropolitan areas to improve the capacity of the health care system to plan for and respond to large-scale emergencies and disasters. As the only source of federal funding for health care system readiness, the HPP improves patient outcomes, minimizes the need for federal and supplemental state resources during large-scale emergencies, and enables rapid recovery. Under the current law, the eligibility and funding parameters for this program make it inaccessible to Tribal communities. Tribes, Tribal organizations, and IHS-funded health care facilities should be expressly included as eligible entities. HHS should also act administratively to develop HPP cooperative agreements and establish a practice that promotes Tribal inclusion in this program.

As the nation's roadmap to strengthen and adapt health care, public health, and emergency preparedness and response, the National Health Security Strategy (NHSS) must set an example for making sure Tribes are visible and included in preparedness planning. We recommend that HHS review and update the NHSS to better reflect the needs and priorities of Tribal communities, and to ensure that the NHSS supports and strengthens Tribal health infrastructure and emergency preparedness and response

HHS should also review and update the authorities and funding provided to the Biomedical Advanced Research and Development Authority (BARDA), with specific attention to ensuring that BARDA is able to effectively engage with Tribes and Tribal organizations in the development and deployment of medical countermeasures. To that end, we recommend that HHS review and update Project BioShield to ensure that it adequately addresses the unique needs and challenges faced by Tribal communities in emergencies, and to ensure that it provides sufficient support for the development and deployment of Tribally appropriate medical countermeasures.

We recommend that HHS expand the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) program to include other types of emergency responders, such as community health workers and traditional healers.

NIHB also recommends expressly making Tribes eligible for grant programs administered by ASPR, increasing formula-based funding opportunities and flexibility for Tribes, streamlining application and reporting requirements, improving Tribes' access to timely and accurate data, enhancing Tribal data sovereignty and security, improving technical assistance and support, enhancing communication and coordination with Tribal governments, and developing culturally sensitive and appropriate programs and services.

Centers for Disease Control and Prevention (CDC)

The importance of the foundational, structural work the CDC does to uphold the national public health system and protect the health and security of the American people cannot be overstated. Like all other jurisdiction in the United States, Tribes rely on the research, data, experts, resources, and systems produced across the CDC, in every one of the agency's centers, institutes, and offices.

The health of the nation is threatened by any efforts that undermine our vital national surveillance systems and disease registries, including HIV/AIDS surveillance, cancer surveillance, diabetes surveillance, the Pregnancy Risk Assessment Monitoring System (PRAMS), Maternal Mortality Review Information Application, heart disease and stroke surveillance, epidemiology related to smoking, school-based health surveillance, and other population health surveillance. These data systems have all been targeted by the Administration recently for elimination, yet they are fundamental to being able to reduce population-level rates of deadly conditions, including those said to be priorities under the Make America Healthy Again initiative.

Tribal governments are public health authorities recognized by Title 42 of the U.S. Code and require the same kind of investment in public health as states and territories. In addition, resources for public health are part of the federal government's trust and treaty obligations to Tribes. The CDC primarily provides direct funding for Tribes through four cooperative agreements: Good Health and Wellness in Indian Country, Tribal Epidemiology Centers Public Health Infrastructure, Tribal Practices for Wellness in Indian Country, and Strengthening Public Health Systems and Services in Indian Country, totaling about $88 million for FY 2024 according to the 2025 Native American Crosscut produced by the Office of Management and Budget. Tribes and Tribal organizations received less than 1 percent of CDC resources, even though the combined AI/AN population would represent the 15th most populous state, with the 12th largest landmass. Tribal Nations need increased and dedicated resources for public health infrastructure and capacity building, increased resources for public health education and monitoring, and protections for Tribal data sovereignty.

CDC must also improve transparency regarding how much money Tribes are receiving from the agency. The FY 2024 OMB Native American Funding Crosscut provides only one page (out of a 282-page document) to describe how funding is reaching Tribal communities. Other HHS operating divisions provided much more detailed funding information. CDC should provide detailed funding information to Indian Country on the number of awards made to Tribes and Tribal organizations.

In short, CDC must do better when it comes to serving Tribal Nations. CDC's structure continues to rely almost exclusively on state and local public health departments, without fully engaging with Tribes and Tribal Epidemiology Centers (TECs). There was great opportunity with the "Moving Forward" Reorganization, but Tribal representatives were not included in a meaningful way at the decision-making table, and the resulting structure

relegated Tribes to the periphery of CDC policy- and decision-making. As the Trump Administration again seeks to restructure the agency to improve efficiency, there is a renewed opportunity to ensure Tribal consultation is appropriately held at the very beginning of the reorganization process and that Tribes are consistently engaged through every stage.

Good Health and Wellness in Indian Country Cooperative Agreement

The Good Health and Wellness in Indian Country (GHWIC) cooperative agreement is housed under the Center for Chronic Disease Prevention and Health Promotion. This program focuses on evidence-based strategies to prevent chronic diseases and reduce health disparities, with a particular emphasis on diabetes, heart disease, and obesity. Some examples of activities that can be supported by the GHWIC cooperative agreement include implementing culturally appropriate physical activity programs, increasing access to healthy foods, improving diabetes management, and reducing commercial tobacco use. The GHWIC program is CDC's largest investment in improving Tribal health. In FY 2024, GHWIC was funded at $24 million and had 27 direct recipients with several of these recipients being Urban Indian Organizations. This means only a small fraction of Tribal Nations are being served by this program. Yet, CDC serves ***every state and territory*** through block grants. CDC must increase its budget request for this program dramatically to at least $574 million to provide minimum base funding of $1 million to all Tribal Nations.

Tribal Epidemiology Centers Public Health Infrastructure Cooperative Agreement

The Tribal Epidemiology Centers Public Health Infrastructure program (TECPHI) is a CDC cooperative agreement that complements IHS funding to increase Tribal epidemiology center (TEC) public health capacity and infrastructure. TECs operate with limited resources and staff, which hinders their ability to provide comprehensive public health services. Additional funding would enable TECs to hire more staff, expand their programs, and provide more services to Tribal communities. Additionally, TECs need robust data systems and infrastructure to collect, analyze, and share public health data. However, the current funding levels for the TECPHI cooperative agreement are not sufficient to support these critical data infrastructure needs. Sustained funding for the TECPHI cooperative agreement is essential for ensuring that TECs have the resources they need to provide comprehensive public health services to Tribal communities and respond to emerging health threats.

Tribal Practices for Wellness in Indian Country Cooperative Agreement

The Tribal Practices for Wellness in Indian Country (TPWIC) cooperative agreement provides funding to support Tribal programs and initiatives that address key chronic disease risk factors, such as tobacco use, poor nutrition, and physical inactivity. Through this program, Tribes and Tribal organizations can implement culturally tailored interventions and strategies that are grounded in traditional Tribal knowledge and practices, as well as evidence-based practices. HHS should increase the amount provided in the TPWIC

cooperative agreement and increase the number of direct recipients for the next iteration of this agreement.

Strengthening Public Health Systems and Services in Indian Country

The Strengthening Public Health Systems and Services in Indian Country cooperative agreement provides funding to Tribes and Tribal organizations to conduct a range of activities that promote public health capacity building and quality improvement. These activities include workforce development, program planning and implementation, data collection and analysis, performance management, and quality improvement. These capacity building activities and infrastructure investment are critical for ensuring Tribal public health systems are prepared both to address the next public health emergency and to successfully pursue the President's goals to Make America Healthy Again.

Public Health Emergency Preparedness Cooperative Agreements

Administered by the CDC, the Public Health Emergency Preparedness (PHEP) cooperative agreement is a critical source of funding for state, local, and territorial public health departments. Since 2002, the PHEP cooperative agreement has provided assistance to public health departments across the nation to target the development of emergency-ready public health departments that are flexible and adaptable. Unfortunately, Tribes are not directly eligible for this program and can only be included through state planning.

The legal construct of Tribal exclusion and passing the consultation and coordination requirement off to the states is inconsistent with the treaty and trust obligations of the United States. It is a violation of Tribal sovereignty to force dependence on state authority. As public health authorities with cognizable jurisdictions, it makes sense to amend the U.S. Code to include Tribes in the PHEP cooperative agreement. We request that CDC propose this legislative change in its FY 2027 budget request.

Public Health Infrastructure Grants

The COVID-19 pandemic emphasized the gaps in our public health systems, and the need for investment into public health infrastructure. The Public Health Infrastructure Grant represents a historic investment in public health. However, Tribes continue to be left out of these system building initiatives. For over a year, NIHB and Tribal leaders have continued to remind the CDC that Tribes were not eligible for the $4.3 billion awarded through the Public Health Infrastructure Grants. We recognize that there was money provided directly to the Indian Health Service to go to Tribes for this purpose; however, Tribal communities never received this money. In fact, much of the money provided to IHS was rescinded in the Fiscal Responsibility Act, with an additional $350 million rescission in the FY 2024 appropriations law. For Tribes to be left out of initial funding streams, and then to have almost $800 million from IHS rescinded, just adds insult to injury and continues to forget Tribal Nations in the fabric of the nation's public health.

We are willing and ready to work with you as partners to rethink how CDC serves Tribes and TECs to ensure that public health infrastructure is supported in Indian Country. CDC can, and must, do better when it comes to including Tribal Nations in public health decisions.

Centers for Medicare & Medicaid Services (CMS)

Medicare, Medicaid, CHIP, and Marketplace plans reimbursement are vital sources of funding for Indian health programs. Together, they supplement the drastically inadequate direct funding from the Indian Health Service (IHS) and help fulfill the federal government's trust responsibility for Indian health. Hospitals and clinics across the Indian health system rely on reimbursement from CMS programs to keep their doors open in some of the most rural and remote areas of the country. Before any reforms to CMS programs are made, Tribal consultation must be held in accordance with the United States' legal obligations to Tribes.

CMS Tribal Technical Advisory Group (TTAG)

The government-to-government relationship between Tribal Nations and the United States serves as the foundation of the CMS Tribal Technical Advisory Group (TTAG) and how we drive forward solutions that will best serve to improve the health of AI/AN people. The TTAG was established by statute in 2004 to provide input on CMS policy and program issues that impact AI/AN people. The TTAG has subject-specific subcommittees that meet on a regular basis to be more effective and perform in-depth analysis of Medicare, Medicaid, CHIP, and the Health Insurance Marketplace policies that have Tribal implications. While advisory groups are not a substitute for Tribal consultation, NIHB supports collaborative policy developed between sovereigns or their diplomatic delegates. NIHB recommends that CMS act on the Tribally driven administrative and legislative policy priorities of the TTAG, which include immediate action as part of this Administration's commitment to setting the stage for meaningful change with the FY 2027 budget proposal, and ultimately, the enacted budget.

CMS Division of Tribal Affairs (DTA) and Tribal Serving Workforce

As restructuring, reduction in force, and other changes that impact the CMS workforce are being ordered and implemented, we request that Tribal serving positions are not reduced or impacted. Additionally, we request an exemption from the current hiring freeze to fill vacancies for the DTA Office, Native American Contacts (NACs), and other Tribal serving positions to ensure that CMS can appropriately fulfill its legal obligations to Tribes and Tribal citizens. The work of the Division of Tribal Affairs and other CMS staff supporting AI/AN people are essential for the federal government to fulfill its trust and treaty obligations, which also include supporting this statutory advisory group. DTA helps to resolve the unique program and payment issues impacting Indian Health Care Providers (IHCPs) and helps meet Tribal consultation requirements. DTA leadership brings the expertise and attention necessary to make these programs available for us. The federal staff of the DTA office and serving as NACs are valuable and irreplaceable partners, and the FY 2027 budget should include sufficient resources to ensure the sustainability of those positions.

Medicaid

Congress authorized Indian health system access to the Medicaid program to help address dramatic resource shortages and to implement the federal government's trust and treaty responsibilities to provide healthcare to American Indians and Alaska Natives (AI/ANs). To ensure that states do not bear the increased costs associated with allowing Indian health care providers access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for eligible services received at or through Indian health care providers (IHCPs) (100 percent Federal Medical Assistance Percentage, or "FMAP"), consistent with the federal legal obligation to provide for AI/AN healthcare. These resources are critical to support expanded services and staff at Indian health clinics and hospitals.

The United States' treaty and trust obligations apply equally to all Tribes; however, the current statute is not fulfilling those obligations equally through the Medicaid program. While Congress provided equal access to the Medicaid program to all IHCPs, in practice, access has not been equal because states have the option to select some (or none) of the optional Medicaid services and may reimburse at differing rates for similar or identical services. The result is that the amount and type of services that can be billed to Medicaid varies greatly from state to state.

We are aware that the Administration is considering significant Medicaid reforms, such as work requirements. Protections for AI/AN beneficiaries should be upheld in alignment with the Indian Health Care Improvement Act and the Indian Self-Determination and Education Assistance Act. IHS Medicaid spending in 2025 is projected to be only 0.21 percent of total Medicaid spending and will not adversely affect the overall effort to cap and control federal Medicaid spending.

Tribal Nations are concerned that any cuts to Medicaid program benefits or eligibility could have devastating consequences for the survival of many Indian health facilities. As Cherokee Nation Principal Chief Hoskin stated during a recent meeting of the Secretary's Tribal Advisory Committee, "We can be partners in achieving an efficient system…Every Medicaid dollar is going to a Tribal citizen and a community that needs a clinic. We are the best stewards of these dollars. We will be disproportionately harmed if Medicaid spending contracts. While they seek to cut the fat, they would be cutting our muscle and bones." Exemptions for AI/AN should be included in any federal cutbacks to Medicaid, and CMS should advise states to include exemptions for AI/AN in any rollbacks of services or eligibility made through State Plan Amendments or 1115 demonstration waivers, which is consistent with previous policies.

Extend Affordable Care Act Premium Tax Credits

We urge the immediate extension of the enhanced premium tax credit provisions beyond their scheduled expiration in 2025. Failing to extend the premium tax credit will jeopardize health care access for more than 21 million Americans who depend on the ACA marketplace

for coverage. The ACA premium tax credits are a lifeline for many AI/AN people who face significant barriers to accessing affordable health care. The expiration of enhanced eligibility and access to these tax credits will result in an estimated 3.8 million Americans becoming uninsured[20] and loss of coverage for 40% of American Indians and Alaska Natives with Marketplace plans.[21] In Oklahoma alone, the expiration of the premium tax credits is projected to cause average premiums to spike the average cost of a benchmark silver plan from $58 per month to $153 per month in 2026 if subsidies expire. This increase will price many individuals and families out of coverage entirely, exacerbating chronic health conditions and ultimately increasing overall healthcare costs.

Health Resources and Services Administration (HRSA)

The proposed elimination of HRSA will significantly endanger Tribal public health systems, and maternal and child health (MCH) services across Indian Country. HRSA has long served as a critical federal partner in strengthening Tribal healthcare infrastructure and delivering lifesaving support for families, infants, and mothers.

HRSA's Tribal Affairs Office plays a central role in supporting the development of essential public health and clinic infrastructure in Tribal communities. Through Congressionally Directed Spending, HRSA provides direct investments in Tribal health clinics, including construction, expansion, renovation, and other capital improvements. Generations of systemic underfunding, displacement, and economic marginalization have left many Tribes without the necessary capital to initiate or complete critical infrastructure projects. The elimination of this funding will delay, if not permanently halt, ongoing Tribal efforts to modernize health facilities, expand capacity, and meet community needs. Funding for these infrastructure project must continue to reach Tribes through self-governance contracts and compacts to uphold trust and treaty obligations.

HRSA also houses the Healthy Start program. In FY 2024, two Tribal-led organizations received $1 million each through Healthy Start. While this is a modest number, the impact is profound for local capacity building to support pregnant women, new parents, and infants with culturally competent care. Healthy Start supports mothers and families during preconception, pregnancy, and postpartum, to ensure every child's first few years of life are healthy. Healthy Start programs offer maternal supportive services to address chronic disparities including hypertension, substance use disorder, severe maternal morbidity for

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[20] Center on Budget and Policy Priorities. (2024). Health Insurance Costs Will Rise Steeply if Premium Tax Credit Improvements Expire. Retrieved from: https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire#:~:text=Improvements%20to%20premium%20tax%20credits,to%20Congressional%20Budget%20Office%20estimates.

[21] Urban Institute. (2024). The Impacts of Enhanced Premium Tax Credits on Coverage by Race and Ethnicity. Retrieved from: https://www.urban.org/research/publication/impact-enhanced-premium-tax-credits-coverage-race-and-ethnicity

pregnant and postpartum women, and addresses low birth weight. Healthy Start programs offer home-visiting, peer support groups, and care coordination. Without Healthy Start, preventable maternal and infant mortality may worsen.

Without HRSA, the MCH crisis in Indian Country will worsen dramatically. AI/AN women already face some of the highest maternal mortality and morbidity rates in the United States. AI/AN women are 2.3 times as likely to die from pregnancy-related causes and nearly twice as likely to experience severe maternal morbidity compared to other demographics.[22] These disparities are rooted in and perpetuated by historical and ongoing trauma and neglect of Tribal health systems. AI/AN women regularly report difficulties they face accessing prenatal and obstetric care, including provider shortages, staggering travel distances to receive care, racial discrimination, bias from healthcare providers, and many other challenges.

In addition, the gaps in the healthcare workforce will only worsen under the proposal to eliminate most workforce programs at HRSA, including Title VII Health Professions and Title III Nursing Workforce programs. Programs include the Health Careers Opportunity Programs, Primary Care Training and Enhancement, Area Health Education Centers, the Behavioral Health Workforce Education and Training Program, and other workforce development programs. This will further the provider shortage, harming all clinics and facilities. Reports that programs for loan repayment within the National Health Service Corps have been halted is very concerning for Tribes not only because of the Tribal set-aside within that program, but because this will significantly impact recruitment and retention of health workforce which has been at critical levels for years.

Finally, HRSA's rural health care programs and its administration of the section 330 program for Community Health Centers/Federally Qualified Health Centers is a vital support for Tribal and Urban Indian programs. These programs secure access for communities including non-Native patients who often have no alternative to access health care in very rural areas. HHS and HRSA should preserve the funding of these programs and work with Tribes to best support technical assistance. HHS should appeal any proposed reductions to these types of programs.

The path toward a healthier America must meet the committed federal obligations to Tribal Nations. Dismantling HRSA will not only worsen AI/AN health outcomes, but it will also undermine and abandon federal obligations to Tribal Nations. Indian Country needs committed investment in health system infrastructure and MCH programs.

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[22] Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health (Nov. 16, 2022): https://www.cdc.gov/hearher/aian/disparities.html

Indian Health Service (IHS)

Full Funding

Since 2003, Tribal leaders, technical advisors, and other policy advisors have met during the annual national Tribal Budget Formulation work session to collaboratively develop an estimate for full IHS funding. The IHS need-based funding aggregate cost estimate for FY 2027 is $73 billion.[23] For FY 2027, the National Tribal Budget Formulation Workgroup continues to request the Hospitals & Health Clinics ($18.5 billion for FY 2027) and Purchased/Referred Care ($12.6 billion for FY 2027) IHS line items receive the largest increase. The Workgroup also requests the Mental Health ($5.4 billion), Indian Health Care Improvement Fund ($4.6 billion), Alcohol and Substance Abuse ($4.2 billion), and Dental Services ($3.8 billion) line items receive the next largest increases for IHS. The annual Workgroup request includes a detailed justification for spending by IHS account or budget policy issue, and NIHB supports the Tribally driven, data-based cost estimates and justifications of the National Tribal Budget Formulation Workgroup for the IHS.[24]

Mandatory Funding

IHS spending should be provided through mandatory direct appropriations with adjustments for inflation and population growth in an allocation mutually agreed to by Tribes. NIHB supports Tribes in their call for a direct appropriation codified in statute. Additionally, and as the House and Senate Appropriations Interior, Environment, and Related Agencies Subcommittees have reported for years, certain IHS account payments, such as Contract Support Costs (CSC) and Payments for Tribal Leases, fulfill obligations that are typically addressed through mandatory spending. For the first time in FY 2024, IHS accounts were cut to make room for growing CSC and Section 105(l) Lease Payments.

Without a mandatory IHS budget as the NTBFW has proposed, the costs for these accounts must come from within the discretionary caps placed on the budget. With an already dramatically underfunded health system and the rising costs of providing healthcare nationwide, there is little room for crimping to accommodate these increasing costs. This of course is also compounded on top of years of sub-inflationary increases the Agency's budget has weathered, diminishing purchasing power for years. Further, without the appropriations to provide necessary increases and address these growing required costs, the Agency continues to struggle to meet service needs.

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[23] National Tribal Budget Formulation Workgroup. The Federal Trust Responsibility to Tribal Nations: A Strategy to Advance Indian Healthcare, The NTBFW's Request for the Indian Health Service FY 2027 Budget.
[24] *Id*.

Expand and Sustain IHS Advance Appropriations

Advance appropriations provide a full-year appropriation one year in advance, which provides much needed stability for IHS and Tribes to plan long-term for health care delivery and staffing and ultimately serves to improve efficiency of healthcare facilities and significantly reduce waste. Advance appropriations allow IHS, Tribes, and UIOs to focus on the delivery of healthcare and improving health outcomes across Indian Country. It creates efficiency at IHS by reducing the number of short-term payments and drawdowns. Finally, it reduces the need for emergency operating and contingency plans for the next unpredictable federal spending outcome.

Evaluation of the implementation is underway, but from the Tribal perspective, implementation went exceedingly well. Advance appropriations have helped continuity of services and program planning even during uncertain budget and funding environments, including recent funding pauses. Although some Tribal grants were impacted, advance appropriations helped to ensure availability of resources for Tribes. We urge the Administration to commit to IHS advance appropriations in FY 2027 and into the future, and to expand advance appropriations to all accounts within the IHS budget.

Sanitation Facilities Construction

All AI/AN communities and homes should have adequate access to running water and sanitation services, like other homes in the United States. Yet, many rural Indian communities only have fractions of residential subdivisions connected to fully operating water and sanitation for both kitchens and bathrooms. These communities typically have a washeteria building (a combination of a water treatment plant and laundromat, with toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a five-gallon bucket and haul their sewage from their home in a different five-gallon bucket. These communities rely on water hauled from rivers, streams, ponds or livestock water wells and stored in drums, with honey buckets or outhouses in place of toilets. It should be inconceivable that any communities in the United States in the twenty-first century lack in-home water and sanitation. Making America healthy again must begin with ensuring safe drinking water supplies and adequate waste disposal facilities. Investing in this infrastructure not only prevents disease and improves health but also supports the livelihoods of families and economic opportunities for communities.

The IHS Sanitation Facilities Construction (SFC) Program – an integral component of IHS disease prevention activities – has brought potable water and constructed or rehabilitated waste disposal facilities for AI/ANs and Tribal communities since 1960. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other water- and food-related diseases have been dramatically reduced by about 80 percent since 1973. However, the need for adequate sanitation infrastructure remains critical as many Tribal communities still rely on aging community-based water and sanitation infrastructure (e.g. un-piped water or

sanitation). The NTBFW recommends $1.15 billion for the Sanitation Facilities Construction program in FY 2027.

The Workgroup also recommends that IHS create and fund an Operation and Maintenance account to support sanitation and water infrastructure that has already been constructed, protecting the previous federal investment and ensuring this infrastructure remains functional for decades to come.

Healthcare Facilities

According to the Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress, the need for facilities funding remains enormous. In 1992, the IHS established its current new construction priority list. Of the original 27 facilities on the list, over 30 years later, seven are still waiting to be fully funded. The IHS hospitals now average 39 years of age, over three times older than the average age of U.S. not-for-profit hospitals (which is 11.5 years). Aging facilities risk code non-compliance, lower productivity, and compromises for healthcare services quality. At the existing replacement rate, a new 2026 facility would not be replaced for **290 years**.

Preventive Health

Preventive health is important because it can reduce disease burden, decrease morbidity and mortality, and improve the quality of life of people. IHS preventive health services include public health nursing, community health representatives, immunizations, and health education. These kinds of preventive services have proven to be among the most effective in driving down overall healthcare costs borne by the federal government by protecting individuals and communities from getting sick in the first place. In rural and remote Tribal communities where many healthcare services are inaccessible locally, preventive care is even more critical to prevent disease and injury and decrease the need for more expensive types of care.

The Public Health Nursing (PHN) program is a community health nursing program that focuses on health promotion and disease prevention nursing services to individuals, families, and community groups throughout Indian Country. Home-based services, where available, are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable diseases, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems.

Community Health Representatives (CHRs) were critical as part of the COVID-19 response, for their connection to communities and as a bridge to services at healthcare facilities. As highly trusted members in the community for the last 50 years, CHRs deliver preventive health education and case management to Tribal members in home and community settings. CHRs are part of the direct provision of health services to AI/ANs and are authorized in

IHCIA. Without the services provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients would not receive their necessary follow-up services, and many would have difficulty accessing health services, leading health conditions to worsen. In FY 2018, IHS reported that more than half of the visits performed by CHRs were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN patients and health care resources through outreach by specially trained Tribal community members. Therefore, the Tribal CHR programs must remain present in Tribal communities. Inadequate funding for the CHR Program will result in insufficient staff to address the chronic health needs and infectious diseases that require constant follow-up, as well as affect high-risk clients who receive preventive health screening education, monitoring, patient assessments and home visits. Reductions for the CHR program will result in a serious public health threat wherein high risk, elderly and disabled clients with chronic diseases will be left without case management and home health care services such as bathing, personal care, feeding and medication adherence. PHN and CHRs are essential for filling in service gaps within the Indian healthcare system.

Self-Governance & Tribal Management Grants

The Workgroup requests $7.86 million to support and expand self-governance training and technical support through the Office of Tribal Self-Governance (OTSG). This request supports an expansion of the IHS Tribal Self-Governance program and funding for Planning and Negotiation Cooperative Agreements to assist Tribes preparing to enter the IHS Tribal Self-Governance program. This line funds Tribal needs across IHS Areas and at Headquarters for any Tribe that has elected to participate in the IHS Tribal Self-Governance program.

Additionally, this funding supports the IHS Director's Tribal Self-Governance Advisory Committee, which advises the IHS Director on Self-Governance policy decisions. The OTSG is responsible for a wide range of critical agency functions to honor the IHS's relationship with Tribes and their citizens under the authorization of Title V of the ISDEAA. Title V authorizes Tribes and Tribal Consortia to enter Self-Governance compacts, self-determination contracts, and related funding agreements to assume federal PFSAs and associated Tribal Shares, placing the accountability of PFSA service provision with Tribal Nations. Today, Tribes administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

Under the ISDEAA, the Tribal Management Grants were established to assist federally recognized Tribes and Tribal Organizations (T/TO) in planning, preparing, or deciding to assume all or part of existing IHS programs, services, functions, and activities (PFSAs) through an ISDEAA Title I contract. The grant program also assists established ISDEAA contractors and compactors in further developing and improving their management capabilities.

Indian Health Professions

The Workgroup requests $380.73 million for the Indian Health Professions program. Within Indian Country, both the IHS and Tribal communities face persistent challenges in recruiting and retaining qualified medical personnel for their facilities. Rurality and geographic isolation of IHS and Tribal facilities compound this issue, as does chronic underfunding. These ongoing provider shortages significantly complicate the delivery of care to patients. This issue underscores the critical need to cultivate AI/AN health professionals from Tribal communities. To address this, broader initiatives to encourage and facilitate the entry of AI/AN individuals into health careers must be implemented. Such efforts encompass facilitating access to federal and state-funded scholarships, increasing loan repayment programs, and fostering partnerships with educational institutions to provide necessary support and resources.

The federal trust responsibility, upheld by the Eighth Circuit Court of Appeals in Rosebud Sioux Tribe v. United States, emphasizes the provision of health care as a fundamental obligation. In that case, the Court discussed the duty of the government to provide "competent physician-led health care," affirming its existence and reinforcement through the Snyder Act and the IHCIA. Appropriations must be made to fulfill this commitment and ensure the availability of "competent physician-led health care" across Indian Country.

According to the GAO IHS and Tribes has an "average vacancy rate for physicians, nurses and other care providers of 25%." Current vacancy rates make it nearly impossible to run an efficient, quality health care program. With competition for primary care physicians and other practitioners at an all-time high, the situation is unlikely to improve without a substantial investment in staffing. The Indian Health Professions program should be fully funded to increase scholarships and loan repayments to meet this essential need.

Health IT Modernization

The Workgroup requests $686.43 million to fully fund the modernization of the IHS Health Information Technology (IT) system, PATH EHR in FY 2027. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, electronic health record (EHR), enterprise e-mail services, and regional and national help desk support for approximately 20,000 network users utilizing the current system known as RPMS, which was implemented in Indian Country in 1985. Increased funding for the implementation of a new system, PATH EHR, is critically important. No other health system in the country operates on a 40-year-old EHR. Full funding is necessary for rolling out and implementing the EHR across Indian Country.

The GAO identified RPMS as one of the 10 most critical federal legacy systems in need of modernization.[25] Since FY 2020, the NTBFW has supported a new budget line specifically for Health IT. The NTBFW also has recommended a meaningful investment to maintain and update the outdated IHS RPMS while replacement efforts are underway, as the delivery of health care cannot stop, and insufficient funding for the modernization program has resulted in further implementation delays. A significantly longer than expected timeline for this project will have lasting negative impacts on the Indian health system. Additionally, the NTBFW further requests funding to support the investments that Tribal Nations and organizations have already made in modernizing their own health IT systems.

An adequately resourced IHS Health IT program is critical to ensure the provision of quality and safe care and will reduce inefficient and costly consequences associated with an outdated health technology system. We request the President's Budget for FY 2027 include substantial investments for both Tribal and IHS Health IT modernization efforts to address the changing technology and resource environment of healthcare. Without consistent funding for such important high-level programs, systems transitions can become marred by stalls, leadership changes, and implementation delays. Any cuts to Health IT modernization within the IHS budget only sets the Indian health system back further, leading to more inefficiencies and waste of previous investments.

Reauthorize the Special Diabetes Program for Indians

Congress established the SDPI in 1997 to address the disproportionate impact of type 2 diabetes in AI/AN communities. This program has grown and become our nation's most strategic and effective federal initiative to combat diabetes in Indian Country. SDPI has effectively reduced incidence and prevalence of diabetes among AI/ANs and is responsible for a 54 percent reduction in rates of End Stage Renal Disease and a 50 percent reduction in diabetic eye disease among AI/AN adults.[26] A 2019 federal report found SDPI to be largely responsible for $520 million in savings in Medicare expenditures per year.[27]

Still, diabetes and its complications remain major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (13.6 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (6.9 percent).[28] In some

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[25] GAO-21-524T, INFORMATION TECHNOLOGY: Agencies Need to Develop and Implement Modernization Plans for Critical Legacy Systems https://www.gao.gov/assets/gao-21-524t.pdf

[26] Indian Health Service, *Special Diabetes Program for Indians 2020 Report to Congress*, available at https://www.ihs.gov/sdpi/reports-to-congress/, accessed on: April 2, 2024.

[27] Department of Health and Human Service, *The Special Diabetes Program for Indians: Estimates of Medicare Savings*, ASPE Issue Brief, May 10, 2019, available at https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf, accessed on: April 2, 2024.

[28] Centers for Disease Control and Prevention, National Diabetes Statistics Report website, available at: https://www.cdc.gov/diabetes/data/statistics-report/index.html, accessed on: April 2, 2024.

AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[29]

We strongly support the permanent reauthorization of the SDPI at a minimum of $250 million annually, with automatic annual funding increases matched to the rate of medical inflation. Additionally, we support amending the SDPI's authorizing statute, the Public Health Service Act, to permit Tribes and Tribal organizations to receive SDPI funds through self-determination and self-governance contracts and compacts. Further, SDPI should be exempted from mandatory sequestrations which limit funding unnecessarily for such a highly successful public health program.

Hold the Indian Health Service Harmless in any Spending Cuts or Control Measures

The IHS budget remains so small in comparison to the national budget that spending cuts or budget control measures would not result in any meaningful savings in the national debt, but it would devastate Tribal Nations and their citizens. We appreciate Secretary Kennedy's emphasis on the importance of Indian health, and we urge HHS to ensure the FY 2027 budget reflects Tribal health as a priority. In whatever budget cuts HHS seeks to make, IHS must be held harmless. We cannot balance the budget on the backs of the First Americans.

National Institutes of Health (NIH)

NIH has had growing success working more closely with Tribes to enhance health, strengthen life, and reduce illness and disability in Native communities. This improving relationship is thanks in large part to the diligent work of the NIHB Tribal Health Research Office (THRO). Continued funding and full staffing for this office are critical; disruptive staff cuts hinder government-to-government relationships and ongoing research in Tribal communities. The Secretary has taken a good first step by reinstating Dr. Karina Walters as the Director of the THRO, and we encourage the Administration to do more in support of Tribal research and data.

The NIH has a critical role to play in service of the Secretary's goal to "Make America Healthy Again." Better inclusion of Tribes in research grants and investment in Native researchers will ensure the highest priority, most impactful research is funded, increasing efficiency and efficacy. NIH can support the critical work of Tribal researchers on addressing chronic disease through traditional ecological knowledge, traditional medicines, and language revitalization. Returning to traditional, local, and regional food systems is a vital strategy for addressing chronic disease in Tribal communities, as it plays an enormous role in improving nutrition as well as enhancing the cultural connectedness that is a proven resilience factor that improves long-term health. Tribal leaders have also called for continued NIH funding to

[29] Lee ET, Howard BV, Savage PJ, et al., Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study, Diabetes Care, 1995;18:599-610.

address opioids/fentanyl and the effects of climate change. The FY 2027 budget should include Tribal set-asides and expand investment in Tribal-led research.

The impacts of funding cuts and recissions to Tribes and Tribal research programs across NIH have been significant, including direct funding cancelation. Funding uncertainty undercuts the Administration's goals of a healthy America and are counter to the federal trust responsibility for protecting AI/AN health. Per HHS's Tribal consultation policy, NIH consultation on funding changes must occur regarding any funding and reorganization impacts to Tribes.

Substance Use and Mental Health Services Administration (SAMHSA)

The Substance Use and Mental Health Services Administration (SAMHSA) provides critical resources to Tribes and Tribal organizations through Tribal behavioral grants and a Tribal set-aside within the State Opioid Response grants, known as the Tribal Opioid Response grant set-aside. The resources provided through SAMHSA are critical to addressing the behavioral health crisis in Indian Country, but additional resources and certain policy modernization is needed to maximize federal investments in outcomes rather than paperwork for Indian Country.

The proposed elimination of SAMHSA in the OMB passback on HHS would dismantle essential Tribal programs, including the Tribal behavioral health grants, Circles of Care program, and other mental health programs. These programs are vital to the operation of mental and behavioral health initiatives in Indian health clinics and facilities. AI/AN populations experience disproportionately higher rates of mental health conditions compared to the general population. The proposed cuts would eliminate essential education, prevention, intervention, and treatment resources, placing AI/ANs populations at an even greater risk.

According to the Albuquerque Area Southwest Tribal Epidemiology Center, the opioid-related overdose death rate for AI/ANs is 13.7 deaths per 100,000, which exceeds the national rate of 13.1 per 100,000. The unique mental health challenges within AI/AN populations are best served through culturally appropriate response models delivered by trusted behavioral health specialists, healthcare providers, and community health representatives. In the reorganization of State Opioid Response Grants, the five percent Tribal set-asides mandated in legislative statute must continue to be honored.

The Circles of Care program provides critical infrastructure for Tribal substance abuse prevention and wellness services, local capacity building to improve mental health, and support systems for children, youth and families. The Circles of Care program allowed Tribes, Tribal organizations, and urban Indian organizations to develop culturally appropriate approaches to mental health services. Native Connections was a five-year grant program that helped AI/AN youth address behavioral health needs across all HHS regions. Native youth have a suicide rate four times higher than any other racial or ethnic group in the U.S. The

elimination of these programs will significantly undermine Tribally based wellness strategies, potentially leading to higher rates of substance use and suicide amongst AI/ANs.

We are also concerned about the elimination of funding for Certified Community Behavioral Health Centers, Overdoes Prevention (naloxone), Comprehensive Opioid Recovery Centers, building Community of Recovery, and other proposed substance abuse prevention and treatment programs. Tribal Nations and cities across the U.S. are fighting opioid epidemic. In 2022, nearly 108,000 people died from drug overdose and approximately 82,000 of those deaths involved opioids. These vital services increase local capacity to bring awareness, resources, and expertise to prevent and address opioid overdoses and deaths.

SAMHSA also supports Tribal self-governance. Tribal leaders have long advocated for the option to receive behavioral health funds through ISDEAA contracts and compacts, which would streamline the funding and create efficiency. One step towards this goal is the Behavioral Health and Substance Use Disorder Resources for Native Americans program established in the FY 2023 Omnibus. The flexibility and formula-based structure of these grants aligns with long-standing Tribal recommendations and promotes efficient, effective outcomes. However, the possibilities created by this program have never been fully realized, since Congress has not appropriated the necessary funds. The FY 2027 budget should seek to extend the authorization of this program and ensure it is funded, promoting efficiency and local control.

Conclusion

This Administration can break the cycles of inefficiency and destruction. It can stop terminating our people by terminating the programs we rely on. Tribal Nations seek no more than the duty affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. While we recognize the difficult decisions involved in the HHS reorganization, the federal government has a responsibility to provide obligated resources for the promotion of health outcomes for AI/AN citizens. We encourage the Trump Administration to review in detail the Tribal Budget Formulation Workgroup's request for IHS and all the collaborative policy developed by Tribal advisory committees and through Tribal consultation with HHS. Empowering Tribes works. Listening to Tribes works. Government-to-government collaboration works. Thank you, again, for the opportunity to provide written testimony. We look forward to continuing to work with you for the betterment of the United States' First peoples.