Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

November 24, 2025

The Honorable Mehmet Oz
Administrator
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Rural Health Transformation Program in Indian Country

Dear Administrator Oz,

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), we respectfully submit the following comments regarding the CMS Rural Health Transformation (RHT) Program. We appreciate CMS' efforts to improve access to quality healthcare in rural and underserved areas and recognize the program's potential to advance health equity across diverse communities. For the RHT Program to be genuinely effective in Indian Country, implementation must honor the federal government's trust and treaty obligations to Tribal Nations, uphold Tribal sovereignty, and ensure equitable participation and access to funding for all Tribes. The recommendations below outline key steps CMS should take to align the RHT Program with these responsibilities better and to promote lasting, government-to-government collaboration with Tribal Nations.

Ensure Application Reviewers Understand Indian Country

We request that CMS ensure the application review teams have a thorough understanding of the United States' unique legal and political relationship with Tribal governments and how this relationship forms the basis of the Indian health system. This federal trust responsibility is the reason why the Indian health system exists. All federal agencies, including CMS, have a duty to fulfill this responsibility and to protect the interests of Indian Tribes and communities, including the provision of quality healthcare to American Indians and Alaska Natives. This is extremely important because AI/AN people face the most significant health disparities of any population in the United States. AI/AN people experience higher mortality rates for various diseases, lower life expectancy, and disproportionately higher rates of certain chronic and infectious diseases compared to other population groups. Our healthcare programs and services must not be interrupted or reduced; the public safety of our people depends on them.

We respectfully request that CMS ensure all application review teams understand the Indian health system and the critical importance of RHTF funding for Indian Country. The RHTF website explains that applications will undergo an in-depth data-driven merit review led by federal and non-federal rural health experts. While senior federal review directors will oversee this process, the TTAG is concerned about the level of understanding of some involved in this process, particularly regarding the Indian health system, the government-to-government relationships between the federal government and Tribes, and the facility data challenges associated with making resource allocation decisions.

Rural Facilities Discrepancies and Source Data Issues

CMS and the RHT Program application review teams should use the most recent CMS/IHS Facilities List to validate Tribal facilities in state applications, rather than the CMS Provider of Service File. The CMS/IHS Facilities List is a trusted facility data source that is provided annually to the state Medicaid programs for the purposes of paying facilities at the IHS-OMB all-inclusive rate and for states to claim 100 percent FMAP.

The CMS data sources are missing many IHS and Tribally operated facilities. For example, the HRSA health center data lists 13 sites in Alaska, while the IHS/CMS Facilities List maintained under the CMS/IHS MOU includes 70 health centers (regional clinics) and 139 Alaska Village Clinics. These 209 clinics are statutorily designated as FQHCs, most located in extremely remote rural areas of Alaska, yet the HRSA facility data lists only 13 sites.

Federally Qualified Health Centers (FQHCs) are eligible facility types under the definition of rural health facilities. The data sources explained in the NOFO will be the most recent "HRSA Health Center and Look-Alikes" data file. Indian Health clinics operated by a Tribe or Tribal organization are statutorily designated as FQHCs.[1] However, these centers and look-alikes may not be included in the HRSA data file. This is because many of these facilities are enrolled as providers of clinic services and not FQHCs, or they may not receive a community health center grant from HRSA to be included on the HRSA list. A vast number of these Tribal clinics are in rural locations.

Tribal Inclusive Applications

We request that the CMS application review and grant award processes ensure that state RHT Programs direct funding to Tribal governments. Additionally, we request that CMS prioritize applications that demonstrate meaningful collaboration with Tribes during the drafting of their respective RHT Program plans. During the recent CMS TTAG and HHS STAC meetings, HHS senior officials stated that CMS would not require Tribal consultation between states and Tribes as states developed their plans. In the states where federally recognized Tribes are located, Tribal participation in the development of state plans varied. This involvement ranged from no participation at all to full partnership with Tribes. Tribes need CMS assistance in ensuring that each State ensures that Tribes receive funding and resources made available by the RHTP.

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[1] 42 U.S.C. § 1396d(*l*)(2)(B).

Issue Post-Award Guidance to States

The TTAG recommends CMS issue post-award guidance to the states clarifying that they may make set-aside awards to Tribes and Tribal organizations. During the October 8, 2025, All-Tribes Webinar discussing the RHT Program, Alina Czekai, Director of the Office of Rural Health Transformation, clarified that states will have the authority to determine how to pass funding through to Tribes. Director Czekai elaborated that states will have discretion to designate Tribes as sub-awardees or subrecipients. We thank the agency for making that clarification during the All-Tribes call. Importantly, that information must be made clear to states at the start of program implementation to ensure Tribes can reasonably access the RHTF. Additionally, several states have proposed Tribal set-asides in their RHTF applications. CMS guidance should support these types of collaborations with Tribes and signal to other states they can do the same if Tribes request similar set-asides. CMS guidance should make clear that states can create set-aside funding for Tribes during implementation, even if the initial application did not initially propose such a set-aside

Conclusion

We urge CMS to include Tribes meaningfully and to uphold the federal government's trust and treaty responsibilities at every stage of implementing the RHTF. This inclusion must incorporate building the building reviewer's understanding of Indian Country, ensuring and prioritizing Tribal-inclusive applications, and issuing clear post-award guidance that affirms Tribal access to funding.

Sincerely,

W. Ron Allen

W. Ron Allen, TTAG Chair
Chairman, Jamestown S'Klallam Tribe

CC: Mark Cruz, Senior Advisor to the Secretary