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USET SPF Tribal Talking Points
HHS 2023 Annual and Regional Tribal Consultations

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS FY 2024 Appropriations

Summary

On March 9th, the Biden-Harris Administration released the first details of its Fiscal Year (FY) 2024 Request to Congress, which contains, for the second time, historic policy and funding proposals for Indian Country. These proposals represent a dramatic shift in federal Indian policy and the delivery of trust and treaty obligations—for which USET SPF has consistently and passionately advocated. USET SPF appreciates the Biden-Harris Administration's continued support for mandatory, as well as substantially increased and predictable, funding for an agency charged with fulfilling sacred promises to Tribal Nations.

The Request would shift funding for the IHS from the discretionary to the mandatory side of the federal budget, a move that stabilizes the agency and is more representative of perpetual trust and treaty obligations. The Biden-Harris Administration first proposed this mandatory funding scheme in FY 2023, but the proposal was not adopted by Congress. However, in the Consolidated Appropriations Act of 2022 Congress provided, for the first time ever, advance appropriations for the Indian Health Service (IHS), providing a measure of budgetary certainty for a majority of IHS line items through FY 2024.

Further, a substantial request of $9.7 billion for IHS in FY 2024 includes a 10-year plan to close funding gaps, increasing IHS funding to $44 billion in FY 2033—a 519% increase over this period—and exempting agency funds from sequestration. This change would make meaningful inroads in the chronic underfunding of the IHS. Year after year, USET SPF has urged multiple Administrations and Congresses to request and enact budgets that honor the unique, Nation-to-Nation relationship between Tribal Nations and the United States, including providing full and mandatory funding.

In FY 2024 and beyond, HHS must support and advocate for full funding of the Indian Healthcare System, to include all of its Operating Divisions, in fulfillment of the trust obligation. This necessarily includes working with Indian Country to increase Tribal Nation inclusion in HHS agencies and programs and determine the level of funding shortfall across the Department, as well as full funding figures for all federal Indian programs administered by HHS—not only IHS. The chronic underfunding of federal Indian programs continues to have disastrous impacts upon Tribal governments and Native peoples. Native peoples experience some of the greatest disparities among all populations in this country. However, these systemic issues have existed for decades, across numerous Administrations and Congresses. Indeed, the U.S. Commission on Civil Rights' *Broken Promises* report (and the *Quiet Crisis* report before that) found deep failures in the delivery of federal trust and treaty obligations, concluding that federal funding to Indian Country remains "grossly inadequate" and a "barely perceptible and decreasing percentage of agency

budgets." The Commission recommended that Congress provide "steady, equitable, non-discretionary funding" to Tribal Nations.

Talking Points

- USET SPF celebrates the inclusion of advance appropriations for the IHS in the Consolidated Appropriations Act of 2022. As one of the earliest and most vocal supporters of advance appropriations, we are pleased that the IHS will now receive a small measure of certainty in the budget process. We strongly urge Congress to maintain advance appropriations for the IHS, including necessary increases for inflation and population growth, until the agency is provided with full and mandatory funding.

- Our region celebrates the President's proposal to substantially increase IHS funding and shift it to the mandatory side of the budget. The Tribal Nations in the Nashville Area have long called for this pivotal change, which would more fully honor the federal government's sacred promises to Tribal Nations.

- Tribal Nations are committed to working with the Administration and our allies on Capitol Hill to make this proposal a reality. However, we urge HHS and IHS to work with Tribal Nations to draft and educate Congress on legislative language to implement this change, including determining what it would take to full funding the IHS. USET SPF supports the formation and work of the IHS Sub-Workgroup on Mandatory Funding to determine this figure, and we advocate for further consultation with Tribal Nations on full funding. Secretary Becerra should then advocate for this bill with his former Congressional colleagues, so that they understand and appreciate why mandatory and increased funding for IHS is necessary.

- HHS' budget request should include a full and complete picture of unfulfilled trust and treaty obligations. The only way the United States can effectively measure how well it is fulfilling its obligations is in comparison to a full funding for Indian Country budget number. Each HHS Operating Division (OPDIV) should be required to work in partnership with Indian Country to determine what is required for complete fulfillment of fiduciary trust and treaty obligations. This includes ensuring that Tribal Nations have full governmental parity and inclusion across the Department.

- Much of the federal funding across Indian Country, including a majority of HHS funding, is delivered through the competitive grant process and often through the states. Not only is this an abrogation of the federal trust responsibility to force Tribal Nations to compete for federal dollars, grant funding fails to reflect the unique nature of the federal trust obligation and Tribal sovereignty by treating Tribal Nations as non-profits rather than governments.

- The sacred trust obligation to Tribal Nations transcends measurements, outputs, data, and statistics. While these things are important, the obligations due to Tribal Nations should not be based on these measures. Rather, these are things that Tribal Nations should monitor as an internal matter to ensure we are providing strong services to our citizenship. Together, we must explore a new approach to the oversight of federal dollars that better respects Tribal sovereignty and the trust obligation.

- President Biden has also promised to work with Tribal Nations to expand Indian Self-Determination and Education Assistance Act (ISDEAA) contracting and compacting. Expansion of ISDEAA throughout HHS has long been a priority of Indian Country. In 2013, the Self-Governance Tribal

Federal Workgroup (SGTFW), established within the Department of Health and Human Services (HHS), completed a study exploring the feasibility of expanding Tribal self-governance into HHS programs beyond those of IHS and concluded that the expansion of self-governance to non-IHS programs was feasible, but would require Congressional action. The Department must uphold its responsibility to Tribal Nations and work with Congress to make ISDEAA authority for other HHS programs a reality.

- HHS should work with Congress to ensure all federal Indian funding can be transferred between federal agencies, so that it may be received through contracts and compacts. The Administration must support the authority of the executive branch to make interagency transfers at the request of and for the benefit of Tribal Nations, thus expediting essential funding to Tribal communities as intended.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Limited Access to CDC Surveillance Data for Tribal Public Health Entities

Summary

Over the years, states have cultivated extensive public health infrastructure. This includes the establishment of reportable disease and vital statistics reporting mechanisms, outbreak investigation, contact tracing, data collection, and quarantine measures for all residents, including Native American people. This data is then shared with the CDC through cooperative agreements. However, Tribal Nations and Tribal Epidemiology Centers (TECs) continue to experience frequent challenges in accessing not just public health data on both the federal and state level, but Tribal data as well, which often is not reported back to the Tribal Nation.

Despite being designated as Public Health Authorities, both Tribal Nations and TECs continue to experience frequent challenges in accessing data on both the federal and state level—on top of the consistent lack of investment in TECs and Tribal public health capacity. TECs continue to petition both the CDC and state public health departments for this vital information but have only received state data where there are positive Tribal-state relationships and some extremely limited COVID-19 testing data from CDC. While CDC was ultimately given a directive to share data with TECs, this information was of poor quality and further hindered the work of TECs, including USET. In turn, COVID-19 response at the Tribal level was without an accurate picture of the reach of the disease into our communities. Indeed, Tribal Nations and TECs continue to struggle with access to CDC and HHS data three years into the COVID-19 response. Access to the HHS Protect System, which houses COVID-19 and other data sets, has been a frustrating and time-consuming process. The TECs have repeatedly asked for a listing of data sets available in HHS Protect, and have yet to receive this information. Without knowing what HHS Protect contains, we are unable to prioritize which datasets to request. In 2022, HHS initiated consultation on the development of an HHS Tribal Data Sharing Policy. USET SPF submitted comments to HHS urging the agency to comply with data sharing directives and respect the sovereignty of Tribal Nations.

Talking Points

- As Public Health Authorities, TECs provide invaluable Tribal Nation-specific public health data and information to Tribal leaders, health directors and public health professionals in Indian Country. CDC must ensure that TECs have access to critical public health data from federal and state governments. Both should be statutorily required to share all available public health data with TECs

and Tribal Nations. This should be made a requirement of state cooperative agreements with CDC.

- CDC must take steps to improve the quality of public health data shared with TECs and Tribal Nations. This includes requiring states work with Tribal Nations to correct racial misclassification.

Good Health and Wellness in Indian Country

Summary

CDC's Good Health and Wellness in Indian Country (GHWIC) initiative supports a multitude of services to Tribal Nations, Tribal organizations, and TECs nationwide. Namely, GHWIC focuses on reducing commercial tobacco use and exposure, improving nutrition and physical activity, increasing support for breastfeeding, increasing health literacy, and strengthening team-based health care and community-clinical links. Over the past several FYs, GHWIC mostly received level funding reauthorization. In FY 2023, the President's Budget again proposed level funding for the GHWIC program, despite requests from Tribal Nations and organizations to increase program funding. USET SPF appreciated the decision by Congress to increase program funding from $22.5 million to $24 million in FY 2023 despite the level funding proposal from the Administration. However, we are disappointed that the FY 2024 President's Budget again proposed level funding for the program at $24 million. While program continuity is critical, we encourage the Biden Administration to not only support continuity for the program in FY 2024 and beyond, but to also advocate to Congress for increased funding.

Talking Points

- Over 100 Tribal Nations are served by GHWIC through the reach of Tribal organizations and TECs, including USET SPF member Tribal Nations and the USET TEC, where funding is used for health surveillance and promotion.

- The eight USET SPF member Tribal Nation GHWIC sub-awardees utilize funding from the CDC to implement a total of eight health promotion policies or practices, directly affecting more than 25,000 individuals.

- Funding for GHWIC ensures Tribal Nations, as well as the USET TEC, are able to actively implement policies that promote physical activity, increase healthy eating options, and/or protect the population from secondhand smoke within our communities. USET SPF urges the Administration to not only support this vital investment of Tribal public health, but to advocate for increases in funding to Congress to expand the reach of these critical services.

- Despite prior requests to increase funding for the GHWIC program and the decision of Congress to increase program funding in FY 2023, the President's Budget Request for FY 2024 again proposed level funding for the program, choosing not to increase funding over FY 2023 enacted levels. We urge the CDC and the Administration to advocate for increases in any final appropriations legislation.

HEALTH RESOURCES & SERVICES ADMINISTRATION (HRSA)

HRSA Definition of Rural

Summary

HRSA's narrow definition of 'rural' continues to impede Tribal Nation access to vital resources. Under the CARES Act passed in March 2020, a $15 million set-aside was authorized to be administered by HRSA to support Tribal Nations in preventing, preparing, and responding to COVID-19 in rural communities. However, this critical funding was subjected to HRSA's definition of "rural" via grant funding, thus creating an arbitrary and unnecessary barrier for many Tribal Nations during a national crisis. HRSA shares in the federal trust obligation to all Tribal Nations—regardless of rurality—and all funds must be distributed in a manner reflective of our special status and relationship with the federal government. With this in mind, USET SPF asserts that HRSA must ensure that all Tribal Nations have equal access to all federal resources to which we are entitled by designating all Tribal Nations as "rural" under its rules.

Talking Points

- Due to HRSA's current narrow definition of "rural," many Tribal Nations have been unable to access HRSA rural health resources. This has been particularly problematic for Tribal Nations who sought, but were ultimately rejected from, HRSA's targeted rural allocations within COVID-19 relief funding.

- All Tribal Nations should be considered rural for the purposes of HRSA funding since the federal trust obligation applies to all Tribal Nations equally. We remind HHS and HRSA that Tribal Nations and our homelands predate the founding of the U.S. However, because U.S. policies progressively forced relocation and reservations upon Tribal Nations and Native people, our communities are now subject to "urban" and "rural" designations which are inappropriately utilized to determine the types of resources that will be made available to us.

- Funding for all federal Indian programs, including programs associated with COVID-19 relief, and should not be subject to a grant-based methodology. The federal government must treat and respect Tribal Nations as sovereigns in fulfillment of its trust and treaty obligations to Tribal Nations, as opposed to grantees. This includes removing burdensome application and reporting requirements that ignore the diplomatic relationship between Tribal Nations and the United States, and take valuable time away from service provision.

NATIONAL INSTITUTES OF HEALTH (NIH)

NIH Research Initiatives in Indian Country

Summary

Since 2015, the National Institutes of Health (NIH) has repeatedly failed to seek input from Indian Country and has disregarded guidance from Tribal leaders, Tribal Organizations, and its own Tribal Advisory Committee regarding initiatives overseen by the agency. This includes previous failures in addressing ongoing concerns regarding NIH initiatives including the *All of Us* research project, Data Sharing and Management, and Intellectual Property. Since then, NIH has released two reports regarding its Tribal consultation efforts, including the *All of Us* Research Program as well as Data Sharing & Management.

In 2021, NIH published a Tribal consultation report that included a list of baseline commitments to Tribal Nations regarding research and data collection. These commitments include rules to never recruit on Tribal lands or disclose participants' Tribal affiliations without a Tribal Nation's agreement. Additionally. NIH highlighted plans to create a training for researchers on the responsible use of Native American data, and to explore hosting workshops with Native American researchers and community members to learn more about research priorities within Tribal communities. We recommend that NIH continue to work with Tribal Nations, as well as the NIH TAC, to determine if these policies and best practices can be implemented throughout all NIH programs impacting Tribal Nations.

Further, in September 2020, NIH released its final Tribal consultation report on the NIH Draft Policy for Data Management & Sharing. In the report, NIH acknowledges historic atrocities associated with research on Native Americans along with data oversight and privacy concerns and commits to partnering with Tribal Nations to inform responsible research practices. NIH also committed to soliciting input in accordance with the HHS Tribal Consultation Policy and the NIH Guidance on the Implementation of the HHS Tribal Consultation Policy. As an Operating Division of HHS, NIH must be incorporated into the HHS Tribal Data Sharing Policy when it is finalized. USET SPF submitted comments to HHS regarding the Policy that recommended several actions to improve data sharing and Tribal data sovereignty. As a research entity, NIH must be held to stronger data sharing requirements to protect subject data. Data collection and sharing within Indian Country must include protocols for integrating Tribal consent and oversight as well as protections for Tribal data ownership and Native people. NIH must remember when it is conducting research in Indian Country that as an arm of the federal government, it must account for and work to mitigate the historical trauma and distrust felt by Tribal Nations throughout our contact with researchers. The agency must continue to ensure that NIH-facilitated or funded research should not occur in our communities or with our people without Tribally determined protections in place.

Talking Points

- We remind NIH that, as an agency of the federal government, it has a legal and moral trust responsibility to Tribal Nations. This includes upholding the sovereign status of Tribal Nations, as we seek to protect, regulate, and maintain ownership over the data of our citizens and Nations.

- NIH must recognize and always consider the shameful and deeply unethical history between research and Tribal Nations and take the necessary steps to ensure that past abuses never happen again. Tribal Nations must have full confidence that research and data collection will be conducted in a way that acknowledges and seeks to correct past abuses, including through the use and development of Tribal Institutional Review Boards, community-based participatory research, and informed consent.

- NIH has previously failed to adhere to the HHS Tribal consultation policy. While the NIH Tribal advisory committee serves to provide guidance to the agency, it is not a substitute for Tribal consultation. Any proposals from NIH must include meaningful and ongoing consultation with Tribal Nations as this data must be Tribally-guided. Further, Tribal Nations must have jurisdiction over Native American data and must be able to consent to the publication of that data before it is disseminated to the public by NIH.

- All research in Tribal communities and with Native individuals must contain protocols for integrating Tribal consent and oversight, as well as protections for Tribal data ownership and Native participants. Without these protections in place, NIH-facilitated or funded research should not occur in our communities or with our people.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA FY 2024 Appropriations

Summary

Several federal Indian programs are administered through SAMHSA. These include Tribal set-asides and grant-based programs to address substance abuse and behavioral health crises within our communities. These grant-based programs are typically authorized by Congress with slight increases or level funding. USET SPF is pleased that the President's Budget Request for FY 2024 includes a $20 million increase for the Tribal Opioid Response Grant (TOR) program, as well as the $500,000 requested increase for Tribal Behavioral Health grants, particularly given the funding stagnation these line items have seen in the past. We encourage SAMHSA and the Administration to advocate for the inclusion of the funding increase in the FY 2024 appropriations legislation.

When it comes to the Tribal Set-Aside under State Opioid Response Grants, USET SPF is pleased that the President's Budget Request for FY 2024 continues to request $75 million for the program. The Tribal set-aside within the State Opioid Response Grants program was originally authorized under the FY 2018 omnibus after strong advocacy from Indian Country regarding the disproportionate impact of the opioid crisis in Tribal communities. In ensuring that all Tribal Nations would have access to these funds, SAMHSA committed to delivering dollars on a non-competitive formula basis. While this funding continues to be critically important in Indian Country, many of the grant requirements, including those related to data and reporting and use of funds, preclude some Tribal Nations from participating. Tribal Nations must have greater flexibility in the use of Opioid Response grant dollars to address substance abuse in our communities.

As part of the Consolidated Appropriations Act of 2022, Congress authorized the Native Behavioral Health Resources Program at SAMHSA, which would provide $80 million to award mental health and substance use disorder prevention, treatment and recovery services formula grants to Tribal Nations. However, Congress did not appropriate funding in the Consolidated Appropriations Act for the Program. USET SPF, along with partner organizations, sent a letter to the Office of Management and Budget (OMB) Director Shalanda Young urging the Administration to include the full authorized amount of $80 million in the President's FY 2024 Budget Request. Unfortunately, this program was not included in the President's Budget Request and remains unfunded.

For FY 2024 and beyond, we urge SAMHSA to work with Congress to ensure all program funding is increased and available for distribution via ISDEAA contracting and compacting so that all Tribal Nations have access to critical resources to address addiction in our communities. We reiterate that the grant-based funding model is an abrogation of the federal trust responsibility by forcing Tribal Nations to compete for federal dollars. This process often precludes Tribal Nations from having access to those dollars at all and fails to reflect the unique nature of the federal trust obligation and Tribal sovereignty by treating Tribal Nations as non-profits rather than governments.

Talking Points

- Tribal Nations continue to experience the devastating effects of the opioid crisis in our communities, often seeing higher levels of addiction, overdose, and death than non-Indian communities. We are pleased to see that the Administration demonstrated its understanding of its scope and impact in Indian Country through its request of a 36% increase for the Tribal Opioid Response (TOR) Grant Program, and the inclusion of the $75 million Tribal Set-aside in the State

Opioid Response (SOR) Grant Program. We urge the Administration to engage in strong advocacy before Congress to secure these funding increases, and to work toward an even larger set aside in future FYs.

- We strongly support and commend SAMHSA's commitment to distributing Tribal set-aside dollars from the Opioid Response Grants via non-competitive formula and urge the agency to apply this methodology to other grant programs within its purview.

- SAMHSA must commit to meaningful consultation with Tribal Nations for this and future distributions of opioid funding to avoid unexpected barriers to access. Some Tribal Nations are unable receive this funding due to inappropriate and onerous grant requirements, including data and reporting requirements. SAMHSA must be more explicit in indicating if these requirements can be waived and should explore additional opportunities to provide waivers.

- Tribal Nations must not be subject to burdensome administrative reporting requirements for use of critical program funding under SAMHSA. Conditioning access to federal funds delivered to Tribal Nations in fulfillment of the trust responsibility on reporting is an abrogation of the trust obligation to provide healthcare to Native Americans. Those reporting requirements mandated by law must be streamlined and only the minimum required, so that Tribal Nations may continue to focus on providing for the health and wellness of our citizens.

- All SAMHSA program funding must be made available for distribution via ISDEAA contracting and compacting. This will ensure all Tribal Nations have access to critical resources to address addiction and improve mental health in our communities. The grant-based funding model is a violation of the federal trust responsibility by forcing Tribal Nations to compete for federal dollars and often precludes Tribal Nations from having access to those dollars at all. This fails to reflect the unique nature of the federal trust obligation and Tribal sovereignty by treating Tribal Nations as non-profits rather than governments.

- USET SPF urges SAMHSA to identify funding for substance abuse aftercare as Tribal Nations have reported a critical need for aftercare services. These services must be provided to address those that are returning from substance abuse treatment programs, particularly opioid abuse, through detox, rehabilitation, and aftercare services.

- To better support critical priorities in behavioral health in Indian Country, the Administration and Congress must support the Native Behavioral Health Resources Program as authorized and appropriate the full authorized amount of $80 million. USET SPF urges SAMHSA and the broader administration to vocally support funding for this program throughout the appropriations process this year. Beyond this program, the Administration must work to prioritize increased and flexible behavioral health funding and resources in Indian Country.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicaid as a Reflection of Federal Trust and Treaty Obligations

Summary

Medicaid is a critical mechanism the federal government utilizes to fulfill its trust and treaty obligations to provide health care to American Indians and Alaska Natives (AI/AN). However, significant gaps remain in access to Medicaid for AI/AN, including substantially different eligibility and access to services based on where we reside. Barriers in access to Medicaid, run deeply counter to the terms of our sacred relationship. It is further inappropriate to place Native American access to a federal program in the hands of states, as differing state eligibility requirements, reimbursement rates and covered services create gaps in access across Indian Country.

USET SPF supports the Administration's efforts to dismantle policies that would limit access to Medicaid, and we will continue to advocate against this and all regulatory or legislative actions that are harmful to the trust obligation and the Indian Healthcare System. Further, USET SPF is encouraged by the Biden Administration's support for innovative approaches to Medicaid programs, such as the new plan in New Jersey to provide housing and nutrition benefits to Medicaid beneficiaries. CMS and the Biden Administration should further explore how the waiver process could be used to pursue similarly innovative approaches to healthcare in Indian Country.

USET SPF intends to work with the Administration and Congress on policies that promote equal access to Medicaid for Native American people—regardless of where they reside. We remain vigilant in ensuring that all future efforts that attack the constitutionality of the unique relationship between the U.S. and Tribal Nations are challenged and opposed. USET SPF supports the legislative and regulatory priorities and efforts of the CMS Tribal Technical Advisory Group (TTAG), including the authorization of Medicaid reimbursement for qualified Indian Provider services, the extension of 100% Federal Medical Assistance Percentage (FMAP) for Urban Indian organization, and reimbursement for services provided by IHS providers outside IHS/Tribal facilities (a Four Walls issue fix). USET SPF has also advocated in the past for a fully federal Medicaid program for Tribal Nations as an opportunity to fix equity and access issues within Medicaid.

Beyond these efforts focused on Medicaid, the CMS TTAG also has a set of priorities for the Medicare program, including requests to eliminate Medicare Part B premiums and deductibles for IHS-eligible people, ensuring parity in Medicare reimbursement policies, and the expansion of telehealth services. USET SPF supports the TTAG's Medicare legislative priorities, Medicare regulatory priorities, Medicaid legislative priorities, and Medicaid regulatory priorities.

Talking Points

- The United States has a unique obligation to provide healthcare to American Indians and Alaska Natives (AI/AN), founded in treaties and other historical relations with Tribal Nations, as well as reflected in numerous statutes and case law. This trust obligation and relationship has been solidified in law and policy and has become the cornerstone of federal Indian policy –which CMS reflects within its own Tribal Consultation Policy.

- Congress recognized federal trust and treaty obligations over forty years ago by amending the Social Security Act to authorize Medicaid reimbursement for services provided within IHS and Tribally-operated healthcare facilities. This further obligates CMS to ensure Medicaid access for

individuals eligible to receive IHS services and critical third-party reimbursements are protected for the Indian Healthcare System.

- USET SPF thanks the Biden Administration for recognizing the irreparable harm of the last Administration policies permitting states to limit access to Medicaid and for immediately dismantling further efforts to advance Medicaid work requirements and block grants. Limiting access to Medicaid for Native Americans is counter to the execution of the trust responsibility and would have a unique and adverse effect in Indian Country.

- Critical Medicaid third-party reimbursements are one mechanism the federal government utilizes to fulfill its trust and treaty obligation to provide health care to Native Americans. Medicaid funding within the Indian Healthcare System represents roughly two-thirds of third-party revenue at IHS, and 13% of overall IHS spending. To this end, CMS must authorize Medicaid reimbursements for all Qualified Indian Provider Services in all states, regardless of that state's specific Medicaid services.

- Significant gaps remain in access to Medicaid for Native Americans, including substantially different eligibility and access to services based on where we reside. We call upon the Biden Administration to work closely with Tribal Nations to enact policies that would ensure Native Americans have more equitable access to Medicaid, in fulfillment the federal government's trust responsibility, including greater control for Tribal Nations through a 51st -state model, as well as a more standardized approach to Native American access to the program across the country.

- USET SPF calls upon CMS to provide reimbursement for services furnished by Indian Health Care Providers outside of an IHS or Tribal Facility. Under the current system, IHS and Tribal clinics can only get reimbursed for services provided inside the facility. This restricts reimbursements for services like home visits, or services referred outside the IHS or Tribal facility. It will expand the type of services that 100% FMAP can be used for and offset limited purchased/referred care appropriations.

- In pursuit of greater access and equity within the Medicaid program, CMS must fulfill the TTAG's priority of extending the Office of Management and Budget (OMB) Encounter Rate for telehealth services furnished by Indian providers. CMS should also expand the definition of permissible Medicare telehealth services and make permanent the flexibilities provided in this space during the PHE.

- CMS must do more to educate states on expectations related to Tribal consultation and work with Tribal Nations to ensure those expectations honor our guidance.

CMS COVID-19 Flexibilities and Medicaid Unwinding

Summary

In the Consolidated Appropriations Act of 2022, Congress indicated that the "unwinding" of temporary flexibilities and the Medicaid/Children's Health Insurance Program (CHIP) continuous enrollment provision was no longer connected to the Public Health Emergency (PHE). Congress decided alternatively that the requirement that states maintain their Medicaid and CHIP rolls during the PHE (the continuous enrollment provision) would end on March 31, 2023. Beginning on February 1, 2023, Medicaid and CHIP programs are allowed to restart eligibility redeterminations for Medicaid and CHIP beneficiaries, and beginning on April 1,

2023, programs may begin disenrolling beneficiaries from the program. It is estimated that as many as 236,000 Native Americans – and millions more non-Native Americans - could lose their Medicaid coverage during unwinding.

In addition to the continuous enrollment provision coming to an end, many other temporary authorities adopted by states during the PHE will also end when the PHE ends. The Biden Administration announced in February that the PHE will end on May 11, 2023. We encourage CMS to compel states to maintain certain flexibilities, like access to telehealth services. Though coverage varies from state to state, IHS eligible individuals enrolled in Medicaid are eligible to receive telehealth services. In addition, CMS should issue specific guidance to states to maintain Medicaid reimbursement for Indian Health Care providers at the OMB encounter rate. CMS has been issuing guidance to state programs and Medicaid providers on how to prepare for the end of these flexibilities. CMS has also issued fact sheets on waivers and the transition out of the PHE.

Talking Points

- CMS must consult with and support Tribal Nations as we work to assist our citizens through Medicaid unwinding, including through the following:
    - Require states to consult with Tribal Nations regarding their unwinding operational plan development and share access to the states' Medicaid rolls to assist with eligibility redeterminations.
    - Encourage states to align Medicaid renewals with those for other programs.
    - Seek distribution of Indian-specific guidance on Marketplace plans for American Indians and Alaska Natives (AI/ANs) who will lose Medicaid coverage and enter the Marketplace
    - Advocate that states apply for 1902(e)(14)(a) waivers, which offer various flexibilities to states as they seek to establish eligibility determinations to facilitate renewals that lead to fewer procedural terminations during the 12-month unwinding period; and
    - Request continued consultation with CMS to discuss coverage loss concerns and oversight.

- CMS should work with Tribal Nations to determine the best way to share state Medicaid data sets on those AI/ANs who are facing disenrollment and encourage state Medicaid agencies to work with Tribal Nations to link AI/AN beneficiaries who are being dropped from the Medicaid rolls with AI/AN navigators in order to ensure that they effectively transition over to marketplace coverage.

- USET SPF strongly supports the expansion of access to Medicare and Medicaid telehealth services and urges that these flexibilities be made permanent once the COVID-19 Public Emergency has ended.

INDIAN HEALTH SERVICE (IHS)

IHS FY 2024 Appropriations

Summary

In a historic first, the Indian Health Service (IHS) received advance appropriations for FY 2023 and FY 2024 under the Consolidated Appropriations Act of 2022. Under this funding model, the IHS received $4.9 billion for the IHS Services Account in FY 2023 and will receive $4.6 billion for the Services Account at the beginning of FY 202 on October 1, 2023, regardless of whether or not Congress has passed full-year appropriations at that time. USET SPF and other Tribal Nations and organizations had long advocated for advance appropriations as a short-term method for stabilizing the IHS budget following years of budget cuts and uncertainty. Advance appropriations insulate the IHS from delays or interruptions in funding caused by political infighting during budget negotiations and provides a level of budgetary certainty for the chronically underfunded agency. In addition to authorizing advance appropriations for the IHS, Congress increased total funding for the IHS to $7.1 billion for FY 2023.

In another historic budget request, the Biden-Harris Administration has requested a significant increase in funding for the IHS in FY 2024, requesting $9.7 billion, a 36% increase over FY 2023 enacted levels. This includes $8.1 billion in discretionary funding, and $1.6 billion in mandatory funding for Contract Support Costs, 105(l) leases, and the Special Diabetes Program for Indians (SDPI). More importantly, the President's Budget Request also proposes making all IHS funding mandatory beginning in FY 2025 in a 10-year proposal to drastically increase resources at the IHS.

The 10-year plan for mandatory funding would shift funding for the Indian Health Service (IHS) from the discretionary to the mandatory side of the federal budget, a move that stabilizes the agency and is more representative of perpetual trust and treaty obligations. The 10-year plan, which starts with a request of $9.1 billion in FY 2023, would serve to close funding gaps, increasing IHS funding to $44 billion in FY 2033—a 519% increase over FY 2023 enacted levels—and exempting agency funds from sequestration. In total, the mandatory budget proposal would provide nearly $288 billion to IHS over 10 years. Year after year, USET SPF has urged multiple Administrations and Congresses to request and enact budgets that honor the unique, Nation-to-Nation relationship between Tribal Nations and the United States, including providing full and mandatory funding. We appreciate the Biden Administration's continued efforts to propose pathways for mandatory funding for the IHS.

As it has become clear that mandatory funding for IHS will take some time to consult upon and achieve, USET SPF is urging Congress to maintain advance appropriations until full and mandatory funding for IHS is enacted.

Talking Points

- Our region celebrates the President's continued commitment to proposals that would substantially increase IHS funding and shift it to the mandatory side of the budget. The Tribal Nations in the Nashville Area have long called for this pivotal change, which would more fully honor the federal government's sacred promises to Tribal Nations.

- Tribal Nations are committed to working with the Administration and our allies on Capitol Hill to make this proposal a reality. However, we urge HHS and IHS to work with Tribal Nations to draft and educate Congress on legislative language to implement this change, including determining what it would take to full funding the IHS. This work should include the newly formed IHS Sub-

working group on Mandatory Funding Appropriations for IHS, as well as extensive formal Tribal consultation. Secretary Becerra should then advocate for this bill with his former Congressional colleagues, so that they understand and appreciate why mandatory and increased funding for IHS is necessary.

- While we continue to call for the full funding of IHS, USET SPF is pleased that the Biden Administration has requested a substantial increase for the agency in FY 2024. We are particularly pleased to see increases in each of the following Nashville Area priority line items:
    - **Hospitals & Health Clinics**
    - **Purchased/Referred Care**
    - **Alcohol & Substance Abuse**
    - **Mental Health**
    - **Electronic Health Record System**
    - **Dental Health**
    - **Community Health Representatives**
    - **Maintenance and Improvement**
    - **Health Education**
    - **Self-Governance**

Special Diabetes Program for Indians (SDPI)

Summary

USET SPF is pleased with the President's FY 2024 Budget Request for the Special Diabetes Program for Indians (SDPI), which proposes $250 million in mandatory funding, and exempts the program from the mandatory sequester. This represents a $100 million increase over currently authorized funding levels, which have remained stagnant since 2004. USET SPF has long advocated for increased resources for the SDPI program, as well as protection from sequestration. The President's Budget Request also reauthorizes the SDPI for three years and includes inflationary increases each Fiscal Year. This proposal would provide $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026. It is vital that Congress adopt this proposal, as the SDPI is currently slated to expire on September 30, 2023. Additionally, regulatory changes to the SDPI in FY 2023 reopened the SDPI to new grantees, a move long supported by USET SPF. However, in the absence of a funding increase from Congress and a change in regional funding formulas, this move may cause a strain on the Nashville Area's SDPI grant programs. The SDPI has proven successful, and should be a permanently authorized, mandatorily funded program. Congress must also extend ISDEAA compacting and contracting authorities to the SDPI. Tribal Nations are well positioned to take over administration of the program, and the change would lead to better outcomes on the local level. The current grant funding model is not representative of the U.S.'s trust and treaty responsibility. USET SPF looks forward to supporting future legislative efforts to expand ISDEAA authorities to the SDPI.

Talking Points

- As the SDPI is slated to expire on September 30, 2023, Congress must act to reauthorize the program and increase funding to this vital program. We support the President's Budget Request proposes $250 million in mandatory funding for FY 2025 that would be protected from sequestration, as well as a three-year reauthorization with $10 million inflationary increases each fiscal year. For years, the SDPI has been funded at $147 million in sequestered funds, despite increasing inflation and additional grantees.

- Given the sustained success of the program and its importance in Indian Country, Congress must permanently authorize the SDPI program. This would ensure the continued success of the program while removing the uncertainty associated with reauthorizations and allowing Tribal Nations to develop more robust SDPI programs.

- Beyond increasing funding, open the SDPI program to ISDEAA self-governance contracting and compacting. Grant funding models are not representative of the trust responsibility, and self-governance agreements would allow for greater flexibility to meet the needs and priorities of each Tribal Nation grantee. Legislation proposing to extend ISDEAA capabilities to the SDPI program has been introduced in prior Congresses, we need the Administration's support in advancing this priority.

- The Nashville Area is home to several newly-recognized Tribal Nations that are new SDPI grantees. While we are appreciative of their inclusion in the program, they currently lack historical data on diabetes prevalence, which is impacting their funding. USET SPF supports using updated user population and diabetes prevalence data in funding allocations, as well as a base funding allocation for newly-recognized Tribal Nations.

Health IT (Information Technology) Modernization

Summary

Since 2018, IHS has been working to modernize its Health Information Technology (HIT) systems—namely, replacing its current Electronic Health Record, the Resource Patient Management System (RPMS). However, it continues to appear as though much of the discussion and policymaking around HIT modernization occurs at the agency and departmental levels, as opposed to in consultation and coordination with Tribal Nations. While IHS does provide updates when asked, these typically involve high level presentations, rather than the mutual dialogue and decision-making required by consultation. Throughout the HIT modernization process thus far, IHS has engaged in a decision-making process that fails to meaningfully include and implement the guidance of Tribal Nations.

On April 8th, 2022, USET SPF submitted comments in response to IHS' March 10th, 2022, consultation on Health HIT Modernization. Though presented as a consultation/confer session, the March 10th meeting amounted to little more than an update for Tribal Nations on the unilateral decisions IHS is making around HIT modernization. The question-and-answer session at the end of the presentation cannot be considered consultation. While we appreciate the addition of focus groups, these also do not represent consultation. Our comments urge that IHS increase its transparency as decisions are made, as well as redouble its efforts to ensure Tribal consultation guides this work and the diverse HIT circumstances throughout Indian Country are included in these efforts. Unfortunately, in the nearly 12 months since USET SPF submitted these comments, the Health HIT Modernization effort has not improved its transparency and consultation. IHS continues schedule "consultations" on the HIT Modernization effort, but these consultations continue to lack meaningful engagement with Tribal Nations and organizations.

The President's Budget Request for FY 2024 includes $913 million for the EHR modernization effort, an increase of $690 million, or 319%, above FY 2023 enacted levels. USET SPF supports the increased funding and the justifications provided by the IHS, which include RPMS stabilization, interoperability, and the initial build of the system among others. However, this significant funding increase underscores the

need for greater transparency and engagement with Tribal Nations, as it remains largely unclear what resources Tribal Nations and facilities will receive in the transition process.

USET SPF asserts that the federal government has fallen short of its trust obligation to Indian Country by under-resourcing our health IT. In partnership with Tribal Nations, IHS must work to ensure that the entire Indian Health System is brought into the 21st century. This includes transparent and direct Nation-to-Nation dialogue as this process proceeds, as well as working to address the diverse circumstances of Tribally operated facilities, as well as those operated by IHS.

Talking Points

- IHS must work to increase transparency in the HIT modernization process. This includes consulting with us on a sovereign-to-sovereign basis, and then working to implement the guidance received as it seeks to replace RPMS and integrate the replacement into existing systems.

- While we appreciate IHS' focus on interoperability, we underscore that a growing number of Tribal Nations have been forced to purchase commercial-off-the-shelf (COTS) systems due to the outmoded nature of the Resource Patient Management System (RPMS) and the indeterminant timeline for full implementation of HIT modernization. Without additional funding, these Tribal Nations have absorbed the full cost of these purchases. While IHS continues to state that it supports the sovereign decision to opt for COTS, this decision is most often rooted in the federal government's failure to fund HIT and maintain systems reflective of 21st century health care. We urge IHS to develop a HIT modernization plan that includes full reimbursement for Tribal Nations that have or plan to implement COTS.

- Tribal Nations must not be burdened with costs associated with transitioning to a new EHR nor the subsequent costs for maintenance. While IHS has assured Tribal Nations and IHS facilities that their funding requests include the cost of transitioning Tribal programs to a new system, it remains largely unclear if Tribally operated facilities that utilize RPMS will be financially liable for updates associated with an EHR upgrade. Funding for a replacement EHR must be made available to Tribally operated facilities, as these costs may require millions of dollars that would have to come out of Tribal coffers, should we not have access to new IT modernization funding. This would impact our ability to utilize our resources to provide essential services to our communities.

- RPMS currently houses a significant amount of historical data. To preserve and ensure Tribal healthcare providers have access to this critical data, USET SPF underscores that all historical data must be able to be uploaded to a new EHR. .

- Additionally, an upgraded health IT system must maintain and improve upon current RPMS quality measurement tools and functions that allow IHS and Tribally operated facilities to track and evaluate certain analytics and assist the agency and Tribal Nations with various reporting requirements. Comprehensive data collection and analytics must be available in disease surveillance as Tribal Nations require this information when quantifying health issues within our communities, such as COVID-19 and the opioid crisis.