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USET SPF Priority Talking Points *in Brief*
U.S. Department of Health and Human Services 2024 Annual and Regional Tribal Consultations

In an effort to better support our Tribal leaders during the consultation process, the following talking points provide a brief overview of USET SPF's most pressing priorities for agencies within the Department of Health and Human Services (HHS). The attached full document of briefing and talking points offers more in-depth information about each HHS operating division and the identified priorities of USET SPF member Tribal Nations. We hope that this overview document will provide convenient, high-level talking points for our member Tribal Nations for the 2024 HHS Annual Tribal Budget Consultation and throughout the 2024 HHS Regional Tribal Consultations.

Implementation of E.O 14112

- In December 2023, President Biden signed Executive Order (E.O) 14112, "Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination." The wide-ranging EO directs federal agencies to: 1. Assess their unmet financial obligations to Tribal Nations; and 2. Remove existing barriers to the accessibility, equity, flexibility, and utility of federal funding and support programs for Tribal Nations. We appreciate the ambitious nature and scope of this EO, as it seeks to do more to address the federal government's chronically unmet obligations to Tribal Nations and to advance many of Indian Country's longstanding priority reforms for increasing our exercise of sovereignty in our use of federal funding.

- In order for this EO to make the meaningful change that it promises, appropriate research and consultation must be undertaken. To that end, substantial and adequate federal resources must accompany this effort. The Administration should work across federal departments, including utilization of federal staff who have relevant subject matter expertise, in order to come to reasonable assumptions and defensible estimation methodologies around funding shortfalls. Additionally, it is important to note that some of the funding delivery and flexibility changes sought in the EO can be implemented without cost through both regulatory and legislative changes. This includes the expansion of the Tribal 477 Program and new programs designed based on its principles, expansion of Tribal self-governance, and direct funding to Tribal Nations across the federal government, as well as deference to Tribal decision-making in use of funds and program administration.

HHS Fiscal Year (FY) 2025 Appropriations:

- Despite the insulation provided by advance appropriations, the Indian Health System still feels the effects of extended appropriations negotiations and the threat of government shutdowns. The entirety of the IHS budget, inclusive of the line items currently excluded from the advance

appropriation, must be provided with full and mandatory appropriations to shield the agency from budgetary uncertainty and fulfill the U.S. government's trust and treaty obligations to Tribal Nations.

- Much of the HHS budget is delivered via competitive grant mechanisms, often through states. When funding is provided through states rather than directly to Tribal Nations, HHS must hold states accountable to appropriately distributing the funding intended for Tribal Nations. Grant funding is an abrogation of the federal trust responsibility and does not reflect the sovereignty of Tribal Nations. In accordance with E.O 14112, HHS must commit to employing funding mechanisms that provide Tribal Nations with more direct funding that includes greater deference to Tribal Nation sovereignty and self-determination.

- President Biden has also promised to work with Tribal Nations to expand Indian Self-Determination and Education Assistance Act (ISDEAA) contracting and compacting – a commitment reaffirmed in E.O 14112. 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 comply with E.O 14112 and uphold its responsibility to Tribal Nations by actively supporting efforts to expand Indian Self Determination and Education Assistance Act (ISDEAA) authorities to all HHS programs and services.

Centers for Medicare and Medicaid Services (CMS):

- USET SPF supports the efforts by CMS to find and implement a permanent solution to the Four Walls problem, which prevents Tribal and IHS facilities from claiming the Medicaid reimbursements rate (including at the IHS All Inclusive Rate) for services provided outside of the "four walls" of their facilities. We urge CMS to work quickly to identify and implement a regulatory fix in consultation with Tribal Nations.

- Improvements must be made to CMS programs to better deliver upon trust and treaty obligations and reflect the unique circumstances of Tribal Nations and our citizens. USET SPF supports the CMS Tribal Technical Advisory Group's (TTAG) Medicare and Medicaid legislative and regulatory priorities.

- As Medicaid unwinding continues and nears its end, CMS must continue to identify ways to engage Tribal Nations and improve processes to prevent the inappropriate disenrollment of Tribal citizens. Tribal Nations have consistently reported issues with their state Medicaid offices and disproportionately high rates of procedural disenrollments in Indian Country. While we commend CMS for their efforts to correct wrongful state activities in the Medicaid unwinding process, we remain concerned about the effect this process and the high rates of disenrollment will have on Tribal Nations and communities.

Centers for Disease Control and Prevention (CDC):

- Tribal Nations and Tribal Epidemiology Centers (TECs) continue to struggle with accessing timely and appropriate public health data from the CDC and other entities. Tribal Nations and TECs are statutorily designated Public Health Authorities and require timely access to usable, quality data in order to properly protect and serve our communities. CDC has released new guidance for requesting and responding to requests for data from the agency, but more work must be done to

improve Tribal Nation and TEC access to data, in accordance with federal law and trust and treaty obligations.

Health Resources and Services Administration (HRSA):

- HRSA's narrow definition of "rural" has resulted in many Tribal Nations being deemed ineligible for HRSA services and programs. All Tribal Nations should be considered rural for the purposes of HRSA funding because the federal trust obligation applies to Tribal Nations equally, regardless of their location.

Indian Health Service (IHS):

- USET SPF strongly supports the Administration's commitment to increasing IHS funding and shifting it to the mandatory side of the budget, which would more fully honor the federal government's trust and treaty obligations to Tribal Nations. However, we are disappointed that the FY 2025 request proposed a total of $8.1 billion for the IHS, only a $1.1 billion increase over the FY 2023 enacted level. In comparison, the FY 2024 request proposed a total funding level of $9.7 billion, a $2.5 billion increase over FY 2023 enacted.

- Tribal Nations are committed to working with the Administration and our allies on Capitol Hill to make the proposal for IHS mandatory appropriations 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 a full funding figure might encompass for the IHS. USET SPF supports the 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. While this effort requires substantial work and coordination, USET SPF urges the Sub-Workgroup to work quickly and efficiently to develop a comprehensive full and mandatory funding estimate for IHS in order to push this proposal forward with Congress soon.

- The Special Diabetes Program for Indians (SDPI) is slated to expire on December 31, 2024 if Congress fails to take action to reauthorize the program. IHS must support legislative efforts to reauthorize this critical program, as well as efforts to increase program funding and expand Indian Self Determination and Education Assistance Act (ISDEAA) authorities to the SDPI. In the last round of appropriations negotiations, Committees in both chambers of Congress proposed funding increases and a two-year reauthorization for the program. USET SPF continues to support these proposals, as well as the proposal in the FY 2025 President's Budget Request to reauthorize the SDPI for three years, exempt it from sequestration, and fund the program at $260 million starting in FY 2025 and increasing to $270 by FY 2027.

National Institutes of Health (NIH):

- NIH, as a primarily research-focused agency, must always remember and consider the traumatic history Tribal Nations have with research on our communities and people. NIH must ensure that research conducted in Indian Country is done in a culturally sensitive fashion that includes Tribal Institutional Review Boards, community-based participatory research, and informed consent. Research in Tribal communities must always incorporate Tribal consent and oversight, including protections ensuring Tribal Nations maintain ownership of our data and that our consent is obtained prior to any data sharing or dissemination of research findings. NIH must keep this in mind as it works to develop a Tribal data sharing policy for the agency.

Substance Abuse and Mental Health Services Administration (SAMHSA):

- SAMHSA should continue its efforts to advocate for and distribute Opioid Response Grant (and other SAMHSA program) dollars via Tribal-specific, non-competitive methodologies, as it does with the simple formula and guaranteed funding minimum provided in the Tribal Opioid Response Grant (TOR) program. However, USET SPF urges SAMHSA to commit to identifying and advocating for opportunities to distribute agency funding through Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts.
- SAMHSA must join Tribal Nations in advocating for the full authorized funding amount for the Native Behavioral Health Resources Program, which was authorized by Congress, but not appropriated funding. SAMHSA must vocally support appropriation of the full authorized amount of $80 million and push for proper implementation of the program.

Should you have any questions or require additional information, please do not hesitate to contact Ashton Martin, USET SPF Health Policy Analyst, at 629-736-1433 or by email at amartin@usetinc.org.

USET SPF Tribal Talking Points
HHS 2024 Annual and Regional Tribal Consultations

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS FY 2025 Appropriations

Summary

On March 11, 2024, the Biden-Harris Administration released the first details of its Fiscal Year (FY) 2025 Request to Congress, which contains important policy and funding proposals for Indian Country. The Request continues to propose dramatic shifts 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. This commitment was reaffirmed with the signing of Executive Order (E.O.) 14112, Reforming Federal Funding and Support for Tribal Nations To Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination, which directs the federal government to design and administer federal programs and services for Tribal Nations "in a manner that better recognizes and supports Tribal sovereignty and self-determination."

The Request, in accordance with E.O 14112, 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 and again in FY 2024, 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.

Congress again provided advance appropriations for the IHS – this time for FY 2025 – in the Consolidated Appropriations Act of 2024. On October 1, 2024, the IHS will receive a $5.12 billion advance appropriation for the majority of the agency's line items. The FY 2025 advance appropriation still excludes Electronic

Health Record (EHR) Modernization Project, the Indian Health Care Improvement Fund, Sanitation Facilities Construction, Healthcare Facilities Construction, Contract Support Costs (CSC) and Section 105(l) lease payments. USET SPF strongly supports shifting all of these line items to the mandatory side of the budget but believes that CSC and Section 105(l) lease agreement payments should be immediately shifted to the mandatory side of the budget.

Importantly, the President's Budget request includes a 10-year plan to close funding gaps by shifting the IHS budget to the mandatory side of the budget, increasing IHS funding to $42 billion in FY 2034—a 500% increase over this period—and exempting agency funds from sequestration. The mandatory funding proposal would shift the entirety of the IHS budget – including the line items currently excluded from the advance appropriation – to mandatory funding. 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. USET SPF urges Congress and the Administration to maintain advance appropriations until full and mandatory appropriations for the IHS are achieved. USET SPF continues to support the work of the Sub-Workgroup on Mandatory Funding for IHS to create an estimate and proposal for full and mandatory IHS appropriations that reflects the full scope of the U.S.'s perpetual trust and treaty obligations to Tribal Nations. The Sub-Workgroup should create this estimate in close consultation with Tribal Nations and organizations to ensure that the priorities of Indian Country are fully captured in the proposal. USET SPF urges the Sub-Workgroup and the Administration to work efficiently to develop and advocate for this proposal in Congress.

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 requests that HHS share specific information and proposals regarding how the agency is implementing E.O 14112's mandate for flexibility in federal funding, including identification of any statutory and regulatory changes that are necessary to ensure that Federal funding and support programs effectively address the needs of Tribal Nations. USET SPF also reminds HHS that in the absence of guidance for addressing funding shortfalls, the agency should, and is required under the E.O., to begin immediately by identifying areas where it can independently incorporate funding and program flexibilities.

- USET SPF celebrates the inclusion of advance appropriations for the IHS in the Consolidated Appropriations Act of 2024, which would provide $5.12 billion for the IHS in FY 2025. Maintaining advance appropriations for the IHS –achieved for the very first time in 2022 – is vitally important for

protecting IHS against budgetary uncertainty. 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 continues to strongly support 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. In addition, this change would fulfill the purpose and spirit of E.O 14112 to address many centuries of broken promises and federal failures to provide full funding in the fulfilment of trust and treaty obligations.

- 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 a full funding figure might encompass for the IHS. USET SPF supports the 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. While this effort requires substantial work and coordination, USET SPF urges the Sub-Workgroup to work quickly and efficiently to develop a comprehensive full and mandatory funding estimate for IHS in order to push this proposal forward with Congress soon.

- 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, but grant funding also 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 – a commitment reaffirmed in E.O 14112. 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 comply with E.O 14112 and 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 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. In early 2024, HHS released the first draft of the policy. USET SPF submitted comments urging HHS to reconsider and strengthen the policy, as the first draft failed to fully recognize the rights and authorities of Tribal Nations and TECs as public health authorities and stands to diminish Tribal access to public health data if implemented in its current form. We urge HHS to fully recognize its statutory responsibility to share public health data with Tribal Nations and TECs and urge that future drafts of the policy incorporate enforceability measures and better protections for the authorities of Tribal Nations and TECs.

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. 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. CDC must ensure that TECs have access to critical public health data from federal and state governments.

- As an arm of HHS, CDC is statutorily required to share all available public health data with TECs and Tribal Nations, and state governments should be required to do so as well. This should be made a requirement of state cooperative agreements with CDC.

- CDC must take steps to improve the quality and quantity of public health data shared with TECs and Tribal Nations. Under statute, CDC, as an arm of HHS, is required to share all the public health data in the possession of the HHS Secretary with Tribal Nations and TECs. This includes requiring states work with Tribal Nations to correct racial misclassification and ensure bidirectional data sharing, as well as internal work to consult and coordinate with Tribal Nations to identify and secure access to data sets that would aid Tribal Nations and TECs in our efforts to provide for the health and wellness of our communities.

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 2025 President's Budget again proposed level funding for the program at $24 million, as well as Congress's decision to maintain level funding at $24 million for FY 2024. While program continuity is critical, we encourage the Biden Administration to not only support continuity for the program in FY 2025 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 2025 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 for FY 2025 and beyond.

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 complying with E.O 14112 by 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. USET SPF urges HRSA to immediately begin identifying ways to reconfigure its programs and services to deliver resources to Tribal Nations in a way that satisfies E.O 14112 and fulfills the federal government's trust and treaty obligations.

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 research and data protection 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.

As part of HHS's efforts to create a Department-wide Tribal and TEC data sharing policy, NIH has been directed to create an agency-specific Tribal data sharing policy. NIH intends to publish a draft policy for Tribal consultation in spring/summer 2024. USET SPF submitted comments to HHS in 2022 and 2024 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 well as our designation as public health authorities, 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, ideally through a binding data sharing policy, 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 often 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.

- 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. Further, Tribal Nations must have jurisdiction over Native American data and our consent must be sought for the publication of that data prior to any dissemination by NIH.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA FY 2025 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 disappointed that the President's budget has proposed only a $5 million increase for the Tribal Opioid Response Grant (TOR) program for FY 2025, rather than the $20 million increase proposed in the FY 2024 President's Budget. Further, the President's budget has elected to propose a total funding level of $23.7 million for Tribal behavioral health grants, a funding level even with the FY 2024 level provided in the continuing resolution (CR). Given the funding stagnation of these programs in recent years, USET SPF is disappointed that the Administration chose to largely maintain FY 2024 spending levels. USET SPF understands that the Fiscal Responsibility Act (FRA) limited spending increases in Congress, but we urge SAMHSA and the rest of the administration to ensure that Indian Country is not penalized due to these funding caps. We encourage SAMHSA and the Administration to advocate for the inclusion of the funding increase beyond the President's proposal in the FY 2025 appropriations legislation in pursuit of fulfilling the federal trust responsibility.

When it comes to the Tribal Set-Aside under State Opioid Response Grants, USET again disappointed at the very slight funding increased proposed in the President's budget. In the FY 2024 request, the Administration had proposed $75 million for the Tribal set-aside, but the FY 2025 request only proposes a $60 million set-aside – a paltry $5 million increase over the FY 2024 CR level. 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 in either FY 2023 or FY 2024. 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 in FY 2024, and was still not included in the FY 2025 request. USET SPF continues to urge the Administration to request funding for this program in the budget process, and we urge Congress to appropriate the full authorized amount of $80 million in its FY 2025 spending bills.

For FY 2025 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, particularly due to the high rates of fentanyl overdose in our communities. Given these continued struggles, USET SPF is disappointed in the negligible $5 million increase for the Tribal Opioid Response Grant (TOR) program, as well as the Administration's decision to reduce their request for the Tribal set-aside in the State Opioid Response Grant (SOR) program from $75 million in the FY 2024 request to $60 million in the FY 2025 request.

- Further, the decision to propose no increase for Tribal behavioral health grants over the FY 2024 enacted level is disappointing, particularly given the depth and range of behavioral health issues plaguing Indian Country. We urge the Administration to consider advocating for additional increases before Congress during FY 2025 appropriations negotiations, and we expect future Presidential budget requests to contain more meaningful increases for these vital programs.

- 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. In accordance with E.O 14112, SAMHSA must work to identify opportunity to streamline funding application and reporting requirements, 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 that are 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.

- In accordance with E.O 14112, 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 improve access to Medicaid. Further, USET SPF is encouraged by the Biden Administration's support for innovative approaches to Medicaid programs. 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 permanent Four Walls issue fix). Regarding the "Four Walls" issue, USET SPF appreciates Deputy Administrator Dan Tsai's announcement that CMS is working to identify a regulatory fix for this issue. We urge CMS to work to develop and propose this fix as soon as possible. USET SPF has also advocated in the past for a fully federal Medicaid program for Tribal Nations as an means 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.

- 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 requirements 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 appreciates CMS's commitment through Deputy Administrator Dan Tsai to identifying and implementing a permanent fix for the "Four Walls Issue." 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. A fix will expand the type of services that 100% FMAP can be used for and offset limited purchased/referred care appropriations.

    - As of spring 2024, CMS is operating under a grace period that permits Tribal and IHS facilities to continue to claim the Medicaid reimbursements rate (including at the IHS All Inclusive Rate) for services provided outside of the "four walls" of the facility through 2025. CMS has indicated that it is currently working to identify a permanent regulatory fix for this issue. USET SPF e calls upon the agency to work quickly and efficiently to implement a fix as soon as possible to ensure continued operation and reimbursement of healthcare programs..

- 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.

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 were allowed to restart eligibility redeterminations for Medicaid and CHIP beneficiaries, and beginning on April 1, 2023, programs began disenrolling beneficiaries from the program. Prior to the beginning of Medicaid unwinding, reports estimated that over 230,000 Native Americans would lose their Medicaid coverage during unwinding. As of November 2023, a little over 6 months into the unwinding process, reports show that over 400,000 Native Americans have been disenrolled from Medicaid. Despite efforts by Tribal Nations and organizations to mitigate the volume of Native Americans disenrolled during this process, Medicaid unwinding has had serious consequences in Indian Country.

The report also indicates that more than 70% of those disenrolled during unwinding may have still been eligible for Medicaid but were disenrolled for procedural reasons (such as failure to return paperwork). State policies and practices have played a central role in these procedural terminations. For example, Tribal Nations and organizations have reported their citizens receiving unmarked mail containing important information regarding their eligibility, resulting in many failing to fill out and return what they assumed was "junk mail."

In August 2023, in response to concerns over the high rate of procedural disenrollments, CMS issued a letter to state Medicaid offices requiring them to review their systems for determining Medicaid eligibility and ensure they are compliant with federal regulations. The letter reported that CMS found major errors in state systems and as result, substantial numbers of individuals (including over 1 million children) have been improperly disenrolled from the Medicaid program. Therefore, CMS required all state Medicaid agencies to review their renewal procedures to ensure compliance with federal regulations or risk consequences, including financial penalties. States that were not compliant were required to pause procedural terminations, reinstate coverage for affected individuals (including retroactively), fix the state systems and procedures, and implement one or more of the mitigation strategies CMS outlined in the letter.

As Medicaid unwinding continues, CMS must take additional steps to ensure state compliance with federal regulations and mitigate the amount of procedural disenrollments from Medicaid. We urge CMS to issue additional guidance to states on working with Tribal Nations and organizations to facilitate eligibility redeterminations.

Talking Points

- CMS must continue to 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 implementation 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 2025 Appropriations

Summary For the second time ever, the Indian Health Service (IHS) has received advance appropriations for the majority of the agency's budget. Under the Consolidated Appropriations Act of 2024, the IHS will receive $5.19 billion in advance appropriations for FY 2025, a slight $61.43 million increase over the FY 2024 advance appropriation. The IHS will receive the $5.19 billion on October 1, 2024 regardless of whether or not Congress has passed full-year appropriations for the rest of the federal government by that time. Advance appropriations insulate the IHS from delays or interruptions in funding caused by political infighting during budget negotiations and provide a level of budgetary certainty for the chronically underfunded agency. As part of the regular appropriations process later this year, Congress will still need to appropriate funds for the programs and services currently excluded from the advance appropriation. This includes funding for Electronic Health Records modernizations, the Indian Health Care Improvement Fund, Sanitation Facilities Construction, Healthcare Facilities Construction, Contract Support Costs (CSC) and payments for Section 105(l) leases. For FY 2024, the total IHS budget for all line items was $6.96 billion.

Looking ahead, the President's Budget Request for FY 2025 proposes additional funding increases for the IHS, as well as a proposal to shift the budget to mandatory spending starting in FY 2026. For FY 2025, the Biden Administration proposes a total of $8.1 billion for the IHS, which includes $8.0 billion in discretionary spending and $260 million in mandatory funding for the Special Diabetes Program for Indians (SDPI). This request is a $1.1 billion increase over the FY 2023 enacted level, but is a reduction compared to the President's $9.7 billion IHS budget request for FY 2024.

USET SPF is pleased that the Biden Administration has again elected to propose shifting the IHS budget to mandatory funding beginning in FY 2026 in a 10-year proposal to significantly 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 would serve to close funding gaps for the agency, increasing IHS funding to roughly $42 billion by FY 2034 – an approximate 500% increase over the FY 2023 enacted level – and exempting agency funds from sequestration. In total, the mandatory budget proposal would provide over $288 billion over 10 years. Year after year, USET SPF has urged multiple Administrations and Congresses to request and enact budgets that better 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 and will continue to advocate for Congress to enact this proposal.

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.

It is important to note that the President's FY 2025 request for the IHS does not propose shifting CSC and Section 105(l) lease payments to mandatory in FY 2025, instead it proposes that these items remain as indefinite discretionary appropriations until FY 2026. The President's request proposes a total of $979 million for CSC, a $10 million increase over FY 2023, and proposes $349 million, a $238 million increase over FY 2023, for Section 105(l) lease agreements. However, under the President's mandatory funding proposal, these line items would be shifted to mandatory as well with the entirety of the IHS budget.

USET SPF will continue to advocate for full and mandatory funding for the whole of the IHS budget.

Talking Points

- Our region celebrates and strongly supports 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 the proposal for IHS mandatory appropriations 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 a full funding figure might encompass for the IHS**. USET SPF supports the 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. **While this effort requires substantial work and coordination, USET SPF urges the Sub-Workgroup to work quickly and efficiently to develop a comprehensive full and mandatory funding estimate for IHS in order to push this proposal forward with Congress soon.**

- 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 $260 million in mandatory funding, and exempts the program from the

mandatory sequester. This represents a $113 million increase over FY 2023 post-sequestration enacted 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 December 31, 2024. Under FY 2024 appropriations, the SDPI was only given a long-term funding extension, not a full reauthorization, meaning that the program will again expire at the end of the year if Congress fails to take action on legislation to reauthorize or extend the SDPI. In the final FY 2024 appropriations package, Congress provided the SDPI with an additional $130 million, bringing the annualized total for the program at $160 million in FY 2024. USET SPF applauds any increase for this vital program but urges the IHS to conduct Tribal consultation on the distribution of this funding increase. We further urge Congress to adopt the President's request for a SDPI funding level of $260 million to ensure the continued success of this critical program. 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 and others have also consistently supported the expansion of Indian Self-Determination and Education Assistance Act (ISDEAA) authorities to the program and intend to continue to focus on this critical change.

Congressional efforts over the past few months have proposed a short reauthorization of the SDPI at $170 million over two fiscal years. This would represent the first funding increase for the SDPI since 2004. The $170 million/two-year proposal has appeared in multiple pieces of legislation in both the House and Senate but has not yet been fully passed. Most recently, a two-year, $170 million SDPI reauthorization passed the full House in a broadly-supported, bipartisan piece of legislation called the Lower Costs, More Transparency Act. The bill renews several federal health programs, requires increased reporting requirements for insurers, and amends Medicare reimbursement policies, among other things. As of now, the Senate has not yet taken up the bill, and will likely not take it up in its current form, but the continued inclusion of a funding increase for the SDPI is a good sign that the program will eventually be fully reauthorized with a funding increase. USET SPF will continue to advocate for increased resources and full renewal for the SDPI.

Talking Points

- As the SDPI is slated to expire on December 31, 2024, Congress must act to reauthorize the program and increase funding to this vital program. We support the President's Budget Request of $260 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, the SDPI program should be opened 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 recipient.. Legislation proposing to extend ISDEAA capabilities to the SDPI program has been introduced in prior Congresses, but 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 (EHR), the Resource Patient Management System (RPMS).In late 2023, the IHS achieved a critical advance in the modernization effort when it announced the selection of the vendor that will build and configure the new system. IHS selected General Dynamics Information Technology, Inc. (GDIT) to build, configure, and maintain a new IHS enterprise Electronic Health Record system utilizing Oracle Cerner technology. This marks the start of the "Buy and Build" phase of the modernization effort, the last step before the IHS will deploy and operate the new EHR system. GDIT will "serve as systems integrator to pull together multiple aspects of the EHR solution, manage a large team of subcontractors, and monitor that the new system works with other hardware, software, and operational components at each site." The IHS chose to use an Indefinite Delivery, Indefinite Quantity (IDIQ) contract structure to support the recurring needs anticipated in the enterprise EHR. Under the IDIQ contract structure, the IHS will issue specific task orders for technical support and services. This gives the IHS the ability to adjust what it purchases, incorporate lessons learned, user input, and availability of new technology.

Over the next few years, IHS will work to build and configure the new EHR system with the vendor prior to transitioning programs and facilities into the new system. USET SPF previously submitted comments to the IHS on this program urging transparency and consultation throughout the implementation process. Our comments also requested funding for implementing the new EHR system at Tribal facilities, as well as funding for Tribal Nations that independently transitioned to a commercial off-the-shelf (COTS) EHR ahead of the IHS process.

The President's Budget Request for FY 2025 proposes a total of $435.1 million for the EHR modernization effort, an increase of roughly $217 million over FY 2024 enacted levels. This is a reduction in the request compared to FY 2024, when the President's Budget request proposed $913 million for the effort.

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 funding

increase yet again 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 continue to 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, or otherwise made easily accessible in the Four Directions Warehouse system.

- 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.

USET SPF will continue to monitor these issues and revise talking points as necessary. For more information, please contact Ashton Martin, USET SPF Health Policy Analyst, at amartin@usetinc.org.