1. **Does the current structure of the Indian Health Service (IHS) of being divided into 12 regions best serve the needs of tribal communities?**

Answer: The IHS area system helps keep local Tribal communities closer to the administrative functions of IHS. It also means that Tribal leaders have access to decision makers at the local level when there are concerns with IHS care. Each area, just like each tribe, is unique. The needs in the Great Plains are different than those in the Navajo or Nashville areas. For this reasons, the area system still serves a purpose.

Unfortunately, the area offices have varying cooperative relationships with the Tribal Nations in their region. While some work collaboratively and in partnership, others area offices are reported to withhold information – both financial and epidemiological – from Tribes. We are encouraged recent IHS actions to help standardize practices and management across the 12 areas. We hope that this results in improved care throughout the system and greater accountability for the IHS area offices to the Tribal Nations that they serve.

   a. Would you suggest any changes to the IHS operating structure that you believe would improve healthcare service to tribal communities?

Answer: Changes in the operating structure of IHS should be done with full consultation and consent with Tribal Nations. NIHB acknowledges that there are still challenges with the IHS area system. Funding and resources across 12 areas could be more equitable. For example, some service areas have no IHS funded hospital facilities at all, making them more dependent on scarce Purchased/referred care dollars. Areas also vary widely in terms of patient population and number of Tribal Nations. The Indian Health Care Improvement Act, for example, has made the provision for a Nevada Area Office, but that aspect of law has never been implemented.

2. **Please further expand on your testimony about the expansion of tribal self-governance program: Which programs specifically do you think should have this authority?**

Answer: Tribal advocates have identified 23 programs specifically at HHS to be part of a Self-Governance Demonstration program. These selected programs are federal programs that Tribal Nations are already operating under competitive or formula-based grants. We feel that these programs are all basic lifeline services that would allow Tribal health programs to effectively and seamlessly provide care to their people.

In addition, incorporating these programs into a Self-Governance agreement allows Tribes to provide much needed wrap-around services to their citizens with its programs operating in collaboration rather than in silos created by federal

agencies. HHS has identified most these programs in previous reports – dating back to 2003 -- as being feasible for self-governance. Other programs have been newly created by congress since the initial Self-governance report was issued in 2003.

Most importantly, self-governance would allow Tribal Nations to implement programming in our Tribal Nations that is culturally appropriate and tailored to local needs. For example, the proposal includes several programs under the Centers for Disease Control and Prevention (CDC). As you know, Indian Country was impacted by the COVID-19 pandemic in greater numbers than other communities. If we had robust, culturally appropriate public health services, we would have been able to quickly spring into action to improve information going to community members and disseminate available resources. Allowing self-governance programs puts local communities in the driver's seat to respond to local needs. States and localities are already receiving this support from CDC. It is time that Tribal Nations receive this support as well.

Self-governance also allows small tribal communities to more effectively pool limited resources so that they can get the most impact for the small dollar amounts. This also includes spending less time on bureaucracy which includes applying for and reporting on federal grants. Since 2013, Tribes and Tribal Organizations have continued to make the expansion of Self Governance at HHS a top priority in their communications to Congress and with the Department. Expanding Self-Governance at HHS is the logical next step for the Federal government to promote Tribal sovereignty and Self-Determination and improve services to American Indians and Alaska Natives and will help people get the services they need.

a. Have you heard from the Department of Health and Human Services about any concerns they have about including the programs you think should be included within the tribal self-governance program?

Answer: In recent months, HHS has not been engaged in a substantive way on this topic with Tribal Nations. While the Secretary and other political leadership have noted an overall desire to support Tribal Self-governance expansion, we have seen little effort to engage in a collaborative process to work through how self-governance would be implemented. They have noted implementation concerns related to providing equitable funding, statutory barriers, and the ability to consolidate eligible programs as concerns. From the perspective of Tribal Nations, these concerns exemplify some of the great benefits of Tribal Self-governance. It would allow Tribes to implement programs efficiently and effectively, without unnecessary government bureaucracy. It would also shift away from the competitive grants process which creates unstable or inaccessible funding sources for Tribal governments. Too often, competitive grants only reward communities with high levels of institutional resources and capacity, not necessarily where needs are greatest.

3. **In your testimony, you mentioned that allowing IHS facilities to make reprograming decisions with tribal consultation at a local level could help meet health service deliver priorities. Could you further expand on that idea for the subcommittee, and also provide any examples of where local reprogramming authority would have been beneficial?**

Answer: Yes, being able to make funding decisions for real time health issues would be very helpful. For example, if there was an urgent need to provide behavioral health funding due to a recent surge in overdose deaths, the local IHS could quickly reevaluate resources and target them to an area that was needed in the community. Because direct service tribes have to go through so many burdensome approval processes, it often takes too much time and we don't have time to waste when there is a serious, targeted health challenge going on, like substance abuse.

Health care crises are often quick and in real time. There may be a need to get resources deployed to increase disease surveillance from one area to another. Having local funding flexibility will ensure that health systems can be more nimble, instead of depending solely on a budget created many months ahead of time. It is critical that any budgetary changes of this nature be done in consultation with local tribal communities. The ability to respond in real time to local needs honors Tribal sovereignty and self-determination. This principle still applies if the Tribe choose to allow IHS to provide their health services.

Questions from Rep. Leger Fernández for Janet Alkire, Great Plains Area Representative, National Indian Health Board

1. Could you share more on the anticipated impacts and loss of services that would occur if the FY24 enacted congressional budget reflects FY22 enacted levels for the Indian Health Service (IHS)?

Answer: If the FY 2024 enacted congressional budget reflects FY 2022 enacted levels for the IHS, it is likely that the IHS will face a reduction in purchasing power greater than or equal to the impacts of sequestration on the IHS budget in FY 2013, which devastated Indian health system hospitals and health clinics. We need only look back a decade to see quite clearly what this would do to Tribal healthcare.

During the FY 2013 funding sequestration, the IHS faced a roughly five percent cut in funding, which had devastating impacts on Tribes' and IHS's ability to provide healthcare services. The reductions in funding, staffing, and services had significant impacts on healthcare outcomes for Tribal communities.

The reductions in staffing levels meant that there were fewer healthcare professionals available to provide care to Tribal communities. This led to longer wait times for appointments and reduced access to critical healthcare services. The reductions in funding and staffing levels also led to reductions in preventive healthcare services, such as

immunizations and cancer screenings. Some healthcare facilities had to reduce operating hours or even close temporarily due to the funding cuts.

With longer wait times for appointments and reduced access to primary care, many Tribal members had no choice but to seek care in emergency rooms. This led to increased utilization of emergency room services, which can be more expensive and less effective for managing chronic conditions.

The reductions in funding and staffing levels made it more difficult for the IHS to recruit and retain healthcare professionals. This is a challenge that the IHS already faces, and the funding cuts during the FY 2013 sequestration made it even more difficult to attract and retain qualified healthcare professionals to serve in Tribal communities.

The funding cuts during the FY 2013 sequestration also led to delays or cancellations of critical construction projects, which resulted in deteriorating healthcare infrastructure and reduced access to healthcare services. The delays or cancellations of critical construction projects meant that healthcare facilities in Tribal communities continued to deteriorate, creating safety concerns for patients and workers. This had a negative impact on access to healthcare services and healthcare outcomes for Tribal communities.

The increase from FY 2022 to FY 2023 was roughly 5 percent – the same amount sequestered in FY 2013. When taking into consideration fixed costs like pay costs, contract support costs, and payments for tribal leases, as well as medical and non-medical inflation and the population growth, it is very easy to predict the harmful impacts of funding the IHS at FY 2022 levels. Unfortunately, I can guarantee it will devastate our already starved annual budget.

This is evidenced in the significantly worse health outcomes for American Indians and Alaska Natives (AI/ANs), as detailed in the National Indian Health Board's written statement. One impact of lower budgets has meant a lack of quality medical providers due to lower pay scales, remote locations and lack of housing for professionals. AI/ANs experience some of the greatest disparities when it comes to maternal health and behavioral health, for example. With even fewer resources available to recruit and retain OB/GYNs or behavioral health teams, these challenges will get even worse if funding is reduced.

As Congress considers reducing funding levels, it is critical to understand that these services are not "nice to have" programs that the federal government provides each appropriations cycle. The IHS budget is the fulfillment of the United States' sacred promise to Tribal Nations. Failure to fund the IHS decade upon decade has already resulted in significant loss of life for AI/ANs. Funding reductions to the IHS budget will not make much of a dent in the fiscal challenges of the United States, but it will do irreparable harm to those citizens of this nation that depend on IHS for life or limb services.