

# National Indian Health Board



## **2022 LEGISLATIVE AND POLICY AGENDA FOR INDIAN HEALTH**

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**2022 LEGISLATIVE AND POLICY AGENDA FOR INDIAN HEALTH**

Established by Tribal leaders fifty years ago to advocate as the national, united voice of federally recognized Tribes, the National Indian Health Board (NIHB) seeks to support and reinforce Tribal sovereignty, ensure fulfillment of the federal government's trust responsibility and treaty obligations to Tribal nations, and strengthen the government-to-government relationship between the federal government and Tribes across this nation. Our work is dedicated to continually advancing these canons in support of Indian health care and public health in Tribal communities and educating and reinforcing how these canons apply across the entire United States government.

The NIHB Board of Directors set forth the *2022 Legislative and Policy Agenda for Indian Health* to advance the organization's mission and vision. This agenda lays out a blueprint for ensuring that all American Indian and Alaska Native peoples and communities can achieve the highest level of health and well-being. The *2022 Legislative and Policy Agenda for Indian Health (2022 Agenda)* guides the work of NIHB as we strive to identify and advance national Tribal health priorities. Our objectives are to educate policymakers about Tribal priorities, advocate for and secure resources, build Tribal health and public health capacity, and support Tribally led efforts to strengthen Tribal health and public health systems. Our goal is to ensure that American Indians and Alaska Natives (AI/AN) people receive the health care and public health services necessary to achieve the best possible health outcomes.

This document focuses on nine key areas that will bring us closer to that vision. The policy briefs accompanying each priority of the *2022 Agenda* offer a concise yet expansive, nuanced, and intersectional analysis of the problems we are tackling. The priorities are bolstered by facts and figures, a description of the solution we seek, and a list of the federal policy and program steps that will help bring us closer to our vision.

In addition to helping us shape our advocacy efforts toward a shared vision and goals, the priority policy briefs will serve as a foundation for other educational and advocacy materials (e.g., one-pagers, white papers, policy briefs) advanced throughout the year.

Each category starts with a summary section that introduces the subject matter, previews the problems that need to be addressed, and highlights the priorities that NIHB will pursue to reach our vision. Each priority policy brief includes:

- An introduction to the issue
- A detailed assessment of the problem that needs to be addressed
- Our vision for change
- A list of recommended steps, or actions, that Congress, the Administration, and states can take towards achieving the vision
- A list of resources and related NIHB Resolutions

**Introduction**

*Federal Trust Responsibility.* Tribal nations are separate and distinct domestic sovereign governments. The United States Constitution, several Supreme Court decisions, and numerous laws and treaties recognize this status and distinction. Since colonization, the United States has executed hundreds of treaties with Tribal nations in which millions of acres of Tribal lands and natural resources were ceded, often involuntarily, in exchange for the resulting federal trust obligations and responsibilities that exist in perpetuity, including, but not limited to, health care for American Indians and Alaska Natives (AI/AN) These obligations and responsibilities do not exist as welfare but as repayment on a nation-to-nation agreement. Therefore, the United States owes a special duty of care to Tribal nations, which governs every aspect of the federal government's relationship with the Tribes.

From this canon of law and policy, the federal government has committed to honoring and advancing Tribal sovereignty, fulfilling treaty promises, and upholding the trust responsibility to Tribes. This relationship requires that the federal government acts transparently, respectfully, and consistently on a government-to-government basis with Tribes across Indian Country.

### ***AI/AN Health Status***

Tribal nations continue to suffer the highest health disparities of any other demographic. According to the *Broken Promises Report* of 2018 by the U.S. Commission on Civil Rights, “[d]ue at least in part to the failure of the federal government to adequately address the wellbeing of Native Americans over the last two centuries, Native Americans continue to rank near the bottom of all Americans in health, education, and employment outcomes.” The average life expectancy for all American Indian and Alaska Native (AI/AN) people is 5.5 years less than other Americans. In some Tribal communities, the life expectancy is up to 20 years less than the average American.

According to the CDC, in 2019, AI/ANs had the second-highest age-adjusted mortality rate of any population at 767 deaths per 100,000 people. In addition, AI/ANs have the highest uninsured rates for adults aged 18 to 64 (32.9 percent) and children under the age of 18 (16.7 percent); higher rates of infant mortality (2.7 times the rate for whites); higher prevalence of diabetes (2.3 times the rate for White Americans); and significantly higher rates of suicide deaths (20 percent higher than non-Hispanic White Americans). AI/ANs also have the highest hepatitis C mortality rates nationwide and the highest rates of type II diabetes, chronic liver disease, and cirrhosis deaths.

Over the last few years, Tribes have seen improvements in the government’s efforts to support Tribal sovereignty and honor the trust responsibility for health care. However, the Indian health system remains critically underfunded, and AI/ANs experience some of the poorest health outcomes compared to all other demographics in many areas of health status. While profound health disparities still plague our Tribal communities, we now face many new challenges, including a once-in-a-century but ongoing pandemic and the significant economic downturn resulting from this public health emergency.

The COVID-19 pandemic had a disproportionate impact on AI/AN people and exposed many of the inequities Tribes experience. These inequities have led to more tragic COVID-19 outcomes, poorer health status and a higher incidence of chronic conditions, lower access to health care, lower access to modern water and sanitation systems, and overcrowded housing, among other inequities. COVID-19 relief packages have made some progress in fighting the pandemic but have not addressed the underlying causes of the severely disproportionate harm suffered by Tribal communities. It is a critical time to increase the resources to Indian Country. It is also vital to adjust the legal and policy landscape to support Tribal sovereignty and improve Tribal health care and public health services.

### ***Tribal Self-Determination: Self-Governance and Direct Service Tribes***

Tribal self-determination is the hallmark of federal Indian law. As sovereign governments, Tribes have inherent authority and responsibility to meet their citizens' healthcare and public health needs. The *Indian Self-Determination and Education Assistance Act of 1975* (ISDEAA) provides the legal framework through which Tribes can exercise their right to self-determination and self-governance.

Under the ISDEAA, Tribes and Tribal Organizations have the option to either (1) administer programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting) or (2) assume control over health care programs and services that the IHS would otherwise provide (referred to as Title V Self-Governance Compacting or TSGP). Tribes that elect to enter contracts or compacts to assume control over health care programs are given the status of “Self-Governance Tribes.”

Conversely, Direct Service Tribes (DST) elect, in whole or in part, to receive health care directly from the Indian Health Service (IHS). The decision to receive health care directly is an expression of self-

determination. It acknowledges that the federal government has a legal and moral obligation to provide health care to Indian Tribes as defined in treaties, statutes, and Executive Orders.

Both Self-Governance and Direct Service Tribes' status reinforces the government-to-government relationship between Indian Tribes and the United States and guarantees that the federal government will meet the health care needs of Tribes.

### *Advancing Indian Health Care*

In 2022, NIHB will continue to advocate for fulfilling the federal trust responsibility and preserving and strengthening the political relationship between the United States and Tribes. We will partner and collaborate with both the Legislative and Executive branches of government to press for quality health care for AI/ANs and the systems-level change that will improve the AI/AN health status across Indian Country.

***Overarching Principles.*** Throughout the 2022 Agenda, several vital ideas remain foundational no matter the subject area. All our policy recommendations adhere to these overarching principles:

- *Trust Responsibility:* The United States has a unique trust responsibility to Tribal nations, which was forged through treaties and other promises made to Tribal leaders in exchange for land and other crucial resources in building the United States of America. Tribal nations have already paid the United States in full for all necessary health care and public health services in perpetuity.
- *Health Equity:* Health equity is both a moral imperative and a fundamental part of the trust responsibility. Tribes call on the Administration to take decisive steps to immediately address health disparities in AI/AN communities while preserving the investments and health improvements achieved over these past several years.
- *Full Funding for Health Services:* Fulfilling the trust responsibility requires that the United States fully fund all necessary health care and public health services for American Indians and Alaska Natives. The Administration must work with Congress to provide an appropriately scaled and sustainable investment for primary and preventative health, including public health services. The Administration must propose a budget for the IHS that is bold, effective, and contains essential policy reforms to ensure that AI/ANs experience the highest standard of care possible.
- *Tribal Sovereignty:* Respecting the inherent sovereignty of Tribal nations requires that all funding provided should allow Tribes maximum flexibility and control over the use of that funding. Tribes are in the best position to know their needs and priorities and to determine the most effective use of available funding. To the maximum extent possible, all government funding should be allocated directly to Tribes; available through self-governance contracts and compacts; and require minimal administrative burden.
- *Tribally Led:* The trust responsibility requires, among other things, that Indian Country inform the decisions of each agency. Initiatives involving Indian Country should be Tribally led wherever possible.
- *Interagency Cooperation:* Addressing these issues and fulfilling the trust responsibility will involve interagency cooperation across the Executive Branch.

## **TREATIES, TRUST, AND THE GOVERNMENT-TO-GOVERNMENT RELATIONSHIP**

American Indian and Alaska Native (AI/AN) Tribal nations are sovereign governments recognized under the Constitution of the United States, treaties, statutes, Executive Orders, and court decisions. To strengthen the government-to-government relationship, the federal government must respect Tribal sovereignty and self-governance, commit to fulfilling federal trust and treaty responsibilities, and conduct regular, meaningful, and robust consultation with Tribal nations. These canons are cornerstones of federal Indian policy.

### **PRIORITIES FOR INDIAN HEALTH**

To strengthen Tribal sovereignty and the government-to-government relationship, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Implement Meaningful, Robust, and Tribally Driven Tribal Consultation Policies
- B. Support and Expand the White House Council on Native American Affairs
- C. Elevate the IHS Director to Assistant Secretary for Indian Health
- D. Establish Interagency Agreements Between HHS Operating Divisions and IHS
- E. Increase Tribal Representation in All HHS Operating Divisions and Appoint a Senior Advisor to the Secretary
- F. Expand and Strengthen Tribal Self-Governance Throughout HHS
- G. Support Tribal Advisory Committees and Technical Assistance

#### ***A. Implement Meaningful, Robust, and Tribally Driven Tribal Consultation Policies***

Tribal consultation is a necessary part of the federal trust responsibility. Section 1 of the [Presidential Memorandum on Tribal Consultation](#) states, "[t]he [f]ederal [g]overnment has much to learn from Tribal nations, and effective communication is fundamental to a constructive relationship." The Memorandum required agencies to engage in "regular, meaningful, and robust consultation with Tribal officials in the development of Federal policies that have Tribal implications."

Tribal leaders seek to improve the government-to-government relationship between Tribal nations and the federal government. Tribal consultation must allow the heads of governments to come together, share concerns, generate ideas and solutions, negotiate their roles and responsibilities, and agree on a course of action. Federal agencies regularly conduct Tribal consultations; however, current Tribal consultation policies fail to provide Tribal leaders adequate opportunity to engage in the process fully.

To honor Tribal sovereignty, the U.S. Department of Health and Human Services (HHS) and its operating divisions must consult and collaborate with Tribal leaders to develop Tribal consultation policies. These policies must be meaningful, thorough, and consistent across the agency, reflecting Tribal input and priorities. HHS should adopt a uniform definition of Tribal consultation that is informed and agreed to by Tribes. Additionally, HHS and its operating divisions should engage in a Tribally led process to implement policies that strengthen the government-to-government relationship, improve agency accountability, and facilitate informed Tribal decision-making. Tribal consultation policies must explicitly include the legal rights Tribes have to determine their representation, as articulated through ISDEAA.

#### ***Administrative Action:***

- *National Tribal Consultation:* Tribal consultation policies should be revised through a national Tribal engagement process led and informed by Tribal entities.

- *Leadership*: Tribal consultation policies should require the top appointed agency official to be engaged in all Tribal consultation activities. Likewise, Tribes may choose who represents them during Tribal Consultation to be consistent with ISDEAA and prevailing law.
- *Training*: Agencies must require all staff to train on the United States-Tribal government-to-government relationship. Further, those who work in areas that regularly interact with Tribal governments and Tribal consultation must undergo additional training and participate in regular continuing education opportunities.
- *Uniform Definition*: HHS must adopt an agency-wide uniform definition of “Tribal consultation” that incorporates the principles of Free, Prior, and Informed Consent (FPIC) that is consistent with the *United Nations Declaration of the Rights of Indigenous Peoples* (UNDRIP) that the United States affirmed.
- *Actions Triggering Consultation*: All Tribal consultation policies must assure Tribes and their leaders that any federal action that impacts Tribes or may impact how Tribes govern their citizens is subject to consultation.
- *Initiating Consultation*: Ensure that all Tribal consultation policies make it clear that Tribal governments and their representatives have the right to ask for consultation whenever they desire and provide proscribed steps to initiate a Tribal consultation.
- *Adequate Notice*: Ensure all Tribal Consultation policies require at least 30-day notice for consultation, with limited exceptions for emergency items. Additionally, the deadline for written input should be at least 60 days or more following the consultation date.
- *Informed Notice*: Adopt a uniform requirement to send a Dear Tribal Leader Letter (DTLL) for every consultation and mandate that the letter include any pertinent information (such as a Federal Register notice).
- *Accountability*: To facilitate accountability, all agencies should, at minimum, issue a DTLL after every Tribal consultation that details what participants discussed, what Tribal leaders requested, expected follow-up actions, and a timeline for those actions and requests.
- *Reporting*: Tribal Consultation policies must require agency officials to draft a report of all consultation activities and provide a copy of the report to the appointed Agency or Operating Division leader, the agency’s Tribal Advisory Committee (TAC), the HHS Secretary, and the Secretary’s TAC (STAC). The report should be published online and distributed via a DTLL within 60 days of each consultation.
- *Tribal Recommendations*: Tribal consultation policies should require the agency to address why the agency did not implement specific Tribal recommendations. In any follow-up mechanism used, the agency must include a mechanism for Tribal leaders to inquire further about why their request or proposal was not incorporated or suggest alternative approaches that may be mutually beneficial. Moreover, the agency must institute a mechanism for Tribes to have redress for Tribal consultation violations.
- *Access*: To increase participation and achieve equity and access, agencies must expand the methods through which Tribal representatives can participate in Tribal consultations.
- *Early Engagement*: Engage Tribal representatives early in the policy and regulatory making process through various mechanisms, such as utilizing TACs and Listening Sessions, so that any proposed policies can be Tribally informed from the start, and engage with NIHB to ensure broad coverage reach of Tribes and.

## RESOURCES

- [NIHB Resolution 18-16](#): Request for an improvement in the Tribal Budget Consultation Process

## ***B. Support and Expand the White House Council on Native American Affairs***

In 2013, President Obama established the White House Council on Native American Affairs (WHCNAA) in [Executive Order 13647](#) to improve the coordination of federal programs and the use of available federal resources to benefit Tribes and Tribal communities. The WHCNAA also supports and organizes the annual White House Tribal Leaders Summit to provide an opportunity for the leaders from all federally recognized Tribes to interact directly with the President and representatives from the highest levels of the Administration. The WHCNAA met with Tribal leaders on an annual basis until 2017. The White House revived the WHCNAA in 2020 and hosted a White House Tribal Leaders Summit in November 2021.

The WHCNAA and the Summit are critical opportunities for the heads of governments to come together, share concerns, generate ideas and solutions, negotiate their roles and responsibilities, and agree on a course of action. However, an annual summit is not enough to make meaningful advancements in Indian Country. There must be greater engagement with Tribal leaders to facilitate meaningful dialogue and input. Moreover, the federal government must establish safeguards to ensure that the WHCNAA and the Summit withstand changes in administration. Continuity is necessary to experience meaningful and consistent improvement in the government-to-government relationship and trust responsibility. Likewise, distinct WHCNAA points of contact are needed to ensure that Tribal leaders have a direct forum with the officials who presently serve on the WHCNAA.

### ***Administrative Action:***

- *Meetings:* The WHCNAA should hold at least six regular meetings with Tribal leaders.
- *Tribal Representation:* Tribal leaders should be seated as full council members or as an advisory committee. The selection should be made in a manner consistent with the *Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA)*.
- *Contact:* Expand the WHCNAA's role; provided resources to the Executive Director to staff an office designated as the point of contact for Tribal leaders to share any concerns regarding the various government agencies.
- *Reports:* The WHCNAA should issue annual reports on their work and progress toward coordinating federal resources, addressing issues, and improving the government-to-government relationship between Tribes and the federal government.
- *Tribal Priorities:* The WHCNAA should consult with national Indian organizations, like the National Indian Health Board (NIHB), and Tribal leaders to incorporate Tribal health priorities into the Summit and other WHCNAA initiatives.
- *Technical Assistance:* WHCNAA should enlist regional and national health organizations, like NIHB, to provide Tribal engagement support and Technical Assistance.

## ***C. Elevate the IHS Director to Assistant Secretary for Indian Health***

The [Indian Health Service \(IHS\)](#), within the [U.S. Department of Health and Human Services \(HHS\)](#), is the principal federal entity charged with fulfilling the federal trust responsibility for Indian health care. However, the Director of IHS does not report directly to the Secretary of HHS. To address Tribal health needs, the HHS Secretary must hear directly from the lead advocate for Indian Health programs. Elevating the IHS Director to an Assistant Secretary for Indian Health would raise the priority and presence of Indian health matters.

*Previous Actions.* Various members of Congress have introduced Bills to elevate the IHS Director since the 108th Congress. Elevation has been a priority for Tribal nations and put forth as part of the reauthorization of the *Indian Health Care Improvement Act (IHCIA)*. Congress has yet to advance this measure beyond Committee action.

### ***Congressional Action:***



- *Elevate*: Elevate the Director of IHS to Assistant Secretary for Indian Health within HHS.
- *Interim*: Ensure the Director is nominated and confirmed while elevation legislation is pending.

## RESOURCES

- [NIHB Resolution 19-07](#): Resolution to Support the Elevation of the Director of the Indian Health Service to Assistant Secretary of the U.S. Department of Health and Human Services
- [H.R. 6406](#): The *Stronger Engagement for Indian Health Needs Act of 2022*

### ***D. Establish Interagency Agreements Between HHS Operating Divisions and IHS***

The COVID-19 pandemic exposed the importance of ensuring the different operating divisions of the U.S. Department of Health and Human Services (HHS) have a mechanism for distributing funding to Tribes equitably and expediently. Early in the pandemic, the lack of an established mechanism throughout HHS and its Operating Divisions for distributing funds caused significant delays in funding distribution. Interagency agreements between the Indian Health Service (IHS) and other HHS operating divisions could have prevented these problems. Agencies must establish interagency agreements to ensure the expedient transfer of allocated funds during future pandemics or other similar emergencies.

#### ***Congressional Action:***

- *Agreements*: To ensure their durability, Congress should mandate interagency agreements that include a fixed renegotiation timeline.

#### ***Administrative Action:***

- *Agreements*: Facilitate interagency agreements between IHS and HHS operating divisions.
- *ISDEAA*: Confirm that Tribes can receive all funding through *Indian Self-Determination and Education Assistance Act* (ISDEAA) contracts and compacts.

### ***E. Increase Tribal Representation in All HHS Operating Divisions and Appoint a Senior Advisor to the Secretary***

The fulfillment of the trust responsibility requires Indian Country to inform the decisions of each operating division within the U.S. Department of Health and Human Services (HHS). American Indians and Alaska Natives (AI/AN) representatives must always be at the table. Inadequate representation creates a disconnect between the agencies and Indian Country, resulting in ineffective policies, delayed delivery of services, inattention to critical Tribal priorities, and can inadvertently cause harm to Tribes. Moreover, President Biden called for his Administration to be more representative of the people they serve – this starts with a thorough understanding of the trust responsibility and other federal Indian laws and policies.

To address these issues and provide a Tribally informed policy and agency-wide approach, Tribal leaders have repeatedly requested the appointment of a Counselor to the Secretary for AI/AN Health Law and Policy as a political appointee within the HHS Immediate Office of the Secretary. To make informed policy decisions, the Secretary needs a Counselor with an extensive background in federal Indian law and policy, including a deep understanding of Tribal nations and the relationship with the federal government.

Additionally, Tribal leaders have asked the administration to establish a Tribal “desk” in the various HHS operating divisions. A Tribal member who has comprehensive knowledge and understanding of federal Indian law would staff this “desk” and serve as a critical advisor and coordinator in carrying out the trust responsibility and government-to-government responsibility for the agency or operating division.

#### ***Congressional Action:***

- *Counselor to the Secretary*: Establish a Schedule C, Counselor to the Secretary for AI/AN Health Law and Policy position to advise the Secretary of Health and Human Services.

***Administrative Action:***

- *Operations*: Seat Tribal representatives in all the HHS operating divisions.
- *Advisor*: Appoint a Counselor with specific Indian legal, history, and policy background in the HHS Immediate Office of the Secretary. The Counselor should have a vast understanding of Tribal sovereignty and the trust responsibility and understand how health and public health operate in Indian Country.
- *Counsel*: Seat a federal Indian law expert, with a background in health and public health, in the HHS Office of General Counsel (OGC).

***F. Expand and Strengthen Tribal Self-Governance in HHS***

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. A self-governance program model promotes efficiency, accountability, and best practices in managing Tribal programs and administering federal funds at the local level. Because Tribes can tailor programs according to the communities' needs, self-governance results in more responsive and effective programs.

The Indian Health Service (IHS) is the only entity within the U.S. Department of Health and Human Services (HHS) implementing Tribal self-determination contracting or self-governance compacting under the *Indian Self-Determination and Education Assistance Act (ISDEAA)*. However, not all IHS programs are subject to these agreements. For example, Tribes cannot receive IHS behavioral health grants (e.g., Methamphetamine and Suicide Prevention Initiative; Domestic Violence Prevention Initiative) under ISDEAA agreements. The Administration should work with Tribes to ensure IHS can implement all programs via a self-governance model and allocate funding to Tribes under ISDEAA agreements.

*Expansion.* The federal government should expand self-determination and self-governance authority to include all agencies and offices across HHS, providing greater flexibility for Tribes. Greater flexibility would allow Tribes to deliver critical services in collaboration with agencies such as the [Administration on Aging](#), the [Administration on Children and Families \(ACF\)](#), the [Centers for Disease Control and Prevention \(CDC\)](#), the [Substance Abuse and Mental Health Administration \(SAMHSA\)](#), and the [Health Resources and Services Administration \(HRSA\)](#).

*Previous Actions.* The [Tribal Self-Governance Amendments of 2000](#) directed HHS to conduct a study to determine whether a demonstration project extending Tribal self-governance to HHS agencies other than IHS was feasible. [The HHS study](#), submitted to Congress in 2003, determined that a demonstration project was feasible. In 2003, Senator Ben Nighthorse Campbell introduced [S.1696, the HHS Tribal Self-Governance Amendments Act of 2004](#), to authorize these demonstration projects; however, Congress failed to pass the bill without Administration support.

A second study was completed in 2011 by the HHS Self-Governance Tribal Federal Workgroup that determined Congress must pass additional legislation for the expansion. A [2013 report](#) of the same workgroup developed detailed recommendations to overcome legal and logistical barriers to self-governance expansion. Despite these findings supporting the expansion of Tribal self-determination and self-governance, Congress has yet to act.

***Congressional Action:***

- *Expand*: Permanent expansion of the ISDEAA to all HHS agencies and affirm that all programs at IHS, as determined by Tribes, are eligible to be contracted and compacted.

***Administrative Action:***

- *Expand:* Use legal and administrative authorities to expand Tribal self-determination and self-governance across all IHS grant programs and support expansion to all HHS operating divisions.

**RESOURCES**

- [NIHB Resolution 18-03](#): Support for Promoting the Government-to-Government Relationship Between the United States and Tribes and Protecting Tribal Sovereignty

***G. Support Tribal Advisory Committees and Technical Assistance***

Tribal Advisory Committees (TACs) and Tribal technical assistance (TA) from national, regional, and intertribal organizations complement the Tribal consultation process. While these entities are not a substitute for Tribal consultation, TACs play an indispensable role in government-to-government relationships. The purpose of a TAC is to seek consensus, exchange views, share information, provide advice and recommendations, and facilitate any other interaction related to intergovernmental responsibilities or administration of agency programs. TACs offer the opportunity to ensure that the priorities of Indian Country are represented in all phases of policy development.

The [Unfunded Mandates Reform Act \(UMRA\)](#) exempts TACs from the requirements of the [Federal Advisory Committee Act \(FACA\)](#), which manages federal advisory committees. The purpose of UMRA's FACA exemption is to facilitate communication between the federal government and state, local, and Tribal governments without the FACA acting as a hindrance to effective intergovernmental consultation. However, narrow interpretations of the UMRA FACA exemption have prevented effective communication and collaboration between federal agencies and Tribal leaders.

The Tribal leaders who serve as TAC members rely heavily on national Tribal organizations to provide the TA needed to have a meaningful exchange with federal officials. Tribal leaders have the right to be advised on all relevant technical areas, and often, a single technical advisor does not have expertise in all subject areas. In many instances, federal agencies limit the Tribal organization's ability to provide TA and insist that only one person can serve as technical advisor to a specific TAC member, and only they can receive TAC information. This view arises from an extremely narrow, questionable interpretation and use of the UMRA FACA exemption. This faulty interpretation enables federal officials to consistently obstruct the National Indian Health Board (NIHB) and other Tribal organizations' ability to broadly serve the Tribes and the TACs.

***Congressional Action:***

- *TACs:* Expand and codify Federal TACs within all operating divisions of HHS.
- *Clarify:* Clarify that the TACs are exempt from the FACA through the UMRA.
- *Amend:* Amend the UMRA to allow Tribal leaders serving on TAC to freely utilize, without limitations, technical and subject matter experts in the execution of their duties.

***Administrative Action:***

- *TACs:* Ensure that each agency has a TAC that operates according to Tribal leaders' preferences for staffing and representation (including technical advisors), meeting schedule, time, agendas, and financial support for travel and TA support of the Tribe's choosing.
- *Technical Assistance:* HHS and its operating divisions must support and resource the work of Tribal organizations, such as NIHB, which are the Tribes' chosen, vital link to ensuring that Tribal leaders have access to the subject matter expertise that helps them prepare to meaningful feedback to or engage proactively with Federal or Administration Personnel.

- *Transparency:* All agencies should allow the public to watch but not participate during all TAC meetings to facilitate transparency.

**RESOURCES**

- [National Indian Health Board TAC Resources Website](#)
- [NIHB Resolution 18-11](#): Support for Financial Resources to Provide Technical Resources to Federal/Tribal Advisory Committees and Workgroups

## EQUITABLE AND COMPREHENSIVE FUNDING

The federal government has a trust and treaty responsibility to provide comprehensive health care services to Tribal nations. Those health care services require stable and robust funding to be efficiently, reliably, and adequately allocated to meet Tribal priorities. Since its inception, IHS has been chronically underfunded. For example, in 2018, the Indian Health Service (IHS) spending for medical care per user was only \$3,779, while the national health care spending per capita was \$9,409 – an astonishing 60 percent difference.

This underfunding correlates directly with the higher rates of premature deaths and chronic illnesses suffered throughout Tribal communities. The average life expectancy for all AI/AN people is 5.5 years less than other Americans. In some Tribal communities, the life expectancy is up to 20 years less than the average American.

### **PRIORITIES FOR INDIAN HEALTH**

To ensure Indian health receives equitable and comprehensive funding, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Attain Full Funding and Mandatory Appropriations for Indian Health
- B. Secure Advance Appropriations for Indian Health
- C. Fully Fund All Provisions of the Indian Health Care Improvement Act
- D. Establish Tribal Set-Aside Funding in all HHS Operating Divisions
- E. Affirm Tribes' Ability to Recover all Contract Support Cost

#### ***A. Attain Full Funding and Mandatory Appropriations for Indian Health***

*Segmented Increases.* Appropriations for the Indian Health Service (IHS) increased by roughly fifty percent between FY 2010 and FY 2020. Still, the increases only addressed population growth, staffing for new or existing facilities, and full funding of contract support costs (CSC) and Section 105(l) lease agreements. The failure to keep pace with annual medical and non-medical inflationary increases has effectively reduced the budget and translated into insufficient healthcare services, dilapidated healthcare facilities, severe water and sanitation infrastructure deficiencies, and significant workforce shortages. **While the increase addresses a few critical needs, the United States must fully fund the entire IHS budget, not just segments of it.**

Congress faces internal challenges in passing full funding through the discretionary appropriations process. The Appropriations Subcommittee on Interior, Environment, and Related Agencies, which has jurisdiction over IHS funding (and other programs) had a restrictive spending cap of only \$36 billion in FY 2020. This limitation makes it extremely difficult to achieve meaningful increases to and full funding of the IHS budget.

*New Strategy.* Without full funding, Tribes face the impossible task of eliminating disparities alone. A different strategy is needed. Support exists for reclassifying CSC and Section 105(l) leases properly as mandatory funding. The federal government must commission a comprehensive Tribally driven assessment study on the remaining budget programs to determine the best path to achieving full and mandatory funding.

#### ***Congressional Action:***

- *National Study:* Fund a Tribally driven study to determine strategies for IHS mandatory appropriations.
- *Funding:* Pursue full funding for the Indian health care system.

- *Reclassify*: Reclassify Section 105(l) leases and CSC as mandatory appropriations.
- *Next Steps*: Evaluate and – as determined by Tribes – seek mandatory appropriations for the remaining IHS budget.
- *IHCIA*: Fully fund and implement remaining provisions of IHCIA.

***Administrative Action:***

- *Workgroup*: Support a Tribal workgroup to identify full funding for IHS.
- *Study*: Work with Tribes and provide needed data as part of a Tribally driven study to determine strategies for IHS mandatory appropriations.
- *National Study*: Engage a national Tribal organization, such as NIHB, to coordinate the Tribally driven study to determine the best path to achieve full and mandatory funding.

**RESOURCES**

- [NIHB Resolution 14-01](#): Support for the Proposal to Enact Permanent Mandatory Appropriations for Contract Support Costs Under the *Indian Self-Determination and Education Assistance Act*
- [NIHB Resolution 21-02](#): A Resolution Concerning 105(l) Lease Agreements
- [NIHB Resolution 19-06](#): Resolution Calling on Congress to Establish an Indefinite Discretionary Appropriation for the Indian Health Service to Fund Section 105(l) Lease Obligations under the *Indian Self-Determination and Education Assistance Act* (ISDEAA)

***B. Secure Advance Appropriations***

Stable funding is necessary for continuity of care, operations, and certainty in planning and management. The federal funding becomes unstable when subject to continuing resolutions (CRs) and government shutdowns. These CRs and shutdowns force the Indian Health Service (IHS) and Tribes to forego long-term planning and instead focus only on the most urgent health needs. These funding disruptions also create substantial administrative costs for health programs. The Government Accountability Office (GAO) cited several impacts to the Indian health system in its 2018 Report.

*Mitigation.* Advance appropriations would provide an important tool for the federal government to better meet its trust obligations for AI/AN health. It would mitigate the effects of the CRs and shutdowns and restore a measure of stability to Indian health care funding. For example, the advanced funding would allow Tribes to enter long-term contracts with outside vendors and suppliers without the threat of funding disruptions and facilitate more robust strategic planning in program development and implementation.

***Congressional Action:***

- *Enact*: Secure passage of advance appropriations for the entire IHS budget.

**RESOURCES**

- [2018 GAO Report](#)
- [FY 2022 Tribal Budget Formulation Workgroup Recommendations](#)
- [NIHB Resolution 14-03](#): Support for Advance Appropriations for the Indian Health Service

***C. Fully Fund All Provisions of the Indian Health Care Improvement Act***

Congress permanently reauthorized the *Indian Health Care Improvement Act* in 2010. IHCIA is the legal foundation for health care delivery in the Indian/Tribal/Urban (or I/T/U) health care systems as served by IHS. This law facilitates the federal government’s promise and obligation to significantly improve the health of American Indian and Alaska Native (AI/AN) people. Yet, many provisions of this law remain to be funded and implemented.

Most notably, the law enhances workforce development, health services and facilities, behavioral health, and access to health care services. New authorities for long-term and home-based services are included and could help increase the average life span of AI/AN, up to 5 years shorter than other populations. In addition, the particular emphasis on behavioral health programs is significant to help address the substance use disorders, suicides, and compounded COVID-19 behavioral health challenges facing Tribal communities.

The IHCIA highlights the critical importance of facilities to Tribal communities. Yet, health care facilities construction was funded at only \$259 million for FY 2021 when, according to IHS, the estimated total costs in FY 2021 were approximately \$21 billion.

The lack of these health care facilities during the COVID-19 pandemic was particularly tragic. Tribal communities suffered more from COVID-19 infections, hospitalizations, and deaths but did not have sufficient hospitals, ICUs, or adequate social distancing space in clinics to serve the AI/AN people.

*Unimplemented Provisions of IHCIA (S. 1790)*

Major Provisions In IHCIA Reauthorization	Percent Of Provision Not Full Funded
Subtitle A—Indian Health Manpower	67% of provisions not yet fully implemented
Subtitle B—Health Services	41% of provisions not yet fully implemented
Subtitle C – Health Facilities	43% of provisions not yet fully implemented
Subtitle D—Access to Health Services	11% of provisions not yet fully implemented
Subtitle F—Organizational Improvements	0% of provisions not yet fully implemented
Subtitle G—Behavioral Health Programs	57% of provisions not yet fully implemented
Subtitle H—Miscellaneous	9% of provisions not yet fully implemented

***Congressional Action:***

- *IHCIA*: Fully fund and implement remaining provisions of IHCIA.

***D. Establish Tribal Set-Aside Funding in all HHS Operating Divisions***

The Indian Health Service (IHS) is the primary entity charged with the federal trust responsibility of addressing the health disparities among American Indian and Alaska Native (AI/AN) Tribal nations and peoples. However, all operating divisions within the U.S. Department of Health and Human Services (HHS) have the responsibility to uphold the trust obligations for the health and public health of Tribal nations. Since the trust responsibility extends to all agencies, funding from these agencies should be dedicated and direct to Tribal nations. Direct funding eliminates the administrative burden imposed by the grant process for both agencies and Tribes. However, most other agency funding is in the form of competitive grants, which substantially limits the availability and accessibility for Tribes. The existing framework forces Tribes to compete for these funds, pitting them against states and local governments with greater grant writing capacity. As a result, Tribes regularly lose out on funding.

***Congressional Action:***

- *Set-Aside*: Create Tribal set-aside funding in the annual appropriations for each HHS operating division.

- *Funding*: Ensure funding can flow to Tribes through *Indian Self-Determination and Education Assistance Act* (ISDEAA) contracts and compacts, with maximum flexibility and minimum administrative burden, and is allocated through a formula to all Tribes, not through competitive grants.

***Administrative Action:***

- *Set-Aside*: All HHS Operating Divisions should use available authorities to create a 4-5% Tribal set-aside.
- *Allocation*: Each agency must work with Tribes through a consultative process to devise a formula, to allocate funding equitably.
- *Budget*: Each agency should conduct an annual Tribally led budget formulation process, mirrored off the IHS budget formulation process, to ensure the agency includes Tribal requests and recommendations in their budget request to Congress.

***E. Affirm Tribes' Ability to Recover all Contract Support Costs***

The *Indian Self-Determination and Education Assistance Act* (ISDEAA) represents the cornerstone of this nation's federal policy toward Tribes. Under ISDEAA, the federal government through the Indian Health Service (IHS), enters into inter-governmental contracts with Tribes under which Tribes administer health care services, either through contracts or self-governance compacts, for the benefit of Tribal members.

In the 1988 amendments to ISDEAA, Congress in 1988 observed that the single greatest impediment to successful implementation of the Indian Self-Determination Policy was the consistent failure of the Indian Health Service to pay full fixed contract support costs associated with the administration of transferred programs. Congress recognized that the failure IHS to pay full fixed contract support costs has often led to reductions in programs, amounting to partial termination of the federal government's trust responsibility.

As a result, Congress amended ISDEAA to authorize funding for (1) costs for the operation of programs or portions thereof for the contract or compact period and (2) Contract Support Cost (CSC), such as worker's compensation and overhead. ISDEAA provides that the government must pay CSC for the "activities" required to "ensure compliance with the terms of the contract and prudent management" — but only if those activities "normally are not carried on by" the government agency that would otherwise operate the program. CSC include start-up, direct, and indirect contract support cost.

In enacting these provisions, Congress recognized the importance and necessity of the CSC to the "prudent management" of Indian health programs. Moreover, Congress has supported a flexible administration of CSC which would enable Tribes to effectively operate health care programs. As a matter of law, Congress has authorized full funding of these costs as well. These principles reflect the cornerstones of Tribal self-determination and self-governance policy and set forth a clear direction from Congress to bolster, not arbitrarily restrict, CSC.

*Cook Inlet v. Dotomain*. A recent D.C. Circuit Court of Appeal case, *Cook Inlet Tribal Council, Inc. v. Dotomain*, wrongfully decided how CSC should be defined, contrary to Congress' direction on CSC. In *Cook Inlet*, the Court found that certain facility costs may not fall under the umbrella of items that are reimbursable as CSC. Because these facility costs are "normally" incurred by IHS in their administration of a program, they should be considered secretarial operational costs and not eligible for reimbursement as a CSC.

This decision could seriously impact Tribes' ability to administer their health care services and programs and treat their patients. Indian health care services are chronically underfunded. Tribal health care providers already stretch these limited resources to overcome significant health disparities and inequities among the Tribal population. This task is made even more complicated by funding reductions and instability.



Tribes can not pay for these costs without the CSC funding and, instead, be forced to divert funding from patient care to pay for the overhead and other CSC. These reductions will diminish access to care across the Indian health system. Congress specifically authorized CSC in the ISDEAA to avoid this situation.

This decision is now being applied in federal-Tribal contracts negotiations to deny millions of dollars for necessary health care operational support. Congress authorized this type of funding in the ISDEAA, and, in the absence of a clarifying amendment, the direction and intent of Congress will continue to be frustrated – to the detriment of health care for American Indian and Alaska Native (AI/AN) people.

### *Congressional*

- *Amendment:* Enact a clarifying amendment to the ISDEAA to restore the status quo for CSC administration.

### *Administrative*

- *CSC Administration:* Work with the Tribes and Tribal representatives through CSC workgroup and Tribal consultation to clarify and improve the CSC policy and administration.

### RESOURCES

- NIHB Letter to the [House Committee on Appropriations](#) and the [Subcommittee on Interior Appropriations](#)
- NIHB Letter to the [House Committee on Natural Resources](#) and the [Subcommittee for the Indigenous Peoples of the United States](#)
- NIHB Letter to the [House Native American Caucus](#)
- NIHB Letter to the [Senate Committee on Appropriations](#) and the [Subcommittee on Interior Appropriations](#)
- NIHB Letter to the [Senate Committee on Indian Affairs](#)

**INNOVATIVE AND SUSTAINABLE INFRASTRUCTURE**

Access to clean water, proper sanitation and health care facilities, broadband, and a modernized health information technology infrastructure are fundamental and critical components in improving health outcomes in the 21<sup>st</sup> century. The COVID-19 pandemic highlighted the importance of these basic needs and demonstrated the devastating consequences of gaps in these systems. The great and immediate need to solve these issues, coupled with the passage of the *Infrastructure Investment and Jobs Act* (IIJA), presents a unique opportunity to address these critical infrastructure issues and create an equitable future for American Indian and Alaska Native (AI/AN) people.

**PRIORITIES FOR INDIAN HEALTH**

To build an innovative and sustainable infrastructure to support Indian health, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Implement Tribal Water and Sanitation Infrastructure Investments
- B. Prioritize Support for Health Care Facilities Construction
- C. Modernize Health Information Technology in Indian Country
- D. Ensure Access to Reliable High-Speed Internet

***A. Implement Tribal Water and Sanitation Infrastructure Investments***

Human health depends on safe water, sanitation, and hygienic conditions. The COVID-19 pandemic highlighted the importance of these basic needs and illustrated the devastating consequences of gaps in these systems, including the spread of infectious diseases. According to the [2019 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities](#), over 26 percent of homes on Tribal lands need sanitation facility improvements, while over 12 percent of all American Indian and Alaska Native (AI/AN) homes do not have adequate sanitation facilities. Even more troubling, roughly 1.6 percent of AI/AN people do not even have access to safe drinking water. Many AI/AN communities simply cannot follow the sanitation and hygiene recommendations of the Centers for Disease Control and Prevention (CDC) because of a lack of water and sanitation infrastructure.

The *Infrastructure Investment and Jobs Act* (IIJA), enacted in November 2021, provided \$3.5 billion for the IHS Indian sanitation program to address the known sanitation deficiencies in Tribal communities. The 2019 IHS Sanitation Facilities Construction Report outlines the deficiency levels and projects. Two considerations are important to note. First, IHS evaluates the list of projects each year, and new projects can be added. Second, this \$3.5 billion in funding may not cover operations and maintenance funding needs. These evolving and additional costs will need to be monitored and addressed appropriately in subsequent annual budget requests.

***Congressional Action:***

- *Operations and Maintenance:* Examine and provide operations and maintenance funding for current and new sanitation facilities operated through the IHS Sanitation Facilities program.
- *EPA Program:* Increase Tribal set-asides to five percent for the [Clean Water State Revolving Fund](#) and the [Drinking Water State Revolving Funds](#).

***Administrative Action:***

- *Monitoring:* Monitor how new projects not already included in the [2019 IHS Sanitation Facilities Construction Report](#) affect the funding levels and ensure the IHS and coordinating agencies, such as the EPA, work expeditiously to provide for the required coordinated costs of specific sanitation projects.

## RESOURCES

- [2019 IHS Sanitation Facilities Construction Report](#)

### ***B. Prioritize Support for Health Care Facilities Construction***

The Indian health system is beset by antiquated and deficient health care facilities that are primarily unequipped to respond to the ongoing COVID-19 pandemic. The average age of an Indian Health Service (IHS) hospital is 37.5 years, compared to 10 years for mainstream hospitals. IHS facilities can accommodate roughly 52 percent of needs based on American Indian and Alaska Native (AI/AN) population sizes. IHS and Tribal hospitals have a severe shortage of intensive care unit (ICU) beds or complete lack of inpatient facilities and no space for specialty care such as dialysis treatment. In small villages and remote Tribal locations, there is no ability to place a patient in isolation or quarantine.

*Joint Ventures and Small Ambulatory Project.* For the Joint Venture Construction Program (JVCP), Tribes secure the funding and construct the health care facilities, and the IHS provides funding for staffing. Generally, these projects enable Tribes to obtain health care facilities faster than through the Health Care Facility Construction Program, even though the federal government should be funding the entire costs as part of the trust responsibility and treaty obligations. However, many JVCP projects will be delayed or lose resources for construction projects without an influx of funding. Congress must provide funding for all JVCP projects for all Tribes that satisfy eligibility for the past and current JVCP competition.

The Small Ambulatory Program (SAP) funds small ambulatory clinic construction with caps of approximately \$2 million per project and no staffing funds. They are crucial for Tribes not on the 1993 Health Care Facilities Construction Priority List (“Priority List”) or participating in JVCP. They are especially critical for those IHS Areas with no IHS or Tribally operated hospitals.

*Cost Estimate.* There is an urgent need to fund those facilities on the Priority List, JVCP, SAP, and specialty care facilities such as dialysis centers, long-term care facilities, and inpatient behavioral health care treatment facilities. According to IHS, the total cost for these facilities is approximately \$22 billion.

*Maintenance and Improvement.* Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for IHS and Tribal health care facilities. Adequate funding is vital to ensure functional healthcare facilities meet building/life safety codes, conform to laws and regulations, and satisfy health accreditation standards. IHS distributes the M&I program funding using a formula allocation methodology based on industry standards of health facilities. Current funding levels for M&I are below about 78 percent of the total needed for all eligible facilities. According to IHS, as of 2021, the backlog of essential maintenance and repair is estimated to be \$945 million to fully fund all M&I needs.

*Equipment.* Most medical equipment has an average useful lifespan of 6 years. Still, medical and lab equipment in most IHS facilities is more than twice that old, posing a severe public health risk for Tribal communities.

The Indian health system nearly buckled under the pressure of the pandemic. Fully funding health care facilities construction is how Congress can adequately prepare the IHS and Tribally operated health clinics and hospitals for the next public health emergency.

The IHS and Tribes need equitable and flexible funding to increase hospital and clinic capacity and ensure related costs such as maintenance, routine improvements, and equipment are adequately covered. The Indian health system must also have the funding and flexibility to acquire, renovate, or construct alternative triage units to manage this pandemic.

### ***Congressional Action:***

- *Funding:* Fully and equitably fund construction of health care facilities across all twelve IHS Service Areas, including the Priority List, the JVCP projects, SAP projects (with no arbitrary cap of \$2 million), and specialty care facilities.
- *JVCP:* Ensure regular cycles of JVCP, with the selection of new projects no less than every two years.
- *Maintenance and Improvement:* Fully fund the backlog of M&I projects for IHS-funded Tribal programs.

### ***C. Modernize Health Information Technology in Indian Country***

The Indian Health Service (IHS) provides the technology infrastructure for a nationwide health care system, including a secure wide area network (WAN), enterprise email services, and regional and national help desk support for approximately 20,000 network users. IHS's health information technology (HIT) supports the health care operations of the Indian health system with comprehensive health information solutions, which includes an electronic health record (EHR) and more than 100 applications.

The HIT system currently used by IHS and many Tribal and Urban Indian healthcare organizations is the Resource and Patient Management System (RPMS). This comprehensive health information suite supports a broad range of clinical, population health, and business processes from patient registration through the billing cycle. In recent years, advances in health-related standards and technologies, an increasingly complex regulatory environment around HIT, and the decision of the VA, IHS' long-time collaborative partner, to move to a commercial off-the-shelf HIT solution, have combined to make the current approach to IHS HIT development and support non-sustainable going forward.

*Tribal Migration to COTS.* Due to increasing interoperability issues and failure to meet the needs of many Tribal health systems, many Tribes, at their own expense, have moved away from the outdated RPMS to better, more interoperable systems. Many Tribes have implemented Commercial Off-the-Shelf (COTS) EHR systems. Since many Tribes have elected to purchase their own COTS, a growing patchwork of EHR platforms exists across the Indian health system.

*IHS HIT Modernization Project.* In 2018-2019, HHS and IHS collaborated on analyzing options for modernization of the IHS HIT infrastructure. The assessment focused on the people, processes, and technology that are part of the current RPMS ecosystem, seeking to achieve a detailed understanding of the current system's utilization, capabilities, effectiveness, and gaps. Upon careful review of the findings from the analysis, IHS leadership concluded that a total replacement of RPMS is the most appropriate, realistic, and sustainable option for IHS HIT modernization. IHS has initiated the acquisition process and will release the formal request for proposal (RFP) in Q2 of this year.

*Shortfalls.* An IHS HIT program with proper resources creates efficiencies to (1) care for patients; (2) pay providers; (3) coordinate referral services; (4) recover costs; and (5) support clinical decision-making and reporting, all of which results in better care, efficient spending, and healthier communities. The National Tribal Budget Formulation Workgroup has estimated the cost of EHR modernization for the Indian health system at \$3 billion. The FY 2021 IHS appropriations for an EHR modernization are \$34.5 million, and HIT is \$182.15 million. This funding is insufficient to adequately create the efficiencies required to overhaul and operate a modern EHR system.

#### ***Congressional Action:***

- *Funding:* Provide funding to establish a fully functional and comprehensive HIT system for the Indian health system that is fully interoperable with Tribal, urban, private sector, and VA HIT systems. The funding should include maintenance costs and offset costs Tribes incurred to modernize their EHR systems without federal action.

***Administrative Action:***

- *Advisory Group on Interoperability:* The VA-IHS memorandum of understanding (MOU) includes a goal of interoperability between the IT systems used by both agencies. The agencies must establish an advisory group composed of Tribal leaders, Tribal technical assistants, subject matter experts, and federal representatives to ensure continued progress toward this goal.
- *Advisory Group on HIT Modernization:* IHS must establish a Tribal Advisory Committee (TAC) or another transparent engagement process to provide opportunities for Tribal engagement with the Project Management Office (PMO) to manage the next steps in the HIT Modernization Project. (While the Information Systems Advisory Committee has been involved in some aspects of the HIT Modernization Project, this committee does not fulfill the need for focused, robust Tribal engagement on HIT modernization).
- *Funding:* Engage the National Tribal Budget Formulation Workgroup to identify and quantify funding needs and other support for HIT and EHR modernization.
- *Transparency:* To facilitate transparency regarding the HIT Modernization project, IHS should create a website where Tribal leaders can find all public reports, meeting minutes, presentations, updates, and relevant materials collected or developed during the project.
- *Strategic Review:* IHS should conduct a strategic review of the IHS HIT Modernization Project to determine how the progress aligns with the project's key performance indicators and goals for stakeholder engagement, which included goals for robust Tribal governance and engagement in the project. A report of the findings, including how IHS will address any shortcomings identified, should be published and presented to Tribal leaders and officials from the U.S. Department of Health and Human Services (HHS).

***D. Ensure Access to Reliable High-Speed Internet***

The expansion of telehealth during the COVID-19 pandemic has increased the importance of broadband as a public health issue; however, the lack of broadband access presents multiple barriers for Tribes.

*Disparity.* According to a [2019 Federal Communications Commission \(FCC\) Report](#), only 46.6 percent of homes on rural Tribal lands had access to fixed terrestrial broadband at standard speeds, an astounding 27 points lower than non-Tribal lands. This disparity illuminates Tribes' inability to provide or fully realize the benefits of telehealth to address the impacts of the COVID-19 pandemic. In addition to public health implications, the lack of broadband access presents a barrier to economic development, particularly detrimental in an era where remote work has been necessary and will continue to be more widely adopted.

*Funding.* The *Infrastructure Investment and Jobs Act (IIJA)* provided \$2 billion for Tribal broadband. This funding is a step in the right direction. The IIJA programs should ensure Tribes can determine the best methods for expanding their broadband infrastructure in a manner that acknowledges Tribal sovereignty, particularly in protecting cultural resources. It is unclear whether the funding is sufficient to cover all Tribal lands and what areas, infrastructure, and services lack adequate funds.

***Congressional Action:***

- *Gap Analysis:* Fund a study of Tribal lands to determine where gaps in access to broadband exist and the best technologies to address them.
- *Funding:* Ensure the allocation of IIJA and other broadband funding is made directly, expeditiously, and flexibly according to Tribal priorities and decisions.

***Administrative Action:***

- *Alliances:* Tribes, Tribal representatives, NIHB, Indian Health Service (IHS), and Bureau of Indian Affairs (BIA) must establish a relationship with the Federal Communications Commission (FCC)

Office of Native Affairs and Policy (ONAP) to ensure that broadband deployment happens equitably across Indian Country and in a way that respects Tribal sovereignty and promotes Indian health care service delivery (e.g., Electronic Health Records, Health Information Technology, Telehealth).

- *Oversight:* The ONAP should provide an annual update to Indian Country to report progress and demonstrate equity regarding broadband deployment.

## **HEALTH EQUITY**

The [2018 Broken Promises Report](#) by the U.S. Commission on Civil Rights highlights in stark terms how the United States' historical unjust treatment of Tribes and American Indian and Alaska Native (AI/AN) people led to the inequities experienced across Indian Country today. The report states that despite the trust and treaty obligations agreed to by the federal government, “the U.S. government forced many Native Americans to give up their culture and, throughout the history of this relationship, has not provided adequate assistance to support Native American interconnected infrastructure, self-governance, housing, education, health, and economic development needs.” Historical and current policies perpetuating barriers in these areas have contributed to the vast disparities in rates of illness and death AI/AN communities experience.

Achieving health equity, therefore, requires a decolonization approach and mindset. It requires increased investment in both the priority health issues disproportionately harming Tribal communities, as well as in AI/AN social determinants of health. Working in collaboration with Tribal communities, the federal government will need to remove obstacles to health such as poverty, discrimination, and their consequences, including lack of agency, access to good jobs with fair pay, quality education and housing, safe environments, and health care.

The resilience and strength of AI/AN peoples, rooted in community and cultural traditions, has allowed Tribes to survive and often beat the odds, despite the long history of injustice against them. These invaluable resources – including resilience, community, and rich cultural traditions – must be honored and supported throughout all efforts to pursue health equity for AI/AN peoples.

### **PRIORITIES FOR INDIAN HEALTH**

To address chronic health disparities and promote health equity in Indian Country, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Study and Invest in Social Determinants of Health
- B. Promote and Sustain Environmental Health Improvements in Indian Country
- C. Address Housing and Homelessness in Indian Country
- D. Identify, Enact, and Resource Solutions for the Crisis of Missing & Murdered Indigenous People
- E. Establish Permanency and Self-Governance for the Special Diabetes Program for Indians
- F. Prioritize Indian Country in HIV Funding

#### ***E. Study and Invest in Social Determinants of Health***

Where people live, work, play, and practice cultural traditions profoundly influence their health. Research demonstrates that the conditions around us – social, economic, environmental, etc. – are the strongest factors in determining which populations are healthy and which experience higher rates of disease, disability, and death. These factors, known as *social determinants of health*, play a more significant role in determining population health than genetics or health care. Societal conditions like poverty, discrimination, and the physical design of our communities shape access to resources like healthy food, stable and safe housing, social connection, education, health care, and clean air and water. Because these societal conditions do not affect everyone equally, not everyone has the same opportunities to be healthy. These disparities lead to preventable differences in health status, as those with fewer opportunities to be healthy are more likely to get sick or injured or even die prematurely. These preventable disparities are known as health inequities.

Decades of research have documented health inequities experienced by American Indians and Alaska Natives (AI/AN). However, efforts to improve health and well-being in Indian Country have often focused on trying to help individuals beat the odds, rather than investigating and investing in ways to enhance the lives of all AI/AN people. Significant improvement in population health requires additional attention to and

investment in the social determinants of health. Resolving issues around housing, food, water, education, jobs, transportation, and cultural connectedness will sustainably improve health and wellbeing for the entire community over the long term.

*Initiatives.* President Biden intended to carry out his domestic agenda through the *Infrastructure Investment and Jobs Act* (IIJA) and the proposed *Build Back Better initiative*, pending in Congress. While the IIJA addressed infrastructure renewal, the *Build Back Better bill* focused on various social and health-related programs. Both Congress and the Administration should include Tribes as part of any domestic agenda package, particularly when addressing social health determinants.

***Congressional Action:***

- *Inclusion:* Include Tribes in legislation intended to address health-related social programs to reduce poverty-impacted issues, e.g., maternal health care.
- *Fund:* Fund a process led by Tribes, Tribal representatives, and Tribal organizations such as NIHB to identify and study AI/AN social determinants of health.

***Administrative Action:***

- *Determinants:* Consider social determinants of health such as housing, food, water, education, jobs, transportation, and cultural connectedness, when addressing Indian health care disparities.
- *Budgeting:* Create budget requests to study and address social determinants of health in Indian Country.
- *Medicaid:* Encourage and approve Section 1115 Demonstrations addressing social determinants of health.

**RESOURCES**

- [2018 Broken Promises Report](#)
- [2017 Robert Wood Johnson Foundation Report: What is Health Equity?](#)
- [NIHB Resolution 18-08:](#) Building Relationships to Explore and Understand Commonalities in Health Disparities, Health Outcomes, Determinants of Health, and Health Systems Amongst Indigenous Populations of Other Countries

***F. Promote and Sustain Environmental Health Improvements in Indian Country***

The health of the environment directly impacts public health in Indian Country. Improving environmental health aids in preserving Tribal nations and cultures and promotes health and well-being.

*Status.* Contaminated drinking water, harmful air pollutants, destruction of natural habitats, climate change, extreme weather, and exposure to toxic heavy metals are just some of the environmental health issues that Tribal communities struggle to prevent, mitigate, or overcome, often with little or no support from the federal government. Twenty-five percent of the nation's 1,300 Superfund sites designated by the Environmental Protection Agency (EPA) are located either in or near Indian Country, even though Indian Country is only approximately two percent of the national land area. Decreased environmental health impacts physical and mental health and emotional and spiritual wellness for AI/AN communities and individuals.

*Traditions.* Lower population counts of species that Tribes use for subsistence and ceremonial practices harm the overall wellness of Tribal members. Many Tribes also rely on traditional foods, and the loss of this sustenance is particularly acute in areas where there are few other affordable, healthy foods for purchase.

***Congressional Action:***



- *Climate Change*: Provide resources to Tribes that address the health effects of climate change, including for long-term planning, mitigation, and adaptation activities.
- *Funding*: Establish dedicated funding for Tribes for environmental health improvement efforts.
- *Lead Removal*: Provide oversight to agencies such as Housing and Urban Development (HUD) to ensure federal lead removal programs provide resources, training, and screening tools directly to Tribes.
- *Subsistence and Sustainance*: Provide Tribes adequate tools to preserve subsistence, traditional sustenance, and other healthy food sovereignty approaches.

#### ***Administrative Action:***

- *Advisory Boards*: Seat Tribal representatives on all advisory boards formed to work on climate change and other environmental issues.
- *Council*: Ensure the White House Council on Native American Affairs (WHCNA) and Tribal Nations Summit examines and engages on health effects as part of the discourse on and response to climate change and environmental health challenges in Indian Country and involves Tribal nations as full partners in federal planning and mitigation activities.
- *Research and Communication*: Create a Tribally led study into current and pervasive challenges related to environmental health and climate change adaptation.
- *Priorities*: Prioritize Tribal sanitation, clean water infrastructure, and electrical utilities.

### ***G. Address Housing and Homelessness in Indian Country***

Housing is a social determinant of health. All Tribal communities should have access to stable, safe, sanitary, and affordable housing. Homelessness, unstable housing, and overcrowded housing in Indian Country affects health outcomes. Studies demonstrate that homelessness and substandard housing are risk factors for domestic violence, human trafficking, missing and murdered Indigenous peoples (MMIP), substance abuse, mental illness, COVID-19, and other health problems in Indian Country.

Housing issues disproportionately impact AI/AN communities, with roughly 23 percent of existing homes in Tribal areas needing repairs, upgrades, or reconstruction compared to 5 percent of all U.S. households. There are estimated to be up to 85,000 homeless AI/ANs living in Tribal areas, contributing to significantly higher rates of overcrowded housing on Tribal reservations and lands, with 16 percent of AI/AN peoples experiencing overcrowded housing compared to 2 percent of all households nationwide. Moreover, disproportionate rates of poverty further exacerbate housing issues. AI/AN communities experience the highest poverty rates of any demographic at 26.2 percent compared to 14 percent nationwide, with median household income levels 32 percent below the national average.

While overcrowding and a shortage of affordable housing are not new problems, the COVID-19 pandemic has added a new layer of complexity and urgency. Overcrowding makes physical distancing impossible. Additionally, AI/AN populations have disproportionate levels of underlying conditions like heart disease and diabetes, making Tribal communities particularly susceptible to complications from COVID-19.

On June 24, 2021, Senator Brian Schatz (D-HI), Lisa Murkowski (R-AK), Jon Tester (D-MT), and John Hoeven (R-ND) reintroduced the [\*Native American Housing Assistance and Self-Determination Act of 2021\*](#) (S. 2264). This Act would reauthorize the [\*Native American Housing Assistance and Self-Determination Act of 1996\*](#) (NAHASDA) through 2032. Funding under NAHASDA programs is the primary source of federal assistance to ensure American Indians, Alaska Natives, and Native Hawaiians have access to safe, accessible, and affordable housing. Authorization for most NAHASDA programs expired in 2013, although Congress has continued to fund them. Bills that would reauthorize NAHASDA have been introduced in every Congress since 2013.

#### ***Congressional Action:***

- *Reauthorize*: Reauthorize the *Native American Housing Assistance and Self-Determination Act of 1996* (NAHASDA).

***Administrative Action:***

- *Funding*: Remove barriers to funding and provide specific Tribal set-asides for Tribal governments and Tribal organizations.

**RESOURCES**

- [NIHB Resolution 20-06](#): Support for Addressing Housing and Homelessness in Indian Country as a Public Health Priority

***H. Identify, Enact, and Resource Solutions for the Crisis of Missing & Murdered Indigenous People***

Over the past decade, the crisis of missing and murdered Indigenous peoples (MMIP) in Indian country has gained renewed national attention. The crisis has been ongoing for decades, and the situation remains severe. In 2020 alone, the [National Crime Information Center recorded](#) 9,575 missing American Indian and Alaska Native (AI/AN) persons. According to the [Centers for Disease Control and Prevention \(CDC\) 2018 National Vital Statistics Survey data](#), homicide was the 6<sup>th</sup> leading cause of death for AI/AN women under 45 years old. The [CDC and other studies](#) report that AI/AN women die from homicide at more than double the rate of non-Hispanic White women.

As many Tribal communities are working to reestablish traditional practices and norms, Indigenous women play meaningful and essential roles to preserving and bolstering a Tribe's cultural presence. The loss of life for these sacred Indigenous women is detrimental to their families and friends and for the sake of a Tribal nation rebuilding. In addition, because the crisis disproportionately falls on women, the frequency with which AI/AN women are missing or murdered has larger implications for rebuilding traditional cultural structures.

At face value, the violence involved in MMIP is a significant public health concern where discussions of violence prevention efforts touch upon intimate partner violence, child abuse, mental health, elder abuse, and sexual violence. However, addressing the MMIP crisis also presents its own unique set of additional challenges because of the sheer scope of the crisis and its required engagement across multiple professional disciplines and different legal jurisdictions. For example, [a 2018 report by the Urban Indian Health Institute \(UIHI\)](#) identified several issues that impact timely law enforcement interventions. These issues included racial misclassification of AI/AN persons, lack of recognition for Tribal nations and citizenship, poor record keeping procedures, and vague judicial and criminal jurisdictional authority. Generally, if the perpetrator is not AI/AN, the [Tribal government has limited criminal jurisdiction](#) even if the crime was committed on Tribal lands. In addition, not only are accurate counts of MMIP lacking both in Tribal and urban areas, but information around perpetrators and the conditions and events leading up to such incidents are scant.

The crisis of missing and murdered Indigenous people exist at a complex intersection of health, law, and culture and deserves an in-depth investigation from multiple points of view. Like most other forms of violence, MMIP is wholly preventable. However, sufficient resources remain an issue. Without advance appropriations for health care, Tribes can lose behavioral health care providers during Continuing Resolutions and shutdowns, leaving these traumatized victims without treatment. Bold and aggressive investments in behavioral health prevention and treatment are needed to confront these problems. But much more is needed. Violence reduction and prevention efforts must focus on the victims' trauma and the underlying behavioral health problems contributing to violence.

*Executive Order 14053*. In November 2021, President Biden signed an Executive Order (EO) to address the crisis of MMIP. This EO contains important health initiatives to assist in addressing this crisis, including

examining the adequacy of research and data collection efforts at the CDC and the National Institutes of Health (NIH).

*Violence Against Women Act.* The *Violence Against Women Act* (VAWA), first passed in 1994, was amended in 2013 to include a provision allowing Tribes to claim jurisdiction over non-Natives who commit violent crimes against an AI/AN woman living on Tribal land. While this signals a step in the right direction, it stops short of giving Tribes the full ability to prosecute these crimes and limits sentencing authority.

The U.S. Department of Justice's (DOJ) Office of Violence Against Women (OVW) hosts an annual Tribal consultation to solicit recommendations from Tribal leaders on enhancing the safety of AI/AN women from domestic violence, dating violence, sexual assault, stalking, and sex trafficking; strengthening the federal response to said crimes; and administering funds and programs for Tribal governments established by VAWA.

*Executive Order 14053.* In November 2021, President Biden signed an Executive Order to address the crisis of MMIP. The order states that “[t]he Federal Government must prioritize addressing this issue and its underlying causes, commit the resources needed to tackle the high rates of violent crime that Native Americans experience over the long term, coordinate and provide resources to collect and analyze data, and work closely with Tribal leaders and community members, Urban Indian Organizations (UIOs), and other interested parties to support prevention and intervention efforts that will make a meaningful and lasting difference on the ground.” The order directs the coordination of federal agencies to prevent and respond to violence against AI/AN people and calls for additional support for Tribal and non-federal law enforcement and data improvement.

*Other Previous Actions.* In 2020, Congress took a significant step forward by passing two pieces of legislation — *Savanna's Act* and the *Not Invisible Act of 2019*. This legislation includes important provisions for improving law enforcement and justice protocols, and access to relevant data, to better address missing or murdered AI/AN people. On April 1, 2021, Interior Secretary Deb Haaland announced the formation of a new [Missing & Murdered Unit](#) within the Bureau of Indian Affairs (BIA) Office of Justice Services to provide leadership and direction for cross-departmental and interagency work involving missing and murdered AI/AN peoples.

#### ***Congressional Action:***

- *Reauthorize VAWA Title IX:* The bill, S.3623, the *Violence Against Women Act Reauthorization Act of 2022*, reaffirms Tribal authority to seek justice for Native victims for certain violent crimes committed by non-Indians. Justice is an essential step toward healing and recovery for victims and communities.

#### ***Administrative Action:***

- *Resources:* The DOJ must ensure Tribes have the resources necessary to take advantage of the enhanced jurisdiction provided under VAWA.
- *Prevention Efforts:* Fund Tribes, Tribal Health Departments, and Tribal organizations, such as NIHB, to sustain robust violence prevention programs in Indian Country.

#### **RESOURCES**

- [NIHB Resolution 17-04](#): Supporting the Violence Against Women Act in Indian Country
- [Executive Order 14053: Improving Public Safety and Criminal Justice for Native Americans and Addressing the Crisis of Missing or Murdered Indigenous People](#) (November 2021)
- [Missing and Murdered Indigenous Women & Girls: A Snapshot of Data from 71 Urban Cities in the United States](#) (Urban Indian Health Institute, 2018)

## ***I. Establish Permanency and Self-Governance for the Special Diabetes Program for Indians***

Congress established the Special Diabetes Program for Indians (SDPI) in 1997 to address the disproportionate impact of type 2 diabetes among American Indians and Alaska Natives (AI/AN). This program has grown and become our nation's most strategic and effective federal initiative to combat diabetes in Indian Country.

*Benefits.* The SDPI has effectively reduced the incidence and prevalence of diabetes among AI/ANs and is responsible for a 54 percent reduction in rates of end-stage renal disease and a 50 percent reduction in diabetic eye disease among AI/AN adults. In a [2020 Report to Congress](#), IHS stated that, as a direct result of SDPI, the prevalence of diabetes in AI/AN adults decreased 15.4 percent in 2013 to 14.6 percent in 2017. A [2019 federal report](#) found SDPI primarily responsible for \$52 million in savings in Medicare expenditures per year.

*Reauthorization.* Tribes have sought three amendments to the SDPI: (1) funding increased to \$250 million per year with annual increases tied to the rate of inflation; (2) permanency; and (3) funding distribution pursuant to the *Indian Self-Determination and Education Assistance Act* (ISDEAA). After 15 months of short-term extensions (6 in total), Congress reauthorized the program until the end of FY 2023 at \$150 million annually – the same level since 2004. This funding level does not allow all Tribes to participate in the program. The increased level would expand the program to more Tribes. Likewise, instead of just 2 to 3 years, making the program permanent would provide certainty and continuity of care and operations for Tribal programs.

The program operates primarily through grants. Distributing the SDPI funding under the ISDEAA through contracts and compacts would prevent administrative delays and allow Tribes receive all administrative and operational resources entitled to them under the ISDEAA, including contract supports costs (CSC).

### ***Congressional Action:***

- *Increase:* Permanently reauthorize SDPI at a minimum of \$250 million automatic annual funding increases tied to the rate of medical inflation.
- *ISDEAA:* Authorize Tribes and Tribal organizations to receive SDPI awards through ISDEAA contracts and compacts.
- *Baseline:* Increase baseline funding to address stagnant funding and expand the program's reach to additional Tribes.

## **RESOURCES**

- [NIHB Resolution 21-04](#): Support for a Permanent Reauthorization of the Special Diabetes Program for Indians to Include Annual Funding Increases tied to Medical Inflation; *and*, Support for an Amendment to the *Public Health Service Act* to Permit Tribes and Tribal Organizations to Receive Special Diabetes Program for Indians Funds through Self Determination and Self-Governance Contracts and Compacts

## ***J. Prioritize Indian Country in HIV Funding***

According to the Centers for Disease Control and Preventions' (CDC) [HIV Surveillance Report](#), from 2015 through 2019, the rate for diagnoses of the human immunodeficiency virus (HIV) infection in the United States among American Indian and Alaska Native (AI/AN) adults and adolescents increased by 18 percent. The rate of HIV infection among AI/ANs in 2019 was 10.5 per 100,000. Although the Biden administration's [National HIV/AIDS Strategy](#) has a renewed focus on Health Inequities, the number of

diagnoses of HIV infection among AI/AN peoples continues to rise. The current national HIV/AIDS strategy does not sufficiently address the unique prevention and care realities of Indian Country.

*National Plan.* As part of this national plan, the HHS must examine, in consultation with Tribes, how to best design a framework and objectives for Tribes and AI/AN peoples as a population that is statistically at higher risk for acquiring or dying away from HIV or viral hepatitis. This framework must also incorporate Tribes in all federal government's HIV response activities and include approaches to best capture AI/AN data accurately and respectfully.

*Availability of Care.* Linkage to care is proven to be one of the most effective and straightforward interventions undertaken with a person newly diagnosed with HIV or who has fallen out of care. However, only a handful of providers across the entire Indian health care system have the training necessary to provide HIV specialty care for AI/AN people. Many providers are geographically scattered across the country.

As a result, many AI/ANs are required to rely upon referral care to providers outside the Indian health system and their communities, often traveling hours for appointments. While technically knowledgeable, these providers may not have the experience or the cultural knowledge to provide comprehensive, competent care to AI/AN people living with HIV. The lack of local providers, distance to HIV specialists, and lack of culturally competent serve as deterrents for many AI/AN peoples to seek ongoing care and monitoring.

*Funding.* Funding allocated and directed by the federal and state governments rarely make it to Tribal programs, and the few programs with direct Tribal funding are not sufficient. The U.S. Department of Health and Human Services (HHS) should, as part of its national HIV response, direct funding to support Tribal-specific training, technical and capacity-building assistance, outreach, and education, in addition to services, care, prevention, and treatment.

***Congressional Action:***

- *Increase IHS Funding:* Authorize and increase direct funding to Tribes and the Indian Health Service (IHS) to expand HIV programs.
- *Expand Funding Opportunities:* Ensure that funding opportunities to combat HIV are available to AI/ANs.

***Administrative Action:***

- *Consultation:* Consult with Tribes to develop an AI/AN-specific strategy to address the HIV epidemic in Indian Country.

**RESOURCES**

- [NIHB Resolution 20-03](#): Federal Support for Tribal HIV Programming

## **TRIBAL BEHAVIORAL HEALTH**

Resilience is a key component of mental health and wellness; however, its development is necessitated by experiences of trauma and adversity. The enduring spirit of American Indian and Alaska Native (AI/AN) communities is a prime example of resilience. The historical and intergenerational trauma of AI/AN peoples comes from federal colonialist policies designed to eradicate AI/AN identity and forced assimilation into mainstream culture. Loss of land, language, and cultural connection—including the forced separation of children from their Tribal communities—has created a history of systemic behavioral health inequities. These inequities manifest in several behavioral health-related symptoms, like substance misuse, suicide, stress-related disorders, and interpersonal violence.

To reduce AI/AN behavioral health inequity and improve health outcomes, there must be a deliberate, multi-agency collaborative effort that elevates Tribal sovereignty and encourages Tribes to direct their behavioral health initiatives with minimal administrative burden or restriction. Just as the federal government enacted initiatives to eradicate AI/AN identity, their contemporary response must be equally vigorous for the reclamation of that identity. Resilience and accompanying protective factors begin with acknowledging and addressing AI/AN-specific historical and intergenerational trauma. With that foundation, agencies can strengthen Tribal behavioral health systems and encourage infrastructure and capacity expansion. The strengthening of systems then supports the advancement of specific Tribal prevention, treatment, and recovery services that support culturally respectful healing and the pursuit of wellness.

### **PRIORITIES FOR INDIAN COUNTRY**

To reduce AI/AN behavioral health inequity and improve health outcomes, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Address Historical and Intergenerational Trauma
- B. Strengthen Behavioral Health Systems
- C. Advance Tribal Prevention, Treatment, and Recovery Services

#### ***A. Address Historical and Intergenerational Trauma***

Dr. Maria Yellow Horse Brave Heart describes historical trauma as the “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” and includes the harm to human health from chronic stress and trauma. These impacts are magnified when entire communities experience and re-experience past and present trauma.

Substance use disorders (SUDs) are among the many health problems worsened by racial discrimination and oppression, both historical and current. Research has directly linked historical trauma to substance use among American Indian and Alaska Native (AI/AN) peoples. In addition to increasing risk for substance use disorders, historical trauma and psychological stress for AI/AN adults may contribute to mental health disparities through heightened psychological stress responses to life stressors. Such negative impacts can be exacerbated for more vulnerable populations such as youth and Two-Spirit AI/AN people.

The purpose of discovering, uncovering, and talking about historical and intergenerational trauma is to support healing. Findings suggest that interventions for AI/ANs with SUDs and possibly other chronic

health problems may be more effective if they address social determinants of health such as racial discrimination and historical trauma.

The federal government must support the development of priorities that include both evidence-based practices and culturally respectful practice-based evidence to support healing for Tribal members. Tribal and federal strategic efforts and programs provide existing pathways to build or expand strategies that more effectively address healing from trauma.

*Boarding Schools.* In June of 2021, Interior Secretary Deb Haaland announced a Federal Indian Boarding School Initiative, including a secretarial memo to prepare a report on cemeteries and potential burial sites, with the delivery of the report by April of 2022. The ongoing initiative sheds light on historical and intergenerational trauma caused by federal programs to eradicate AI/AN culture, language, and identity through forced assimilation. The detrimental, intergenerational harm from boarding school policies is associated with increased SUDs, mental illness, and numerous chronic health conditions. As we examine our past, we must continue to look toward the future to identify and address these policies' impact on our communities.

*Indian Mascots and Anti-Defamation.* Negative AI/AN stereotypes and imagery – especially those perpetuated by sports mascots – impact every AI/AN person's self-image and mental well-being and foster ongoing discrimination against all AI/AN citizens. Native mascots, their associated imagery and cheers are specifically destructive to AI/AN youth and contribute to negative thoughts and feelings AI/AN youth experience. A 2019 study [on the psychosocial effects of Native American mascots](#) found that Native mascots “lower self-esteem, lower community worth, less capacity to generate achievement-related possible selves, and greater levels of negative effect.” Further, the study found that Indian mascots increase prejudices among the non-Native population. According to study, “mascots activate, reflect, and/or reinforce stereotyping and prejudice among non-Native persons.” In 2004, the [American Psychological Association](#) called for the immediate retirement of Native mascots based on their contribution to adverse mental health outcomes.

The *Respect for Native Americans in Professional Sports Act of 2015*, H.R. 3487, was introduced in the 114<sup>th</sup> Congress. The bill applied antitrust laws to a professional sports league that used or promoted or allowed a member team or franchisee to use or promote the use of derogatory mascots. However, the bill was never passed.

#### ***Administrative Action:***

- *Flexibility:* Allow Tribes – within existing programs and new funding streams – the flexibility to develop, tailor, and implement support mechanisms that best address their local and specific manifestations of trauma.
- *ACEs:* Review and modify behavioral health and SUD programs to recognize and address the impacts of adverse childhood experiences (ACEs) among AI/AN populations.
- *Trauma:* Develop a Tribal-led research agenda on historical and intergenerational trauma to aid in building knowledge in areas that require further investigation.
- *Effective Trauma Support:* Use existing workforce development and learning centers to intensify education for health, behavioral health, and other professionals about historical and intergenerational trauma and support efforts to address trauma more effectively in clinical and professional settings.
- *Interdepartmental Work:* HHS must partner with the U.S. Department of the Interior (DOI) and Tribal leaders to determine how to best support the mental health needs of Tribal nations.
- *Trauma Connections:* Commit the resources necessary to support grieving and mourning for relatives lost to Indian boarding schools, provide education that directly addresses and informs the

public of these realities, and research the relationship between historical and intergenerational trauma and AI/AN behavioral health.

- *Cultural Resilience*: Dedicate resources to creating programs and funding opportunities for Tribes and Tribal organizations to address the impacts of historical trauma and bolster cultural resilience in AI/AN communities.
- *Study*: Fund a study to assess the impacts of Native mascots and stereotypes on the health of AI/AN people.

## RESOURCES

- [NIHB Resolution 13-01](#): Support for the National Native American Boarding School Healing Coalition's Proposal for the Establishment of a National Commission to Investigate and Report to the United States Congress on the Effects of the Forcible Removal of Children and Subsequent Abuse and Neglect Resulting from the Boarding School Policy Adopted and Implemented During the 19th and 20th Centuries

### ***B. Strengthen Behavioral Health Systems***

Many barriers impact access, quality, and availability of health, behavioral health, and related services for American Indian and Alaska Native (AI/AN) people. These issues include provider and personnel shortages, limited resources, and obtaining services without traveling great distances. Additionally, there are concerns related to funding, such as amounts, distribution mechanisms, allocations, sufficiency, and reporting requirements. Adequate resources must be provided to address the chronic behavioral health needs of Indian Country.

Tribal nations have differing and diverse needs. These differing needs add to the complexity of identifying options for improving behavioral health services for Tribal communities. Therefore, assessing applicable systems and how they interact with Tribal communities and community members is necessary to identify challenges and realistic opportunities for identifying resources for needed services. Additionally, all stakeholders and funders must be involved in this process to create a collaborative and effective behavioral health system.

*Funding*. Tribes have long advocated for greater access to funding streams and direct funding from federal programs rather than through states. Tribal behavioral health programs frequently struggle because of insufficient funding, or programs are only funded only for a finite period. Available funds are often limited and competitive, with restrictive funding formulas, burdensome administrative and reporting requirements, and a compartmentalized approach that does not support holistic, Tribal behavioral healthcare that is comprehensive and culturally appropriate.

*Law Enforcement and Justice Programs*. Due to the lack of accessible services, many AI/AN peoples with mental and substance use disorders often end up in the criminal justice system. Incarceration often compounds preexisting conditions. To address this disparity, Tribes seek enhanced collaboration between behavioral health and criminal justice systems.

*Youth*. The U.S. Surgeon General recently reported that AI/AN youth are at the highest risk of mental health challenges which the pandemic has compounded, and recognized that AI/AN youth experienced some of the starkest disparities in mental and behavioral health outcomes before the COVID-19 public health emergency began.

#### ***Congressional Action:***

- *Priorities*: Prioritize behavioral health and related programs, and workforce development in all budgeting processes.



- *Legislation:* Pass legislation that allows behavioral health parity with medical providers regarding documentation and administrative burden.

#### ***Administrative Action:***

- *Set-Asides:* Create set-aside, non-competitive, direct funding for Tribes in all available funding streams to support behavioral and mental health initiatives.
- *Funding Flexibility:* Increase flexibility in funding requirements to Tribes to support culturally based programming that meets the programmatic needs of Tribal communities.
- *Funding:* Prioritize behavioral health and related programs in all budgeting processes.
- *Grant Coordination:* Develop flexibilities that allow Tribes with multiple federal grants to lower administrative costs, increase integration of funded programs, and enhance collaborative reporting.
- *Reporting:* Streamline all reporting requirements to reduce burdens on Tribal nations receiving funding. Additionally, reduce Substance Abuse and Mental Health Services Administration (SAMHSA) *Government Performance and Results Act* (GPRA) reporting requirements for services, funding, and grants.
- *Telehealth:* Support expansion of telebehavioral health services to additional Tribal communities or clinics.
- *Culturally Appropriate:* Support Tribal efforts to incorporate cultural interventions into program activities that allow Tribes to meet program expectations more effectively.
- *Data Systems:* Support, establish, or improve data collection systems to support the collection of information on behavioral health and substance use disorder (SUD) prevention, treatment, and recovery activities, including suicide prevention activities that is managed locally or in collaboration with Tribal Epidemiology Centers (TECs).
- *Tribal Consultation:* Consult with Tribes on programs that Tribes are eligible for before developing program announcements.
- *Suicide Prevention:* Support Tribal consultation to implement national suicide prevention initiatives, particularly 988, and its efficacy in serving Tribal members.
- *Inpatient Facilities:* Increase funding to expand inpatient psychiatric treatment facilities.
- *Technical Assistance:* Engage Tribes on technical assistance (TA) and support needs before articulating TA requirements.
- *Integrated Care:* Work with Tribes to identify current regulations which may create barriers to a coordinated and integrated approach to SUD care for patients between medical and behavioral health care providers.
- *Justice-Involved:* Support and promote Tribal Healing to Wellness Courts, Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery.
- *Interagency Collaboration:* Strengthen collaborations among health, behavioral health, and justice system programs of the Indian Health Service (IHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Health and Human Services (HHS), the U.S. Department of Justice (DOJ), and the U.S. Department of the Interior (DOI) to strengthen programs for AI/AN youth in collaboration with tribal courts to create alternatives to incarceration that incorporate Tribal values, culture, and tradition in programming that addresses behavioral health issues.

#### **RESOURCES**

- [NIHB Resolution 17-08](#): Healing Through Culture: A Request to Fund Substance Abuse Intervention and Prevention Programs for American Indian/Alaska Native Youth that Promote High Self-Esteem and Resilience Through Cultural Enrichment
- [NIHB Resolution 21-03](#): Support for a Special Behavioral Health Program for Tribes

### ***C. Advance Tribal Prevention, Treatment, and Recovery Services***

The lived experiences of American Indian and Alaska Native (AI/AN) historical trauma and adversity have contemporary descriptions and diagnoses: adverse childhood experiences (ACEs), post-traumatic stress disorder (PTSD), substance use disorders (SUDs), and suicidal ideation—all of which have accompanying strategies for prevention, treatment, and recovery.

Following an intervention, services should provide ongoing, comprehensive support for treatment, recovery, and prevention. Existing systems must be strengthened to assess the availability of critical services, gaps in services, and opportunities for improvement to meet community needs.

*Tribally Directed Programs.* Tribes know best the needs of their communities. However, many federal programs are created without consulting Tribes. Moreover, many preventions, treatment, and recovery funding opportunities impose program, evaluation, and reporting requirements that limit Tribes' ability to address the needs of their communities. Additionally, many funding opportunities require the predominant use of narrowly defined Western interventions and evidenced-based practices while restricting traditional cultural interventions and Tribal practice-based evidence.

*Scope of Programming.* Tribes often face service-related challenges, including funding, staffing, facility shortages, and service quality. As such, many Tribes do not receive or cannot provide a full continuum of service for their Tribal members. Tribal members must often leave their community and travel great distances to receive care, and in some cases, to be denied the service for their members. Tribes continue to advocate to expand the scope of programming to ensure that Tribal members can receive vital care within their communities.

*Bills.* The *Native Behavioral Health Access Improvement Act of 2021* has been introduced in the House and Senate in the 117<sup>th</sup> Congress. This legislation would advance additional Tribal priorities, including funding. It will reach every Tribe in a Tribally designed and approved formula (rather than competitive grant), requiring minimal reporting and allowing Tribes to receive the funding through self-determination contracting or self-governance compacting mechanisms.

#### ***Congressional Action:***

- *Access:* Secure passage of the *Native Behavioral Health Access Improvement Act of 2021*.
- *Suicide Prevention:* Pass comprehensive legislation to address suicide and increase suicide prevention among AI/AN communities.

#### ***Administrative Action:***

- *Reentry Programs:* Support culturally and spiritually based programming and healing that aligns with the diversity and needs of distinct Tribal populations.
- *Suicide Prevention:* Support comprehensive suicide prevention efforts, including integrated behavioral health services, screening and assessment, coordinated crisis response and protocols for youth and adults, and ensured continuum of care.
- *SUD Services:* Support and fund Tribally led comprehensive substance abuse use (SUD) programs that provide a full continuum of wraparound services. This includes support for primary prevention programs, residential and dual diagnosis treatment facilities, peer recovery support systems, harm reduction services, medication-assisted treatment, intensive outpatient therapy, transitional housing, and diversion programs.
- *Trauma-Informed:* In coordination with Tribes, establish trauma-informed interventions to reduce the burden of substance use disorders, including opioids.

- *NHSC*: Direct the Health Resources and Services Administration (HRSA) National Health Service Corps (NHSC) Program to prioritize the recruitment of psychiatrists, behavioral health professionals, and other practitioners to work in Tribal facilities.
- *Assessments*: Support Tribes' ability to conduct self-assessment and use those results to implement their own Tribal best practices in response to discovered needs.

**RESOURCES**

- [NIHB Resolution 21-05](#): Tribal Health Data Access Improvement

**EMERGENCY PREPAREDNESS AND RESPONSE**

American Indian and Alaska Native (AI/AN) Tribes are sovereign nations with the authority and responsibility to maintain the safety and well-being of their citizens. Thus, in the context of emergency preparedness, Tribes have the authority to engage in preparedness and response activities using methods most appropriate for their communities. Furthermore, due to the unique circumstances of Tribes, emergency response in Tribal communities may need to look different from in other jurisdictions.

The COVID-19 pandemic hit Indian Country especially hard, with a devastating impact on lives, communities, and local economies. The public health emergency (PHE) has highlighted where systems have not served Tribes effectively under real-world conditions. As the pandemic continues to evolve, improvements in these systems through close collaboration with Tribes will be vital to weather the public health emergency successfully. The COVID-19 pandemic has also highlighted Tribes' abilities to lead successful community-grounded efforts to protect their people, such as through the imposition of widespread health and safety restrictions and the launch of successful vaccination campaigns. The federal government must help Indian Country build upon these successes.

**PRIORITIES FOR INDIAN COUNTRY**

To expand Tribal capacity for emergency preparedness and response and to strengthen COVID-19 response and recovery efforts, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Improve COVID-19 Pandemic Response and Recovery Efforts
- B. Expand Emergency Preparedness and Response Capabilities in Indian Country

***A. Improve COVID-19 Pandemic Response and Recovery Efforts***

At the time of this writing, COVID-19 transmission remains dangerously high. Despite alarming gaps in population-specific COVID-19 health disparities data, available information demonstrates that Tribal communities face a disproportionate burden from this public health crisis. A 2022 [Kaiser Family Foundation analysis](#) found that AI/ANs were three times as likely to be hospitalized and over twice as likely to die from COVID-19 as their White counterparts.

*Underlying Conditions.* Indian Country has a higher percentage of people at higher risk for adverse outcomes from COVID-19. AI/AN communities continue to face significant chronic health disparities, especially for conditions like diabetes and respiratory illnesses, which increase the risk of a poor COVID-19 health outcome, including death. Without bold and substantive investment in the Indian health system and public health capacities, these disparities and conditions will continue to go unaddressed, leaving Indian Country more vulnerable to COVID-19 outbreaks. The Indian health system needs the tools necessary to address the disparities and underlying conditions.

*ICU and Capacity.* Limited intensive care unit (ICU) capacity to address a surge of COVID-19 cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars. These funds are typically used to pay for specialty care not otherwise available from the IHS or Tribal health care facilities. This rationing of critical health care services must be addressed through a combination of an infusion of funding, construction of health care facilities, and accompanying staffing, equipment, and other items needed to provide critical services for the COVID-19 and other patients.

*Funding Shortfalls.* The COVID-19 relief packages enacted in 2020 and 2021 provided a significant amount of funding but limited the uses and deadlines for spending. This funding provided initial testing, vaccines, personal protective equipment (PPE), and other specific pandemic-related needs. However, much of the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* funding was delayed to Tribal nations due

to litigation. The truncated deadline diminished the ability of the Indian Health Service (IHS) and Tribal nations to build capacity, such as hiring and finding space or locations to accommodate social distancing at clinics.

Moreover, this funding did not address the facilities and staffing needs, increasing the ICU, triage, emergency room, or urgent care capacity. It also did not address the underlying conditions, such as diabetes, cancers, behavioral health issues, and necessary prevention, treatment, and other interventions which could have reduced the risks of pandemic deaths, hospitalizations, or other trauma arising from this pandemic.

***Congressional Action:***

- *Funding:* Substantial, direct, and set-aside funding for Tribes in future COVID-19 relief funding, that is flexible and available until expended. The *CARES Act* deadline expired in December 2020, and the Administration authorized the funds to be obligated instead of spent by the deadline, but the deadline needs to be retroactively extended.
- *ISDEAA:* Allow non-IHS funding to be distributed through IHS, using pre-existing mechanisms for quickly distributing funds to Tribes.
- *Reporting:* Allow minimal and streamlined reporting requirements to reduce bureaucracy and not overburden limited staff resources.
- *Culturally Appropriate:* Provide funding to the Indian health system for culturally appropriate outreach to improve public health activities to combat COVID-19, including those to reduce vaccine hesitancy.

***Administrative Action:***

- *Accurate Data:* The Centers for Disease Control and Prevention (CDC) must work with states, IHS, and other stakeholders to ensure that complete and accurate data is being captured and shared with Tribes to effectively respond and recover from COVID-19, and other similar public health emergencies.
- *Adequate Supplies:* Ensure adequate supplies of PPE, COVID-19 tests and related supplies, and other material resources are secured for the Indian health system providers and Tribal communities.
- *Permanent Authorities:* Extend and make permanent telemedicine and other health care delivery efforts that mitigate COVID-19 spread and increase access to care.
- *Capacity:* Improve the capacity of the Indian health system to handle COVID-19 surges and mass vaccination events, and address increased staffing needs:
  - Require the U.S. Public Health Service Commissioned Corps (Corps) to deploy additional officers to Indian Country during this public health emergency.
  - Provide support for cross-training non-clinical staff to assist in vaccination (under supervision of providers).
  - Support other Tribally driven solutions through funding and policy flexibilities.
- *Vaccine Acquisition:* Increase the volume of vaccines through allocations that reflect and address the higher risks in Indian Country and give Tribes maximum flexibility to obtain vaccines through IHS, the state, or directly from the federal government, depending on what the Tribe determines best for their nation.
- *Vaccination Deployment:* Provide support for the vaccine rollout and related activities, including funding, policy flexibilities, and technical assistance (TA).
- *Supply Chain:* Work with Tribes to identify ongoing supply chain issues and design feasible solutions.

**RESOURCES**

- [NIHB Resolution 21-01](#): Promoting and Prioritizing AI/ANs in the DC Metropolitan Area for the COVID-19 Vaccine

### ***B. Expand Emergency Preparedness and Response Capabilities in Indian Country***

Planning for, responding to, and recovering from man-made or natural disasters and emergencies in Tribal communities can pose unique challenges. Among other challenges, these can include lack of resources, the complexity around jurisdiction, and lack of understanding among partners working with Tribes. Furthermore, many Tribal nations are in rural or isolated areas, making them the first or only responders to emergencies or man-made or natural disasters. As a result, Tribal preparedness and response efforts may differ from Indian country efforts.

Tribal nations have experienced natural disasters at devastating levels for the last several years. Additionally, fires, floods, tornadoes, and oil spills that originated outside Tribal boundaries also affect Tribal nations. These kinds of disasters continue and have complicated COVID-19 response efforts, compounding the harm resulting from the pandemic.

*Emergency Declarations.* Tribal nations request disaster assistance to help save lives and rebuild their communities. When Congress amended the *Robert T. Stafford Disaster Relief and Emergency Act* in 2013, it provided Tribal nations with a path to request a presidential emergency or major disaster declaration.

*Funding.* Tribal nations need additional funding to build baseline capacities in their emergency preparedness and response programs. Investment in Tribal readiness has not kept pace with investment in state and local preparedness programs. Tribal governments must access resources and tools to strengthen essential emergency management capacities and core capabilities. More funding is needed to ensure Tribes have sufficient training, staff, plans, equipment, and other critical capacities to respond efficiently and effectively to the next disaster or emergency. Equitable funding will enable Tribal nations to help more Tribal citizens and non-Tribal citizens who reside within their jurisdiction during a man-made or natural disaster.

*Climate Change.* Climate-related disasters like wildfires and floods have been devastating for many Tribal communities, and the effects of climate change continue to worsen. Many Tribes are located in regions especially vulnerable to climate disasters. [Recent research](#) has shown how past federal government policies have led to conditions in which some groups – like Tribes – are more burdened by climate change than others. Key among these, past U.S. policies forced the migration of Tribes far from their homelands to their present-day lands, which are on average [more exposed to climate change risks](#) and hazards, including more extreme heat and less precipitation. For example, nearly half of Tribes now experience heightened wildfire hazard exposure. These findings reinforce the critical importance of the federal trust responsibility. To fulfill the obligation to protect American Indians and Alaska Natives (AI/ANs), the federal government must prioritize Tribal climate resilience.

Climate resilience requires identifying risks and vulnerabilities so Tribes can plan to mitigate those risks and prepare for potential disasters. Many Tribes need funding for climate hazard and risk assessments. For example, Tribes in Alaska need an assessment of the risks associated with decreasing sea ice, rising sea levels, and increasing ocean acidification, impacting fishing and aquaculture, health, and local economies. Tribes need additional funding for climate adaptation work, training for first responders, and community education on climate readiness.

#### ***Administrative Action:***

- *Increase Funding:* Increase and prioritize funding to assist Tribes in increasing their emergency preparedness capacity to plan for, respond to, and recover from disasters and emergencies in Tribal communities.

- *Direct Funding:* All emergency preparedness and disaster relief funding should go directly to Tribes and not be funneled through states.
- *Hazard Assessments:* Fund climate change hazard assessments to identify specific risks Tribes are facing now and will face in years to come.
- *Climate Resilience:* Increase and prioritize funding for climate resilience, including climate adaptation work, first responders training, and community education.

**EMPOWERED HEALTH CARE WORKFORCE**

The health care workforce is the backbone of any healthcare system. However, many Tribes have experienced dramatic longstanding health care provider shortages and recruitment and retention issues. The COVID-19 pandemic has stretched the already understaffed Indian health facilities to crisis standards of care.

Indian Country needs new strategies and innovative approaches to ensure the Indian health system has the workforce it needs. With federal support, Tribes can expand upon successful innovations like the Community Health Aide Program (CHAP) and programs that invest in students pursuing education in health care fields. With sufficient investment and new strategies for recruitment, retention, resource sharing, and training, Indian Country will be able to provide high-quality care both now (during the specialized conditions of the pandemic) and for years to come.

**PRIORITIES FOR INDIAN COUNTRY**

To address the chronic Tribal health workforce shortages, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Ensure a Sustainable Tribal Health Care Workforce
- B. Support and Expand the Community Health Aide Program (CHAP) and the Dental Health Aide (DHAT) Program

***A. Ensure a Sustainable Tribal Health Care Workforce***

The Indian Health Service (IHS) and Tribal health care providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at IHS sites, estimated vacancy rates are as follows: physicians (34 percent); pharmacists (16 percent); nurses (24 percent); dentists (26 percent); physician's assistants (32 percent); and advanced practice nurses (35 percent). Current vacancy rates make it nearly impossible to operate a quality health care program. With competition for primary care physicians and other practitioners at an all-time high, the situation is unlikely to improve soon. IHS cannot meet workforce needs with the current strategy. To strengthen the health care workforce, IHS and Tribal programs need investment from the federal government to educate, recruit, and expand the pool of qualified medical professionals.

*GME Program.* The Health Resources and Services Administration (HRSA) Graduate Medical Education (GME) Program prepares residents to provide high-quality care, particularly in rural and underserved communities. Few GME programs are located in rural American Indian and Alaska Indian (AI/AN) communities. Most Teaching Health Centers are in Federally Qualified Health Centers (FQHCs), Rural Health Clinics, and Tribal health centers, all of which are important to creating a sustainable health workforce in Indian Country. There remains room for continued improvement in creating opportunities and incentives for medical students to work in Tribal communities, for example, by conditioning receipt of GME funds on placement in Tribal communities or by creating a separate Tribal GME program altogether. These measures would enlarge the Tribal health workforce and create a more sustainable model for recruiting providers.

***Congressional Action:***

- *Tax Exemption:* Make the IHS Scholarship and Loan Repayment Program payments tax-exempt.
- *Expansion:* Increase funding for IHS scholarship opportunities, prioritize students committed to returning to the Tribal communities from which they came, and expand the eligibility categories to include other non-clinical health professionals, such as health administration professionals.
- *Residency:* Create new and additional set-aside funding for Tribal medical residency programs.



- *Tribal GME Program*: Develop, through Tribal consultation, a Tribal GME program through which Tribes have access to funding enhancements for Tribal medical residency programs.
- *Authority*: Provide full Title 38 personnel authorities to the Indian health system.
- *Incentives*: Fund additional incentives for medical professionals who choose to work at IHS and Tribal sites, including flexible housing options and increased living support for spouses and families.

***Administrative Action:***

- *Recruitment and Retention*: Improve and incentivize the recruitment and retention of health care providers, medical professionals, and medical support and administrative staff throughout Indian Country through collaboration with the Administration and the Tribes.
- *Rural*: HRSA must include IHS and the staffing of the Indian health system as part of any rural health workforce agenda.
- *GME*: Create opportunities for medical students to work in Tribal communities by expanding access to GME funds for Indian health providers.
- *Staffing Packages*: Fund and make eligible project funding under Joint Venture and Small Ambulatory Programs for a full staffing package.
- *STEM*: Fund science, technology, engineering, and math (STEM) educational programs for AI/AN middle and high school age students.

**RESOURCES**

- [NIHB Resolution 13-02](#): Support for the American Indian Public Health Track of the Master of Public Health Program, North Dakota State University

***B. Support and Expand Community Health Aide and Dental Health Therapy Aide Programs***

Since the 1960s, the Community Health Aide Program (CHAP) has empowered frontline medical, behavioral, and dental providers to serve Alaska Native communities, successfully expanding access in these communities to urgently needed health and dental services. This program complements but is distinct from the Community Health Representative (CHR) program, which many Tribes rely upon to ensure patients can access appointments for treatment and other services. Additionally, most of the medical, behavioral, and dental providers under CHAP come from the communities they serve, meaning CHAP is now a crucial pathway for American Indian and Alaska Native (AI/AN) peoples to become health care providers. The *Indian Health Care Improvement Act* (IHCIA) authorized the Indian Health Service (IHS) to expand the CHAP to Tribes outside Alaska. Based on the IHCIA and the CHAP's success in Alaska, IHS developed CHAP expansion policies from 2016 to 2020.

*DHATs*. The IHCIA includes a provision (25 U.S.C. § 1616l (d)) that limits Tribes wanting to utilize Dental Health Aide Therapists (DHATs) under CHAP to those in states that license dental therapists. This provision raises a barrier between Tribes and oral health care services. However, many Tribes have begun actively engaging with states to ensure Tribes can employ dental therapists and have their services reimbursed by state Medicaid programs.

*CHAP Education Programs*. As IHS continues to expand CHAP, Tribal communities remain well-positioned to recruit providers to serve their communities with cultural competence and technical skill. Tribal colleges are natural training sites for CHAP providers, and the federal government should support the establishment of CHAP education programs at Tribal colleges and universities.

***Congressional Action:***

- *Amendment:* Amend the IHCA (25 U.S.C. § 16161 (d)) to remove the state approval requirement for Tribal DHATs under CHAP.
- *CHAPs:* Continue expanding CHAPs, including funding for IHS to support CHAP expansion and CHAP education and certification programs, such as the Alaska Dental Therapy Education Program.
- *Scholarship and Loans:* Expand the authority and funding of the IHS Scholarship and Loan Forgiveness Programs to include CHAP providers as eligible beneficiaries.

***Administrative Action:***

- *Certifications:* Establish CHAP infrastructure, including certification boards and Academic Review Committees, at the national and area level.
- *CHAP Certification and Education Programs:* Prioritize Tribal educational institutions establishing regional CHAP education and certification programs.
- *DHAT Guidance:* Revise the IHS guidance issued in January 2014 that states Tribes could only employ DHATs with the state legislature's permission. Federal statutes require this only under the CHAP expansion.
- *AFAs:* Include DHAT positions in Annual Funding Agreements (AFAs) for Tribes located in states with dental therapy licensing laws.
- *Report:* Publish a comprehensive report on the impact of DHATs under CHAP, including patient safety, patient satisfaction, provider retention, and other community-level health outcomes.
- *OPM:* Direct the Office of Personnel Management (OPM) to publish a federal position description for dental therapists, not specific to CHAP.
- *Workforce Development Grants:* Include dental therapy programs as eligible applicants for dental health care and dental health workforce development federal grants, especially those issued from the Health Resources and Services Administration (HRSA).

**RESOURCES**

- [NIHB Resolution 19-01](#): Support for Coverage of Oral Health Care Services under Medicare

## ACCESS TO QUALITY HEALTH CARE

Access to quality health care is a key component of the federal trust responsibility and treaty obligations recently reaffirmed in *Rosebud v. United States*, an Eighth Circuit Court of Appeals case. The Court held that the 1868 Fort Laramie Treaty obligated the United States to provide “competent physician-led health care” to the Rosebud Sioux Tribe. This decision is also a positive affirmation of the federal trust responsibility to provide a certain standard of health care that is also culturally appropriate.

In so doing, the federal government must work to eliminate barriers to access and ensure that Indian health care providers have the resources needed to provide quality health care. American Indian and Alaska Native (AI/AN) people must access culturally appropriate care that is rooted in their traditional practices. Investment in innovations like telehealth capabilities will reduce barriers related to geographic distance, provider shortages, or pandemic conditions. Further, the federal government must reinforce the ability of Medicare and Medicaid to reimburse for services provided to AI/ANs at Indian health facilities. Third party payers are an essential element of the Indian health funding puzzle and any restrictions to reimbursement should be examined.

Finally, throughout all these issues, care must be taken to ensure all members of Tribal communities can access care, including those with specialized needs. Some groups, like veterans, those in remote or rural areas, the elderly, or those with low incomes, face additional barriers to healthcare and frequently experience health inequities. These groups need special consideration to ensure injustices are remedied and not perpetuated.

### **PRIORITIES FOR INDIAN HEALTH**

To increase access to quality health care for AI/AN people, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Remove Barriers that Inhibit Integration of Traditional Practices
- B. Advance Telehealth Capacity in Indian Country
- C. Improve Services for Veterans
- D. Strengthen the Role of Medicaid in AI/AN Healthcare
- E. Increase Access and Financial Support for Indian Health Through Medicare

#### ***A. Remove Barriers that Inhibit Integration of Traditional Practices***

Recognizing Tribal sovereignty means recognizing the sovereign right of Tribal nations to utilize traditional practices to provide for the health of their people. Traditional medicine is central to many Tribal cultures and effectively treats many of the chronic health issues faced by American Indian and Alaska Native (AI/AN) peoples. Various operating divisions within the U.S. Department of Health and Human Services (HHS) have recognized traditional practices and their efficacy and effectiveness. Despite its effectiveness and existence from time immemorial, traditional practices are still blocked from inclusion in the contemporary health care delivery system. Tribal nations experience many barriers when seeking reimbursement for this treatment or when attempting to include traditional and cultural practices and activities as grant activities.

#### ***Administrative Action:***

- *Grants:* Agency Notice of Funding Opportunity (NOFO) announcements should recognize the value and applicability of cultural and traditional practices as authorized grant activities.
- *Privacy:* Respect Tribal decisions to keep sacred and cultural knowledge private. It is important to note that some Tribes may wish cultural knowledge and wisdom to remain with the knowledge keepers such as elders, traditional healers, storytellers, and AI/AN peoples.

- *Flexibility:* Work with Tribes to design innovative and culturally tailored Tribal traditional models of health promotion programs and healing interventions, provide additional funding to support unique and traditional AI/AN health promotion efforts.
- *Insurance:* Encourage private insurers to cover traditional medicine.

### ***B. Advance Telehealth Capacity in Indian Country***

The expansion of telehealth during the COVID-19 pandemic represents a paradigm shift in health care delivery. Telehealth can lead to greater access to health care from relatively underutilized to widely adopted and utilized. Telehealth can bridge geographic distances between provider and patient, which is particularly important in rural and remote Tribal communities where vacancy rates and lack of transportation are significant barriers to accessing health care. In Tribal communities where it is available, telemedicine has dramatically improved access to care, accelerated diagnosis and treatment, avoided unnecessary medivacs, expanded local treatment options, and reduced Medicaid costs.

Despite the potential, several barriers inhibit the ability of Tribes to take full advantage of telehealth. First, the Indian health system lacks the resources to build out the telehealth infrastructure. Also, Indian health care providers depend on reimbursements through Medicare and Medicaid. However, existing Medicare and Medicaid laws and regulations make accessing telehealth reimbursements difficult and restrictive. While existing waivers provided through the public health emergency (PHE), such as those that allow the patient to access care from home or receive care through audio-only means, have expanded access to reimbursements, those waivers will sunset at the end of the PHE. The Biden administration and Congress need to work to eliminate these barriers.

*Resources.* The *Infrastructure Investment and Jobs Act* (IIJA) provided \$2 billion for Tribal broadband, including telehealth, authorized funds. However, to use these funds for telehealth, the basic infrastructure such as mapping, planning, design, construction, cabling, easements, rights-of-way, and many other things must be in place before telehealth can be established and carried out. Assuming there are funds still available for telehealth, it may be years before any telehealth benefits can be developed or realized from this funding stream.

#### ***Congressional Action:***

- *Expansion:* Expand access to telehealth by establishing dedicated funding streams and eliminating regulatory barriers to third-party reimbursement for Indian health providers.
- *Health Professionals:* Expand the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian health system.

#### ***Administrative Action:***

- *MOU:* Recommend that the Federal Communications Commission (FCC) enter into a memorandum of understanding (MOU) with IHS to coordinate health information technology (HIT) and telehealth efforts to utilize all government resources best.
- *Waivers:* Maintain current telehealth waivers throughout and beyond the public health emergency to ensure the telehealth delivery system remains a viable option for Indian health care service delivery.

### ***C. Improve Services for Veterans***

The United States has a dual responsibility to American Indian and Alaska Native (AI/AN) Veterans: one obligation specific to their political status as members of federally recognized Tribes and another specific to their service in the Armed Services of the United States. AI/AN people serve in the Armed Forces at nearly five times the national average and at higher rates per capita than any other group. According to

current estimates, there are over 140,000 AI/AN Veterans. In a [2018 Veterans Health Administration \(VHA\) Survey of Veteran Enrollees' Health and Use of Health Care](#) (“2018 Survey”), the VHA reported having 217,580 patients who self-identified as AI/AN – representing 2.5 percent of the agency’s enrolled patient population.

Despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal nations and the entire United States, AI/AN Veterans continue to experience some of the worst health outcomes and face the greatest challenges to receiving quality health services among all Americans.

*Behavioral Health.* In FY 2014, the Veterans Health Administration’s (VHA) Office of Health Equity reported higher rates of mental health disorders among AI/AN Veterans compared to non-Hispanic White Veterans, including rates of post-traumatic stress disorder (PTSD) (20.5 percent vs. 11.6 percent), depression symptoms (18.7 percent vs. 15.2 percent), and major depressive disorder (7.9 percent vs. 5.8 percent). From 2001 to 2015, suicide rates among AI/AN Veterans increased by 62 percent (up from 50 percent in 2001 to 128 in 2015).

*Quality of Care & Accessibility.* Across the board, AI/AN Veterans report higher rates of issues around quality of care and accessibility that have undermined trust in the VHA system and left AI/AN Veterans significantly more vulnerable to adverse health outcomes, including COVID-19. For instance, the 2018 Survey found that only 66.9 percent of AI/AN Veterans reported that it was easy to schedule medical appointments in a reasonable time, compared to 78.7 percent of White Veterans.

The 2018 Survey also found that 67.2 percent of AI/AN Veterans reported easy access to the local U.S. Department of Veterans Affairs (VA) or VA-approved facility (compared to 82.7 percent of White Veterans), and 65.7 percent of AI/AN Veterans reported short wait times after arriving for an appointment (compared to 80.6 percent of White Veterans). AI/AN veterans are disproportionately dissatisfied with the care that they are receiving through the VA. 45.2 percent of AI/AN Veterans reported prior dissatisfaction with the level of VA care received – nearly double the rate for White Veterans.

*Previous actions.* The VA-Indian Health Service (IHS) Memorandum of Understanding (MOU) establishes a framework for coordination and partnership between the VA and the IHS to leverage and share resources and investments supporting each organization’s mutual goals. Congress passed three AI/AN Veterans health laws on December 24, 2020: the *Native American Veterans PACT Act* which eliminates copayments for AI/AN Veterans accessing VA healthcare, the *Veterans Affairs Tribal Advisory Committee Act of 2019*, and the *PRC for Native Veterans Act* which clarifies that the VA and the U.S. Department of Defense (DoD) are required to reimburse IHS and Tribal health programs for healthcare services provided to AI/AN Veterans through an authorized referral.

#### ***Congressional Action:***

- *IHCPs:* Include pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement as Indian Health Care Providers (IHCPs).

#### ***Administrative Action:***

- *Consultation:* The VHA and IHS should consult with Tribes regarding the MOU operational plan to develop quantifiable goals and objectives similar to those of Tribal Health Programs (THPs), including quality services and culturally responsive care for Native Veterans.
- *Workgroup:* Establish a workgroup, in conjunction with IHS, to develop the Purchased Referred Care (PRC) addendum to ensure that all issues related to PRC services, patient and escort travel, and billing and reimbursement processes are taken into consideration the VA.

- *Collaboration*: Establish written guidance, agreements, and policies to identify how the VHA and IHS can collaborate to streamline care and access to health care for AI/AN Veterans.
- *Peer-to-Peer*: Rural Native Veteran Health Care Navigator Program should incorporate a peer-to-peer or veteran-to-veteran element that would allow AI/AN Veterans to serve as navigators for other AI/AN Veterans seeking resources.
- *Veterans Liaison List*: The VHA should consult with Tribes and work through their MOU with IHS to create and publish an active list of available Veterans Liaisons and Tribal Veterans Representatives across all IHS and VHA regions. The VA website must include a section dedicated to AI/AN Veterans' resources and programs.
- *Interoperability of VA-IHS Electronic Health Records*: The VA-IHS MOU mentions a goal of interoperability between the IT systems used by both agencies. The agencies should establish an advisory group composed of Tribal leaders, Tribal technical assistants, subject matter experts, and federal representatives to ensure continued progress to this goal.
- *Interoperability of Tribal-VA Electronic Health Records*: The VHA must provide technical assistance (TA) to Tribes at the local and regional levels to ensure and implement coordination of electronic health records.
- *Health Equity*: Work with the VA Tribal Advisory Committee (TAC) and consult with Tribes to inform the implementation of the VHA Health Equity Action Plan.
- *Cultural Competency*: Improve cultural and linguistic competency and the diversity of the VA health-related workforce.
- *Priorities*: VHA and IHS must prioritize AI/AN Veterans' mental and behavioral health and work with other federal agencies to develop more AI/AN Veterans' resources. The unique experiences must inform these resources of AI/AN Veterans.

## RESOURCES

- [2021 VA-IHS Memorandum of Understanding](#)
- [VHA Health Equity Action Plan \(2019\)](#)
- [2019 GAO Report: VA and Indian Health Service](#)
- [Testimony of National Indian Health Board before House Veterans Affairs Committee](#)

### ***D. Strengthen the Role of Medicaid in AI/AN Health Care***

Medicaid plays an integral role in ensuring access to health services for American Indian and Alaska Native (AI/AN) peoples and provides critically essential funding support for the Indian health system overall through third party revenues. In fact, in many places across Indian Country, reimbursements from Medicaid have enabled Indian health facilities to provide medical services that were previously unfunded by the annual appropriations.

*Third Party Revenues.* To ensure financial health, Indian Country must protect and strengthen access to third party revenues within the Indian health system. Third party revenues significantly contribute to the financial stability of Indian health system clinics and hospitals. According to a [2019 report by the GAO](#), between FY 2013 and FY 2018, third party collections at Indian Health Service (IHS) and Tribal facilities increased by \$360 million, with 65 percent of the increase coming from Medicaid.

*Enrollment.* Tribes are also seeing success in getting their people enrolled into Medicaid, and it is becoming a more significant piece of the Indian health funding calculus. Data shows that the number of AI/AN people with Medicaid increased from 1,458,746 in 2012 to 1,793,339 in 2018. This increase of 334,593 AI/AN enrollees is a 23 percent increase over 2012. In 2018, 34 percent of all AI/AN people had Medicaid coverage compared to 30 percent in 2012. This creates an increased urgency to ensure that the Medicaid program fully reimburses providers for their services.

***Congressional Action:***

- *Oral Health Care:* Establish standardized oral health care benefits for AI/ANs under state Medicaid programs.
- *Reimbursements:* Authorize Medicaid reimbursements for all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the IHCA—referred to as Qualified Indian Provider Services—when delivered to Medicaid-eligible AI/AN peoples.
- *Income Level:* Create an optional eligibility category under federal Medicaid law providing authority for states to extend Medicaid eligibility to all AI/AN peoples with household income up to 138 percent of the federal poverty level (FPL).
- *Managed Care:* Clarify that states cannot mandate AI/ANs into managed care plans, including those enacted through waivers. This exemption cannot be bypassed using the HHS Secretary’s waiver authority.
- *DSH Payments:* Work with Tribes to develop a methodology for calculating Medicaid Disproportionate Share Hospital (DSH) payments that considers the uniqueness of the Indian health care system.
- *Four Walls:* Amend Section 105(a)(9) of the *Social Security Act* (SSA) to clarify the definition of “clinic services” and ensure that services provided through an Indian health care program are eligible for reimbursement at the OMB/IHS all-inclusive rate, no matter where the service is provided.
- *Traditional Healing:* Authorize reimbursement for traditional healing services through Medicaid, including amending Section 1905 of the SSA to make traditional medicine a “mandatory benefit” that states must cover through their Medicaid program.
- *Providers:* Authorize reimbursement for additional provider types that render behavioral health services through Medicaid, including licensed professional counselors, licensed marriage and family therapists, and similar types of excluded providers.
- *Substance Abuse:* Reduce barriers in the Medicaid program to treat substance use disorders (SUDs).

***Administrative Action:***

- *Telehealth:* Encourage states to increase Medicaid telehealth reimbursement for Indian Health Care Providers (IHCPs).
- *Exemptions:* Ensure that AI/AN people are exempt from additional restrictions on Medicaid access, such as work requirements.
- *Managed Care:* Clarify that states cannot mandate AI/ANs into managed care plans, including those enacted through waivers.
- *Traditional Healing:* Work with states to help them file Section 1115 waivers to obtain Medicaid reimbursement for traditional practices.
- *Tribal-State Consultation:* Encourage Tribal consultation at the state level and enforce State Plan Amendment (SPA) requirements for Tribal consultation.

**RESOURCES**

- [NIHB Resolution 19-01](#): Support for Coverage of Oral Health Care Services under Medicare
- [NIHB Resolution 19-04](#): Resolution on the CDC Tribal Public Health Agenda

***E. Increase Access and Financial Support for Indian Health through Medicare***

Medicare plays an essential role in the Indian health system by providing additional coverage for American Indians and Alaska Natives (AI/AN) who are elderly or have specific disabilities. Reimbursements from

Medicare serve as a critically important funding source for Indian health providers and have enabled the expansion of services in many areas. Because of this, strengthening and expanding Medicare reimbursements for services can protect the financial health of the Indian health system.

However, many Medicare rules and policies do not align with the trust responsibility or fit the Indian health system. For example, to cover Medicare Part B premiums for citizens, Tribes must reimburse the beneficiary for their premium payment. For a person who cannot afford the premium, paying it and waiting for reimbursement results in undue financial hardship. Employers and unions can sponsor premiums and, by extending the same opportunity to Tribes, would both recognize Tribal sovereignty and streamline the payment process for the Tribe and beneficiary.

*GME Program.* To equitably account for workforce shortages and other inequities in Indian Country, the Centers for Medicare and Medicaid Services (CMS) should require a Tribal set-aside within the annual Medicare funding of \$16 billion in the Graduate Medical Education (GME) program. CMS should require service to Tribal communities, assign slots specifically to Tribal provider facilities, and remove administrative impediments to participation in GME funding by Tribe-operated hospitals. If this improvement requires a legislative fix, the Administration should report this back to Tribes. Further, through Tribal consultation, CMS should develop a Tribal GME program through which Tribes have access to funding enhancements for Tribal medical residency programs. This program must account for the alternative payment methodology of Tribal health care delivery and cost-reporting requirements and provide funding for all services needed to operate such a program.

#### ***Congressional Action:***

- *Reimbursements:* Ensure parity in Medicare reimbursement for Indian Health Care Providers (IHCPs) by authorizing 100 percent reimbursement for services provided. Since Indian health care providers cannot bill their patients, they generally only receive 80 percent reimbursement for the services they provide.
- *Traditional Healing:* Authorize reimbursement for traditional healing services through Medicare.
- *Providers:* Include pharmacists, Licensed Marriage and Family Therapists (LMFTs), licensed professional counselors, and other providers as eligible provider types under Medicare for reimbursement.
- *Telehealth Waiver:* Permanently extend the existing waiver authority for telehealth under Medicare.
- *Dental Care:* Create a dental benefit under Medicare that does not require enrollment in managed care.
- *OMB/IHS All-Inclusive Rates:* Reimburse the OMB/IHS All-Inclusive Rate for telehealth services under Medicare.
- *Cost-Sharing:* Exempt AI/AN people from all Medicare penalties or cost-shares. AI/AN people are exempt from these items under Medicaid. Also, before its elimination in the *Tax Cuts and Jobs Act*, AI/ANs were exempt from the Shared Responsibility Payment under the *Affordable Care Act* (ACA). These exemptions are required to establish consistency with other federal authorities.

#### ***Administrative Action:***

- *Telehealth:* Expand Medicare reimbursement of audio-only telehealth and communications technology-based services. This includes expanding the ability to provide direct supervision via audio-only means, adding more services to the telehealth benefit permanently, and removing other restrictions on telehealth and communications technology-based services.
- *OMB/IHS All-Inclusive Rate:* Ensure that Medicare is reimbursing all Indian health care providers at the OMB/IHS all-inclusive rate.



- *Part B Premiums:* Allow direct sponsorship of Part B premiums by Indian health programs.
- *Part D:* Simplify and streamline reimbursement for Medicare Part D by ensuring that claims from IHS and Tribal facilities are reimbursed at the highest possible rate—not a discounted rate—by Pharmacy Benefit Managers (PBMs).
- *In-Network:* Require all Medicare Advantage (MA) plans to automatically deem Indian Health Care Providers (IHCPs) as in-network even if they do not enroll in a provider agreement and reimburse IHCPs at the OMB/IHS all-inclusive encounter rate. This automatic deeming and rate-setting should not supersede rates that an IHCP has negotiated and prefers over the OMB/IHS all-inclusive rate.
- *Hospital Star Rating System:* Exempt IHS hospitals from the Hospital Star Rating System. The current system results in artificially low ratings for IHS hospitals, which results from the fact that they serve a vulnerable population and are often so small in volume that one adverse outcome has an outsized impact on their rating. In addition, the Indian health system is chronically underfunded, and these types of rating systems punish underfunding rather than providing additional, needed support.
- *GME Program:* Require a Tribal set-aside within the annual Medicare funding of \$16 billion in the GME program, require service to Tribal communities, assign slots specifically to Tribal facilities, and remove administrative impediments to participation in GME funding by Tribally operated hospitals.
- *Tribal GME Program:* Develop, through Tribal consultation, a Tribal GME program through which Tribes have access to funding enhancements for Tribal medical residency programs. This program must account for the Tribal alternative payment methodology and cost-reporting requirements and provide funding for all services needed to operate such a program.

## RESOURCES

- [NIHB Resolution 19-01](#): Support for Coverage of Oral Health Care Services under Medicare

**TRIBAL PUBLIC HEALTH CAPACITY AND INFRASTRUCTURE**

Public health infrastructure is the basic organizational and physical structures and facilities needed to operate a public health system. Public health infrastructure provides communities, Tribes, states, and the Nation the capacity to prevent disease, promote health, and prepare for and respond to emerging threats and ongoing health challenges. Infrastructure is the foundation for planning, delivering, evaluating, and improving public health.

As sovereign nations, American Indian and Alaska Native (AI/AN) Tribes maintain inherent public health authority to promote and protect the health and welfare of their citizens, using the methods most relevant for their communities. Through resilience and innovation, Tribes have built their own public health systems to serve their people, resulting in highly varied approaches to public health across Tribal communities. Such innovation has led to outstanding success in some areas, such as COVID-19 vaccine distribution. However, modern Tribal public health systems evolved along a different trajectory than their non-Tribal local and state counterparts and are often overlooked and unrecognized in the U.S. public health system.

The national plan for improving population health in the United States – Healthy People 2030– highlights challenges in defining and describing public health infrastructure among Tribal public health systems and the importance of innovation and support to promote system improvements in Indian Country. It further notes that adopting the suggested recommendations may be problematic for communities subject to chronic federal underinvestment in vital public health skills, tools, and foundational structures of local public health governance. Although Tribes have worked hard to build capacity, many systems still require long-term investments to bridge gaps. The recent public health emergency has exposed such detrimental gaps in Tribal public health infrastructure; these gaps have hampered effective emergency response, ultimately leading to lives lost.

Health People 2030 highlights three essential components of public health infrastructure: (1) agencies capable of assessing and responding to public health needs; (2) a capable and qualified workforce; and (3) up-to-date data and information systems. In addition to Tribal health research capacity, these components are critical for building Tribal public health systems prepared to withstand the current public health emergency and protect AI/AN peoples for decades to come.

**PRIORITIES FOR INDIAN HEALTH**

To strengthen Tribal public health capacity and infrastructure, the National Indian Health Board (NIHB) will pursue the following priorities:

- A. Strengthen Tribal Public Health Agencies and Authority
- B. Develop an Empowered Public Health Workforce
- C. Expand Surveillance and Epidemiology Capabilities
- D. Invest in Tribal Health Research Capacity

***A. Strengthen Tribal Public Health Agencies and Authority***

The [2019 Public Health in Indian Country Capacity Scan](#) (PHICCS) reported that Tribes are the primary provider of public health activities in Indian Country across all public health activity and service categories. Tribal public health systems are highly variable and often complex. A variety of Tribal agencies deliver public health services, in addition to numerous Tribal and non-Tribal external entities, including federal agencies, state and local health departments.

The 2019 PHICCS report also highlighted gaps in public health planning, assessment, quality improvement activities; accreditation; and Tribal law as a public health tool. Future efforts in public health infrastructure should focus on building capacity at a local level. With sufficient investment and complete Tribal control,

Tribes can adapt their public health infrastructure to meet the unique needs of their people and circumstances. This will lead to innovation and advances that will protect public health for American Indian and Alaska Native (AI/AN) peoples for decades to come.

*Tribal Public Health Priorities.* To strengthen Tribal public health, the two most fundamental priorities remain (1) consistent and equitable funding and (2) recognition and respect of Tribal public health authority. While Tribal health organizations maximize their available resources to administer various public health activities and services with the existing public health workforce, Tribal public health remains inadequately resourced. Increased stable funding, technical assistance (TA), and public health education are needed to ensure Tribes can improve the health and well-being of Tribal communities. Furthermore, the sovereign political status of Tribal nations presents opportunities for advancing public health capacity but requires that federal agencies honor the federal trust responsibility and respect Tribal sovereignty.

*Block Grants.* Block grants are a funding option that strengthens Tribal sovereignty while providing flexible and equitable funding. Block grants, such as Services Block Grant distributed by the Centers for Disease Control and Prevention (CDC), allow broad flexibility to recipients to improve their public health infrastructure, including critical components such as surveillance capacity strengthening, workforce development, and evaluation. However, as of March 2021, only two Tribes received a collective \$92,386 (0.06 percent), even though AI/ANs make up 2.9 percent of the total U.S. population) of the over \$145 million distributed to 61 state, territorial, and Tribal recipients. As part of the federal trust responsibility, Tribes must have equitable access to non-categorical, non-competitive funding streams to build their public health capacity, allowing maximum flexibility and sustainability.

***Congressional Action:***

- *Flexibility:* Tribal public health systems require flexibility in funding to improve infrastructure and capacity.

***Administrative Action:***

- *Guidance:* Provide official guidance to federal, state, local, and territorial public health systems that affirms Tribal nations' role as legally established governmental public health authorities.
- *Addressing Infrastructure Gaps:* Support the development of a Tribally led plan that identifies strategies to address gaps identified in the PHICCS.
- *Accreditation:* Support the development of public health accreditation competencies and frameworks that reflect the specific needs of Tribes.
- *Public Health Law:* Support development of Tribal public health laws and the use of law as a public health tool.
- *Public Health Planning:* Support Tribes in public health planning, assessment, and quality improvement activities.
- *Full Funding:* Ensure consistent and appropriate funding to address those needs identified through a Tribal public health infrastructure assessment.
- *Set-Asides:* Minimum 5 percent set aside across all Centers for Disease Control and Prevention (CDC) Centers, Institutes, and Offices (CIOs) for Tribes and Tribal organizations to integrate Tribal public health needs and priorities across the entire CDC and its programs.
- *Funding Allocation:* The CDC should use allocation and distribution mechanisms to allow all federally recognized Tribes to receive funding.
- *Flexible Funding:* The CDC should ease funding restrictions that may limit how Tribes apply for and use funding.

***State Action:***

- *Recognition of Status*: Establish a policy that details the state’s recognition of the Tribes' inherent public health authority status.
- *Access to Reporting Systems*: Immediately grant Tribes and Tribal Epidemiology Centers (TECs) access to infectious disease reporting systems for their jurisdiction.

## RESOURCES

- [Public Health in Indian Country Capacity Scan Report](#) (NIHB, 2019)
- [NIHB Resolution 13-03](#): Support for Tribal Public Health Accreditation
- [NIHB Resolution 20-05](#): Support Direct Funding from CDC to Tribes and Tribal Organizations for Public Health Work in Indian Country
- [NIHB Resolution 19-04](#): Resolution on the CDC Tribal Public Health Agenda

### ***B. Develop an Empowered Public Health Workforce***

Workforce is a core component of public health service delivery. Public health employees play an integral part in delivering critical public health services and activities within Tribal communities. However, the makeup of public health workforce in Tribal communities is widely variable as Tribes do not always have designated “public health” staff (i.e., staff hired for the sole purpose of providing public health services). For many Tribes, significant overlap exists between their health care and public health systems, with some essential staff bridging both functions.

For years, Tribes have called for investments in a skilled health and public health workforce. Over the last two years, in the wake of the COVID-19 pandemic, the United States has made historic investments in public health infrastructure, with specific funds tied to workforce through the *American Rescue Plan* and other bills. Strategic use of these investments requires a thorough understanding of Tribes’ workforce needs – and challenges – to support their public health efforts.

However, very little reliable information exists about national-level estimates for Tribal public health workforce. The Health Resources and Service Administration (HRSA) and the Indian Health Service (IHS) maintain estimates of clinical healthcare clinical personnel shortages, but no such equivalent for public health positions. Although [national estimates of public health workforce needs](#) have not included Tribes, these estimates demonstrate a severe lack of public health personnel. For example, local health departments serving less than 100,000 currently have less than half the needed public health staff. The available evidence suggests the shortages in Indian Country are even direr.

The [2019 Public Health in Indian Country Capacity Scan](#) (PHICCS) is one of the first surveys to assess Tribal public health workforce needs nationally. The scan found that behavioral health staff represented both the highest average number of funded and filled positions and the most needed positions currently vacant. Tribal health organizations frequently cite the need for more front-line workers such as community health representatives and public health nurses. However, Tribal health organizations note that epidemiologists, statisticians, and public health informatics specialists are least likely to be funded.

Many community health representatives (CHRs) serve as crucial links between social services, behavioral health, preventative health and education, financial counseling, and more. In many Tribal communities, these frontline professionals carry essential roles in delivering public health services and addressing the social determinants of health. They represent significant and unique positions for Tribal public health systems. The stated need for more of these professionals may indicate the need for cadres that bridge public health, health care, social determinants of health, and culturally appropriate care and services. In the complex and varied Tribal public health systems, investments should be made to strengthen both public health and clinical care workforce.

Beyond public health workforce staffing numbers, PHICCS reported the top public health workforce development needs in Indian Country. The most common conditions identified include the following: training, including on technical skills (i.e., data collection and analysis) and general training on public

health; professional development, including certification and licensing; staffing; needs related to assessment, performance improvement, and accreditation; and technical assistance (TA), including assistance on epidemiology, data analysis, and public health informatics.

***Congressional Action:***

- *Funding:* Provide Tribes and Tribal organizations dedicated and recurring funding to recruit and sustain a robust Tribal public health workforce.

***Administrative Action:***

- *Assessment:* Ensure assessments of public health workforce needs include the needs of Tribes.
- *Technical Assistance:* The Centers for Disease Control and Prevention (CDC) must provide Tribes technical assistance (TA), training, and other resources to support workforce development. Tribal public health systems must have access to the same TA as other public health systems – regardless of whether funding was provided from the CDC through grants or, either directly or as a pass-through, to Tribes in contracts or compacts with the IHS.
- *Youth Training:* Invest in training programs for American Indian and Alaska Native (AI/AN) youth that provide pathways into public health. Such programs are essential to building the next generation of public health professionals.
- *Tribal Control:* Tribes must determine the best resources to fit their unique public health system structures and needs. Future workforce development efforts need to recognize Tribal sovereignty by allowing flexibility in program and funding opportunities.

***State Action:***

- *Liaison:* Establish a Tribal public health or data liaison position within the state health departments to ensure robust communication and collaboration with the Tribes in their area.

**RESOURCES**

- [Staffing Up: Determining Public Health Workforce Levels Needed to Serve the Nation](#) (de Beaumont, PHNCI, and PHAB; 2021)

***C. Expand Surveillance & Epidemiology Capabilities***

The [2019 Public Health in Indian Country Capacity Scan](#) (PHICCS) report cited surveillance and epidemiology capacity as an area where Tribal health organizations lag significantly behind their state/local counterparts. Having accurate, real-time data is necessary for Tribal public health officials to determine where the needs are. While the Tribal Epidemiology Centers (TECs), supported by the Indian Health Services (IHS) and the Centers for Disease Control and Prevention (CDC), have helped address this data gap and build public health capacity to promote health and prevent disease in American Indian and Alaska Native (AI/AN) communities, Tribes still cite the need for increased data capacity and support.

Current data access and capacity in Indian Country is spotty at best. Often, needed public health data does not exist for AI/AN populations or is incomplete and unreliable. In other instances, data collected by non-Tribal entities may be so administratively burdensome to obtain that Tribal access is severely restricted. Improving the situation requires stronger cooperation from local, state, and federal public health agencies and increased capacity for Tribes and Tribal organizations to conduct their own data work.

*Funding.* Tribes, Tribal organizations, and TECs lack consistent funding for surveillance activities. For example, for the 2021-2022 budget year, CDC awarded \$247 million under its Epidemiology and Laboratory Capacity (ELC) Program to a total of 64 recipients. Among those recipients were 50 states, five cities, and nine territories. However, there were no Tribal entities who were recipients of the ELC program.

*Syndromic surveillance.* During the COVID-19 pandemic, the need for syndromic surveillance has become much more urgent, and expanding this capability will serve public health far beyond the current public health emergency. Syndromic surveillance provides public health officials with a timely system for detecting, understanding, and monitoring health events. By getting real-time data of health incidents, public health can detect unusual levels of illness to determine whether a response is warranted. Syndromic data can serve as an early warning system for public health concerns. Having accurate syndromic data can help public health officials know if an observed uptick in emergency department visits is due to a known incident or if another emergency or outbreak is happening simultaneously. Nationally, such surveillance systems are used in response to COVID-19 and other infectious diseases, opioid overdoses, e-cigarette or vaping product use-associated lung injury, Zika virus infection, and natural disasters. Continued and increased support for syndromic and other surveillance capabilities is critical to allow Tribal public health officials to act swiftly and effectively when public health incidents occur.

*Health Data Access.* As sovereign nations, Tribes are inherently public health authorities. Additionally, Section 214 of the *Indian Health Care Improvement Act* (IHCIA) designated TECs as public health authorities. Despite being designated public health authorities under federal law, state, and local health departments, routinely deny Tribal nations and TECs access to public health data.

*Misclassification.* Common disease and risk factor data for AI/AN populations is often incomplete or missing in federal and state data due to the relatively small size of these populations and widespread demographic misclassification. This issue has stifled Tribal public health activities for decades but has taken on a new level of urgency given the COVID-19 pandemic. Due to misclassification and under-sampling of AI/AN populations in public health disease surveillance systems, available data underrepresents the impact of COVID-19 and other public health concerns.

Multiple studies demonstrate that surveillance systems frequently misclassify AI/ANs or omit them from surveillance systems entirely. These issues continue to exacerbate health disparities, including those from COVID-19.

***Congressional Action:***

- *Data Sharing:* Pass the *Tribal Health Data Access Improvement Act* to improve data sharing and strengthen Tribal public health infrastructure.
- *States:* Require states and localities receiving federal public health funding to recognize the Tribes' inherent public health authority status and grant them access to the infectious disease reporting systems based upon the boundaries of the Tribe.

***Administrative Action:***

- *Data Access:* The U.S. Department of Health and Human Services (HHS) must provide direct access to public health data to all legally established public health authorities such as Tribes, IHS, and TECs.
- *Capacity:* Allow COVID-19 funding to be used to improve IHS and Tribes' data capacity for public health activities related to surveillance, reporting, data flow, and protection of sensitive Tribal, patient, and employee data. The Centers for Disease Control and Prevention (CDC) should provide technical assistance (TA) if its Vaccine Administration Management System (VAMS) portal is utilized until IHS public health data capacity can be improved.
- *Cooperative Agreements:* The CDC should enter into cooperative agreements with Tribes, Tribal organizations, urban Indian organizations, and TECs to address misclassification and under-sampling of AI/ANs on birth and death records as well as health care and public health surveillance systems.
- *Data Accuracy:* The CDC should use whatever tools necessary to achieve improved quality and accuracy of AI/AN birth and death record data collected by local and state governments. This could

include developing guidance for state and local health agencies to improve the quality and accuracy of birth and death record data, tying CDC funding for the state or local health departments to implement data quality improvement processes, or providing specific funding for improvement of data processes.

- *HIT Modernization*: Ensure that new electronic health record systems and other health information technology (HIT) data systems developed by IHS, and the CDC will fulfill necessary Tribal public health functions and facilitate easier AI/AN public health data collection, analysis, and sharing with Tribes and Tribal organizations.

***State Action:***

- *Data Sharing*: Establish data sharing agreements with Tribes and TECs to improve access to public health data.
- *Disease Reporting*: Immediately grant Tribal access to the states' infectious disease reporting systems, based upon the zip codes or boundaries of the Tribes' jurisdiction.
- *Vital Records*: State and local governments should provide adequate training and oversight to ensure birth and death data is recorded accurately, including proper classification of demographic information.

**RESOURCES**

- [NIHB Resolution 21-05](#): Tribal Health Data Access Improvement
- [Tribal Health Data Access Improvement Act](#)

***D. Invest in Tribal Health Research Capacity***

More community-based participatory research (CBPR) is needed to understand the causes, impacts, and interventions required related to the significant health inequities experienced by American Indians and Alaska Natives (AI/ANs). However, AI/AN communities are often overlooked and not represented in research studies. Significant gaps remain in representation and resources for AI/AN health research and appropriate procedures for non-Native researchers to partner with Tribes. When considering current and future CBPR endeavors, inclusion, sovereignty, cultural appropriateness, and Tribal research capacity remain areas of concern for Tribes.

*Sovereignty*. Tribal nations have inherent sovereign rights to govern research with their citizens and on their lands. This includes the right to determine how all research is conducted when it involves their citizens, lands, and resources—regardless of whether Tribes have research laws or oversight mechanisms in place. Too often, non-AI/AN researchers have caused preventable harm to Tribal communities. Now more than ever, it is critical that the National Institutes of Health (NIH) and other federal agencies respect the sovereignty of Tribal nations and work diligently to minimize the risk of harm to Tribal communities.

*Flexibility & Cultural Appropriateness*. Tribal sovereignty and indigenous ways of knowing and healing should have equal value with Western science. For example, culture, relationship-building, and a sense of belonging bring added benefits to traditional therapeutics. Part of this perspective focuses on strengths and resilience rather than deficits. It follows, then, that Tribal communities want to see more research announcements that target strengths and those that honor traditional healing practices.

Furthermore, Western research models are not always the most appropriate for evaluating Tribal health programs. Much of the current evidence base for health programs is not relevant to the specific conditions in Tribal communities. As a result, flexibility is necessary to ensure local knowledge is respected and Tribes can implement programs in the most culturally appropriate ways. There needs to be room for program-based evidence alongside evidence-based programs.

*Invest in Tribal Research Capacity.* For Tribes to address the gaps in health research and services specific to Tribal communities, sufficient funding is essential. With adequate funding, Tribes can build research capacity, strengthen infrastructure, support traditional practices, and protect sovereignty.

More investment is also needed to train the next generation of AI/AN health researchers. Many of the concerns discussed above can be ameliorated by empowering AI/AN researchers to lead studies involving Tribes and Tribal members. Tribal communities want researchers who can connect to where they come from and bring the rich context of indigenous knowledge to their research.

***Administrative Action:***

- *Tribal Consent:* The NIH must work with the NIH Tribal Advisory Committee (TAC) and Tribal nations to develop clear policies and procedures to require researchers to receive prior consent from individual sovereign Tribal nations before collecting data and specimens from their Tribal members and to provide Tribal nations oversight of any data or biospecimens that are associated with or identified to be from a citizen of their Tribal nation.
- *Sovereignty:* NIH should establish an official process for Tribal nations to report any academic partner institutions or researchers who violate Tribal sovereignty, Tribal laws, or any agreements they may have with Tribal nations.
- *Relevance:* Support research of significance to AI/AN populations and prioritize projects highlighted by Tribes as most important for our communities.
- *Traditional Methods:* Support holistic, traditional, Tribal approaches to research and prioritize Tribal healing traditions.
- *Funding:* Prioritize permanent funding for Tribally led research. This will allow Tribes to build the research capacity of Tribal communities and research centers and expand the body of AI/AN-focused research.
- *Tribal Researchers:* Prioritize building Tribal research capacity by working with Tribal communities, universities, and organizations to recruit, train, and support Tribal citizens as scientists and researchers.
- *Administrative Hurdles:* Expand and improve opportunities such as the Native American Research Center for Health (NARCH) by working with Tribes to address challenges in application and overall project success.
- *Technical Assistance:* Support Tribal capacity to secure research funding and provide training and technical assistance (TA) to Tribes, including information on NIH subdivisions, projects, and processes.
- *Timelines:* Allow more flexible timelines on research projects to allow AI/AN researchers more opportunities to find new funding streams and identify new partners and relationships.

**RESOURCES**

- [NIHB Resolution 20-04](#): Resolution to Call upon the National Institutes of Health to Consult with Tribal Nations and Establish Policies and Guidance for Tribal Oversight of Data on Tribal Citizens Enrolled in the *All of Us* Research Program