National Indian Health Board

The President
The White House
1600 Pennsylvania Ave, NW
Washington, DC

Re: Comments of the National Indian Health Board on Implementation of Executive Order 14112

Dear Mr. President:

I write today, on behalf of the 574+ federally recognized Tribal nations we serve, to submit comments on considerations to include as part of the guidance to federal agencies on how to access funding needs for Tribal nations under Executive Order 14112 - Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination. We strongly commend you for issuing this historic Executive Order (EO) that will reinforce Tribal sovereignty and the government-to-government relationship that Tribal nations have with the United States and reform the funding relationship that Tribal nations have with the federal government in fulfillment of their obligations to Tribal nations.

Since first contact, the United States has entered over 350 Treaties with Tribal nations, requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. Yet, the federal government has never lived up to these promises. For too long, the policy of the federal government was one of genocide, forced removal, assimilation, and termination. Beginning with colonization and the Doctrine of Discovery, our people have suffered physical, mental, emotional, and spiritual harm resulting from historical and intergenerational trauma. Colonization further includes a history of genocide against AI/AN people, which spread with westward expansion and forced removal and relocation of numerous Tribes from first contact to the present.

Cultural genocide followed. In 1869, the United States government, as a part of efforts to assimilate AI/ANs into non-Native culture, adopted the Indian Boarding School Policy to eradicate AI/AN language, culture, and identity through forced separation and removal of AI/AN children from their families and Tribal communities. Between 1869 and the 1960s, more than 100,000 AI/AN children were removed from their family homes and placed in over 400 schools operated by the Federal Government and churches.[1] Children were punished for speaking their Native languages, banned from expressing traditional or cultural practices, stripped of traditional clothing and hair, and experienced physical, mental, emotional,

[1] *See*, U.S. Department of Interior, *Federal Indian Boarding School Initiative Investigative Report, Vol. II*, 13, available at: https://www.bia.gov/sites/default/files/media_document/doi_federal_indian_boarding_school_initiative_investigative_report_vii_final_508_compliant.pdf, accessed on August 2, 2024.

and spiritual abuse, including malnourishment, sexual assault, and medical experimentation. Many AI/AN children died at boarding schools while separated from their families and Tribal communities, the actual number of which is currently unknown due in part to suppression and inaccessibility of both government and church records.

It was not until the enactment of the Indian Self-Determination and Education Assistance Act (ISDEAA) (P.L. 93-638) in 1975 that the federal government began to implement policies that firmly acknowledged Tribal sovereignty and the right to self-determination. Over the last 40+ years, we have seen policies that support self-determination improve outcomes for Tribal nations and the citizens that they serve. Outcomes for programs at both the Indian Health Service (IHS) and Bureau of Indian Affairs have improved, program dollars are spent more efficiently, and Tribal citizens are receiving culturally appropriate and accountable care.

Despite the success of self-determination and the clear need for greater resources, federal funding to Tribes continues to fall well below the federal obligations to Indian Country. AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher poverty rates, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. As the US Civil Rights Commission addresses so effectively in Chapter 2 of its 2018 Broken Promises Report, Tribal communities are at substantial health risk since the efforts of the federal government to uphold its trust responsibility for Tribal health care have been so ineffective. The Broken Promises report also noted that Tribal nations face an ongoing health crisis that is a direct result of the United States' chronic underfunding of Indian health care for decades, which contributes to vast health disparities between Native Americans and other U.S. population groups.[2] For example, the IHS Tribal Budget Formulation Workgroup estimates that the IHS's full funding need is approximately $63 billion. The workgroup also strongly requests that funding be appropriated outside of the annual discretionary appropriations process as "mandatory funding." [3] NIHB is proud to support the Marshall Plan for Tribal nations[4] which would make major investments in Indian Country to rebuild economies, education systems and health systems, similar to investments the United States made following World War II in Europe. We must think "outside the box" regarding funding for Tribal nations. Dribbles of competitive grants here and there will not solve the health crises impacting our communities.

IHS has been grossly underfunded for over half a century, but mechanisms exist within IHS for Tribes to operate their own programs through self-governance agreements under the Indian Self-Determination and Education Assistance Act. Because this funding is largely for providing basic healthcare services, supplemental funding is available through Medicare, Medicaid and 3rd party insurance collections. This means that, though sparse, IHS funding is generally reliable and flexible for local community needs. IHS

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[2] *See,* U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter *"Broken Promises"*), 65, available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf, accessed on July 22, 2024.

[3] *See,* Tribal Budget Formulation Workgroup, *A Path Forward to Fully Fund Tribal Nations by Embracing the Trust Responsibilities and Promoting the Next Era of Self-Determination and Health Care Equity and Equality: The National Tribal Budget Formulation Workgroup's Request for the Indian Health Service Fiscal Year 2026 Budget*, 1, available at: https://www.nihb.org/resources/NIHB-FY26-Budget.pdf, accessed on July 31, 2024.

[4] *See,* The National Indian Health Board, *Resolution 22-09: Calling on a Marshall Plan for Tribal Nations*, Available at: https://www.nihb.org/docs/12082022/22-09%20NIHB%20Resolution%20on%20Marshall%20Plan%20for%20Tribal%20Nations.pdf, Accessed on July 31, 2024

is experienced with self-governance and has worked to ensure that reporting is manageable for Tribal nations. Given this successful track record, Tribes recommend that IHS expand all their available funding to self-governance and away from competitive grants.

However, when considering funding from other federal government agencies, the picture is far worse. States and local governments receive large streams of block grant funding to address critical issues like public health infrastructure, emergency preparedness, mental health, substance abuse, and maternal health.[5] However, Tribal nations receive relatively little or no funding from major health agencies like the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the Health Resources and Services Administration (HRSA). When Tribal "set asides" or direct funding programs do exist, as in the case of many programs within the Administration for Children and Families, or SAMHSA, Tribal nations are forced through a competitive grant process, countless hours of grant administration, and small amounts of funding siloed that make the funds less impactful to the community. For example, in the FY 2024 appropriations, the Tribal set-aside for opioid response grants was $63 million, but NIHB has learned from Tribal staff that administering these funds makes it difficult to reach program goals. Instead, Tribes should be given the flexibility to use these funds in conjunction with other funds that they receive from IHS for the same purposes. The same staff administers the programs in the same department, yet federal agencies make it difficult to pool and operate together. Unlike states, which are far larger than most Tribes (with legions of state employees), Tribes are the health care providers and the governments. Therefore, it is critical that health services are specifically integrated together to ensure that dollars are serving Tribal citizens and not the federal bureaucracy.

NIHB was pleased to see that the FY 2025 President's Budget Request for IHS proposed a mandatory fund for public health infrastructure and capacity building that would grow to a total amount of $500 million over nine years. In the budget documents, IHS said, "Funding would enable IHS to implement a public health infrastructure system for IHS, Tribal, and Urban Indian Health Programs… Tribes do not receive dedicated public health funding from CDC, and the IHS does not currently have substantial funding to support ongoing public health and emergency preparedness infrastructure" (CJ-249).

This proposal is a welcome recognition of the points that Tribal leaders have made for many years. We saw during the COVID-19 pandemic the devastating impacts that lack of data, public health systems, and emergency response had on Tribal communities. Systems must change. The whole of the federal government must respect the federal trust responsibility for health – not just the IHS. Further, under the current political environment, $500 million in additional mandatory appropriations—while very welcome—will not likely be enacted. We need this support now. We need the OMB and HHS to explore how they can get direct public health programming support to Tribes immediately. This is, hopefully, one of the larger problems that EO 14112 is aiming to solve in the short term.

Therefore, we recommend that the White House consider the following when issuing plans to federal agencies to implement E.O. 14112.

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[5] *See*, Congressional Research Service, *Block Grants: Perspectives and Controversies*, 5-6, available at: https://crsreports.congress.gov/product/pdf/R/R40486, accessed on July 31, 2024.

1) ***Ensure that implementation plans are sustainable and driven by measurable long-term and short-term goals***

EO 14112 is wide-ranging and ambitious. It is necessary to overhaul how federal funding flows to Tribal nations. It is critical that guidance to federal agencies include interim goals such as timelines and reports for Tribal consultation, actionable steps, and consequences for failing to implement these.

We recommend that OMB require agencies to submit quarterly reports and meet with their peers in other departments to understand how plans come together across the federal government. Each Department/ agency should have a dedicated point of contact who will be held accountable by the White House if the goals are not met in a timely manner.

OMB should also regularly report to Tribal governments via calls and Dear Tribal Leader Letters on the implementation progress. By a certain date, agencies should identify programs to reduce grant burdens and submit legislative proposals. Tribes must also be able to provide feedback on these plans. OMB and federal agencies should regularly report to the Senate Committee on Indian Affairs and the House Natural Resources Committee on progress on implementing EO 14112.

2) ***Provide adequate funding to implement this plan***

Too often, federal projects are sidelined when dedicated resources are not available. It is the President's prerogative to work within existing appropriations to prioritize agency work. We request that the White House ensure that agencies have dedicated funding and staff to implement EO 14112.

3) ***Require agencies to update Tribal nations early and often about their efforts***:

As noted above, the White House Council on Native American Affairs and OMB should host virtual meetings – quarterly at a minimum – for Tribal leaders to understand the progress of the effort to implement EO 14112. If agencies do not have substantive information, calls should still occur so Tribal leaders can continue providing information on federal funding challenges. In addition to regular calls, we recommend releasing written reports, or even Power Point presentations, to Tribes to document progress and check in with Tribal nations.

4) ***Provide training for federal employees who may not have experience working with Tribal governments***.

The requirements in EO 14112 are not limited to the IHS or Bureau of Indian Affairs (BIA). Indeed, the most impactful work will likely be in agencies that do not regularly work with Tribal nations. Therefore, many federal employees working on this implementation will likely not have

experience working with Tribal nations or understanding the diversity and complexity of Indian Country.

The White House should invest in training for career staff to learn about Indian Country, Tribal economies and health systems. When feasible, we strongly recommend conducting travel delegations to Tribes so they can see where the greatest needs are and experience the complex challenges firsthand.

It is also critical for federal career staff to have ownership over these efforts. EO 14112 will not be implemented quickly, but federal employees will guide it to completion. As political cycles in Washington shift, we must find a way to create a paradigm shift for federal funding in Tribal communities. Educating the federal workforce across agencies is one key piece of doing that.

5) ***Encourage federal agencies to "think outside the box" regarding federal funding for Tribes. No current federal model is ideal for Tribal nations***.

As noted above, NIHB supports the principles outlined in the Marshall Plan for Tribal Nations.[6] The plan advocates for a coordinated approach to implementing federal funding to Tribal nations by creating a single department to do so instead of a piecemeal approach that is the current standard. Too often, our federal and legislative partners can only think in terms of competitive grants or allocating funding on a less than equitable basis. Federal grants take scarce Tribal staff away from program implementation and put them on report writing. They reward communities where capacity is already strong and hurt those areas where more funds are needed because they do not have the infrastructure to apply for grants.

Much like U.S. investment in Europe after World War II, today, the federal government must proactively work to rebuild the economies and other human services systems of Tribal nations. Tribes need broad-based, flexible funding. We cannot continue to exist on a patchwork of federal dollars to support our investments. Unlike state and local governments which have the power to tax their citizens, Tribal nations do not. Their lands are held in trust by the federal government. Tribal governments must, then, get better support from the federal government. Implementing EO 14112 should incentivize creating novel approaches to federal funding that would be cross-agency, broad-based, and flexible for Tribes. If federal agencies come back to the White House with recommendations to increase competitive grants or block grants to Tribes for a specific purpose, we have failed. We must rethink our funding structures entirely.

Conclusion

We thank you again, for the signing of this historic Executive Order to reform federal funding for Tribal nations. This unprecedented action will force federal agencies to rethink how they serve Tribal

[6]*See*, United South and Eastern Tribes Sovereignty Protection Fund, Marshall Plan for Tribal Nations: A Restorative Justice and Domestic Investment Plan, Available at: https://www.usetinc.org/wp-content/uploads/2022/11/USET-SPF-Marshall-Plan-for-Tribal-Nations.pdf. Accessed on July 31, 2024.

communities and reaffirm the sovereignty of our Tribal nations. For too long, the federal government has not fulfilled the promises made to our ancestors in exchange for the building of the United States. We reiterate our recommendations to make the implementation of the executive order actionable, and sustainable over the long term. NIHB is ready and willing to assist in any way needed.

Sincerely,

William Smith, *Valdez Native Tribe*
Chairman
National Indian Health Board