



National Indian  
Health Board



# Health Equity in Indian Country

Rethinking How the Centers for Medicare & Medicaid Services  
Approaches Health Equity for American Indians and Alaska  
Natives





## Executive Summary

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In 2021, the Biden-Harris Administration announced health equity as a cornerstone of Administration policy. As health professionals and policymakers made plans to advance health equity, one thing became apparent: American Indian and Alaska Native voices were missing from the conversation. So, in 2022, the National Indian Health Board (NIHB), supported by the Centers for Medicare & Medicaid Services (CMS) and the CMS Tribal Technical Advisory Group (TTAG), sought to correct that narrative by convening Native health leaders from across the country to answer one critical question:

***“What does health equity mean from a Tribal perspective?”***

This report summarizes the results of three events focused on defining Tribal health equity. While the focus of discussion varied across events, sessions, and breakout rooms, several themes consistently emerged as foundational to any work related to health equity in Indian Country. This report lays out these foundational themes and implications for how CMS can more effectively pursue health equity for American Indians and Alaska Natives (AI/ANs).

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*“If you’re going to address disparities as a health equity issue within the federal government, you have to do something distinctively different than you’ve done in the past.”*

*- September Listening Session Participant*

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## Key Drivers of Health Inequities

Advancing health equity in Indian Country requires a thorough understanding of the historical injustices and longstanding structural inequities that have led to the dire health inequities now experienced in Tribal communities. The systemic issues which give rise to AI/AN health inequities are rooted in the long history of harmful federal Indian policies: genocide; uprooting AI/ANs from homelands and Tribal community structures; bans on cultural practices and language; forced relocation to reservations; abusive boarding schools; and other destructive policies. The consequences of such longstanding structural discrimination are many, including:

- ◆ Undercutting of Tribal sovereignty and disempowering of Tribal governments
- ◆ Structural racism and the conceptualization of AI/AN as a “race”
- ◆ Disconnection of AI/ANs from community, identity, and culture
- ◆ Distrust and broken relationships between Tribal nations and federal and state governments
- ◆ Erasure of AI/AN peoples, identities, and histories
- ◆ Disparities in opportunities, like education, jobs, and health care
- ◆ Devaluing of Indigenous ways of knowing

Acknowledging the federal government’s role in creating these health inequities is a necessary first step for any federal health equity initiative to be effective. With a full understanding of the drivers of inequities and their sequelae, federal agencies, in collaboration with Tribes, can more effectively design effective interventions to address

the root causes of health inequities and make long-term, systemic changes to advance AI/AN health equity.

## Foundations of Health Equity in Indian Country

Participants were extremely consistent in what they identified as the critical foundations of health equity in Indian Country; they also commonly cited these foundational pieces as the parts most often missing from federal health equity initiatives. Any federal work on health equity for AI/ANs must be grounded in thorough comprehension and respect for **Tribal sovereignty** and the **federal trust responsibility**. This starts with four key aspects:

- ◆ “American Indian and Alaska Native” is first and foremost a **unique political status**, and is only secondarily, and in specific contexts, a racial identity.
- ◆ **Respect for the nation-to-nation relationship** must be the foundation of any federal health equity initiatives in Tribal communities. Federal agencies must pay special attention to the significant nuances and complexities at this intersection of federal and Tribal jurisdictions; health equity initiatives must flow through the appropriate diplomatic channels that respect the authority of Tribal governments. In addition, the nation-to-nation relationship is between Tribal nations and the U.S. government—not the states; no federal policies or initiatives should subject Tribes to the will of a state.
- ◆ **Timely, meaningful, and robust Tribal consultation** is critical to ensuring health equity plans are appropriate and effective for Indian Country. The federal government must consult with Tribes whenever a change that will impact Tribes or AI/ANs is considered. As Medicaid is a federal program administered through states, CMS is responsible for ensuring that states conduct all necessary Tribal consultations and that these consultations are meaningful and robust.
- ◆ Health equity initiatives for Indian Country must always be Tribally led to **uphold Tribal self-determination**. Tribes should control the resources, plans, policies, and goals intended to achieve health equity for their people. Tribes know their people, communities, social and historical context, needs, and strengths best. Tribes are the experts in charting a path to health equity for their citizens. The federal government is most effective in working toward health equity when it puts its resources behind supporting the leadership of Tribal communities.

In addition, health equity initiatives for Indian Country must remain **rooted in strengths, resilience, and Native identity**. Colonization and the worldviews and values introduced by the colonizers have led to the devastating health inequities Tribal communities are experiencing—but leaning into traditional Indigenous values and worldviews opens new pathways forward. Tribes have the answers. Indigenous knowledge, connection to community and culture, and traditional healing are essential to advancing health equity. We can only achieve health equity for Indian Country when we approach it through a Native lens.

A hundred years of federal reports<sup>1</sup> have documented dire health inequities in Tribal communities and the federal trust responsibility's ongoing failures; yet, these things have not improved.<sup>2</sup> The voices of participants were clear: these issues are too urgent to continue writing reports without following through with the actions and resources to solve the problems. We know what needs to be done. Health equity in Indian Country cannot wait.

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<sup>1</sup> [Meriam Report: The Problem of Indian Administration](#) (1928); [Indian Policy Review Commission Report](#) (1978); [A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country](#) (2003); [Broken Promises: Evaluating the Native American Health Care System](#) (2004); and [Broken Promises: Continuing Federal Funding Shortfall for Native Americans](#) (2018).

<sup>2</sup> See the drastic drop in AI/AN life expectancy over the past few years, documented by the Centers for Disease Control and Prevention in the [“Provisional Life Expectancy Estimates for 2021.”](#)



# A Path Forward: Tribal Recommendations for the Centers for Medicare & Medicaid Services to Advance Health Equity in Indian Country



## I. Center Tribal Sovereignty and the Nation-to-Nation Relationship

- Support and respect Tribal sovereignty and authority.
- Recognize that Tribes and Tribal programs have the knowledge, expertise, and authority to design and deliver services in ways best suited for their people, building on cultural strengths and traditions.
- Change structures and systems to allow Tribes to work directly with the federal government and not through states.
- Provide training on Tribal sovereignty and the federal trust responsibility.



## II. Prioritize Fulfillment of the Federal Trust Responsibility

- Implement the policy recommendations of the CMS Tribal Technical Advisory Group (TTAG).
- Hold states accountable.
- Institute uniform Medicaid eligibility & benefits for AI/AN.



## III. Recognize that Tribes Hold the Answers to Tribal Health Equity.

- Empower Tribes to lead in health equity initiatives.
- Expand flexibility in Medicare.
- Listen to the experiences of people experiencing inequities and allow this input to inform policy development.
- Proactively solicit Tribal input on communications materials for Indian Country.



## IV. Support Tribal Institutions

- Adapt the Medicaid and Medicare programs to cover a wider array of Tribal services, programs, providers, and initiatives.
- Resolve the “four walls limitation.”
- Improve Medicaid prior authorization practices.
- Provide billing and coding support.
- Ensure Indian health care providers are reimbursed by Medicare and Medicaid for telemedicine.





## V. Disrupt Structures of Inequity and Shift the Balance of Power

- Prioritize timely, meaningful Tribal consultation & ensure states' Tribal consultations on CMS programs are timely & meaningful.
- Fully train staff on Tribal consultation, especially how to identify when it is needed.
- Incentivize state Medicaid agencies to work with Tribal liaisons and Indian health advisory boards to improve collaboration with Tribes.
- Expand opportunities for Tribal self-governance in CMS programs.
- Acknowledge the federal government's role in creating the health inequities AI/AN people are experiencing.



## VI. Increase Visibility of American Indians & Alaska Natives

- Include Tribes and AI/AN people on task forces, workgroups, and committees.
- Improve data quality to better represent AI/AN.
- Standardize definitions of AI/AN across agencies, databases, and data warehouses.
- Facilitate Tribal data access.
- Provide resources for improving data.



## VII. Heal Backwards and Forwards

- Make an explicit effort to address systemic racism in CMS policies and operations - including in programs run through states.
- Provide training to CMS staff and program partners on the ongoing impact of historical and intergenerational trauma in Tribal communities.
- Ensure services are trauma-informed and culturally appropriate.
- Recognize the historical, political, legal, and cultural context of health inequities and the communities experiencing them.
- Focus on systemic changes that will improve health and wellbeing for the next seven generations.



## VIII. Focus on Relationships and Connectedness

- Adopt a holistic approach and focus on overall wellbeing, not just health care services.
- Recognize Tribal perspectives of social determinants of health & address these determinants in culturally relevant ways.
- Work with sister agencies and the CMS Division of Tribal Affairs to achieve health equity priorities.
- Expand collaboration of various CMS programs with CMS TTAG.
- Support integration of behavioral and physical health services.



## IX. Honor Indigenous Knowledge

- Reimburse for traditional healing services.
- Set a standard for cultural humility across CMS programs and staff.
- Support providers with culturally specific training.

# Table of Contents

|   |    |
|---|----|
| Executive Summary .....   | 1  |
| Key Drivers of Health Inequities .....                                    | 1  |
| Foundations of Health Equity in Indian Country .....                      | 2  |
| A Path Forward: Tribal Recommendations for CMS .....                      | 4  |
| Introduction: Defining Tribal Health Equity .....                         | 8  |
| CMS Framework for Health Equity .....                                     | 9  |
| Overview of Health Equity Events and Sources .....                        | 10 |
| Part 1: Key Drivers of Health Inequities in Indian Country .....          | 12 |
| Part 2: A Path Forward: Tribal Recommendations for CMS .....              | 15 |
| I. Center Tribal Sovereignty and the Nation-to-Nation Relationship .....  | 15 |
| <i>Recommendations</i> .....  | 16 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 17 |
| II. Prioritize Fulfillment of the Federal Trust Responsibility .....      | 17 |
| <i>Recommendations</i> .....  | 18 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 18 |
| III. Recognize that Tribes Hold the Answers to Tribal Health Equity ..... | 19 |
| <i>Recommendations</i> .....  | 20 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 20 |
| IV. Support Tribal Institutions .....                                     | 20 |
| <i>Recommendations</i> .....  | 21 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 22 |
| V. Disrupt Structures of Inequity and Shift the Balance of Power .....    | 22 |
| <i>Recommendations</i> .....  | 24 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 24 |
| VI. Increase Visibility of American Indians & Alaska Natives .....        | 24 |
| <i>Recommendations</i> .....  | 25 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 26 |
| VII. Heal Backwards and Forwards .....                                    | 26 |
| <i>Recommendations</i> .....  | 27 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 27 |
| VIII. Focus on Relationships and Connectedness .....                      | 28 |
| <i>Recommendations</i> .....  | 28 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 29 |
| IX. Honor Indigenous Knowledge .....                                      | 29 |
| <i>Recommendations</i> .....  | 29 |
| <i>CMS Health Equity Framework Connection</i> .....                       | 30 |
| Part 3: Advancing Equity Through CMS TTAG Policy Recommendations .....    | 31 |
| Conclusion: Where do we go from here? .....                               | 33 |

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## Introduction: Defining Tribal Health Equity

This health equity report could not come at a more urgent time. The COVID-19 pandemic has made it impossible to ignore the stark disparities in deaths and other health outcomes experienced by American Indians and Alaska Natives (AI/ANs). On August 31, 2022, the Centers for Disease Control and Prevention (CDC) released the [Provisional Life Expectancy Estimates for 2021](#), which reported a severe drop in life expectancy for AI/ANs—decreasing by 6.6 years from 2019 to 2021. Not only do AI/ANs, on average, die younger than all other Americans, but this disparity is also worsening at an alarming rate. Our peoples’ life expectancy today is the same as it was for the average American in 1944. Such a crisis of inequity demands a swift and profound response.

Yet we recognize that policymakers commonly view health equity through Western ways of knowing and Western constructions of justice and health. This Western perspective is not the whole story. As health equity has risen to a national priority, the National Indian Health Board (NIHB) and the Centers for Medicare & Medicaid Services (CMS) Division

of Tribal Affairs (DTA) have sought to gain perspectives from Indian Country around a Tribal definition of health equity—one that places current circumstances into a historical context and centers our identities as Native peoples. Across Indian Country, we have heard that health equity means joy and safety; dignity and kindness; justice and sovereignty; health and wholeness for the entire community. It means generosity, since taking care of others is essential for our health. It means understanding the interconnectedness of human health with our lands and waters and all living things. It means creating conditions on a societal level that support health for everyone.

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*“How do we create the conditions for equity for Indigenous peoples? Equity, for me, is fundamentally about justice. So, we might ask: What does a just system for health look like for Indigenous peoples? How do we create the conditions for just systems to thrive?”*  
 – Tribal Health Equity Summit Participant

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In this report, we hope to faithfully portray the perspectives on Tribal health equity we have heard from Indian Country, while acknowledging that this remains a work in progress. This report will provide insight and move the national conversation forward while recognizing that many perspectives have yet to be heard—this is not the final word on health equity in Indian Country, but another step forward. In addition, this report focuses on how CMS, under the U.S. Department of Health and Human Services, can more effectively advance health equity for American Indians and Alaska Natives. The core principles around Tribal health equity, however, remain relevant to anyone working towards health equity in Indian Country, and the lessons here are easily applicable to other federal agencies.

This report summarizes the results of three events hosted by NIH and supported by CMS that focused on health equity for American Indians and Alaska Natives. Participants in these events included representatives from Tribal governments; Tribal public health officials; Tribal, urban, and Indian Health Service health care workers and administrators; Tribal citizens; state and federal government officials; representatives from regional and national Indian organizations; and experts in Indian health policy. While the focus of discussion varied across events, sessions, and breakout rooms, several themes consistently emerged as foundational to any work related to health equity in Indian Country. This report will lay out these foundational themes and the implications for how CMS can more effectively pursue health equity for AI/ANs.



Figure 1. What does health equity mean to you? (Participant responses)

Working towards health equity must begin with a fundamental understanding that **equity is not the same as equality**. While an “equality approach” would dictate that every person or community should be given the same thing in the same way, an “equity approach” recognizes that different individuals and communities will need different things for everyone to achieve optimum health. Health equity can never be achieved through a “one size fits all” approach, since every community has different needs, strengths, assets, social and historical context, cultural values, and other unique elements. This is especially true when it comes to American Indians and Alaska Natives, who have unique rights, political status, and history with the U.S. government. When federal agencies like CMS set out to work on health equity for AI/ANs, the work must take a different path, process, and form than health equity work supporting other populations and communities. CMS must recognize the unique position of Tribes and how approaching AI/AN health equity is distinct from other health equity work.

## CMS Framework for Health Equity

In July 2022, the Office of Minority Health within CMS published the “[CMS Framework for Health Equity 2022-2032](#)” (“the Framework”).<sup>3</sup> The Framework states, “As the nation’s largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come.” The Framework lays out five priority areas for advancing health equity that will be pursued agency wide.

<sup>3</sup> In November 2022, CMS published the “[CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#).” As this additional framework was not published until after the events discussed in this report, it is not referenced here.

The September listening session specifically focused on getting Tribal feedback on the Framework. Participants were glad to see the administration is working on health equity and claiming it as a priority, and they appreciated that CMS was actively seeking feedback from Tribes and were glad for the opportunity to participate in the process. In general, participants agreed with the broad priority areas laid out by the Framework.

Unfortunately, most participants felt the Framework “misses the mark” in some important ways when it comes to Tribes. Multiple participants commented that it seemed like AI/ANs were being shoehorned into the plan, grouped in with everyone else experiencing inequities in a way that did not make sense and would not be effective in advancing health equity for AI/ANs. As discussed in more detail throughout this report, participants agreed that any effective efforts for health equity in Indian Country must approach health equity plans through the lens of Tribal sovereignty, the nation-to-nation relationship, and the federal trust responsibility, as well as conceptualize the work around an understanding of AI/ANs as a group with a unique political status, not as a racial minority. Because the Framework does not include these things, most participants felt it held limited relevance to Tribal communities and AI/ANs. In the words of one commenter, “Their plan totally excludes us.” This sentiment was commonly expressed by participants.

Participants emphasized that if the agency is to succeed in accomplishing its laudatory goals for health equity, CMS will need to rethink its approach to health equity in Indian Country. As CMS moves forward in this critical health equity work, success will require both a nuanced understanding of the unique context of Tribal health equity and a commitment to action.

This report lays out the fundamental aspects of the unique Tribal context and presents recommendations for a more effective approach to advancing health equity in Indian Country. CMS now has a tremendous opportunity to build on the progress made with the first-ever CMS Framework for Health Equity by learning from this process and continuing to improve through strong collaboration with Tribes and by prioritizing listening to the perspectives of those experiencing inequities.

Throughout this report, you will find sections labeled “CMS Health Equity Framework Connection”; these sections highlight specific references to the CMS Framework for Health Equity and recommendations for how the framework can be strengthened.

## Overview of Health Equity Events and Sources

The health equity events that form the foundation of this report were held in May, August, and September 2022. In addition to these main events, NIHB interviewed several key informants to gain additional insight and perspectives. These conversations were intentionally iterative, each one building on and responding to the ones that came before. “Participants” referenced in this report includes anyone who participated in any of these

events or interviews. More information about these events can be found at [nihb.org/health-equity](https://nihb.org/health-equity).

- ♦ **[Inter-Tribal World Café on Health Equity](#)**. Hosted by NIHB on May 13, 2022, in conjunction with NIHB's 2022 Tribal Public Health Summit, this virtual event had 70 attendees and involved several rounds of iterative, small group discussions. From these in-depth discussions, several critical themes emerged around (1) the foundations of health equity in Indian Country and (2) the deep roots of injustices that have led to the inequities our people face today. A visual summary of the World Café findings, as well as areas of connection between these findings and the CMS Framework for Health Equity, can be found [online](#).
- ♦ **[National Tribal Health Equity Summit](#)**. On August 16, 2022, NIHB held the day-long virtual Tribal Health Equity Summit, which involved two keynote addresses, several panel discussions, and breakout discussions for attendees. The Summit had 450 participants. A visual summary of the Summit findings and associated recommendations for CMS can be found [online](#).
- ♦ **[CMS Listening Session on the “CMS Framework for Health Equity”](#)**. On September 28, 2022, NIHB and CMS held an in-person listening session on health equity during the NIHB 2022 National Tribal Health Conference in Washington, DC. About 100 participants attended. During this listening session, CMS presented the CMS Framework for Health Equity. Additionally, NIHB shared a summary of the results from previous health equity events. Participants then had an opportunity to provide additional feedback on how CMS can improve health equity work in Indian Country.

## Part 1: Key Drivers of Health Inequities in Indian Country

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The dire health inequities we face today stem from colonization's historical injustices and are perpetuated by colonization's ongoing legacy. As a keynote speaker said at the Tribal Health Equity Summit, "Taken together, colonization and racism create the conditions where federal health officials ignore the unique needs and histories of Native peoples when considering what health equity is, should, or can be." Advancing health equity for AI/ANs requires understanding this context and history.

The systemic issues which give rise to AI/AN health inequities are rooted in the long history of harmful U.S. Indian policies: genocide; uprooting AI/ANs from homelands and Tribal community structures; bans on cultural practices and language; forced relocation to reservations; abusive boarding schools; and other destructive policies. The following diagram shows in more detail how colonization and its legacy have led to the health inequities Tribal communities are now facing.

Some elements of the devastating legacy of colonization include:

- ◆ Undercutting of Tribal sovereignty and disempowering of Tribal governments
- ◆ Structural racism & the conceptualization of AI/AN as a "race"
- ◆ Disconnection of AI/ANs from community, identity, and culture
- ◆ Distrust and broken relationships between Tribal nations and federal and state governments
- ◆ Erasure of AI/AN peoples, identities, and histories
- ◆ Disparities in opportunities, like education, jobs, and health care
- ◆ Devaluing of Indigenous ways of knowing



Along with the commonly discussed “social determinants of health” like housing, economic stability, health care, transportation, food, etc., these legacies of colonization are powerful drivers at the root of many of the health inequities Tribal communities are experiencing. During the Tribal Health Equity Summit in August, a speaker referred to the important context of “colonization and our Nation's incredibly shameful history with regard to our treatment of Tribal communities.” She explained, “One of the ways this history really does leave its mark is in disparities and health outcomes,” providing the example that “the infant mortality rate is almost twice as high among our Tribal communities than the national average.” Such health disparities in key health outcomes are the visible, lingering result of colonization and its legacy.

Understanding these key drivers of health inequities is critical because it allows us to better shape our response and our strategies to advance health equity. With these key drivers in mind, we can ask better questions and develop better strategies. These are the drivers that must be countered and addressed if we are to achieve health equity for American Indians and Alaska Natives.

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*“We have a large population of people who have a lot of historical trauma regarding pandemics, needles, injections, just general vaccinations, mistrust of the government. And that has led to lower vaccination rates than we would like to see ... so, that’s something where the structural discrimination of settler colonialism that has caused this historical trauma is still having ramifications today in public health.” - World Café Participant*

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# Key Drivers of Health Inequities for American Indians and Alaska Natives (AI/ANs)"



## Colonization introduced foreign structures and systems

- Federalism
- Capitalism
- U.S. government paternalism
- Structural discrimination
- Euro-centric concepts of race



## Colonialist aims separated AI/ANs from community, identity, and culture

- Genocide
- Taking of lands
- Forced relocation to reservations
- Forced assimilation policies
- Federal Indian boarding schools



## Leading to self-perpetuating problems for AI/ANs:

- Disparities in opportunities (education, jobs, healthcare)
- Diminished economic and political power for Tribes, and exclusion from decision-making
- Data practices that exclude AI/ANs from representation
- Severely underfunded public sector



## As a direct result, Colonization produced:

- Historical and intergenerational trauma
- Erasure of AI/ANs from mainstream American society
- Barriers to Tribal self-governance
- Distrust between Tribes and state/federal governments
- Governance structures that limit meaningful Tribal participation
- Generational poverty
- Tension between majority American culture and Native cultures
- Diminished population size of AI/ANs



## AI/ANs are then further separated from their communities and culture

- Tribes have limited resources to address these systemic problems.
- AI/ANs must leave their homes and communities to access resources, meet needs, and pursue opportunities.



## The outcome: Severe health inequities for American Indians and Alaska Natives

- Because of these systemic injustices, AI/ANs face lower life expectancies and higher rates of preventable disease, disability, and death.

## Part 2

# A Path Forward: Tribal Recommendations for CMS

How can we address the key drivers of health inequities in Indian Country and make health equity a reality? Through many rich discussions, nine key themes emerged as essential steps on the path to health equity for AI/ANs.

## I. Center Tribal Sovereignty and the Nation-to-Nation Relationship

**Tribal sovereignty.** Respecting and upholding Tribal sovereignty must come first and foremost in any health equity work in Indian Country. As sovereign governments, Tribal nations have inherent authority and responsibility to meet their citizens' health care and public health needs.

Health equity initiatives in Indian Country must always be Tribally led. Tribes should be in control of the resources, plans, policies, and goals intended to achieve health equity for their people. Tribes know best what their communities need and what will be most effective for advancing health equity. In addition, Tribal sovereignty opens options and potential approaches to health equity that may differ from other communities or populations. For example, Tribal sovereignty allows Tribes to use Tribal law as a powerful tool for protecting public health and advancing health equity in Tribal communities.

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*"If you're going to address equity issues, you're going to have to deal with Indian people differently than you've done in the past. You're going to have to do something structurally different. You're going to have to treat Tribal governments, Tribal programs from a different standpoint."*

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*- Listening Session Participant*

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**Nation-to-nation relationship.** Like all sovereign nations, Tribes maintain nation-to-nation relationships with the U.S. government. Therefore, any federal health equity initiatives must flow through the appropriate diplomatic channels that respect the authority of Tribal governments. Because of the central importance of Tribal sovereignty, implementing federal health equity initiatives in Tribal communities necessitates special attention to the significant nuances and complexities that arise at this intersection of jurisdictions.

**AI/AN as a political status.** Due to the unique relationship the U.S. holds with Tribes and AI/ANs, the term "American Indians and Alaska Natives" denotes people to whom this unique political status applies. Therefore, when we talk about "AI/AN health equity", we are not talking about achieving health equity for a racial minority, but for a political entity whose people have sovereign governments and hold unique trust and treaty rights with the U.S. government. This context makes all work for health equity

in Indian Country unique and distinct from other ongoing health equity work in the country.

This means, among other things, that federal health laws and programs may have provisions that apply differently or only to Tribal health programs and AI/AN program beneficiaries, without violating civil rights laws or the Equal Protection Clause. For example, Medicare and Medicaid could cover traditional healing practices and Tribal-only provider types like Certified Community Health Aide Practitioners, and Congress could lawfully establish a Medicaid benefit category for Indian health care providers and services. Significantly, such actions are not race-based policies, because “AI/AN” is a political status and not a race.

**Challenges with state Medicaid programs.** Participants mentioned that it was inappropriate and frustrating that Tribes must work with states with regard to Medicaid programs, since Tribes hold a nation-to-nation relationship with the United States, not with the states. This is especially problematic in that states may have vastly different priorities and goals in running their Medicaid programs than Tribes do, since Tribes are trying to ensure access to all necessary services for AI/ANs to achieve their optimum health, while many states are primarily trying to reduce costs. These kinds of state goals do not prioritize or effectively advance health equity. Furthermore, since state Medicaid programs are often administered through managed care organizations, Tribes must expend resources coordinating with these additional entities. CMS is responsible for easing this burden on Tribes, facilitating the inclusion of Tribal priorities and perspectives into state Medicaid programs, and ensuring all state Medicaid programs appropriately uphold the federal trust responsibility and effectively advance health equity for AI/ANs.

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*“They have tried to divide us, but by maintaining our family structure, our Tribal structure, we have been resilient, and we have stayed strong through the years. And by continuing to keep us strong as independent sovereign nations, looking out for our past, for our culture, for our language, all of that will hopefully maintain us as a robust community ... As strong independent nations we can come together and impact our health care, our economic plights, our education, etcetera: the social determinants of health.”*

– World Café Participant

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## Recommendations

- ◆ Support and respect Tribal sovereignty and authority.
- ◆ Recognize that Tribes and Tribal programs have the knowledge, expertise, and authority to design and deliver services in ways best suited for their people, building on cultural strengths and traditions.
- ◆ Change structures and systems to allow Tribes to work directly with the federal government and not through states.

- ◆ Provide training on Tribal sovereignty and the federal trust responsibility. CMS must make sure that anyone involved in implementing CMS programs has proper understanding of Tribal sovereignty and the federal trust responsibility, in addition to CMS's specific role in upholding them. This means ensuring sufficient training for CMS employees and the employees of state Medicaid agencies and managed care organizations. Participants cited a lack of understanding as a consistent barrier when working with these entities.

## CMS Health Equity Framework Connection

**Recognition of Tribal sovereignty and the nation-to-nation relationship.** Participants stated that the CMS Framework for Health Equity should recognize the political and legal distinctiveness of Tribal governments and AI/AN people, since this Framework is a guiding document of the agency. This helps ensure this critical distinction is recognized by agency leadership in setting priorities and by agency staff in carrying out the policies and priorities of the agency.

**Careful attention to language.** Overall, participants found it inappropriate that Tribes and AI/ANs are lumped into “racial and ethnic minorities” within the Framework. While racism (of historical, structural, and other forms) has led to many of the inequities facing Indian Country today, participants broadly agreed that focusing on race is not helpful in solving the problem. Reframing the context of AI/AN health equity away from being a racial issue and instead focusing on the unique rights and political status of AI/ANs is an empowering, strengths-based approach that supports Tribal self-determination. For example, some federal agencies have started using the phrase “racial and ethnic minorities and American Indians and Alaska Natives.”

## II. Prioritize Fulfillment of the Federal Trust Responsibility

**Federal trust responsibility.** “What makes health equity different for Tribal communities fundamentally is that this country is built on Tribal lands, on Indian lands, some of which were ceded, and many of which were not,” explained a speaker at the Tribal Health Equity Summit. In exchange for these lands, the United States signed treaties with Tribal nations promising certain rights and services, including health care. These treaties are the foundation of the federal government’s trust responsibility to protect the interests of Indian Tribes and communities, including the provision of health care to AI/ANs. The federal trust responsibility is integral to the unique legal and political relationship the U.S. maintains with Tribal governments, which has been established through and confirmed by the U.S. Constitution, treaties, federal statutes, executive orders, and judicial decisions.

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*“Federal health services to maintain and improve the health of the Indians are consonant with and required by the federal government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”*  
 – Indian Health Care Improvement Act

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Since ensuring good health and wellbeing for AI/ANs is part of the federal trust responsibility, anything that constitutes a barrier to fulfilling the trust responsibility is also a barrier to achieving health equity. Conversely, dedication to fulfilling the trust responsibility advances health equity.

This obligation to ensure the health and well-being of AI/ANs extends across all federal agencies, including CMS. While some participants expressed the position that true support for Tribal sovereignty and fulfillment of the federal trust responsibility would mean ensuring Indian health programs were fully funded directly (instead of passing funding through Medicare and Medicaid), others pointed out that CMS can play a significant role in improving access to quality health care for AI/AN people. Participants largely viewed the Administration's prioritization of health equity as a step towards fulfilling the federal trust responsibility, but many reinforced the urgent need for action and accountability. Participants emphasized that simply creating new frameworks or plans was not enough—Indian Country needs to see results.

## Recommendations

- ◆ **Implement the CMS TTAG policy recommendations.** The CMS Tribal Technical Advisory Group (TTAG) recommendations provide concrete solutions to address many of the concerns that participants raised during the health equity events. Listening session participants emphasized that since the TTAG specializes in improving how CMS programs function for Indian Country, these recommendations are all key to supporting health equity for American Indians and Alaska Natives. (See the section beginning on page 31 for more information).
- ◆ **Hold states accountable.** States are not always supportive of Tribal health equity even when CMS is making it a priority. CMS should provide states with appropriate guidance for instituting the changes necessary to advance health equity for AI/ANs and institute accountability measures to ensure states follow through.
- ◆ **Institute uniform Medicaid eligibility and benefits for AI/ANs.** The federal trust responsibility is owed to all AI/AN people, regardless of their state of residency. Therefore, all AI/ANs should have access to the same baseline benefits no matter where they live, while allowing for some flexibility above that baseline for regional variations to meet diverse needs. To start with, CMS should encourage expanded Medicaid eligibility for AI/ANs in states that have not expanded Medicaid; for example, by using Section 1115 demonstrations. Ensuring AI/ANs can fairly access Medicaid will improve access to care and is a critical step in advancing health equity.

## CMS Health Equity Framework Connection

While in general participants in the September listening session found the priorities outlined in the Health Equity Framework to be important, many expressed concerns that these priorities would be ineffective without a clear implementation plan, a plan for accountability for federal and state agencies, and close attention to the intersection of these priorities with Tribal sovereignty and the federal trust responsibility.

Participants recommended the following as necessary supplements to the Framework:

- ◆ **Expediently create a health equity implementation plan.** This plan should contain timebound, actionable goals (with related metrics for accountability) for all operational divisions within CMS. It should also include specifics for how to effectively implement health equity strategies in Indian Country, informed by the feedback in this report.
- ◆ **Incorporate and act on the input from the three health equity events.** Some participants said it would be helpful to add a Tribal-specific supplement to the CMS Framework for Health Equity to fully incorporate the feedback from all three recent Tribal health equity events. Others said such an addition would only be useful if it was expeditiously executed, written by Tribes, and contained actionable priorities; these participants emphasized that the plan cannot be more “exploration,” but must lead to action and results.
- ◆ **Keep accountable for achieving these health equity priorities.** Develop an accountability mechanism (e.g. a scorecard) to track progress. Ensure Tribal participation is included in the accountability mechanism, so Tribes can speak to how well CMS is fulfilling commitments to health equity in Indian Country.

### III. Recognize that Tribes Hold the Answers to Tribal Health Equity.

**Resilience through culture.** Colonization and the worldviews and values introduced by the colonizers have led to devastating health inequities; leaning into traditional Indigenous values and worldviews opens new pathways forward. We can only achieve health equity for Indian Country when we approach it through a Native lens.

One of the strongest themes to emerge from these health equity discussions was that connection to community and culture is among the most powerful drivers for good health and resilience for AI/AN people. Strengthening connection to community and culture is essential to counter the harmful disconnection that resulted from centuries of historical injustices. For example, AI/ANs currently experience drastic inequities in diabetes rates; this can be traced back to the history of the disruption of traditional food systems through the forced removal of Tribes to reservations, and the subsequent forced reliance on commodity foods. Many Tribal communities have prioritized food sovereignty and bringing traditional food systems back to the forefront of daily life, reintroducing balanced nutrition and a stronger connection to community and culture. Participants shared many examples of how this kind of strengthened connection has led to improved health outcomes.

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*“We’re a lot more adept sometimes at focusing in on what’s not working than really seeing the strengths that we can leverage together.”*  
 - Tribal Health Equity Summit Participant

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**Health equity requires a strengths-based approach.** Previous government health initiatives have often focused solely on problems and disparities; this can leave the inaccurate, harmful impression that the communities experiencing inequities are

somehow inherently deficient. This undercuts these communities' self-determination and sets the stage for government paternalism. Instead, health equity initiatives should recognize that the answers for achieving health equity for a community lie within that community; the strengths, assets, and resilience of individuals and communities are vital to any effective path to health equity. The federal government is most effective in working towards health equity when it puts its resources behind supporting the leadership of Tribal communities. **Tribes know their people, communities, social and historical context, needs, and strengths best—Tribes are the experts in charting a path to health equity for their people.**

### *Recommendations*

- ◆ **Empower Tribes to lead in health equity initiatives.** This will guard against government paternalism in policies and initiatives.
- ◆ **Expand flexibility in Medicare.** Tribes and Urban Indian organizations need the flexibility to be innovative in how they deliver Medicare services, to engage with traditional medicine and embed other cultural treatment modalities into Medicare services. Such flexibility ensures these services are appropriately rooted in culture and contribute to higher quality care.
- ◆ **Listen to the experiences of people experiencing inequities.** This will allow for better input to inform policy development.
- ◆ **Proactively solicit Tribal input on communications materials** for Indian Country.

### *CMS Health Equity Framework Connection*

- ◆ Some participants observed that a shortcoming of the CMS Framework for Health Equity is that it contains little mention of the strengths, assets, and resilience of the people experiencing health inequities. CMS should revise the Framework for Health Equity to be **strengths-focused** so that it becomes a Health Equity plan rather than a Health Disparities plan; **Framework priorities should include identifying, utilizing, and cultivating the health assets and strengths of communities and individuals.**
- ◆ Many participants commented on the relevance and importance of **culturally tailored services in Indian Country (Priority 4)**, although some wanted to see this section go further. Culturally tailored services are most effective when they are designed by Tribes for Tribes.

## **IV. Support Tribal Institutions**

The Indian health system is unique in the United States. Inclusive of systems of facilities run by Tribes, the Indian Health Service, and Urban Indian organizations, the Indian health system is the main source of care for most AI/ANs. Longstanding inequities in funding, resources, systems, and structures related to the Indian health system have contributed to the inequities in health outcomes experienced by the AI/AN people who rely on these facilities for health care. In addition, some policies may effectively support population health in most contexts, but become detrimental within the special

circumstances of the Indian health system. Such policies end up contributing to health inequities by impeding access to quality care for AI/ANs specifically. **A robust health care system specifically designed to meet the needs of AI/ANs is necessary to achieve health equity.**

Medicare and Medicaid can play a significant role in supporting Tribal health equity by ensuring Tribes and Indian health organizations have the resources, funding, and technical assistance necessary to meet their people's needs. Furthermore, policies and requirements that undermine or unduly burden the Indian health system should be eliminated or modified whenever possible. For example, hospital rating systems should recognize that AI/ANs often require longer hospital stays than other patients; hospital participation requirements should be scaled to the size and capacity of Tribal hospitals; and hospital governance requirements should be flexible enough to respect Tribal governmental structures and lines of authority.

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*“Most Tribes have internal understanding of what they need but lack support and resources to handle them.”*

*– Listening Session Participant*

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## Recommendations

- ◆ **Adapt Medicaid and Medicare programs to cover a wider array of Tribal services, programs, providers, and initiatives.**
- ◆ **Resolve the “four walls limitation.”** CMS's "four walls" interpretation of the Medicaid clinic benefit will soon prevent Medicaid-enrolled clinics from billing for services provided outside the physical four walls of the facility when the temporary grace period for such services expires. This includes vital services Tribal programs have furnished for decades at the off-site locations where they are most effective, such as schools, community centers, patients' homes, and by mobile crisis response teams. Participants shared examples of successful, culture-based health programs that will be jeopardized when they can no longer be provided in the most culturally appropriate or effective location. Participants emphasized that location matters and discussed the importance of Indigenous spaces and locations accessible to their patients. The “four walls limitation” is contrary to the stated goals of the CMS Framework for Health Equity, as it hinders Indian health providers from providing accessible, culturally appropriate care.
- ◆ **Improve Medicaid prior authorization practices.** CMS should work with states on prior authorization to cover additional services and improve access to care for AI/AN beneficiaries. Patients would be better served – and health equity advanced – if they can receive needed care immediately, instead of requiring multiple health care visits or complicated bureaucratic maneuvering that may present additional barriers to care.
- ◆ **Provide billing and coding support.** Participants expressed a need for additional training on billing and coding for clinics and providers, and requested that CMS provide resources to ensure sufficient staffing for billing and coding at Indian health facilities.

- ◆ **Ensure Indian health care providers are reimbursed by Medicare and Medicaid for all methods of telemedicine.**

### *CMS Health Equity Framework Connection*

- ◆ **Priority 3, “Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities,”** resonated strongly with participants.
- ◆ Some participants observed that addressing the resource gap would go a long way towards accomplishing most of the health equity priorities outlined in the Framework.

## V. Disrupt Structures of Inequity and Shift the Balance of Power

The health inequities experienced by AI/ANs are rooted in the history and ongoing legacy of colonization – on the structures and policies introduced and maintained by the U.S. government. This means these problems are societal; they cannot be addressed through individuals only. Thorough understanding of colonization as the root of these health inequities allows us to properly assign responsibility—AI/AN communities and individuals did not cause these inequities or bring them on themselves.

One way colonization led to drastic health inequities was by stripping Tribal nations of their political power and self-determination. Because Tribes were systematically excluded from decision-making and subjected to paternalistic federal policies for several hundred years, government policies, programs, and systems have not served the needs of AI/AN people. In order to achieve health equity, these structures of inequity must be dismantled, and power must be returned to Tribal nations.

**Tribal empowerment in state and federal governance.** Undoing centuries of harm to AI/ANs requires dedication to rebuilding relationships and trust among governments and purposeful inclusion of Tribes in decision-making. One of the essential forms of Tribal inclusion in governance is Tribal consultation, described further below. Tribes also need to be included in government decision-making in other ways, like by including Tribes in agency task forces and committees, expanding pathways for AI/ANs to become elected officials and government employees, and supporting active Tribal advisory committees. For example, the [CMS Tribal Technical Advisory Group](#) (TTAG) is critical in informing CMS on how Medicare and Medicaid policy impacts AI/AN people and Indian health care facilities on the ground and provides specific policy recommendations for changes needed to advance health equity. Tribal advisory committees like the TTAG, however, are only effective if federal agency leadership act on the advisory committee’s recommendations and allow them meaningful participation in decision making. TTAG members who participated in the health equity events expressed concern that although the TTAG submitted its list of policy priorities to CMS in 2020, the committee has yet to receive the promised written response from CMS.



**Tribal consultation.** Because Tribes are sovereign nations, any time a state or federal government agency contemplates a policy change that will impact a Tribe or its citizens, that agency has an obligation and responsibility to pursue timely, meaningful, robust Tribal consultation. Meaningful consultation requires two-way communication and collaboration, not just informing Tribes about decisions that have already been made. Tribal consultation must be held at the policy-development stage for regulations as well as sub-regulatory and nonregulatory guidance, like billing manuals, fee schedules, and strategic plans. Consultation should be with government officials with decision-making authority, as well as with agency subject-matter experts and designated Tribal liaisons. As Medicaid is a federal program administered through states, CMS has a responsibility to ensure states are conducting all necessary Tribal consultations, and that these consultations are meaningful and robust.

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*“In my experience, Tribal consultation with the state, with CMS—it's not meaningful. The whole process is just not equal. There are hierarchies; very colonized and not meaningful, and that misunderstanding or lack of knowledge of Tribal sovereignty in that role, it creates a lot of inequities.”*  
 – Participant in the Tribal Health Equity Summit

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Participants cited many examples of when Tribal consultation policies were lacking or unenforced, or when consultation was held in a way that was not meaningful. For example, some states exclusively use virtual consultation—but many Tribal communities do not have broadband access, limiting their ability to participate. Participants also expressed disappointment in follow-up, wanting to see more clearly how the input gained from the consultation was acted on and implemented. Participants reiterated the importance of having high-level agency leadership present at consultations and ensuring Tribal leaders are properly notified in advance; government leaders must be present on both sides of the table to constitute proper Tribal consultation.

**Tribal self-governance.** Respecting Tribal sovereignty, in large part, means deferring to Tribal control by supporting Tribes and Urban Indian organizations (UIOs) to make decisions for themselves on the best way to run programs. Ensuring sufficient flexibility and support for Tribes and UIOs to design their own solutions and priorities for health equity is both more effective and more respectful of Tribal sovereignty. One example shared in the listening session was how Alaska has assumed management of Medicaid travel for Tribal beneficiaries within the Tribal system, which was more effective and cost-saving in a state with so many unique travel challenges. As a participant explained, “that's a self-governance model of managing Medicaid travel on behalf of the Medicaid program. If you were to implement more self-governance processes into your systems, you could achieve many of the issues associated with addressing health disparities.” Others suggested Tribes should also be authorized to verify Medicaid eligibility for patients at Tribal health facilities.

## Recommendations

- ◆ **Prioritize timely, meaningful Tribal consultation** and make sure states' Tribal consultations on CMS programs are timely and meaningful.
- ◆ **Fully train staff on Tribal consultation**, especially how to identify when it is needed.
- ◆ **Incentivize state Medicaid agencies to work with Tribal liaisons and Indian health advisory boards** to improve collaboration with Tribes.
- ◆ **Be responsive to recommendations of CMS TTAG.**
- ◆ **Expand opportunities for Tribal self-governance** in CMS programs.
- ◆ **Make sure the responsibility for addressing health inequities falls on the institutions and systems that created them**, not the individuals experiencing them.
- ◆ **Acknowledge the federal government's role in creating the health inequities** AI/AN people are experiencing.
- ◆ **Reform systems to ensure equitable treatment of AI/ANs regardless of the source of care.**

## CMS Health Equity Framework Connection

- ◆ Strategic documents like the CMS Framework for Health Equity should go through Tribal consultation.
- ◆ CMS will need to work with Tribes to fully address **Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps**. Without Tribal participation, CMS will not be able to effectively identify the inequities that impact Indian Country and the best ways to close gaps. Participants cited this priority as critical for health equity in Indian Country.
- ◆ Participants emphasized that health equity cannot be achieved until the federal government takes responsibility for the injustices that created the inequities in the first place. Some felt the promises and the stated intentions for the Framework rang hollow without such acknowledgment, since it was coming from a federal agency.

## VI. Increase Visibility of American Indians & Alaska Natives

A chief aim of colonization was the erasure of American Indians and Alaska Natives, as federal Indian policy tried to eradicate AI/AN peoples and cultures from existence. While Tribes have been remarkably resilient in preserving our communities and cultures despite these persistent challenges, AI/ANs are commonly invisible in the larger American cultural context. As long as AI/ANs continue to be unseen, the inequities will continue. Crucially, federal agencies like CMS must take active measures to ensure AI/AN people and Tribes are visible in two critical arenas: policy creation and data.

**Inclusion and visibility in policy creation.** Tribes must be included in every step of policy creation. Participants emphasized that often the impact of policies on Tribes is treated as an afterthought, instead of ensuring Tribes are at the table throughout the policy development process. As a result, the policies themselves often leave out Tribes entirely and the cycle of invisibility continues.

**Visibility in data.** High-quality, meaningful AI/AN health data is essential for identifying disparities, setting priorities, designing strategies, and highlighting successes related to health equity. However, AI/AN data is missing so often that AI/ANs have come to be known as the “Asterisk Nation”—a recognition of how often AI/AN data is withheld and replaced by an asterisk to denote that the sample size was too small or the data was statistically unreliable. Racial misclassification, missing data, and other quality issues continue to impede the representation of AI/ANs in many data sets. With AI/AN people and communities so often missing from the data, this becomes one more form of erasure of AI/ANs—our experiences are not represented, our needs are not heard, and our very existence becomes invisible. Improving data practices is crucially important as a step to undo the centuries of AI/AN erasure contributing to the ongoing health inequities in Tribal communities.

At the same time, governmental agencies need to recognize that some AI/AN individuals may be reluctant to self-identify as AI/AN because of the long history of harmful federal Indian policy. Individuals must always have the option of declining to disclose racial identification or Tribal affiliation. In addition, protecting individual data privacy and Tribal data sovereignty are critical.

## *Recommendations*

- ◆ **Include Tribes and AI/AN people** on task forces, workgroups, and committees.
- ◆ **Address data quality.** Improve and expand the collection and reporting of data that identifies AI/AN status. Tribal consultation is needed to identify appropriate methods for addressing data quality. Some participant suggestions for steps forward included:
  - Incentivize compliance with higher data standards.
  - Enforce mechanisms within electronic health records (EHRs) to support entering correct demographic data and make sure EHRs do not default to “White” as the race selection.
  - Provide more uniformity in Medicaid applications.
  - Include “Tribal affiliation” in addition to race, including the ability to enter multiple Tribal affiliations. This supports Tribal sovereignty and puts the emphasis on “AI/AN” as a political status rather than a race.
  - Deliver more communication to enrollees on why this data is collected and how it will be used (explaining why this is important may encourage more enrollees to disclose demographic information).
- ◆ **Standardize definitions of AI/AN** across agencies, databases, and data warehouses. A standardized metric would support interoperability among data sets and expand analysis opportunities, in addition to helping within other grant programs with substantial reporting requirements, like those from the Health Resources and Services Administration (HRSA). This standardized definition should be developed with Tribal consultation.
- ◆ **Respect Tribal sovereignty.**
  - Ensure any data collected is Tribally driven, to make sure the data collected is meaningful to Tribal communities.

- Use sovereignty language, not presented as race data, and use Tribal affiliation.
- Ensure two-way flow of data—data about Tribal members is Tribal data; Tribes must have access to this data.
- ◆ **Address reporting burden.** CMS needs to ensure that any reporting burden is accounted for—including time and resources required to comply with reporting requirements.
- ◆ **Facilitate Tribal data access.** Tribes and Tribal epidemiology centers need access to data to identify priorities, monitor trends, and support public health. CMS is required by federal law to provide this data access, as Tribal epidemiology centers and Tribes are public health authorities. Participants described how important it is to have data on all their Tribal members with Medicare and Medicaid, no matter where patients seek care, and discussed how difficult it can be to access this data from non-Indian health care providers or state agencies. Participants cited access to Medicare and Medicaid data as essential for advancing Tribal health equity priorities.
- ◆ **Provide resources for improving data.** CMS should provide Indian health care providers the resources needed to improve data processes and enable compliance. Participants also suggested it would be helpful to have CMS funding to assist Tribes in designing and conducting Tribal specific social determinants of health data assessments.

### *CMS Health Equity Framework Connection*

- ◆ Several participants said they were disappointed Indian Country was only being asked for input after the Health Equity Framework had already been published, and they cited this as a reason AI/ANs and Tribes are largely invisible within the Framework. Tribes need to be included in the development of policies like the Framework for Health Equity.
- ◆ Most participants agreed that a critical step to advancing health equity is to **“Expand the Collection, Reporting, and Analysis of Standardized Data” (Priority 1)** – especially when it comes to improving the visibility of AI/ANs within CMS data.

## **VII. Heal Backwards and Forwards**

A person's health status today has its roots far in the past; today's living conditions will determine their health status decades in the future. If we are to achieve health equity, we must both address the roots of inequities from far in the past, as well as work to ensure our efforts today will benefit the health and wellbeing of AI/AN people seven generations in the future.

**Historical trauma.** The lingering impact of the past frequently arose with discussions of historical trauma. Historical trauma is the “cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group

trauma experience,”<sup>4</sup> like the recurring injustices and violence experienced by AI/ANs through colonization. Participants described the widespread detrimental impact historical trauma continues to have for AI/AN individuals and communities, and how it has contributed to a multitude of poor health outcomes. As one participant said, “The disparities will continue to exist at least until we can address fully that historical trauma and how it’s impacted all of us.”

**Trace policy genealogies.** Another way past wrongs can cause lingering harm is when the detrimental intentions of colonization and societal racism have been enshrined in laws, policies, and institutional practices. Colonization and racism have a far-reaching legacy; we must understand the historical and ideological roots of policies that are currently in effect and identify who these policies benefit, and who may be left out or harmed. Health equity cannot be achieved until we successfully dismantle the systems and policies that created the inequities.

### Recommendations

- ◆ **Make an explicit effort to address systemic racism in CMS policies and operations,** including in programs run through states.
- ◆ **Provide training to CMS staff and program partners on the ongoing impact of historical and intergenerational trauma in Tribal communities.**
- ◆ **Ensure services are trauma-informed and culturally appropriate.**
- ◆ **Recognize the historical, political, legal, and cultural context of health inequities and the communities experiencing them.**
- ◆ **Focus on systemic changes** that will improve health and well-being for the next seven generations.

### CMS Health Equity Framework Connection

- ◆ CMS should make a concerted effort to address any implicit bias in the Framework. Some participants observed that certain

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*“There are recommendations from past federal reports that have been made dating back almost a hundred years ago. These provide a work plan in terms of how to move forward ... We talked about the Meriam Report [from 1928]. We talked about the Indian Policy Review Commission report in 1978. We talked about ‘A Quiet Crisis’ in 2003, about ‘Broken Promises I’ in 2004, and then ‘Broken Promises II’ in 2018. These five federal reports all document the disparities of Indian people. There have been improvements in these disparities, but there haven’t been any differences in closing that gap.*

*“And our position is this: if you’re going to address disparities as a health equity issue within the Federal Government, you have to do something distinctively different than you’ve done in the past that’s been demonstrated by these reports.”*  
– Listening Session Participant

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<sup>4</sup> Maria Yellow Horse Brave Heart (2003). “The historical trauma response among natives and its relationship to substance abuse: A Lakota illustration.” *Journal of Psychoactive Drugs*. 35(1).



sections of the Framework seem to imply white culture is the default and everyone else constitutes “special cases.”

## VIII. Focus on Relationships and Connectedness

Health equity is complex and requires a broad vision and a holistic approach. Many participants discussed the interconnectedness of people with each other, with the land and water, and with all other living things. Indigenous views of health equity honor this interconnectedness.

**Social determinants of health.** Social determinants are powerful drivers of health that cannot be ignored if we want to achieve health equity. Therefore, non-health sectors can be powerful forces for AI/AN health equity, particularly when supported by Tribal sovereignty, collaboration, emphasis on traditional values, and prioritization of health and wellbeing. Tribal governments, regional and national Indian organizations, Tribal schools and colleges, Indian health systems, and Tribal justice systems are critical points of intervention for advancing health equity. Strengthening these institutions and supporting Tribal self-determination and self-governance in each of these sectors will advance health equity.

When it comes to CMS, addressing issues like housing, food, transportation, social isolation, access to care, and other common social determinants of health will go a long way towards achieving CMS’s goals for health equity. However, CMS must also recognize that social determinants of health can look different from a Tribal perspective. The needs and values of AI/ANs when it comes to common social determinants are often unique. In addition, certain social determinants are critical for AI/ANs that may not be common determinants for other populations (e.g., historical trauma from federal Indian boarding schools; the reservation system; etc.).

**Collaboration and communication.** CMS can also focus on relationships and connectedness through fostering collaboration and transparent communication with Indian Country, states, and other federal agencies. With an issue as complex as health equity, all perspectives, knowledge, and resources from each of these are necessary to achieve success.

## Recommendations

- ◆ **Adopt a holistic approach and focus on overall well-being**, not just health care services.
- ◆ **Recognize Tribal perspectives of social determinants of health and address these determinants in culturally relevant ways.**
- ◆ **Provide resources to address social determinants of health**, including traditional foods and other cultural life ways. Medicaid 1115 demonstration waivers are one promising avenue for addressing social determinants.

- ◆ **Communicate with Tribes and Indian health care providers** about upcoming and recent policy changes.
- ◆ **Work with sister agencies and the CMS Division of Tribal Affairs.** This will ensure an all-agency response to health equity and full inclusion of Tribal priorities and perspectives in CMS's health equity plans.
- ◆ **Expand collaboration of various CMS programs with CMS TTAG.**
- ◆ **Support integration of behavioral and physical health services.**

### *CMS Health Equity Framework Connection*

Participants mentioned that it was promising to see references in CMS's health equity plans to "screening and broader access to health-related social needs" and to "improving coordination for dual-eligibles," as these support a holistic, empowering, strengths-based approach that elevates the voices of enrollees and expands focus on social determinants of health. In addition, some participants remarked that the Framework would be more useful if its language embraced a more holistic view of health equity, broadly encompassing health and wellness. For example, replacing the phrase "health care" with "health care and services" would be inclusive of behavioral health, public health, social determinants of health, and other critical aspects of a holistic view of health.

### **IX. Honor Indigenous Knowledge**

Indigenous knowledge holds tremendous value in insight, perspective, and understandings of health and healing. Indigenous knowledge represents a critical part of connection to culture and is essential for healing individuals and communities.

Achieving health equity requires respecting traditional ways of knowing and honoring diverse worldviews on health and well-being. Hundreds of years of federal policies designed for cultural genocide sought to wipe out Indigenous knowledge. Now, widespread bias permeates Western culture. This legacy of colonization dictates whose knowledge is considered legitimate and whose truth is allowed to count. Such devaluing of Indigenous knowledge compounds the harms of historical trauma and is one more way AI/ANs are disconnected from community and culture. Now, federal agencies must go to significant lengths to make sure this harm is counteracted by honoring and valuing Indigenous knowledge.

### *Recommendations*

- ◆ **Reimburse for traditional healing services.** Integrating traditional health services with medical, dental, and behavioral health services allows for holistic care to tend to the mind, body, and spirit of AI/AN individuals. Participants shared multiple examples of how various health care programs are more effective at improving health for AI/AN people when they incorporate traditional medicine. Tribal nations, Tribal organizations, and UIOs have developed processes and policies for credentialing traditional practitioners in parity with Western clinical privileges. They have also

developed several traditional health models that CMS can reimburse. Medicare and Medicaid reimbursement for traditional health services would support access to culturally appropriate services, which will improve health outcomes for AI/ANs and advance health equity. Designing the paths to credentialing and billing for traditional healing services must be Tribally led and approached with sensitivity and cultural humility, since traditional healing often includes protected, sacred practices.

- ◆ **Set a standard for cultural humility across CMS programs and staff.** While ideally anyone working with a Tribe would be culturally competent, it is not possible to be fully competent in someone else's culture, let alone every culture. Cultural humility is therefore a needed standard. Cultural humility is a lifelong commitment to self-reflection starting with an examination of one's own beliefs and cultural values and recognition of power dynamics and imbalances, combined with a willingness to learn from others.<sup>5</sup>
- ◆ **Embrace "promising practices"** alongside "evidence-based practices."
- ◆ **Support providers with culturally specific training**, like Native doulas.

### *CMS Health Equity Framework Connection*

- ◆ One aspect of honoring Indigenous knowledge is acknowledging and appreciating the wide diversity of Tribes. CMS should ensure language used in the Health Equity Framework appreciates the diversity of Tribes and does not unintentionally homogenize Indian Country. For example, the CMS Framework for Health Equity states, "addressing mental health disparities among AI/ANs requires understanding healing, locally relevant coping strategies, and treatment that is consistent with cultural beliefs and practices within *this community*" (emphasis added). However, describing 574 sovereign nations as a singular community is inappropriate.

<sup>5</sup> Definition adapted from [University of Oregon – Division of Equity and Inclusion](#).

## Part 3: Advancing Equity Through CMS TTAG Policy Recommendations

Federal delivery of health services and funding of programs to maintain and improve the health of American Indians and Alaska Natives (AI/ANs) are consonant with and required by the federal government's historical and unique legal relationship with Indian Tribes, as reflected in the U.S. Constitution. CMS established the Tribal Technical Advisory Group (TTAG) to enhance the nation-to-nation relationship, honor federal trust responsibilities and obligations to Tribes and AI/AN people, and increase understanding between CMS and Tribal health programs, including those administered by the Indian Health Service (IHS).

The CMS TTAG serves as an advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs served by Medicare, Medicaid, CHIP, or any other health care program funded (in whole or in part) by CMS. In this role, the TTAG policy and legislative priorities can provide a roadmap for CMS to address health equity in the Indian health system. The CMS TTAG recommendations are in alignment with the intended outcomes of the CMS Framework for Health Equity.

The [TTAG administrative priorities](#) propose specific steps CMS can take, on its own authority, to expand the Medicaid services available to AI/ANs, empower Tribal programs to design and tailor Medicare and Medicaid services to their unique needs and cultures, and provide more uniform and equitable Medicare and Medicaid reimbursement to Tribal programs. For example, the current priorities call on CMS to:

- ◆ Expand Medicaid and Medicare coverage of telehealth services, including audio-only services, to the greatest extent possible, and reimburse these services at the same rate as in-person services.
- ◆ Make all Tribal outpatient health programs eligible for reimbursement at the cost-based “IHS/OMB encounter rate,” regardless of whether and when the program was last operated by IHS or associated with an IHS hospital.
- ◆ Revise its interpretation of the Medicaid “clinic” benefit to eliminate the “four walls” restriction and to cover services furnished by clinic staff in schools, community centers, patients’ homes, and any other appropriate location.

[TTAG’s legislative priorities](#) propose changes that are beyond CMS’s current authority and would require changes to federal statutes. While CMS generally cannot advocate directly for legislative changes, it can support this effort by providing Congress with thorough and timely technical assistance on any proposed legislation related to TTAG priorities including:

- ◆ Authorize Medicaid reimbursement for all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the Indian Health Care Improvement Act (IHCIA)—referred to as

Qualified Indian Provider Services—when delivered to Medicaid-eligible AI/AN beneficiaries by Indian health care providers.

- ♦ Eliminate Medicare cost-sharing and premiums for AI/AN beneficiaries, as is already the case for Medicaid-covered services.
- ♦ Include licensed marriage and family therapists, licensed professional counselors, doctor of pharmacy providers (Pharm D.), physician assistants, certified community health aide practitioners, behavioral health aides and practitioners, and dental health aide therapists as eligible provider types under Medicare for reimbursement for Indian health programs.

The CMS TTAG policy and legislative recommendations will change over time based on CMS administrative decisions and Congressional action. A copy of the current CMS TTAG policy and legislative priorities can be accessed at [the NIHB website](#).

See also the [Tribal Technical Advisory Group American Indian and Alaska Native Strategic Plan 2020-2025](#), which “includes information and direction on a range of issues with a special and specific focus on CMS. Tribal stakeholders put forward this plan to advance the overarching goal of eliminating health disparities for AI/AN people and ensuring access to critical health services.”



## Conclusion: Where do we go from here?

As the [CDC recently reported](#), life expectancy for AI/ANs is now nearly 11 years less than for the general U.S. population. It is unethical and unacceptable that the United States has allowed this inequity to persist and worsen. Health equity is a crisis in Indian Country. We cannot wait any longer.

For AI/ANs, discussions around health equity will always revolve around Tribal sovereignty, the federal trust responsibility, and how colonization and U.S. government policies have driven the severe health inequities we are now facing. As CMS raises health equity to a high agency-wide priority, moving forward will require both a nuanced understanding of the unique context of Tribal health equity and a commitment to action. This context is vitally important for any health equity plans to be relevant and effective for Tribal communities.

Federal efforts to address AI/AN health disparities fail when they are culturally inappropriate interventions that neglect to recognize the U.S. policies as a contributing factor and disregard the historical and ongoing trauma of AI/AN people. CMS can advance health equity for AI/ANs by keeping its health equity work in context; accepting the federal government's responsibility to ensuring good health and well-being for AI/AN people; conducting meaningful Tribal consultation; being responsive; and recognizing that the answers for health equity lie within AI/AN communities.

One of the top priorities expressed by participants is for CMS to take action for health equity without delay. These were some of the first steps participants said CMS should take:

- ◆ **Implement the CMS TTAG policy recommendations.**
- ◆ **Expediently create a health equity implementation plan.**
- ◆ **Incorporate and act on the input from the Health Equity World Café, the Tribal Health Equity Summit, and the Listening Session on the CMS Framework for Health Equity, as described in this report.**
- ◆ **Initiate Tribal consultation on the CMS Framework for Health Equity and an implementation plan for AI/AN.**
- ◆ **Work with sister agencies and the CMS Division of Tribal Affairs** to ensure an all-agency response to health equity and full inclusion of Tribal priorities and perspectives in CMS's health equity plans. CMS leadership must prioritize efficient implementation of Tribal recommendations without delay.
- ◆ **Keep accountable for achieving these health equity priorities.** Ensure Tribal participation is included in the accountability method, so Tribes can speak to how well CMS is fulfilling commitments to health equity in Indian Country.
- ◆ **Hold states accountable.** States are not always supportive of Tribal issues and health equity even when CMS makes it a priority. CMS should provide states with appropriate guidance for instituting the changes necessary to advance health equity for AI/ANs and institute accountability measures to ensure states follow through. CMS

should ensure states hold timely, meaningful, robust Tribal consultations on state Medicaid policies.

**CMS must commit not only to acting swiftly, but to ensuring that action is sustained over the long haul.** Advancing health equity requires a commitment to honesty, integrity, and a persevering hope that this vision of optimal health for all is possible, and we will make it a reality. With sufficient commitment and use of these recommendations, we could eliminate the health inequities for AI/AN in one generation.

As one of the Tribal Health Equity Summit speakers concluded, “Can we have the courage to challenge the status quo, to be willing to say what we're doing now isn't good enough? Let us endeavor to see the ubiquity of brilliance and learning, to be guided by a belief in the abundance of possibilities and peoples, reject ideologies of scarcity, and move toward understanding the power that resides in us all [as Native people]. Let us commit to teaching us to unlock the power toward creating systems and structures that do not create the perfect bodies to host killer viruses, but to create healthy bodies and institutions that honor the past and move us toward a more equitable, just future.”