

APRIL 2026

THE NATIONAL  
TRIBAL BUDGET  
FORMULATION  
WORKGROUP'S

# REQUEST FOR THE INDIAN HEALTH SERVICE

FISCAL YEAR 2028 BUDGET

ALIGNING WITH THE

Federal Trust Responsibility Through Full Funding

**TO MAKE AMERICAN INDIANS AND  
ALASKA NATIVES HEALTHY AGAIN**

TRIBAL  
CO-CHAIRS



**VICTOR JOSEPH**  
Executive Director,  
Native Village of Tanana



**STEVE KUTZ (COWLITZ)**  
Health Clinic Director,  
Suquamish Tribe



**RICHARD MATENS**  
Executive Director,  
Pamunkey Indian Tribe



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# ACKNOWLEDGMENTS

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Member & Health Oversight  
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# INDIAN HEALTH SERVICE

## FY 2028 NATIONAL TRIBAL BUDGET RECOMMENDATION

### DETAIL OF CHANGES

(dollars in thousands)

SUB IHS ACTIVITY	FY 2026 ENACTED	DETAIL OF CHANGES			FY 2028 PROGRAM INCREASE (C+D+E)	FY 2028 NATIONAL RECOMM. TOTAL
		Current Services	Other Binding Obligations	FY 2028 Program Expansion		
<b>SERVICES</b>						
Hospitals & Health Clinics	2,632,772	140,297	325,000	15,500,214	15,965,511	18,598,283
Electronic Health Record System	190,564	3,443	0	508,146	511,589	702,153
Dental Services	260,360	13,898	0	4,014,633	4,028,531	4,288,891
Mental Health	133,693	6,243	0	5,515,910	5,522,153	5,655,846
Alcohol & Substance Abuse	267,080	12,067	0	4,330,270	4,342,337	4,609,417
Purchased/Referred Care	996,755	45,958	0	12,127,933	12,173,891	13,170,646
Indian Health Care Improvement Fund	74,138	4,535	0	3,680,005	3,684,540	3,758,678
<b>TOTAL, CLINICAL SERVICES</b>	<b>4,555,362</b>	<b>226,441</b>	<b>325,000</b>	<b>45,677,111</b>	<b>46,228,552</b>	<b>50,783,914</b>
Public Health Nursing	114,200	6,706	0	926,665	933,371	1,047,571
Health Education	24,524	2,008	0	390,430	392,438	416,962
Community Health Representatives	65,212	3,359	0	1,696,993	1,700,352	1,765,564
Immunization AK	2,183	111	0	119,081	119,192	121,375
<b>TOTAL, PREVENTIVE HEALTH</b>	<b>206,119</b>	<b>12,184</b>	<b>0</b>	<b>3,133,169</b>	<b>3,145,353</b>	<b>3,351,472</b>
Urban Health	95,419	4,582	0	1,542,786	1,547,368	1,642,787
Indian Health Professions	84,568	1,233	0	88,385	89,618	174,186
Tribal Management	2,986	36	0	99,799	99,835	102,821
Direct Operations	103,805	2,815	0	24,276	27,091	130,896
Self-Governance	6,174	122	0	11	133	6,307
<b>TOTAL, OTHER SERVICES</b>	<b>292,952</b>	<b>8,788</b>	<b>0</b>	<b>1,755,257</b>	<b>1,764,045</b>	<b>2,056,997</b>
<b>TOTAL, SERVICES</b>	<b>5,054,433</b>	<b>247,413</b>	<b>325,000</b>	<b>50,565,537</b>	<b>51,137,950</b>	<b>56,192,383</b>
<b>FACILITIES</b>						
Maintenance & Improvement	170,595	2,818	0	1,280,131	1,282,949	1,453,544
Sanitation Facilities Construction	107,943	506	0	1,557,154	1,557,660	1,665,603
Health Care Facility Construction	184,679	2,829	100,000	3,120,103	3,222,932	3,407,611
Facility & Environmental Health Support	311,407	10,051	0	104,709	114,760	426,167
Equipment	34,598	1,135	0	639,117	640,252	674,850
<b>Total, Facilities</b>	<b>809,222</b>	<b>17,339</b>	<b>100,000</b>	<b>6,701,213</b>	<b>6,818,552</b>	<b>7,627,774</b>
<b>Total, Services &amp; Facilities</b>	<b>5,863,655</b>	<b>264,752</b>	<b>425,000</b>	<b>57,266,750</b>	<b>57,956,502</b>	<b>63,820,157</b>
<b>CONTRACT SUPPORT COSTS</b>						
<b>Total, Contract Support Costs</b>	<b>1,819,000</b>	<b>0</b>	<b>8,958,520</b>	<b>0</b>	<b>8,958,520</b>	<b>10,777,520</b>
<b>SECTION 105(I) LEASES</b>						
<b>Total Section 105(I) Leases</b>	<b>366,000</b>	<b>0</b>	<b>581,656</b>	<b>0</b>	<b>581,656</b>	<b>947,656</b>
<b>SPECIAL DIABETES PROGRAM FOR INDIANS</b>						
<b>Total, Special Diabetes Program for Indians</b>	<b>200,000</b>	<b>0</b>	<b>0</b>	<b>359,232</b>	<b>359,232</b>	<b>559,232</b>
<b>TOTAL, IHS**</b>	<b>8,248,655</b>	<b>264,752</b>	<b>9,965,176</b>	<b>57,625,982</b>	<b>67,855,910</b>	<b>76,104,565</b>

\*The Fiscal Year (FY) 2028 National Recommendation Total column combines the FY 2026 Enacted, FY 2028 Program Increase across each Sub IHS Activity.

\*\*Totals may not add due to rounding.

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# EXECUTIVE SUMMARY

**T** **RIBAL LEADERS** on the National Tribal Budget Formulation Workgroup (NTBFW), serving all 575+ federally recognized sovereign Tribes throughout the twelve Indian Health Service (IHS) Areas, met on February 10 and 11, 2026, to exercise their right to provide meaningful input on IHS budgets and policy in the formulation of the President's FY 2028 Budget Request to Congress.

The political status of Tribal Nations, reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law, creates opportunities to advance the health status of American Indian and Alaska Native (AI/AN) people. AI/AN populations continue to experience unique differences in health outcomes, which can be addressed through our innovative and culturally appropriate healthcare delivery system. The Indian healthcare system is inherently resilient, building upon our innovations to deliver unique, whole-person care and improves health outcomes for our people.

Recent policy developments have also strengthened the Indian health system. In 2024, approval of section 1115 Demonstration Waivers expanded Medicaid and the Children's Health Insurance Program (CHIP) coverage to include traditional healthcare practices delivered through Tribal health systems.<sup>1</sup> This long-time request honors traditional practices our communities have utilized since time immemorial that improve the mental, physical, and spiritual health of AI/AN citizens. Our clinics continue to implement effective and efficient healthcare services, programs, research, operations, and community events as solutions to bring AI/ANs through our doors to receive culturally competent, high-quality care.

For the first time, the Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System (OPPS) Final Rule<sup>2</sup> created a regulatory fix allowing Indian healthcare clinics to get reimbursed at the facility rate for services provided outside the four walls. The OPPS Final Rule also included a high-cost drugs provision to reduce the burden on Tribes paying out-of-pocket for medications critical to Native beneficiaries. These fixes maximize resources desperately needed for the Indian health system and allow clinics to extend their resources further to deliver high-quality and culturally appropriate care to AI/AN citizens.

Indian Country has made major improvements in strengthening the government-to-government relationship and reinforcing the federal trust responsibility to deliver healthcare services to AI/AN beneficiaries. Tribal self-determination has and will continue to improve the health status of our people. Still, as promised and legally mandated, the United States must ensure that the Indian health system receives the appropriate funding resources necessary under the federal trust responsibility to continue implementing Tribal strategies and solutions and advance the healthcare and well-being of Indian Country.

<sup>1</sup> *Centers for Medicare & Medicaid Services Newsroom. (October 16, 2024). Groundbreaking Action to Expand Health Care Access by Covering Traditional Health Care Practices.*

<sup>2</sup> *Federal Register. Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities. (89 FR 93912). Nov., 27, 2024.*

## MALCOM BALDRIGE AWARD

## INDIAN HEALTHCARE LEADERS

**THE SOUTHCENTRAL FOUNDATION AND CHICKASAW NATION DEPARTMENT OF HEALTH** earned the prestigious Malcom Baldrige Award. This award focuses on organizational resilience and long-term success. The Malcolm Baldrige Award is the nation's only presidential award for performance excellence. The Baldrige Award recipients are role-model organizations that help address some of the most critical needs while demonstrating the resilient spirit of the American people. Southcentral Foundation received the award in 2011 and 2017, and the Chickasaw Nation Department of Health received the award in 2024. Southcentral Foundation and Chickasaw Nation are the only Tribal organization and Tribe to have received the Malcom Baldrige Award, and Southcentral Foundation is the only healthcare organization in the United States to have received the Award twice. Both Southcentral Foundation and Chickasaw Nation operate healthcare delivery under the

Indian Self-Determination and Education Assistance Act, and the Award further underscores the success of Tribal Self-Governance to improve the lives of American Indian and Alaska Native people. Receiving this award exemplifies the efforts made by the Southcentral Foundation and Chickasaw Nation Department of Health to bettering the lives of First Americans, strengthening infrastructure and improving the quality of life in communities.

This award focuses on organizational resilience and long-term success. The Malcolm Baldrige Award is the nation's only presidential award for performance excellence. The Baldrige Award recipients are role-model organizations that help address some of the most critical needs while demonstrating the resilient spirit of the American people. Receiving this award exemplifies the efforts made by the Chickasaw Nation Department of Health and the South Central Foundation to bettering the lives of its people.

## IHS NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP PROGRAM EXPANSIONS

FY 2028 BUDGET COMPARISON TABLE

Rank	Program Expansion	FY 2026 Enacted Amount	FY 2028 Program Increase	FY 2028 National Recomm. Total	Percent Change
1	Hospitals & Health Clinics	2,632,772	15,965,511	18,598,283	606%
2	Purchased/Referred Care	996,755	12,173,891	13,170,646	1221%
3	Mental Health	133,693	5,522,153	5,655,846	4130%
4	Indian Health Care Improvement Fund	74,138	3,684,540	3,758,678	4970%
5	Alcohol and Substance Abuse	267,080	4,342,337	4,609,417	1626%
6	Dental Services	260,360	4,028,531	4,288,891	1547%
7	Health Care Facilities Constr./Other Authorities	184,679	3,222,932	3,407,611	1745%
8	Maintenance & Improvement	170,595	1,282,949	1,453,544	752%
9	Community Health Representatives	65,212	1,700,352	1,765,564	2607%
10	Public Health Nursing	114,200	933,371	1,047,571	817%
11	Sanitation Facilities Construction	107,943	1,557,660	1,665,603	1443%
12	Urban Indian Health	95,419	1,547,368	1,642,787	1622%
13	Health Education	24,524	392,438	416,962	1600%
14	Equipment	34,598	640,252	674,850	1851%
15	Electronic Health Record	190,564	511,589	702,153	268%
16	Facilities & Environmental Health Support	311,407	114,760	426,167	37%
17	Special Diabetes Program for Indians	200,000	359,232	559,232	180%
18	Indian Health Professions	84,568	89,618	174,186	106%
19	Alaska Immunization	2,183	119,192	121,375	5460%
20	Direct Operations	103,805	27,091	130,896	26%
21	Self-Governance	6,174	133	6,307	2%
22	Tribal Management Grants	2,986	99,835	102,821	3343%
	<b>Subtotal, Program Expansions</b>	<b>6,063,655</b>	<b>58,315,734</b>	<b>63,843,804</b>	<b>962%</b>
	Contract Support Costs	1,819,000		10,777,520	592%
	105 (I) Lease Cost Agreements	366,000		947,656	259%
	<b>Grand Total</b>	<b>8,248,655</b>	<b>58,315,734</b>	<b>76,104,565</b>	<b>923%</b>

# PROGRAM EXPANSIONS



## 1 HOSPITAL AND HEALTH CLINICS \$18.59 BILLION (+\$15.96 BILLION)

Sufficient funding for Hospitals and Health Clinics (H&HC) remains the top priority for FY 2028, as it provides the base funding for 43 Indian hospitals (51 percent of which are Tribally operated) and 650 Indian health centers, clinics, and health stations (86 percent of which are Tribally operated) in urban, rural, and remote settings. When the construction of a new health facility is completed, the IHS must also offer new staffing packages that require increases to the H&HC account to meet these binding obligations. Within H&HC, the NTBFW also calls for the national expansion of the Community Health Aide Program (CHAP), which grows the mid-level health workforce to increase access to services for Tribal communities.

## 2 PURCHASED/REFERRED CARE \$13.17 BILLION (+\$12.17 BILLION)

Purchased/Referred Care (PRC) was established to enable the IHS and Tribally operated facilities to obtain essential healthcare services from private-sector providers when such services, especially emergent and specialty care services, are unavailable within the Indian healthcare system. Despite this critical role, PRC funding has remained essentially flat for years, with no annual program increases and no adjustments for population growth or medical inflation. Because of these factors, Tribal Nations are forced to absorb these rising costs.

For the IHS Areas with few or no IHS-funded hospitals (known as PRC Dependent Areas) specialty and tertiary care may be rationed because of a lack of financial resources. The consequences of rationing healthcare are devastating for Tribal communities.

## 3 MENTAL HEALTH \$5.65 BILLION (+\$5.52 BILLION)

Mental health disparities in Tribal communities are rooted in the ongoing historical trauma caused by past federal policies and perpetually underfunded health services. The NTBFW calls for increased resources for mental health programs and treatment, including culturally informed care, youth treatment centers, inpatient treatment, and strengthened step-down services to support long-term recovery for Tribal communities.

## 4 INDIAN HEALTH CARE IMPROVEMENT FUND

**\$3.758 BILLION (+\$3.68B)** The Indian Health Care Improvement Fund (IHCIF) was established to support access to care and resources for health care operations based on a calculation known as “level of need” funding along with other factors designed to promote equity in the provision of health services for Tribal citizens. Unfortunately, this account, created to fix inequities, is funded at a fraction of the need. This perpetuates the very issue it intended to fix. The FY 2026 and FY 2027 advance appropriations

provided to the IHS excluded this account. The IHCIF is necessary for eliminating the deficiencies in the health resources and health status of Tribes.

## 5 ALCOHOL AND SUBSTANCE ABUSE \$4.6 BILLION (+\$4.34 BILLION)

Since the COVID-19 pandemic, which exacerbated alcohol and substance challenges among AI/AN, Tribally-based treatment services have experienced increased demand for prevention, treatment, and recovery services while simultaneously facing long-standing resource limitations. Although many Tribal Nations have been successful in integrating culturally appropriate prevention and intervention into behavioral health services, available resources remain insufficient to meet the scale of need in Tribal communities for creating and expanding solutions rooted in Indigenous ways of knowing. The FY 2028 request calls for increased resources that will adequately equip Indian Country to address alcohol and substance misuses.

## 6 DENTAL SERVICES \$4.28 BILLION (+\$4.02 BILLION)

Dental services are critical to the overall health of AI/ANs. Routine oral health care reduces tooth decay and gum disease. The lack of access to traditional foods, limited availability of dental services and government provided commodity rations have contributed to AI/ANs experiencing poor oral health. Dental services provided by the Indian healthcare system offers culturally appropriate services, and trusted dentists and dental health aide therapists to support the oral health needs of AI/AN patients.

## 7 HEALTH CARE FACILITIES CONSTRUCTION & OTHER AUTHORITIES

**\$3.40 BILLION (+\$3.22B)** The current facilities infrastructure available for the IHS are outdated and insufficient space

for modern health care delivery needs. Many IHS operated facilities have a condition index rating lower than US Department of Health and Human Services (HHS) goal and the maintenance and repair backlog is growing. These conditions create difficulties for staff and patients, increase wait times, and contribute to inefficiencies within the Indian health care system that are becoming problematic and can no longer be ignored. Data from the IHS show that its medical facilities range in age from 1 to 171 years, with a median age of 39 years.<sup>3</sup> The Indian Health Care Improvement Act (IHCIA) intended to provide comprehensive health care services to AI/AN people, and provide full funding for facilities construction, programs and services contained within the IHCIA. The total financial need for facilities construction was projected at \$26.6 billion dollars in the 2021 IHS Facilities Needs Assessment Report to Congress. This is more than four times the IHS overall budget of \$6.5 billion in FY 2021.<sup>4</sup> The facilities replacement rate at current funding levels is approximately 290 years.<sup>5</sup> These figures are understated as data is lacking for Tribally operated facilities.

## 8 MAINTENANCE AND IMPROVEMENT \$1.45 BILLION (+\$1.28 BILLION)

Maintenance and Improvement (M&I) funding is consistently ranked a top priority of the Areas due to its essential purpose to ensure that patients receive services in well-functioning healthcare facilities that meet building and life safety codes, conform to laws and regulations, and satisfy accreditation standards. From 2018 to 2022, the IHS's estimates of its backlog of deferred maintenance and repairs more than doubled from \$366 million to \$737 million.<sup>6</sup> Without sufficient M&I funding, the continued deterioration of critical health facilities is the reality that AI/AN people experience across the nation whether they are served at an IHS facility, a Tribally owned clinic, or leased building.

<sup>3</sup> Government Accountability Office, *Indian Health Service: Many Federal Facilities Are in Fair or Poor Condition and Better Data Are Needed on Medical Equipment*, 2023, available at: <https://www.gao.gov/assets/gao-24-105723.pdf>, accessed on: February 25, 2025.

<sup>4</sup> Indian Health Service. *The 2021 Indian Health Service and Tribal Health Care Facilities Needs Assessment Report to Congress*. December 2020. Page 1. Also see *IHS Budget Appropriation FY 2021* accessed January 29, 2025.

<sup>5</sup> *Ibid.* <sup>6</sup> *Ibid.*

## 9 COMMUNITY HEALTH REPRESENTATIVES

**\$1.76 BILLION (+\$1.70B)**

Community Health Representatives

(CHRs) are invaluable in connecting AI/AN patients with medical care. As highly trusted members in the community for the last 50 years, CHRs deliver preventive health education and case management to Tribal members in home and community settings. The 1,600 CHRs employed across Indian Country reach AI/ANs in rural and remote areas to provide health education, training, and screenings within their communities. Their services are critical to improving the health status of AI/AN populations.

## 10 PUBLIC HEALTH NURSING \$1.04 BILLION (+\$933.37 MILLION)

The Public Health Nursing (PHN) program is a community health nursing program that focuses on promoting health and quality of life through culturally sensitive health promotion and disease prevention services throughout Indian Country. Home-based services, where available, are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable diseases, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems. PHN is essential for filling in service gaps within the Indian healthcare system.

## 11 SANITATION FACILITIES CONSTRUCTION

**\$1.66 BILLION (+\$1.55B)**

The Sanitation Facilities Construction (SFC)

Program brings water supply, wastewater disposal, and solid waste disposal to Tribal homes and communities. Sufficient resources for the SFC account prevent communicable and environmentally related diseases such as pneumonia, influenza, and respiratory syncytial virus. The Infrastructure Investment and Jobs Act (IIJA) provides the program with \$3.5 billion over five years (FY 2022-2026) to address a point-in-time deficiency

list. This level of investment is necessary to improve the environment for AI/AN people. However, additional resources and investments are required for long-term maintenance and operation of these facilities.

## 12 URBAN INDIAN HEALTH \$1.64 BILLION (+\$1.54 BILLION)

The United States has a trust responsibility to improve the health of AI/ANs beneficiaries regardless of where they reside.<sup>7</sup> To meet this obligation in urban areas, the IHS contracts with 41 Urban Indian Organizations (UIOs), which operate over 80 facilities in 22 states nationwide. As Native-led organizations, UIOs serve patients from over 500 federally recognized Tribes<sup>8</sup> and provide critically needed primary care, behavioral health, traditional medicine, and social and community services to AI/ANs living in urban areas. Despite the critical services UIOs provide to AI/ANs living in urban areas, UIOs remain critically underfunded and need greater access to grant programs through the IHS, this expansion should not impact funding available to IHS and Tribes. UIOs only receive direct funding for staffing, operations, and facilities through this single line item. Increased funding can improve the quality of care delivered to the growing AI/AN population in urban areas.

## 13 HEALTH EDUCATION \$416.96 MILLION (+\$392.43 MILLION)

Health Education programs are an integral component to cultivating culturally appropriate education and prevention efforts. The goal of these programs is to bridge evidence-based research and materials accessible to community members to improve the health of AI/ANs by providing education and training. Health Educators provide services like injury prevention, sexually transmitted infection prevention education, preventative cancer screenings, and educating the community on immunizations. Health Educators also assist individuals to navigate the Indian healthcare system, improve adherence to health recommendations, and reduce the need for emergency and specialty services, resulting in an improved overall health status for Tribal citizens.

<sup>7</sup> See 25 U.S.C. § 1601(1); Sen. Rpt. 100-508 (1988).

<sup>8</sup> IHS National Budget Formulation Data Reports for Urban Indian Organizations Calendar Year 2021, INDIAN HEALTH SERVICE (2023), [https://www.ihs.gov/sites/urban/themes/responsive2017/display\\_objects/documents/IHS\\_National\\_Budget\\_Formulation\\_Reports\\_Calendar\\_Year\\_2021.pdf](https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/IHS_National_Budget_Formulation_Reports_Calendar_Year_2021.pdf).

## 14 EQUIPMENT \$674.85 MILLION (+\$640.25 MILLION)

The overall state of medical equipment at IHS and Tribally operated facilities is largely unknown because of the lack of complete or reliable data.<sup>9</sup> Medical equipment is costly, with high medical inflation and maintenance cost further driving prices. The high medical equipment maintenance includes costly component repairs and service contracts for operating the medical equipment. The need for compatible equipment to replace outdated, inefficient, and unsupported equipment will also significantly increase as the demand for medical equipment to interface with electronic health records increases. Newer equipment can enhance the speed and accuracy of diagnoses, increase efficiency, and productivity, thereby reducing referrals to the private sector and saving on PRC costs.

## 15 ELECTRONIC HEALTH RECORDS / HEALTH IT

**\$702.15 MILLION (+\$511.58M)** The IHS has a technology infrastructure that supports a nationwide health care system, including a secure wide area network, an electronic health record (EHR), enterprise email services, and regional and national help desk support for approximately 20,000 network users. Tribally operated and Urban Indian health programs rely on robust health information technology to maintain quality healthcare delivery and operational efficiency. That is why increases in funding to replace the current EHR Resource and Patient Management System (RPMS) and support the transition to a new enterprise EHR system (Patients at the Heart [PATH]) is critically important to improve interoperability and functionality. Although modernizing EHR and health IT systems is costly, it is essential. The transition to PATH EHR will improve patient care and provider experience, strengthen data quality, and enable the Indian healthcare system interoperability with secondary and tertiary providers.

<sup>9</sup> Ibid.

<sup>10</sup> Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (March 10, 2019). *The Special Diabetes Program for Indians: Estimates of Medicare Savings*. Retrieved from: [https://aspe.hhs.gov/sites/default/files/migrated\\_legacy\\_files/189221/SDPI\\_Paper\\_Final.pdf](https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/189221/SDPI_Paper_Final.pdf).

## 16 FACILITIES & ENVIRONMENTAL HEALTH SUPPORT

**\$426.16 MILLION (+\$114.76M)** Facilities and Environmental Health Support (FEHS) programs provide and support an extensive array of real property, health care facilities, staff quarters construction, maintenance, operation services, community and institutional environmental health, injury prevention, and sanitation facilities construction services. The program has five focus areas: (1) Children's environment, (2) Safe drinking water, (3) Vector-borne and communicable disease, (4) Food safety, and (5) Healthy homes. The IHS works hard to identify community environmental health hazards and risk factors to propose control measures.

## 17 SPECIAL DIABETES PROGRAM FOR INDIANS

**\$559.23 MILLION (+\$359.23M)** The Special Diabetes Program for Indians (SDPI) is proven to save lives and money. Yet, it remains under-resourced and in a constant state of funding uncertainty. Despite its incredible successes, the SDPI program has only received minimal funding increases over the past 20 years. SDPI reduces the prevalence of diabetes among AI/AN adults and has also demonstrated an estimated net savings to Medicare of up to \$520 million over 10 years due to averted cases of end-stage renal disease.<sup>10</sup> The NTBFW calls for ending the competitive grant nature of SDPI and instead promotes stability in access to and flexibility of funds.

## 18 INDIAN HEALTH PROFESSIONS \$174.18 MILLION (+\$89.61 MILLION)

IHS and Tribal communities continue to face significant challenges in recruiting and retaining qualified medical and public health professionals, particularly in rural and geographically isolated areas. To strengthen Indian health workforce, the IHS provides scholarships and loan repayment opportunities that encourage health professionals to serve Indian Country. These programs should support medical professionals providing care in severely underserved areas

or those returning to work in their Tribal communities, with eligibility including public health professionals, midwives, nutritionists, and other roles critical to improving community health. The workgroup requests adequate funding to address high vacancies and workforce shortages, ensuring uninterrupted care to AI/AN without compromising on quality.

## 19 ALASKA IMMUNIZATION \$121.37 MILLION (+\$119.19 MILLION)

Rural Alaskan residents travel an average of 147 miles one way to access the next level of health care, often relying on air and surface transportation.<sup>11</sup> Approximately 80 percent of Alaska Native communities are located off the road system. In many remote villages, hunting and fishing for subsistence remain a way of life and seasonal workforce influxes tied to regional hunting and fishing further increase population demands. This combination of geographic isolation, health care infrastructure challenges, and seasonal population increases place Alaska Native communities at unique risk of illness and severe health impacts. The Alaska Immunization Program is critically important because it works to eliminate disparities in vaccine-preventable diseases for Alaska Native people.

## 20 DIRECT OPERATIONS \$130.89 MILLION (+\$27.09 MILLION)

The Direct Operations budget supports critical administrative, management, and oversight functions within the IHS. These funds support national health policy development, implementation of self-determination contracting, and the administration of Tribal grant programs to expand Tribal self-determination efforts, and maintenance of the Direct Services Tribal Advisory Committee (DSTAC). As more Tribal Nations assume control of their health programs under ISDEAA, Direct Operations funding has gradually declined, which is a deep concern of this workgroup and Indian Country as a whole. The federal government must continue to support Tribes that rely on the IHS for direct health services as obligated by trust and treaty obligations.

<sup>11</sup> Chhean, E., DelFavero, M., Thoumi, A., Tewarson, H., Haldar, S., Hockenberry, S. (2021, Aug.). *A Case Study of Alaska's State and Tribal Nation Partnerships for COVID-19 Vaccination*. Washington DC: National Academy of State Health Policy, Duke Margolis Center for Health Policy, National Governors Association Center for Best Practices.

<sup>12</sup> Indian Health Service. (2025). *Direct Service Tribes*. Retrieved from: [https://www.ihs.gov/odsct/dst/#:~:text=DST%20Areas,\(As%20of%20July%202021\)](https://www.ihs.gov/odsct/dst/#:~:text=DST%20Areas,(As%20of%20July%202021)).

<sup>13</sup> *Ibid.*

Additionally, through this funding, the Office of Direct Services and Contracting Tribes (ODSCT) provides technical assistance to IHS Area Offices and Tribes with health service and program administration. 18 Tribes choose to receive IHS direct services,<sup>12</sup> and there are 123 IHS-operated facilities providing direct healthcare operations.<sup>13</sup>

## 21 SELF-GOVERNANCE \$6.3 MILLION (+\$1.33 MILLION)

Title V of the ISDEAA authorizes Tribes and Tribal Consortia to enter into self-governance compacts, self-determination contracts, and related funding agreements to assume federal programs, functions, services, and activities (PFSA), and associated Tribal shares, placing the accountability of PFSA service provision with Tribal Nations. This account supports the expansion and implementation of the IHS Tribal Self-Governance program and provides funding for Planning and Negotiation Cooperative Agreements to assist Tribes as they prepare for and enter the IHS Tribal Self-Governance program. The account also funds Tribal shares needed in IHS Areas and Headquarters for Tribes that have decided to participate in the IHS Tribal Self-Governance program. The IHS Self-Governance program promotes self-sufficiency and reduces burden on the federal government by allowing Tribes to operate their clinics.

## 22 TRIBAL MANAGEMENT GRANTS \$102.82 MILLION (+\$99.83 MILLION)

Under the ISDEAA, the Tribal Management Grants were established to assist federally recognized Tribes and Tribal Organizations (T/TO) in planning, preparing, or deciding to assume all or part of existing IHS PFSAs through an ISDEAA Title I contract. The grant program also assists established ISDEAA contractors and compactors in further developing and improving their management capabilities. The program consists of four project types: feasibility studies, planning, evaluation studies, and health management structure. Feasibility, planning and evaluation projects are one-year grant programs, and the health management structure program supports projects between one and three years.

# INTRODUCTION



**T**his budget book is a collection of recommendations and reminders of the federal trust and treaty obligations owed to Tribal Nations and their citizens. The United States' trust responsibility is well established in the United States Constitution, treaties, statutes, and federal laws in recognition of the United States' unique legal and political relationship with Tribes.

The Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. The United States formed a judiciary relationship with Tribal Nations through its acquisition of land and resources whereby the United States is obligated to uphold a fiduciary relationship and responsibility to Tribes and AI/AN beneficiaries. As a result, the IHS is responsible for providing comprehensive health services to AI/ANs to raise the health status of Indian people.

Historic legislation like the ISDEAA and the IHCIA fulfills a special trust responsibility and legal obligation to Tribal Nations to improve health outcomes for AI/AN people and their communities. Congress has also legislated resources to provide Tribes with access to health programs like Medicaid while creating Indian-specific protections within these programs that uphold the government-to-government relationship between Tribes and the United States. Unfortunately, legislation without appropriation continues to exacerbate the health disparities faced by the AI/AN population, and appropriators continue to ignore their obligations to Tribes.

## CELEBRATING 70 YEARS

### 70TH ANNIVERSARY OF THE INDIAN HEALTH SERVICE

Over this last year, the IHS commemorated 70 years of service and partnership with Tribal Nations and urban Indian organizations. Over 70 years ago, the IHS began with a small network of hospitals, health centers, and health stations. Today, it provides direct care through 170+ service units and enters into self-determination contracts or self-governance contracts to support health services administered directly by Tribes. Despite the many changes over the past 70 years, the IHS mission has remained consistent: to raise the physical, mental, social, and spiritual health of American Indian and Alaska Natives to the highest level. Achieving this mission requires the federal government to fully fund Indian health. ■



Federal systems and policies should not affect the legal trust relationship between our sovereign Tribal Nations and the federal government. This workbook outlines the fiduciary obligation to Tribal Nations and AI/AN beneficiaries to improve their health and well-being for future generations.

# TRADITIONAL HEALTH CARE PRACTICES

**T** **RADITIONAL HEALTH CARE PRACTICES** are a vital connection to culture and health for American Indian and Alaska Native people. The traditions passed down in these practices convey important ways of knowing and serve an important role in bridging Tribal health care knowledge and modern medicine. Although traditional health care practices have been authorized within the IHCA for many years, Tribes and Tribal health organizations have prioritized offering traditional health care practices to spite lack of funding opportunities or ability to bill.

In 2024, the Centers for Medicare and Medicaid Services approved section 1115(a) Medicaid Demonstration Waivers, which authorized Medicaid coverage and reimbursement of traditional health care practices provided at the IHS, Tribal, and Urban Indian health programs. This was the first time such waivers had been approved by CMS. Traditional Health care practice Medicaid Waivers had been pending for many years before CMS approved them, starting in 2015 when Arizona became the first state to request coverage of these important services. CMS has since approved Traditional Healing 1115(a) Demonstration Waivers in Arizona, California, New Mexico, and Oregon. The coverage of these services under Medicaid provides the possibility of financial stability, and therefore it also continues to support the federal trust and treaty obligations for healthcare to AI/AN people.

With new resources becoming available to support Traditional Health care practices, Tribes and Tribal organizations across the country are looking at ways to support the growing need for these services. Tribes and Tribal organizations are exploring how to support program expansion through opportunities such as CMS's Rural Health Transformation Program to build capacity for training programs, knowledge transfer processes, and certification procedures of new Tribal Doctors. The CMS Traditional Health care practices 1115(a) Demonstration Waivers offer much needed sustainability to support these traditional healing practices. As more Tribes work to build out their programs, more states are working with Tribes to explore Traditional Health care practices 1115(a) Waivers of their own.

Traditional healing services have a tangible impact on the health and health outcomes of AI/AN people who



access them. Improvements in behavioral, mental, and physical health can be linked to access to Traditional health care practices. One Tribal health organization in Alaska, Southcentral Foundation (SCF), has recently completed research evaluating the impacts and outcomes of patients of that organization's Traditional Healing clinic. SCF's data demonstrates that patients accessing Traditional Healing services have clinically and statistically meaningful improvements in reported pain, overall health, and reduced utilization of primary care and emergency services.

Traditional health care practices have been shown to keep culture flourishing and improve health for patients suffering from an array of ailments. The 1115(a) framework adopted by CMS in 2024 respects Tribal sovereignty and authority. Ensuring that more states can utilize this model waiver for Traditional health care practices will help to improve the health and wellness of Tribal members across Indian Country. ■

## Health Status of Indian Country

There is a significant gap between the life expectancy of AI/ANs and the general population. According to the Centers for Disease Control and Prevention (CDC), in 2023 the average estimated life expectancy at birth for non-Hispanic AI/ANs was 70.1 years (73.5 for females and 66.7 for males), compared to 78.4 years nationally.<sup>14</sup>



AI/AN people are 2.3 times as likely to die from pregnancy-related causes compared to NHW non-Hispanic white people, and in 2024, the mortality rate for American Indian/Alaska Native (AI/AN) infants was 64% higher than infants nationwide.<sup>15</sup> Diabetes related deaths are 65 percent higher,<sup>16</sup> liver cirrhosis mortality is more than three times higher,<sup>17</sup> and one in five AI/AN individuals

reports poor mental or physical health.<sup>18</sup> AI/ANs also experience higher rates of post traumatic stress disorder, substance use disorders, and suicide risks due to intergenerational historic trauma.<sup>19</sup>

These gaps are caused by a combination of the effects of intergenerational epigenetics, non-medical factors that influence the health context, a lack of access to essential health services, and the chronic underfunding of crucial health resources and institutions, including the IHS, that would allow the federal governments to better meeting its treaty and trust responsibilities by fully funding Indian health.

From birth to death, AI/ANs experience unique health-related challenges that can be mitigated through culturally appropriate prevention, intervention, and response models delivered by the Indian health system, Tribal Nations, and trusted community partners. AI/AN health will improve with dedicated funding that supports the cultural values of Indian Country. The continuing underinvestment in our health care system leads to worsening health outcomes. We ask for the fulfillment of the federal trust responsibility by fully funding the Indian health care system for AI/AN citizens.

Achieving the IHS mission to improve AI/AN health outcomes requires sufficient dedicated funding that supports the cultural values of Indian Country. The continuing underinvestment in our health care system leads to worsening health outcomes. We ask for the fulfillment of the federal trust and treaty responsibility by fully funding the Indian healthcare system to care for AI/AN citizens.

<sup>14</sup> Arias E, Xu JQ, Kochanek K. *United States life tables, 2023*. *Natl Vital Stat Rep*. 2025 Jul 15;74(6):1–63. DOI: <https://dx.doi.org/10.15620/cdc/174591>.

<sup>15</sup> Ely DM, Driscoll AK. *Infant mortality in the United States, 2022: Data from the period linked birth/infant death file*. *National Vital Statistics Reports*; Vol 73 No 5. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: <https://dx.doi.org/10.15620/cdc/157006>

<sup>16</sup> 2 CDC, 2024. *Deaths: Final Data for 2021*. *National Vital Statistics Report*, Vol. 73, No. 8. Table 10

<sup>17</sup> Suryaprasad A, Byrd KK, Redd JT, Perdue DG, Manos MM, McMahon BJ. *Mortality caused by chronic liver disease among American Indians and Alaska Natives in the United States, 1999–2009*. *Am J Public Health*. 2014;104 Suppl 3(Suppl 3):S350–S358. doi:10.2105/AJPH.2013.301645

<sup>18</sup> Singh GK, Williams SD, Lee H, Martin EK, Allender M, Ramey CT. *Trends in physical and mental health, mortality, life expectancy, and social inequalities Among American Indians and Alaska Natives, 1990–2019*. *Int J Transl Med Res Public Health*. 2021;5(2):227–53.

<sup>19</sup> American Psychiatric Association. December 2017. *Mental Health Disparities: American Indians and Alaska Natives*. Retrieved from: <https://www.psychiatry.org/getmedia/d008fb53-3566-4a0a-adac-ba1f3b88528c/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf>.

# SUCCESSFUL MODELS

## to Fund the Indian Health Care System

### ADVANCE APPROPRIATIONS FOR INDIAN HEALTH SERVICE

Sustainable federal funding streams like advanced appropriations achieved in FY 2024 and FY 2025, support planning and programming by IHS, Tribal, and Urban Indian Organization's clinics to enhance current services for AI/AN beneficiaries. Advance appropriations have reduced the financial burden on clinics, allowing them to sustain a culturally responsive workforce, operations, and continuum of care for AI/ANs. In 2025, during a historic government shutdown, IHS was still able to provide critical services to AI/AN beneficiaries.

### MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE

More than one million AI/ANs are enrolled in coverage through Medicaid and the Children's Health Insurance Program, allowing AI/AN patients to access care in urban, rural, and remote areas. Medicaid is a critical funding stream to the Indian healthcare system that supports clinic operations and patient care across Indian Country. Since 1976, Congress has required the Centers for Medicare and Medicaid Services (CMS) to reimburse States at 100 percent federal medical assistance percentage (FMAP) for services provided to Medicaid beneficiaries through Indian health care providers to address significant health disparities and resource inequities affecting AI/AN communities and to support the federal government's trust and treaty responsibility to provide health care to AI/AN people. The provision ensures that states can fully claim federal reimbursement for services delivered through IHS and Tribal facilities, strengthening the financial sustainability of the Indian health system.

Although Congress intended equal access to Medicaid, implementation has varied significantly across states. Because states determine what optional Medicaid services to cover, the scope of services that Tribal and IHS facilities can bill to Medicaid differs from state to state. As a result, **despite the federal trust and treaty obligations applying equally to all Tribal Nations, access to Medicaid-funded services is not consistent across Indian Country.**

Continued implementation of 100 percent FMAP is critical to maintaining access to care for AI/AN patients and ensuring that Indian health care providers can bill Medicaid for services without imposing additional costs on states. States must continue to claim 100 percent FMAP for services received through IHS and Tribal providers. Services received through Urban Indian Organizations should also be eligible for 100 percent FMAP reimbursement to ensure equitable access to Medicaid funding and strengthen health care delivery for AI/AN patients living in urban areas. ■



## Funding Methodology

In early 2003, the NTBFW, including representatives from the IHS, Tribal leaders, technical advisors, and other policy advisors, partnered with a team of economic actuarial experts to produce the first IHS Needs Based Budget (NBB) for FY 2005. Since then, the Workgroup has met annually to update the IHS NBB using the most current available population and per capita health care cost information. The updated IHS need-based cost estimate for FY 2028 is \$76.10 billion.

ational health disparities affecting Tribal communities across Indian Country.

■ **STEP 1** The FY 2028 NTBFW methodology begins by establishing a guidance level for topline spending for the IHS in FY 2028, based on the adjusted Need-Based Budget (NBB). This estimate incorporates population data, per capita health care cost information, geographic considerations, and health needs assessment. The adjusted NBB for the IHS is \$76.1 billion for FY 2028.

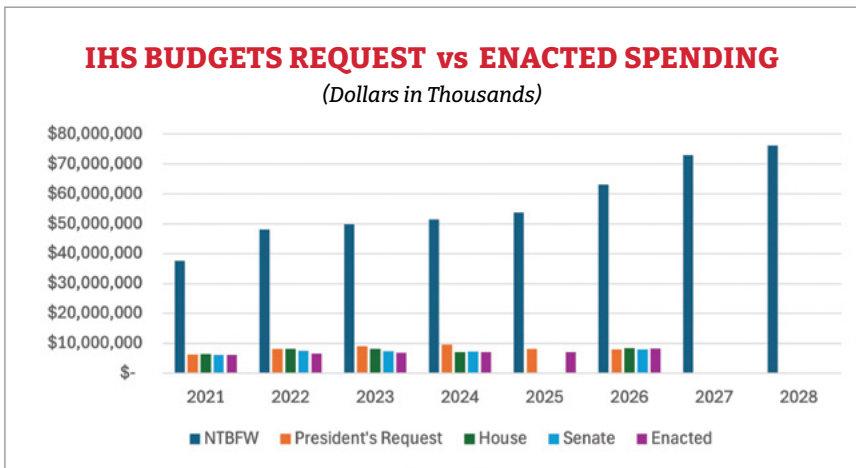
■ **STEP 2** Next, each funded account within the IHS is reviewed using the most recent enacted amounts necessary to maintain current services. The FY 2026 enacted amount for the IHS is \$8.24 billion.

■ **STEP 3** Tribes and Tribal representatives from each of the twelve IHS Areas meet to formulate their budgets using the guidance parameters above and a dedicated worksheet that allows the Areas to calculate their budget scenarios and engage in real-time discussions. Each Area’s submission includes budget tables narratives on budget priorities, hot issues, and success stories.

■ **STEP 4** Before the NTBFW convenes for its annual budget formulation, each of the IHS Areas, along with the TSGAC, DTSAC, and NCUIH, present proposed budgets to Tribal and federal partners. This allows each Area to hear, digest, and discuss national priorities ahead of the NTBFW’s annual budget formulation meeting.

■ **STEP 5** Each year during the annual budget formulation meeting, the NTBFW reviews Area submissions and discusses pressing budget concerns for the IHS. During this meeting, budget policy recommendations are discussed to accompany the national budget submission, often referred to as the “National Roll-Up.” At this stage, the Tribal membership of the NTBFW establishes a theme and develops a tonal direction for the annual budget overall.

■ **STEP 6** Once an agreement is reached on a NTBFW funding request, the recommendations are presented to the IHS Director for active discussion and engagement. For FY 2028, the Workgroup confirmed a funding recommendation resulting in an adjusted NBB of \$76.1 billion for FY 2028 for the IHS.



In 2005, the NTBFWG recommended a 10-year strategy to fully fund federal obligations to AI/AN beneficiaries. More than two decades later, this obligation remains unmet. The comparison chart above illustrates the difference between the Workgroup’s funding recommendation and the amounts proposed in the President’s Budget, as well as the House and Senate budget proposals, and the final enacted appropriations.

The Workgroup continues to use a budget formulation methodology informed by Office of Management and Budget (OMB) guidance used by federal agencies in developing the President’s Budget Request to Congress. Through this process, the Workgroup’s recommendations continue to encourage full funding levels necessary to meet the trust and treaty obligations owed to Tribal Nations. Over time, however, proposed and enacted funding levels have consistently failed to meet the documented needs of Indian Country. These persistent funding gaps have resulted in longstanding intergener-

# 1ST REQUEST

## HONOR TRIBAL SOVEREIGNTY by Protecting and Preserving the Trust Responsibility, Treaty Obligations, and Rights to Tribal Nations and the Preservation of American Indian and Alaska Native Programs and Services

**T**ribal Nations have lived in their homelands from time immemorial and continue to develop programs and services for their communities' health and welfare. Tribal Nations have a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions, regulations, including 25 C.F.R., and administrative law. In exchange for the surrender and reduction of Tribal lands and removal and resettlement, the United States signed nearly 400 treaties and agreements, passed laws, and instituted policies that shape and define the special government-to-government relationship between Tribal Nations and the federal government. This unique relationship compels the federal government to uphold certain obligations and responsibilities to Tribal Nations—one of which is to provide AI/AN healthcare. Congress reaffirmed this obligation in the Indian Health Care Improvement Act (IHCA), which states that *“it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”*

The United States fulfills its trust and treaty obligations through the direct delivery of Tribal programs and services and the provision of federal funding to Tribal Nations and Tribal organizations serving Tribal citizens and communities. Over time, the United States has created a web of different mechanisms used to

deploy federal funding to serve Tribal Nations and Tribal communities. Essential and legally mandated services provided by federal employees include healthcare services through the IHS, law enforcement and public safety through the Bureau of Indian Affairs, and educational services through the Bureau of Indian Education. All programs, services, and funding delivered to Tribal Nations, including through Urban Indian Organizations (UIOs) and Tribal organizations serving Tribal Nations, are integral to the delivery of the United States' trust and treaty obligations. The federal employees necessary for the functioning of Tribal programs and the disbursement of Tribal funds are also part of the trust and treaty obligations. The United States further has a responsibility to conduct robust and meaningful government-to-government consultations with Tribal Nations on all federal actions, including policy and regulatory changes, that may have Tribal implications to ensure continued fulfillment of the federal government's trust and treaty obligations. These actions are not discretionary. They are legal mandates rooted in treaties, the U.S. Constitution, Court decisions, Executive Orders, and long-standing federal statutes.

These federal trust and treaty responsibilities include an obligation to uphold and advance Tribal sovereignty. As such, HHS and all federal agencies and entities must ensure that Tribal Nations have the authority to exercise their inherent sovereignty to receive any funding not required by law to be distributed through grants directly through Indian Self-Determination and Education

Assistance Act (ISDEAA) agreements. HHS must also ensure that all programs and services that serve and support Tribal Nations, Tribal citizens, and Tribal communities remain protected and are not subject to reductions, limitations, or eliminations. Efforts to reduce the federal government's budget or size must ensure that AI/AN programs and services are held harmless and that the federal government's fulfillment of the trust and treaty obligations goes uninterrupted. Above all, Tribal Nations' exercise of Tribal sovereignty and Tribal self-governance and the United States' delivery on its trust and treaty obligations must be honored in the Administration's implementation of its priorities.

## Fully Funding the Indian Health Care Improvement Act (IHCIA)

The IHCIA provides the legislative foundation for the IHS, Tribal health programs, and Urban Indian Organizations. Permanently reauthorized in 2010 under the Patient Protection and Affordable Care Act (P.L. 110-148) (ACA), the ACA expanded services, strengthened the health workforce, and enhanced behavioral health and substance use treatment programs for AI/ANs.

Despite its success, the IHCIA has never been fully funded.<sup>20</sup> Critical programs—such as long-term care for elders, specialty and chronic disease care, and behavioral health treatment—remain under-resourced. Many Tribal Nations must rely on insurance payments, state funds,

third-party reimbursements from Medicare and Medicaid, or their own limited resources to fill funding gaps. These reimbursements often fall short of the true cost of care, forcing difficult choices or service reductions.

For example, IHS Purchased/Referred Care (PRC) covers short-term rehabilitation only, leaving long-term care and elder services largely unfunded across other HHS Operating Divisions. Sustained investment in long-term supports and services remains an urgent need across the Indian Health System.

To achieve equity and uphold the United States' legal obligation, Congress must fully fund all provisions of the IHCIA and ensure that AI/AN health programs are protected from reductions or delays in federal appropriations.



<sup>20</sup> 25 U.S.C. §1621d.

# 2ND REQUEST



Provide **FULL AND MANDATORY FUNDING** to the Indian Health Service (\$75.85 billion in FY 2028)

**I** HS funding levels remain consistently lower compared to other federal health programs. Despite IHS, Tribal, and urban Indian clinics utilizing innovative tactics to extend resources, the lack of adequate funding levels has disrupted the operation of the Indian health system and limits the implementation of long-term solutions for improving the health status of AI/ANs. Providing full and mandatory funding to the IHS will ensure the federal government is upholding trust and treaty obligations to Tribal Nations.

The IHS plays a crucial role in ensuring facilities are appropriately resourced. Appropriate funding levels can improve the management and operations of facilities, update outdated and aging facilities and

equipment, improve retention and recruitment of healthcare professionals, improve equipment available at facilities, and ensure continuity of care to patients. It is essential for the IHS to receive full and mandatory funding to effectively deliver health care services, programs, and activities that address the unique determinants of health for AI/ANs.

For over two decades, the Workgroup has requested full and mandatory funding for the IHS. Numerous federal government reports<sup>21</sup> have documented the need for the federal government to invest in the health-related resources offered by the IHS. AI/AN people rely on the services offered by the Indian health system. The livelihood of Indian Country is tied to the federal government's ability to provide full and mandatory funding to the IHS.

## Clinical Services

### HOSPITAL AND HEALTH CLINICS \$18.59 BILLION (+\$15.96 BILLION)

The Hospitals and Health Clinics (H&HC) account provides funding for essential health services for approximately 3.2 million AI/AN people.<sup>22</sup> IHS and Tribal health programs provide medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy.

For FY 2028, the Workgroup recommends a program increase of \$15.96 billion over the enacted FY 2026 funding level for the H&HC account. Funding the H&HC account has consistently ranked as the number one budget priority for the NTBFWG over the last ten years. The H&HC account provides funding for 605 hospitals and clinics located in 34 states throughout Indian Country. Many of these programs are predominantly located in rural and frontier settings. While these programs serve AN/AI people, many of these health programs also serve non-Tribal individuals and veterans. In remote, rural locations, these programs are often the only health care providers in the region. H&HC funds provide the

<sup>21</sup> Government Accountability Office. (December 2018). *Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs*. Retrieved from: <https://www.gao.gov/products/gao-19-74r>; U.S. Commission on Civil Rights. *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*. (2018). Retrieved from: <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>.

<sup>22</sup> FY 2024 IHS User Population Estimates, January 8, 2026.



greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/AN people, many who live in remote areas that are not easily accessible by road.

The demands for direct care services are a continuous challenge in IHS and Tribal fa-

ilities. The Indian health programs experience constant and increased demand for services due to population growth, inflationary costs, and the complexities of providing care to a population with significant health disparities and chronic disease. Yet the IHS budget over the last five years has not funded costs for inflation, population growth, or Pay Act increases. While there have been program increases for the H&HC line item, that funding has been directed to Joint Venture staffing packages. IHS and Tribal programs have had to absorb the costs associated with population increases and inflation. This has resulted in lost purchasing power in the IHS appropriation. This continues to be exacerbated by the rising costs coming out of the COVID pandemic, workforce shortages, pharmacy costs, and medical supply chain issues.

In FY 2028, the IHS electronic workbook used in budget formulation estimates that \$127.3 million is needed to fund medical inflation. The Agency further estimates that \$70.3 million is needed to keep pace with the growing IHS population. Despite these costs, the IHS appropriation has only received funding for inflation and population growth four times in the last eleven years.<sup>23</sup> Consequently, the IHS budget has lost purchasing power because budgets must absorb the unavoidable costs of inflation and population growth. Medical inflation particularly impacts the H&HC line item as IHS, and Tribal sites fail to keep up with rising medical costs. Underfunding of H&HC translates to rationed care that is less accessible and limits efforts towards making meaningful improvements in health outcomes.

Despite these challenges, IHS and Tribal health programs have been at the forefront of providing quality health care and face a crossroad with the pressure of increasing demand for higher acuity care and deepening

financial instability. The IHS and Tribal health providers across the United States continue to confront persistent workforce shortages, severe fractures in the supply chain for drugs and supplies, and high levels of inflation, collectively increasing hospital costs to care for patients. At the same time, the health care system throughout the United States, including IHS and Tribes, have been met with inadequate increases in reimbursement by public payers, as well as increasing administrative burden due to inappropriate commercial health insurer practices. These issues have created an environment of financial uncertainty for many Tribal hospitals and health care providers operating with little to no margin.

The health professional workforce has challenges in recruiting and retaining providers in rural health care settings and the lack of adequate facilities, health information technology, and equipment. As a result, any underfunding equates to limited health care access, especially for patients that are not eligible for, or who are not eligible or do not meet the medical priorities to receive care through the Purchased/Referred Care (PRC) program. For many people in Indian Country, there are no alternatives other than the direct care provided at an IHS or Tribal facility.

Tribes are committed to working with IHS and HHS to make meaningful impacts in terms of improved health outcomes. AI/AN communities experience significantly higher mortality rates from cancer, diabetes, heart disease, suicide, injury, and substance abuse than other populations. Preventative and primary care programs reduce costly medical expenditures for specialty care and treatment.

### **ELECTRONIC HEALTH RECORDS / HEALTH IT** **\$702.15 MILLION (+\$511.58 MILLION)**

The Workgroup requests \$702.16 million to fully fund the modernization of the IHS Health Information Technology (HIT) system, PATH EHR, in FY 2028. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, electronic health record (EHR), enterprise e-mail services, and regional and national help desk support for approximately 20,000 network users utilizing RPMS, which was implemented in Indian Country

<sup>23</sup> [1] The final appropriation provided increases as follows: in FY 2024 inflation \$109.1 million; FY 2018 inflation \$93.9 million; FY 2017 inflation \$50.3; and FY 2016 pay costs \$19.5 million.

in 1985. Increased funding for the implementation of a new system, PATH EHR, is critically important. No other health system in the country operates on a 40-year-old EHR. Full funding is necessary for rolling out and implementing the EHR across Indian Country.

Just as IHS provides technological support for its health system, Tribally-operated and urban Indian health programs also provide support for mission critical health operations through the purchase of commercial-off-the-shelf (COTS) EHRs. Many Tribal health systems have purchased COTS and are many years ahead of the IHS HIT modernization. These modernization initiatives have been completely funded by Tribal Nations and organizations through non-federal resources, meaning that many Tribal entities have sacrificed significant portions of their own funds to modernize health technology. This often results in less funding available for other priorities within the health system. HIT modernization funding at IHS has not flowed from the agency to the Tribes despite the fact that Tribal Nations operate over 51 percent of Indian hospitals and 86 percent of Indian health centers, clinics, and health stations.<sup>24</sup> As part of the initiative to modernize the federal system, Congress should appropriate additional funding to reimburse Tribal health systems that have invested in COTS and modernized on their own, as the decision to modernize ahead of the IHS initiative is rooted in patient care, and the federal government's failure to adequately fund the Indian Health System. Tribal Nations should not be forced to subsidize the federal government's trust and treaty obligations.

Despite this unequal allocation of resources between IHS and Tribal HIT modernization efforts, Tribal leaders and the NTBFW continue to support full funding for HIT modernization for the whole Indian health system—not just the IHS initiative. Comprehensive and modernized health information solutions are critical to health care operations in Indian Country. Beyond being critically necessary for the provision of care, a fully

modernized EHR is important for the recruitment and retention of health professionals that work within the Indian Health System.

These requested resources will continue to support efforts to stabilize the aging IHS RPMS system while modernization is underway. Now that the IHS is working with the vendor to build out the program and implement it at a pilot site, increased funding for this initiative will be used to support the configuration of the new PATH EHR, as well as transition and implementation efforts. A properly resourced Indian health care delivery system is better able to care for patients, pay providers, provide essential care referral and care coordination services, recover costs, and recruit and retain health professionals.

RPMS is over 40 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization.<sup>25</sup> Since FY 2020, the NTBFW has supported a new budget line specifically for HIT. The NTBFW also has recommended a meaningful investment to maintain and update the outdated IHS RPMS while replacement efforts are underway, as the delivery of health care cannot stop, and insufficient funding for the modernization program has resulted in further implementation delays. A significantly longer than expected timeline for this project will have lasting negative impacts on the Indian health system. Additionally, the NTBFW further requests funding to support the investments that Tribal Nations and organizations have already made in modernizing their own HIT systems.

An adequately resourced IHS HIT program is critical to ensure the provision of quality and safe care and will reduce inefficient and costly consequences associated with an outdated health technology system. We request that the President's Budget for FY 2028 include substantial investments for both Tribal and IHS HIT modernization efforts to address the changing technology and resource environment of health care.

<sup>24</sup> Indian Health Service. (2024). *The Indian Health Care System – Fact Sheet*. Retrieved from: [https://www.ihs.gov/sites/newsroom/themes/responsive2017/display\\_objects/documents/factsheets/IHSProfile.pdf](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf)

<sup>25</sup> GAO-21-524T, *INFORMATION TECHNOLOGY: Agencies Need to Develop and Implement Modernization Plans for Critical Legacy Systems* <https://www.gao.gov/assets/gao-21-524t.pdf>

## DENTAL SERVICES

**\$4.28 BILLION (+\$4.02 BILLION)**

The Workgroup recommends a total of \$4.28 billion for Dental Services. Investments must be made in oral health care to address known oral health disparities faced by AI/AN citizens. While oral health is one of the 34 Leading Health Indicators 2030, which identifies public health priorities to help individuals, organizations, and communities across the United States improve health and wellbeing, lack of access to care, high rates of dental caries and untreated tooth decay contribute to chronic disease, and utilization of the emergency room for dental care among AI/AN people demonstrate a higher level of need ergo require a higher level of funding.

### ► High Rates of Caries and Untreated Tooth Decay Contribute to Chronic Disease


During the COVID-19 pandemic, dental services across the IHS were reduced to only emergency care, and in a population already plagued by high rates of dental caries, the pandemic created gaps in care which further exacerbate the oral health disparities among AI/AN children and adults.<sup>26</sup>

By the age of five, over 80% of AI/AN dental clinic patients have dental caries and over 40% of AI/AN children in preschool have untreated tooth decay.<sup>27</sup>

AI/AN adult dental patients also suffer disproportionately from untreated decay, with twice the prevalence of untreated caries as the general United States population and more than any other racial/ethnic group. Of the AI/AN dental patients aged 35-44, 57% have untreated tooth decay, and 36 percent of AI/AN dental patients over the age of 55 have fewer than 20 teeth, which is considered “non-functioning” by the World Health Organization.<sup>28</sup>

Known impacts of untreated dental caries include chronic diseases such as diabetes, cancer, and cardiovascular disease.<sup>29</sup> Access to oral health care is a public

D E N T A L   C A R E



► LACK OF ACCESS TO CARE

With vacancy rates across the IHS hovering around 35%, IHS and Tribal dental programs have long been challenged to meet the high level of need for oral healthcare services. Many communities do not have on-site dental services to treat advanced caries. Lack of access to professional dental care significantly contributes to the disparities in oral health in the AI/AN population. The geographic isolation of Tribal populations, particularly in Alaska, the inability to attract dentists to practice in IHS or Tribal health facilities in rural areas, and the higher dental hygienist-to-population ratio within the IHS (**1:9,300** while the general population is at **1:2,000**) all negatively contribute to the oral health of AI/AN citizens.

The utilization of mid-level providers such as Dental Health Aide Therapists, part of the Community Health Aide Program provider group, will help bridge access to care gaps, increase the number of AI/AN healthcare providers, and provide an innovative solution to the lack of access to care, found in many rural Tribal communities. ■

health priority across Indian Country, and a population health concern—good health starts with access to clinically appropriate dental services.

<sup>26</sup> Indian Health Service. *IHS Oral Health Surveillance Plan 2022 – 2030*. P. 4 (accessed Mar 13, 2026)

<sup>27</sup> Indian Health Service. *IHS Data Brief November 2025 The Oral Health of American Indian and Alaska Native Dental Clinic Patients Aged 1 to 5 Years: Results of the 2024-2025 IHS Oral Health Survey*. (Accessed Mar 13, 2026).

<sup>28</sup> Indian Health Service. *IHS Oral Health Survey Data Brief November 2022: The Oral Health of American Indian and Alaska Native Adult Dental Patients 35 Years and Older, A Follow Up Report to the 2015 Survey*. (Accessed Mar 13, 2026).

<sup>29</sup> Center for Disease Control and Prevention. Nagdeo, Kiran P, BDS, MPH, *The Missing Piece in Chronic Disease Prevention: Dental Caries*. Aug 7, 2025. (Accessed Mar 13, 2026)

### ► Increased Emergency Room Utilization for Dental Care

Nationally, lost productivity due to untreated dental disease costs over \$45 billion annually, and Medicaid is the most frequently expected source of payment for these emergency room visits.<sup>30,31</sup> Based on a recent survey performed by the CareQuest Institute for Oral Health, AI/AN people are three times more likely than the general population to visit the emergency room for dental care.<sup>32</sup>

Overall, the lack of access to dental care drives higher rates of dental disease, which drives increased instances of chronic disease and increased emergency room utilization among AI/AN people. If we improve access, we improve population health over time.

### MENTAL HEALTH \$5.65 BILLION (+\$5.52 BILLION)

Native American communities are facing a profound mental health crisis driven by historical trauma, systemic inequalities, and limited access to culturally appropriate healthcare. These challenges have resulted in alarmingly higher rates of mental health disorders, substance abuse, and suicide compared to the general U.S. population.<sup>33</sup> The disparities in mental health within Native American communities are a direct consequence of ongoing historical trauma and chronic underfunding of health services, despite the federal government's trust and treaty obligations to ensure the well-being of Native American peoples.

Addressing this issue requires a substantial, long-term investment in mental health services grounded in principles of self-determination and equality. Tribal leaders urgently request \$5.41 billion for FY 2027 to fund quality mental health services in Indian Country. It is essential to support trauma-informed care, culturally responsive services, certified and trained mental health specialists,

inpatient and outpatient treatment facilities, telehealth opportunities, crisis response and triage, case management services, community-based prevention programming, outreach, and health education activities.

This funding request is crucial for healing and empowering Native American communities. It is a call to action for justice, equity, and fulfilling promises. By addressing these mental health disparities, the resilience and strength of Native American peoples are honored and ensure a healthier, more equitable future for all.

### MENTAL HEALTH CRISIS IN NATIVE AMERICAN COMMUNITIES

#### ► Escalating Crisis of Mental Health Disorders

Native Americans experience mental health disorders at alarmingly higher rates than the general population. The suicide rate among Native youth is 2.5 times the national average, the highest among any ethnic group in the United States. As of 2020, AI/ANs have the highest suicide rate at 23.9 per 100,000, which has surged by 55.7 percent over the past decade.<sup>34</sup>

The situation is even more dire for AI/AN adolescents and young adults, with suicide rates reaching all-time highs. Among 15 to 24-year-olds, the rate is 24.6 per 100,000; among 25 to 34-year-olds, it is 29.8 per 100,000.<sup>35</sup> These adolescent rates are 1.9 times higher than the national average for others in the same age group and 2.1 times higher than the national average for other young adults.<sup>36</sup>

Suicide is the eighth leading cause of death among all AI/ANs across all ages.<sup>37</sup> This is not just a statistic. It is a heartbreaking reality that demands urgent action. We must address these disparities with compassion, commitment, and culturally competent care to support the mental health and well-being of Native American communities.

<sup>30</sup> U.S. Centers for Disease Control and Prevention. *Emergency Department Visits for Tooth Disorders: United States, 2020-2022*.

<sup>31</sup> U.S. Centers for Disease Control and Prevention. *NCHS Data Brief, No 531 June 2025. Emergency Department Visits for Tooth Disorders: United States, 2020-2022*.

<sup>32</sup> CareQuest Institute for Oral Health. *American Indian and Alaska Native Communities Face a 'Disproportionate Burden of Oral Disease': Reversing Inequities Involves Challenges and Opportunities*. Boston, MA: March 2023. DOI:10.35565/CQI.2023.2002

<sup>33</sup> American Psychological Association. (October 2023). *The healing power of Native American culture is inspiring psychologists to embrace cultural humility*. Retrieved from: <https://www.apa.org/monitor/2023/10/healing-tribal-communities-native-americans>.

<sup>34</sup> American Psychological Association. (October 2023). *The healing power of Native American culture is inspiring psychologists to embrace cultural humility*. Retrieved from: <https://www.apa.org/monitor/2023/10/healing-tribal-communities-native-americans>.

<sup>35</sup> *Ibid.* <sup>36</sup> *Ibid.* <sup>37</sup> *Ibid.*

### ▶ Contributing Factors to Mental Health Issues

Historical trauma, systemic inequalities, and socio-economic challenges contribute to mental health disparities in AI/AN communities. Historical trauma stemming from centuries of colonization forced relocation, and cultural suppression has left lasting scars on AI/AN communities. This trauma is passed down through generations, contributing to higher rates of mental health disorders, substance abuse, and suicide.<sup>38</sup>

These challenges are worsened by systemic inequalities such as poverty, unemployment, and restricted access to quality education. AI/AN communities often face significant barriers to accessing healthcare, including mental health services. These barriers include geographic isolation, high costs, and a shortage of culturally competent providers.<sup>39</sup>

Discrimination and racism also play a critical role in these disparities. AI/ANs frequently encounter prejudice and systemic barriers that affect their mental well-being. This ongoing discrimination contributes to chronic stress and mental health problems.<sup>40</sup>

Additionally, the high rates of substance abuse in AI/AN communities are both a coping mechanism for dealing with stress and trauma and a contributing factor to mental health disorders. Substance abuse is prevalent due to the lack of resources and support for addressing these issues effectively.<sup>41</sup>

Addressing these fundamental problems requires funding for mental health services, culturally tailored care, and policies that support economic stability and social justice in AI/AN communities. By tackling these underlying issues, we can work towards reducing mental health disparities and improving the overall well-being of AI/AN peoples.

### ▶ Effects on Personal and Community Well-being

Historical trauma, current stressors, and systemic inequalities heavily influence the health of AI/AN individuals and communities. These factors have profound impacts on both individuals and communities.

Psychological distress and mental health disorders are prevalent among AI/AN youth and adults who are descendants of those who experienced historical trauma. The unresolved grief and emotional pain from past generations can manifest in the mental health of current generations. Exposure to intergenerational trauma can lead to PTSD, characterized by symptoms such as flashbacks, nightmares, and severe anxiety.<sup>42</sup> Historical trauma contributes to higher rates of mental health disorders such as depression, anxiety, PTSD, and substance abuse within the community.<sup>43</sup> This widespread psychological distress can lead to a community-wide sense of hopelessness and despair.

Substance abuse is another significant issue, with historical trauma contributing to higher rates of substance abuse among AI/AN youth and adults. The use of drugs and alcohol can be a coping mechanism for dealing with the emotional pain and stress associated with historical trauma.<sup>44</sup> Higher rates of substance abuse within the community can lead to increased instances of liver disease, respiratory issues, and other health complications.<sup>45</sup>

Suicidal behavior is alarmingly high among AI/AN youth and adults, who have significantly higher suicide rates compared to their peers. The loss of cultural identity, feelings of isolation, and the cumulative weight of personal and communal trauma can lead to hopelessness and suicidal thoughts. Studies show that 35% of AI/AN youth have seriously considered suicide in the past year, compared to 19% of all youth.<sup>46</sup>

<sup>38</sup> Mass General Brigham McLean. *Native American Mental Health: What You Need to Know*. Retrieved from: <https://www.mcleanhospital.org/essential/native-american-mh>.

<sup>39</sup> *Ibid.*

<sup>40</sup> *Ibid.*

<sup>41</sup> *Ibid.*

<sup>42</sup> PsychCentral. (May 2022). *Mental Health in Native American and Indigenous Communities*. Retrieved from: <https://psychcentral.com/health/native-american-mental-health>

<sup>43</sup> Mental Health America. *Communities of Indigenous American descent*. Retrieved from: <https://mhanational.org/indigenous>

<sup>44</sup> *Ibid.*

<sup>45</sup> *Ibid.*

<sup>46</sup> *Ibid.*

Behavioral issues and academic challenges are also common among youth affected by historical trauma. These individuals may develop maladaptive coping mechanisms, such as aggression or risky behavior, in response to chronic stress and emotional pain. Historical trauma can also impact academic performance, leading to lower academic achievement and higher dropout rates. Adults may exhibit self-destructive behaviors, including substance abuse, hypervigilance, dissociation, and low self-esteem.<sup>47</sup>

Physical health issues are linked to historical trauma, with higher rates of lifestyle diseases among adults, including heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease. The chronic stress associated with historical trauma can weaken the immune system and contribute to these health problems.<sup>48</sup> Historical trauma is linked to higher rates of chronic diseases such as heart disease, diabetes, and cancer.<sup>49</sup>

Historical trauma's economic and social impact extends to various aspects of life. Adults may face challenges securing stable employment, leading to financial instability and perpetuating cycles of poverty within communities. Historical trauma can impact academic performance, leading to lower educational attainment and higher dropout rates. This can limit economic opportunities and contribute to socio-economic challenges.<sup>50</sup>

Increased violence and aggression within the community can also be a manifestation of historical trauma. This can lead to higher rates of domestic violence, child abuse, and community violence. The loss of cultural identity and community cohesion can lead to social disintegration, with individuals feeling disconnected from their cultural roots and community, exacerbating feelings of isolation and alienation.<sup>51</sup>

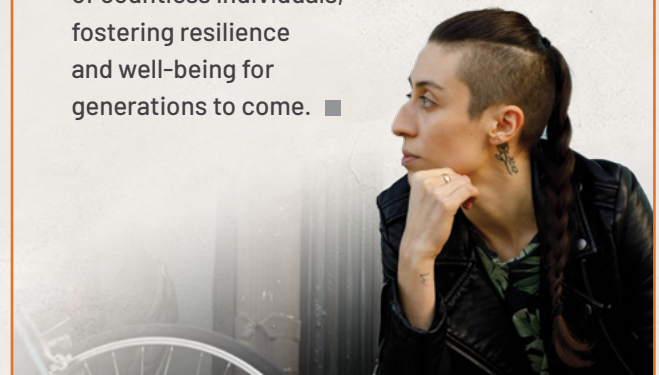
Reduced access to healthcare services is another consequence of historical trauma. Communities may face

## MENTAL HEALTH

### INFRASTRUCTURE AND WORKFORCE DEVELOPMENT

Investing in the development of mental health care infrastructure and expanding the mental health workforce, specifically within AI/AN communities, is not just essential—it's a moral imperative. We must ensure that the care provided is culturally competent, with training tailored to the unique needs of these communities.

This approach is not merely about numbers. It's about addressing the profound mental health disparities faced by AI/AN communities. It's about supporting sustainable, community-led solutions that honor and respect cultural values and practices. By investing in these areas, we can make a tangible difference in the lives of countless individuals, fostering resilience and well-being for generations to come. ■



barriers such as lack of healthcare facilities, cultural insensitivity, and mistrust of healthcare providers. Despite these challenges, many Native American communities demonstrate remarkable resilience. Efforts to revitalize cultural practices, promote

<sup>47</sup> *Ibid.*

<sup>48</sup> *Ibid.*

<sup>49</sup> *Mental Health America. Communities of Indigenous American descent. Retrieved from: <https://mhanational.org/indigenous>*

<sup>50</sup> *Ibid.*

<sup>51</sup> *Ibid.*

<sup>52</sup> *Ibid.*

<sup>53</sup> <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>

community support, and implement trauma-informed care can help mitigate the effects of historical trauma and improve community health.<sup>52</sup>

### ► **The Need for Specialized Mental Health Services**

Current funding allocated for specialized mental health services, particularly those that cater to substance abuse treatment, youth services, and culturally sensitive care tailored to the unique needs of AI/AN communities, is woefully insufficient. This underfunding has dire consequences, and we must address this issue with the urgency it deserves.

- **Inadequate Funding Levels:** Despite the critical need, mental health services for AI/AN communities remain severely underfunded. In FY 2023, per capita expenditures for patient health services were only \$4,078, compared to a national average of \$13,498 per person in calendar year 2022.<sup>53</sup> This stark disparity highlights the urgent need for increased funding to bridge the gap and ensure that AI/AN communities receive the care they deserve.
- **Shortage of Mental Health Providers:** There is a significant shortage of mental health providers in AI/AN communities. In 2022, the ratio of the national population to mental health providers was 350 persons per provider. In rural areas, such as South Dakota, there were approximately 500 people per single provider. This shortage severely limits access to essential mental health services, leaving many without the support they need.
- **Barriers to Access:** Many AI/ANs face significant barriers to accessing mental health care, including cost, stigma, and a lack of culturally competent services. A 2022 survey found that 80% of respondents cited cost, and more than 60% cited shame and stigma as obstacles to accessing mental health services. These barriers prevent individuals from seeking the help they need, exacerbating mental health issues within the community.
- **High Demand for Services:** The demand for mental health services is incredibly high, with one-third of

respondents in a 2022 survey reporting that they could not get the mental health care they needed. This unmet demand underscores the need for increased funding to expand service capacity and reach, ensuring that everyone needing help can access it.

## **JUSTIFICATION FOR THE \$5.52 BILLION FUNDING LEVEL FOR MENTAL HEALTH**

Mental health is a critical aspect of overall well-being, and AI/AN communities deserve the best possible care. To achieve this, it is essential to allocate \$5.52 billion toward enhancing mental health services across AI/AN communities. Through transparent and accountable funding distribution, this funding will provide better mental healthcare outcomes and help ensure that AI/AN communities receive efficient and effective delivery of mental health services.

The federal government has a trust responsibility towards providing mental health services to Tribal Nations. To fulfill this responsibility, allocating \$5.52 billion in funding is necessary. This investment is a moral and practical imperative to promote healthcare equity and enable self-determination among Tribal communities. Moreover, it will have far-reaching benefits for the health and prosperity of AI/AN communities and the nation. As such, the provision of mental health services to Tribal Nations is a crucial priority that should be pursued with commitment and diligence.

## **ALCOHOL AND SUBSTANCE ABUSE \$4.24 BILLION (+\$3.96 BILLION)**

AI/AN populations suffer disproportionately from alcohol use disorder (AUD) and substance use disorders (SUD) when compared with other U.S. populations, having the highest rate of alcohol-induced deaths, highest prevalence of SUD, the highest rate of drug overdose death, and a lack of access to effective, culturally appropriate treatment.<sup>54</sup> AI/AN people are twice as likely as NHW's to die from a drug overdose, and four times as likely as NHW's to die from excessive alcohol use.<sup>55</sup>

<sup>54</sup> Kaiser Family Foundation. Ndugga, Nambi; Hill, Latoya; Rao, Alisha; Artiga, Samantha. *Key Data on Health and Health Care for American Indian or Alaska Native People*. Dec 19, 2025. (Accessed Mar 14, 2026)

<sup>55</sup> *ibid.*

### ► Understanding the Relationship between Alcohol/ Substance Use Disorders and Mental Health

There is an undeniable relationship between mental health and alcohol/substance use disorder, and the use of drugs and alcohol are often coping mechanisms for dealing with the emotional pain and stress associated with historical trauma.<sup>56</sup> Known risk factors of alcohol/substance use disorder in Tribal communities include historical trauma, the socio-economic disadvantages, the history of forced relocation, and increased mental health challenges.<sup>57</sup> Psychological distress and mental health disorders are prevalent among AI/AN youth and adults who are descendants of those who experienced historical trauma, with the unresolved grief and emotional pain from past generations appearing in the mental health of current generations.<sup>58</sup> Exposure to intergenerational trauma often leads to Post Traumatic Stress Disorder (PTSD), which is characterized by symptoms such as flashbacks, nightmares, and severe anxiety.<sup>59</sup>

### ► Acknowledging Disproportionate Rates of Alcohol-Induced and Drug Related Deaths

AI/AN people have similar prevalence rates for AUD, and significantly higher rates of alcohol-induced and drug induce deaths when compared to other populations nationally. The 2024 National Survey on Drug Use and Health reports similar AUD prevalence rates for AI/

AN adults NHW populations, 11.3% and 10.9% respectively, the age adjusted alcohol-induced mortality rate for Non-Hispanic-AI/AN people is over four times greater than the NHW population (57.9/100,000 as compared to 13.4/100,000).<sup>60 61</sup> Similarly, while all populations have seen reductions in drug overdose deaths from 2023 to 2024, AI/AN peoples are dying from drug overdoses at rates dramatically higher than all other populations, with 51.6 deaths/100,000 as compared to NHW people dying from drug overdoses at a rate of 24.7/100,000 in 2024.<sup>62</sup>

Finally, recent CDC data regarding deaths involving stimulants such as methamphetamines is gravely concerning, with reported stimulant-involved deaths increasing for AI/ANs from 11/100,000 in 2018 to 32.9/100,000 in 2023.<sup>63</sup> The segue from opioid misuse to methamphetamine (meth) is common. Unlike opioids, there are currently no FDA-approved medications for treating methamphetamine use disorder or reversing overdoses. However, behavioral therapies such as contingency management therapy can be effective in reducing harms associated with the use of the drug.

### ► Bridging the Barriers to Culturally Appropriate Treatment

The opportunity for change begins when we find ways to bridge the barrier of access to culturally appropriate prevention programming, and access to treatment for

<sup>56</sup> Soto C, West AE, Ramos GG, Unger JB. Substance and Behavioral Addictions among American Indian and Alaska Native Populations. *Int J Environ Res Public Health*. 2022 Mar 3;19(5):2974. doi: 10.3390/ijerph19052974. PMID: 35270667; PMCID: PMC8910676.

<sup>57</sup> *ibid*.

<sup>58</sup> Indian Health Service. Behavioral Health. (<https://www.ihs.gov/newsroom/factsheets/behavioralhealth/>) Accessed Mar 19, 2026.

<sup>59</sup> Yehuda R, Lehrner A. Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry*. 2018 Oct;17(3):243-257. doi: 10.1002/wps.20568. PMID: 30192087; PMCID: PMC6127768.

<sup>60</sup> National Institute on Alcohol Abuse and Alcoholism. Alcohol Use Disorder (AUD) in the United States: Age Groups and Demographic Characteristics, Aug. 2025. (<https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics/alcohol-use-disorder-aud-unit-ed-states-age-groups-and-demographic-characteristics>). Accessed Mar 19, 2026.

<sup>61</sup> Saunders, Heather; Rudowitz, Robin. Kaiser Family Foundation. Alcohol Deaths: National Trends and Variation by Demographics and States. Feb 24, 2026. (<https://www.kff.org/mental-health/alcohol-deaths-national-trends-and-variation-by-demographics-and-states/>) Accessed Mar 19, 2026.

<sup>62</sup> Garnett, Matthew F. M.P.H; Minino, Arialdi M. M.P.H. Center for Disease Control and Prevention. Drug Overdose Deaths in the United States 2023 – 2024. (<https://www.cdc.gov/nchs/products/databriefs/db549.htm>). Accessed Mar 13, 2026.

<sup>63</sup> Tanz LJ, Miller KD, Dinwiddie AT, et al. Drug Overdose Deaths Involving Stimulants – United States, January 2018–June 2024. *MMWR Morb Mortal Wkly Rep* 2025;74:491–499. DOI: (<http://dx.doi.org/10.15585/mmwr.mm7432a1>). Accessed Mar 12, 2026

<sup>64</sup> Health and Human Services Office of Minority Health. Substance Use and American Indians/Alaska Natives. (<https://minorityhealth.hhs.gov/substance-use-and-american-indiansalaska-natives>). Accessed Mar 19, 2026.



AUD and OUD. In 2024 AI/AN youth between the ages of 12 – 17 were almost 20% more likely to have participated in alcohol, tobacco, or drug prevention programs than other groups.<sup>64</sup> Our youth are our future, and the path to healing flows through our unique Tribal cultures. Local adaptations of culturally sensitive treatment protocols are needed to address the significant diversity among AI/ANs, as there are significant differences in the language, culture, customs, and community identities between the 575 federally recognized AI/AN Tribes.

Native communities need integrated care delivery and holistic approaches to wellness that respect AI/AN traditions and perspectives. Incorporating traditions offers a unique and culturally resonant way to promote resilience, help prevent drug use among young people and develop culturally appropriate and community-based prevention strategies and education

Cultural identity and spirituality are important to AI/ANs seeking help for substance abuse, and these individuals may experience better outcomes when traditional healing is incorporated with other treatment approaches.

The IHS and Tribal health systems can break the cycle of addiction and build bridges to healing through early intervention with our at-risk youth, expansion of Youth Regional Treatment Centers, investment in Tribal specific health professionals such as Behavioral Health Aides (part of the Community Health Aide Program), and expansive development of sober housing, youth shelters, and psychiatric units, detox and rehabilitation services, aftercare services and transitional housing.<sup>65</sup>

<sup>65</sup> <https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf>

# ▶ THE OPIOID/FENTANYL CRISIS

**T** **RIBAL COMMUNITIES ARE IN CRISIS** with increased opioid/fentanyl use and record overdoses of AI/AN people. While many of the Workgroup's recommendations address systemic inequities caused by chronic underfunding of the United States' treaty and trust obligations, certain emergent or accelerating issues are so dire that the Workgroup requests this administration's immediate attention. The Workgroup recommends that the United States fully fund Tribes and Tribal and urban organizations to fight the opioid/fentanyl crisis in Indian Country.

**TRIBES ACROSS THE COUNTRY** came together in August 2023 for the National Tribal Opioid Summit (NTOS) to consider the solutions, collaboration, and policy recommendations to directly address the devastating impacts of fentanyl and opioid drug abuse in Tribal communities nationwide. The Summit was widely attended by over 1,000 Tribal leaders, frontline workers, and federal and state policymakers, and the anchor of the evening was a panel of Tribal citizens who candidly and vulnerably shared their lived experiences with opioid misuse, either as former users now in recovery or as affected family members. The resulting NTOS Federal Policy Recommendations include funding recommendations to address this crisis.<sup>66</sup>

## NATIONAL TRIBAL OPIOID SUMMIT RECOMMENDATIONS

- **Implement** a pandemic-type response to address the opioid/fentanyl crisis in Tribal communities.
- **Develop Cross-agency collaboration** and a significant influx of funding over several years would allow Tribes to address, respond, and eradicate opioid/fentanyl use among their people. Tribes also need funds distributed quickly and should not be burdened by grant administrative processes. Opioid funding from all HHS agencies must be transferred to IHS for distribution to Tribes through existing funding mechanisms, including an option for Tribes to receive funding in their ISDEAA compacts and contracts. This was a successful practice during the pandemic (e.g., Centers for Disease Control and Prevention Funding to IHS).

Siloed funding does not allow Tribes to comprehensively address the opioid crisis in their communities or allow the I/T/U health system the flexibility to develop culturally tailored and holistic programs that meet the needs of their communities. Cultural interventions and Tribal-based practices are critical to prevention, healing, and recovery. In addition, other agencies must work with Tribes to address, for example, housing, law enforcement and judicial system issues, to ensure a comprehensive response. ■

<sup>66</sup> 2023 National Tribal Opioid Summit Federal Policy Recommendations.  
Accessed at <https://www.npaihb.org/wp-content/uploads/2023/12/NTOS-Report.pdf>.

## **PURCHASED/REFERRED CARE**

### **\$13.17 BILLION (+\$12.17 BILLION)**

For FY 2028, the Workgroup recommends a total of \$13.7 billion (+\$12.17 billion) for the Purchased/Referred Care (PRC) program. Sustained and substantially increased funding for the PRC program is a critical priority for the Indian Health System in the absence of full funding for the IHS. Tribal Nations across the system depend on the PRC program to secure emergency and/or specialty care services for their citizens, as access to these services is limited or nonexistent in many Tribal communities.

There are a limited number of IHS-funded hospitals in existence, and several IHS Areas have no IHS-funded hospital to provide inpatient, emergency, and specialty care services. When IHS or Tribally operated health facilities do not have the resources or capacity to provide needed care, they contract health services from non-Tribal providers through the PRC program.

PRC allows AI/ANs eligible for the PRC program to access essential health care services from non-Tribal providers when such services are unavailable within the health systems operated by their Tribal Nation or the IHS. Because access to these services is severely limited for most Tribal communities, much of the secondary care and nearly all the tertiary care provided in Indian Country must be purchased from non-IHS facilities using PRC funds. These services include inpatient and outpatient care, emergency ambulatory care, transportation, and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition, and pharmacy services.

Despite widespread reliance on the PRC program and continued advocacy for increased resources, PRC funds are woefully inadequate to pay for the full scope of necessary care. PRC funds generally pay only the highest priority levels of care, such as emergency care or services where life or limb tests apply, and transportation costs to receive such care. IHS and Tribally operated facilities are often located in isolated, rural areas with little access to specialty care services, requiring patients to travel long distances to receive care. Tribal communities

face systemic and long-standing health care challenges, with fewer specialty care physicians, mental health professionals, and acute care hospitals compared to urban and non-Tribal areas. These transportation issues and the exorbitant cost of accessing emergency and specialty care services at non-Tribal facilities mean PRC programs face extraordinary expenses to secure treatment for their patients. As a result, many PRC programs run out of funds and are forced to further limit access to critical emergency and specialty care services.

Chronic underfunding of the PRC program has forced IHS to impose stricter eligibility requirements for patients seeking care through the PRC program, which further limits access to needed services. Eligibility requirements for the PRC program are more restrictive than requirements to receive services directly through an IHS or Tribally operated facility. All PRC services covered by IHS operated facilities are prioritized according to a medical priority level system designed to ensure that the program provides resources only for the most serious medical conditions. In 2024, IHS moved to four priority levels:

1. Preventive and Rehabilitative Services;
2. Medical, Dental, Vision, and Surgical Services;
3. Reproductive & Maternal/Child Health Services; and
4. Behavioral Health Services,

Within each of these priority levels, Priority One services are defined as “essential,” Priority Two services as “necessary,” Priority Three services as “justifiable,” and Priority Four services as “excludable.”<sup>67 68</sup>

Limited funding requires PRC programs to initially cover the highest priority level of services, and then all or some of the lower priority services if resources permit.<sup>69</sup> PRC requests may be denied because the patient did not meet PRC eligibility requirements, or because the services were not within the medical priority for which funding is still available. When this happens, patients may be denied approval for further care. In FY 2023, IHS reported denying or deferring an estimated \$509 million for over 121,000 services for eligible AI/ANs.

<sup>67</sup> Department of Health and Human Services, Fiscal Year 2026 Indian Health Service Justification of Estimates for Congressional Committees CJ-70.

<sup>68</sup> Indian Health Service. Purchased/Referred Care Fact Sheet. Dec 2024. Accessed Mar 3, 2025.

<sup>69</sup> Ibid. CJ-70.

IHS considers PRC denials and deferrals as a measure of unmet need.<sup>70 71 72</sup> Given that AI/ANs also have “the lowest survival rates for nearly all types of cancer of any subpopulation in the United States, with cancers often detected at later stages,”<sup>73</sup> delays in early screening, specialty care, and local access to treatment lead to serious diseases not being identified while at a treatable stage.

Tribal health programs rely on third-party reimbursements from payers like Medicare, Medicaid, and private insurance to pay for ongoing operations, including staff payroll and facility maintenance. For many Tribal Nations operating Tribal health programs under the self-governance authorities in Title V of the ISDEAA, third-party reimbursement can constitute up to 60 percent of their healthcare operating budgets.<sup>74</sup> While Medicaid Expansion has improved the ability for many facilities to approve PRC requests for higher medical priority levels by reducing the amount of funds the facility must spend on other health care priorities, this is not the case for all Tribal Nations, which forces Tribal Nations to rely heavily on PRC funds to bridge this funding gap. The provision of healthcare services is a trust and treaty obligation of the federal government. Tribal Nations and their citizens should not be forced to ration care because of funding shortfalls.

When Congress does not provide annual program increases to PRC or appropriate additional funds for population growth and medical inflation, Tribal Nations are forced to cut health services to absorb these costs. For the IHS Areas with few or no IHS-funded hospitals, the health care delivery consequences are crippling, as these cuts force Tribal Nations to limit the specialty care services they can support for their citizens. Through the IHS Director’s Workgroup on Improving PRC, a PRC distribution formula was developed with a hospital access measure that would increase funding for those Tribal health programs without access to an IHS-funded hospital – often referred to as the “access to care factor.”

<sup>70</sup> *Ibid.* CJ-72.

<sup>71</sup> *Ibid.*

<sup>72</sup> Melkonian SC, Weir HK, Jim MA, Preikschat B, Haverkamp D, White MC. Incidence of and Trends in the Leading Cancers With Elevated Incidence Among American Indian and Alaska Native Populations, 2012-2016. *Am J Epidemiol.* 2021 Apr 6;190(4):528-538. doi: 10.1093/aje/kwaa222. PMID: 33506248; PMCID: PMC8026484.

<sup>73</sup> Cancer Control in American Indian and Alaska Native Populations: A Conversation with Dr. Shobha Srinivasan. National Cancer Institute. Apr 28, 2018. Accessed Mar 3, 2025.

<sup>74</sup> *Ibid.* CJ-143.

<sup>75</sup> Purchased Referred Care. <https://www.ihs.gov/newsroom/factsheets/purchasedreferredcare/> accessed Mar 3, 2025.

<sup>76</sup> Indian Health Service. (2022). IHS Profile. Retrieved from: <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>.

However, the access to care factor is only funded when there are funding increases (above inflation and population growth) to the PRC budget. The PRC program budget has been essentially flatlined in the appropriations process for the last six years.<sup>75</sup> PRC programs, a consistently highly ranked priority for Tribal Nations, remain severely underfunded, restricting access to comprehensive health care services, resulting in limited access to specialty and tertiary health services for AI/ANs. Substantial increases to PRC funding are needed to improve health outcomes, increase access to health care, and reduce health disparities among the AI/AN population. The federal government has a legal responsibility rooted in the U.S. trust and treaty obligations to Tribal Nations to provide all resources necessary to support the health and wellness of Tribal communities, which includes significantly increased and sustained PRC funding.

### **INDIAN HEALTH CARE IMPROVEMENT FUND** **\$3.75 BILLION (+\$3.658 BILLION)**

In FY 2028, the workgroup recommends a total of \$3.75 billion for the Indian Health Care Improvement Fund (IHCIF) to address significant funding disparities between Tribal health programs across all twelve IHS Areas. Historic allocations of resources appropriated to the IHS have created significant inconsistencies throughout the system. Over the years, allocation methodologies have created a disparity of available resources by line item when reflected in a per capita amount. Because of its limited funding, in FY 2023 IHS spent only \$4,078 per user population compared to the average national healthcare spending in FY 2022 of \$13,493.<sup>76</sup> However, some IHS areas and Tribes are not even funded at the IHS national average of \$4,078 per user. This is because some Tribes had a small funding base from the start. Consequently, when increases are provided based on historical funding, the inequity is perpetuated, and the poor funding base minimizes the

impact of such increases.

Congress established the IHCIF as a means for addressing resource disparities across the Indian health system. The fund is designed to consider many factors that result in resource gaps among IHS and Tribal sites or operating units. A formula is used to target IHCIF appropriations to the sites with the greatest need to:

1. Eliminate the deficiencies in health status and health resources of Tribes;
2. Eliminate backlogs in the provision of health care services to Indians;
3. Meet the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;
4. Eliminate inequities in funding for both direct care and contract health service programs; and
5. Augment the ability of the Service to meet health service responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies and resource deficiencies.

Despite the very significant Indian health disparities and a legislative mechanism to address these disparities that are a direct result of resource deficiencies—60% of all IHS sites in 2018 were funded at less than 50% of their “level of need.” The legislation also required a Congressional report documenting the funding level needed to address the current health status and resource deficiencies for each IHS Service Unit, Indian Tribe, or Tribal organization. This report is overdue. The legislation required its submission by March 2013. The NTBFWG recommends that the IHS submit this report to Congress as soon as possible.

Congress has only provided \$258.9 million to the IHCIF for distribution to IHS and Tribal health programs since the fund was established. Unfortunately, the gains achieved through these resources have been negated by rising health care costs, a growing population, and the impact of rescissions and sequestration. IHS and Congress must provide consistent funding to achieve the policy outcomes and economic goals for which the IHCIF was created.

Finally, the FY 2026 IHS Advance Appropriations did

not include the IHCIF despite the fact this funding is recurring to the IHS or Tribal health program receiving the money. In FY 2018, a new IHCIF sub-sub account was created that moved the 2018 IHCIF out of the Hospital and Clinics line item. Prior to FY 2018, the IHCIF was distributed as recurring funding out of the Hospitals and Clinic account. The consequence of creating the new sub-sub account, is that the 2018 IHCIF appropriation is now outside of the Advance Appropriations, while all the other IHCIF allocations made prior to FY 2018 are in the Advance Appropriation. This is not fair to those Tribes that received money through the 2018 IHCIF. This means when there is a continuing resolution, those Tribes funded in 2018 do not get their IHCIF money, while those Tribes funded prior to 2018 receive their IHCIF money as part of the Advance Appropriation. In addition, as a separate sub-sub account, the 2018 IHCIF is not eligible for population growth. Inflation or Pay Act increases when Congress authorizes this type of funding for Hospitals and Clinics. Yet those Tribes funded prior to 2018 receive these types of increases when Congress elects to fund them. The NTBFWG recommends that the IHCIF be included in the Advance Appropriations and the sub-sub account should be eliminated and the 2018 IHCIF be moved back into the Hospitals and Health Clinics line item. This would allow all Tribes receiving IHCIF money to be treated fairly and consistently.



## Preventative Health

### PUBLIC HEALTH NURSING

**\$1.04 BILLION (+\$933.37 MILLION)**

The Workgroup recommends \$1.04 billion for the IHS Public Health Nursing (PHN) program. The PHN is a community health nursing program that focuses on promoting health and quality of life and preventing disease and disability through quality, culturally sensitive primary, secondary, and tertiary health promotion and disease prevention nursing services to individuals, families, and community groups in throughout Indian Country.

Unfortunately, the funding levels for the program, like many others, hold back this successful program from its full potential. Home-based services, where available, are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, pre/postnatal education, parenting education, and screening for early diagnosis of developmental problems.

Some PHN programs can use funds to supplement traditional food programs that focus on food choices that are not only culturally appropriate but considered healthy changes for AI/ANs. Others might support health system patient navigator assistance programs, tobacco cessation programs, cancer screening programs, onsite emergency care assistance, and community mental health support, and education programs. Fully funding the PHN program would provide a more reasonable level of PHN services within all Indian communities and would provide the funds necessary for Tribes to develop the foundation for a stronger infrastructure to implement Tribal public health authorities.

### HEALTH EDUCATION

**\$416.96 MILLION (+\$392.4 MILLION)**

The Workgroup recommends \$416.96 million for the Health Education program. Health Education programs are an integral component of culturally appropriate primary, secondary, and tertiary prevention, as well as bridging the primary care gap with community health outreach and preventive education. The goal of the

Health Education program is to help AI/AN people live well and stay well. Cross-cutting prevention approaches aimed at education-driven voluntary behavior change activities offer the best hope of improving disease-related AI/AN mortality and morbidity.

Health Educators provide a myriad of services such as injury prevention, sexual transmitted infection prevention education, promote preventative cancer screenings, and educating the community on immunizations. Health Educators help people navigate the healthcare system, improve adherence to health recommendations, and reduce the need for emergency and specialty services resulting in improved overall health status. Unfortunately, Health Educators are limited in the scope of services due to chronic underfunding.

Tribal communities are facing the morbidity and mortality of cancer, heart disease, diabetes, chronic liver disease and cirrhosis, suicide, and both unintended and intentional injuries resulting in death and/or disability. These health disparities can be addressed through primary prevention and care to Tribal communities. Preventive services provided by Health Educators who are trained to provide communities with education and awareness relating to preventive health, emergency response, and communicable diseases, have shown that health education and prevention works—such as HIV screening and colorectal screening.

Health Educators often serve a vital role in translating health education messages from English to a Native language, bridging the communication gap that can hold back Tribal public health. Health Educators are extremely valuable in Native communities by raising awareness of lifestyle choices and decisions, helping to prevent countless sick days for workers and students. Health Educators assist individuals to restore or maintain optimal health and guide individuals to practice sanitary and hygienic habits that prevent crippling and deadly diseases from being transmitted.

### COMMUNITY HEALTH REPRESENTATIVES

**\$1.76 BILLION (+\$1.70 BILLION)**

The Workgroup recommends \$1.76 billion for the Community Health Representatives (CHR) program to expand CHRs and the services they provide. CHRs during

the COVID pandemic have shown tremendous strength in their connection to communities and as a bridge to health facilities. Due to their large contribution during the COVID pandemic, many found them valuable and have reignited efforts to expand similar professionals, such as community health workers, nationally. As highly trusted members in the community for the last 50 years, CHRs deliver preventive health education and case management to Tribal members in home and community settings.

CHR are the trusted messengers for public health, helping address vaccine hesitancy, misinformation, and mistrust in medicine. Many continue to provide health information in our Native languages that is culturally relevant and appropriate, with a focus on holistic wellness that encourages Tribal members to seek health and public health services clinically and at home. CHRs are also considered valued team members of the medical or patient-centered medical home teams whose role is to follow-up on patients discharged from health facilities.

CHR are part of the direct provision of health services to AI/ANs and are authorized in IHCA. Without the ser-

vices provided by the estimated 1,600 CHRs employed across Indian Country, thousands of patients will not receive necessary follow-up services, and many will have difficulty accessing health services, resulting in worsening health conditions. In FY 2018, IHS reported that more than half of CHR visits were made to patients with chronic diseases. In short, CHRs help to bridge the gap between AI/AN patients and health care resources through outreach by specially trained Tribal community members. Therefore, the Tribal CHR programs must remain present in Tribal communities.

Inadequate funding for the CHR Program will result in insufficient staff to address chronic health and infectious diseases that require ongoing follow-up, as well as affect high-risk clients who receive preventive health screening education, monitoring, patient assessments, and home visits. Reductions for the CHR program will result in a serious public health threat wherein high-risk, elderly and disabled clients with chronic diseases will be left without case management and home health care services such as bathing, personal care, feeding, and medication adherence.

### ON THE GROUND SUPPORT

The CHR program is unique to each Tribal community's needs. Some Tribes use CHR resources for public health activities that coordinate complex Eclectic services provided by CHR programs, including health promotion, tuberculosis prevention, Rocky Mountain Spotted Fever (RMSF) public health prevention measures, animal control, and Narcan administration information to prevent death due to an opioid overdose. Without an adequate increase to maintain these efforts, Tribes who rely on CHR programs to coordinate and conduct preventive education efforts will have difficulty maintaining adequate health services to support high-risk clients in need of screening, education, and monitoring visits. ■



### ALASKA IMMUNIZATION

**\$121.37 MILLION (+\$119.19 MILLION)**

The Alaska Immunization program works to eliminate disparities in vaccine-preventable disease by making sure that AI/AN people living in the state have access to vaccines. Alaska's immunization program includes

coordination across Tribal health partners to coordinate and advocate for the needs of Tribal immunization programs, educate Tribal staff on immunization recommendations and vaccine-preventable disease. Key immunization programs include the Hepatitis B and Haemophilus immunization (Hib) programs.

The Hepatitis B program was initiated in 1983 to prevent infections among a large population of Alaska Natives with, or susceptible to, the disease. It continues to provide this service in addition to evaluating vaccine effectiveness and the medical management of persons with hepatitis and liver disease. The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now focuses on maintaining high vaccine coverage as a part of a continued effort to prevent communicable disease by providing resources, training, and coordination to Tribal facilities throughout Alaska. Alaska's geography necessitates innovation in program delivery and use of technology, as many Tribal facilities are located in remote areas off any continuous road system. The Program maintains immunization practice procedures in partnership with Alaska's statewide CHAP to ensure Health Aides working in both urban and remote Tribal facilities have the resources needed to provide high-quality vaccination services for Alaska Native families.

To support this extremely important program, the Workgroup requests \$119.1 million to fund the Alaska Immunization program. Eighty percent of Alaska Native communities are located off the road system. Rural residents travel an average of 147 miles one way to access the next level of health care, often by a combination of air and surface transportation. Supplies needed for daily living are limited, and subsistence hunting is often relied on for food. The remoteness of many villages means they lack regular access to law enforcement, courts, or related services, including internet and broadband access.

The 1918 influenza (Flu) pandemic was devastating for Alaska Native communities. Some historians estimate that 8 percent of the Alaska Native population died from the flu, resulting in some villages being reduced to a single household. Villages were abandoned, and surviving members moved to join other villages. History, language, and culture were lost for many Native communities. The Alaska Immunization program works to ensure that this atrocity will never happen again.

### NATIONAL GOVERNOR'S ASSOCIATION STATE-TRIBAL CASE STUDY

Alaska's state public health and Tribal health partnership for COVID-19 was built on a framework of collaboration and co-leadership that leveraged the existing resources of the Alaska Immunization program. The National Governor's Association (NGA) featured this collaboration as an NGA state-Tribal case study that provides best practices for the states to replicate in their relationships with IHS and Tribal health programs. ■

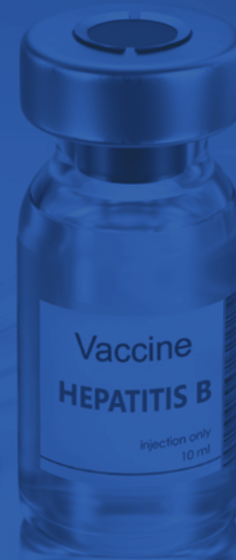


## THE HEPATITIS B PROGRAM

**V**IRAL HEPATITIS, INCLUDING HEPATITIS B, and other liver diseases, continue to be a health disparity for AI/ANs in Alaska. The Alaska Native Tribal Health Consortium (ANTHC) Hepatitis B Program continues to prevent and monitor Hepatitis B infection, as well as hepatitis A, and immunizations maintain high vaccine coverage rates. Health curricula, workforce policy, and educational materials for patients as emerging health risks affect the populations.

The Alaska Immunization Program works to eliminate disparities in vaccine-preventable diseases in Alaska Native people. Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Alaska Immunization program offers clinical expertise in advancing immunizations, vaccine reporting, and data management capacity in an environment of evolving and expanding electronic health record systems.

The immunization program works with statewide Tribal health partners to coordinate and advocate for the needs of Tribal immunization programs, educate Tribal staff on immunization recommendations, and administer vaccines for preventable diseases in Alaska Native communities. Especially at a time when measles, a highly communicable disease that was eradicated in the United States by the year 2000, is showing an increased number of outbreaks across the nation in recent years, **it's extremely important that the Alaska Immunization program receives adequate funding.** ■



## Other Services

### URBAN INDIAN HEALTH

**\$1.64 BILLION (+\$1.54 BILLION)**

The United States has a trust responsibility to maintain and improve the health of American Indian and Alaska Native people no matter where they live.<sup>77</sup> To meet this obligation in urban areas, the federal government contracts with 41 Urban Indian Organizations (UIOs), which operate over 85 facilities in 38 urban areas nationwide. UIOs were created in the 1950s by American Indian and

Alaska Native people living in urban areas, with the support of Tribal leaders, to address severe problems with health, education, employment, and housing caused by the federal government's Relocation policies.<sup>78</sup>

In 1976, UIOs were formally incorporated into the Indian Health system, which is comprised of the Indian Health Service (IHS), Tribal health programs, and UIOs (collectively, the I/T/U system), through the passage of the Indian Health Care Improvement Act (IHCIA).<sup>79</sup> Today, the UIOs are a fundamental and inseparable component of the I/T/U system, providing a wide range of health care and social services to our people in urban

areas, including primary care, oral care, HIV treatment, substance use disorder treatment, behavioral health, elder services, diet and nutrition classes, and Traditional Medicine. Collectively, the UIOs serve patients from over 500 federally recognized Tribes.<sup>80</sup>

The National Tribal Budget Formulation Workgroup recommends \$1.64 billion for the IHS Urban Indian Health line item. UIOs only receive direct funding through a single line item – Urban Indian Health. An increase to this line item will ensure increased federal funding for services at UIOs as well as facilities costs and other expenses. UIOs generally do not receive direct funds from other distinct IHS line items, including the Hospital and Health Clinics, Mental Health, Alcohol and Substance Abuse, Indian Health Care Improvement Fund, Health Education, or any of the line items under the IHS Facilities account. Like the rest of the I/T/U system, UIOs are chronically underfunded, and the Urban Indian Health line item historically is just one percent of IHS' annual appropriation. Only a significant increase to the Urban Indian Health line item will allow UIOs to increase and expand services to address the needs of their American Indian and Alaska Native patients, support the hiring and retention of staff, and open new facilities to address the growing demand for UIO services.

Funding for urban Indian health must be significantly increased if the federal government is to finally, and faithfully, fulfill its trust responsibility. It is imperative that any increase not be paid for by diminishing funding for the other branches of the I/T/U system, which is contrary to the trust responsibility the United States owes to all our people, no matter where they live.

### ► Retain and expand eligibility for IHS UIOs to participate in grant programs

Because UIOs have long suffered from significant underfunding, they often must seek additional funding opportunities through grants to expand services

**Ensure Urban  
American Indian and  
Alaska Native People  
are Included in the  
Implementation of  
Medicaid Community  
Engagement  
Requirements  
Exemptions** 

<sup>77</sup> S. Rep. No. 100-508, at 25 (1988) (stating that “The responsibility for the provision of health care . . . does not end at the borders of an Indian reservation. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not wish to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there.”); see 25 U.S.C. § 1601(1).

<sup>78</sup> S. Rep. No. 100-508, at 25 (1988).

<sup>79</sup> 25 U.S.C. §1651 et seq.

<sup>80</sup> Indian Health Serv., IHS National Budget Formulation Data Reports for Urban Indian Organizations: Calendar Year 2021, [https://www.ihs.gov/sites/urban/themes/responsive2017/display\\_objects/documents/IHS\\_National\\_Budget\\_Formulation\\_Reports\\_Calendar\\_Year\\_2021.pdf](https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/IHS_National_Budget_Formulation_Reports_Calendar_Year_2021.pdf).

<sup>81</sup> OFFICE OF URBAN INDIAN HEALTH PROGRAMS, URBAN INDIAN ORGANIZATION INFRASTRUCTURE STUDY FISCAL YEAR 2023 (2024), [https://www.govinfo.gov/content/pkg/CMR-HE20\\_300-00186499/pdf/CMR-HE20\\_300-00186499.pdf](https://www.govinfo.gov/content/pkg/CMR-HE20_300-00186499/pdf/CMR-HE20_300-00186499.pdf)

and adjust to growing patient needs. Such additional funding includes programs such as the Special Diabetes Program for Indians (SDPI). As UIOs work to provide for the growing needs of urban American Indian and Alaska Native populations,<sup>81</sup> their continued eligibility

for grant or funding initiative opportunities is essential. The preservation and expansion of grant funds for UIOs should not impact the ability of grants distribution to transfer to direct funding for IHS and Tribal facilities.

Medicaid plays a critical role in fulfilling the trust responsibility to American Indian and Alaska Native people and affecting the national policy set forth in the IHCA. In 2023, over 2.7 million American Indian and Alaska Native people were enrolled in Medicaid, including 47% of American Indian and Alaska Native adults under the age of 65.2.<sup>82</sup> Therefore, it is critically important to ensure all American Indian and Alaska Native beneficiaries are included in the implementation of the exemptions for American Indian and Alaska Native people from the Medicaid community engagement requirements. Proper implementation of the exemptions is not only consistent with the trust responsibility and the IHCA, but it is also mandated under the One Big Beautiful Bill Act's (OBBBA) requirement that states must exempt American Indian and Alaska Native people<sup>83</sup> from the community engagement requirements,<sup>84</sup> including urban American Indian and Alaska Native people. Notably, in 2022, 59% of the American Indian and Alaska Native population served

at UIOs were Medicaid beneficiaries.<sup>85</sup> Ensuring UIO American Indian and Alaska Native beneficiaries are included in the exemption implementation is crucial to protecting the health care access of American Indian and Alaska Native people who rely on UIOs to provide critical healthcare services. ■



<sup>82</sup> *Analysis of 2023 American Community Survey (ACS) data (1-year estimates). Includes data on AI/ANs identified as "Alone" or "In Combination."*

<sup>83</sup> *The OBBBA includes the following language: "(aa) is an Indian or an Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act (bb) is a California Indian described in section 809(a) of such Act; or (cc) has otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary." One Big Beautiful Bill Act § 71119(a), 42 U.S.C. § 1396(a)(xx).*

<sup>84</sup> *One Big Beautiful Bill Act § 71119(a), 42 U.S.C. § 1396(a)(xx).*

<sup>85</sup> *INDIAN HEALTH SERV., NATIONAL UNIFORM DATA SYSTEM SUMMARY REPORT 2022, URBAN INDIAN ORGANIZATION (2024), [https://www.ihs.gov/sites/urban/themes/responsive2017/display\\_objects/documents/2022\\_UIO\\_UDS\\_Summary\\_Report\\_Final.pdf](https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2022_UIO_UDS_Summary_Report_Final.pdf).*

## E D U C A T I O N

**CREATING OPPORTUNITIES FOR NATIVE SCHOLARS**

Efforts to encourage AI/ANs into health careers include targeted scholarships, mentorship programs and community-based outreach. Recently, the Pascua Yaqui Tribe, collaborated with the University of Arizona, and Learning Undeafened to develop "Rising Stars," with the vision to create a future of health care professionals of practitioners, researchers, dentist, pharmacist, nurses, psychiatry and other professionals that represent the population they are serving. In 2020, the Cherokee Nation opened the first Tribally-affiliated medical school through partnership with Oklahoma State University. This program includes residency positions for both AI/AN and non-Tribal individuals. These positions are designed to train graduates in the Cherokee Nation Reservation and encourage medical professionals to remain and provide care in Indian Country. The Workgroup recommends including funding to create additional Tribally-affiliated medical school programs and funding for graduate medical education that will keep providers in Indian Country. ■

► **A portion of the recommended amount should be made available as part of the Community Health Aide Program (CHAP) implementation in the lower 48 states.**

This would provide scholarship funding for students seeking a career as a CHAP mid-level provider. Additionally, a portion of the funding should be made available for grants to establish course work for Dental Therapists, Behavioral Health Aides and Community Health Aides at Tribal colleges, universities, and partner institutions. Expanding the use of these funds in this manner remedies a major need for training in or near Tribal communities. These measures elevate our ability to train, recruit and retain AI/AN professionals and mid-level providers seeking to enter health professions through comprehensive efforts.

CHAP is expanding beyond Alaska, but federal funding has not kept pace with implementation needs outside of Alaska. We recommend providing dedicated CHAP funding to build the workforce pipeline and support Tribally driven implementation. CHAP was created in Alaska in the 1960s to address provider shortages and barriers to care in remote and rural Tribal communities. Its success led to expansion outside of Alaska. IHS consulted with Tribes in 2016 and established the CHAP Tribal Advisory Group (TAG) in 2018. However, in November 2024, IHS dissolved the TAG and issued Circular 24-16 without Tribal consultation. Until its sunset, the TAG played a critical role

in building the federal framework for CHAP expansion outside Alaska.

Congress should also support paid internships spanning associate, bachelors, and graduate/professional pathways. This would strengthen recruitment and retention of both Native and non-Native providers committed to serving Tribal health systems, while expanding access to health professions for AI/AN students and building a sustainable, culturally grounded workforce.

Although IHS has offered limited planning and implementation grants, CHAP activities outside IHS Headquarters and Area Offices remain largely unfunded. This lack of sustained support has slowed progress despite strong Tribal leadership. In 2025, IHS seated the National CHAP Board (NCB), with 10 of 12 IHS Areas represented, to draft national standards and oversee Area Certification Boards. While NCB members are working to move implementation forward, they continue to face major barriers: IHS staff are making key decisions without NCB or Tribal input, communication is inconsistent, and processes lack transparency and documentation. As a result, Tribal representatives have not been able to fully exercise the authority granted to the NCB.

The Portland Area has been a national leader in CHAP expansion. As of 2026, it has 24 certified CHAP providers and 70 providers in training across disciplines. The first Portland Area CHAP providers were certified in 2023 by the Alaska CHAP Certification Board, and in November 2024 the IHS Director formally recognized the Portland Area CHAP Certification Board (PACCB). PACCB has demonstrated strong certification infrastructure and oversight grounded in Portland Area Tribal systems and priorities. However, limitations placed on PACCB's authority continue to delay certification and increase costs for Tribes, often requiring them to rely on the Alaska Area Certification Board for services PACCB is already qualified to perform. These barriers slow the deployment of providers into Tribal communities that urgently need primary and community-based care.

Momentum is also growing in the Billings Area. Following Tribal engagement and regional planning, the first federally certified CHAP providers in the Billings Area are expected to begin practice in 2026. Billings Tribes and Tribal Colleges and Universities are actively building education programs across Behavioral Health Aide, Community Health Aide, and Dental Health Aide tracks. The Billings Area is also developing its Area Certification Board and, until federal approval is granted, will rely on a mutually agreed upon partnership with the Portland Area CHAP Certification Board.

In the Oklahoma Area, Tribes are actively developing regulatory infrastructure and education pathways to support CHAP implementation. Efforts are underway to establish Behavioral Health Aide education pro-

grams, while partnerships are being explored to expand Behavioral Health Aide training and develop Community Health Aide and Dental Health Aide education programs. These efforts reflect strong Tribal interest in using CHAP to expand access to care and strengthen the Tribal health workforce.

Additional regions are also preparing for implementation. For example, the Phoenix Area has begun upskilling Community Health Representatives into Community Health Aides and currently relies on a partnership with the Portland Area CHAP Certification Board. National collaboration continues through the annual CHAP Symposium, with the third National CHAP Symposium scheduled for May 2026 in the Billings Area.

Without dedicated CHAP funding directed to Tribes, national implementation will stall despite strong Tribal readiness and workforce demand. To sustain Alaska and ensure successful national expansion, Congress must increase and stabilize CHAP funding and ensure it reaches Tribes directly. Federal CHAP infrastructure should protect Tribal implementation—not control it. Funding should be readily available through IHS Area Offices and directly to Tribes and TCUs to support Area Certification Boards, education programs, and other Tribally driven CHAP activities. Consistent, funding will allow Tribes and Tribal organizations to train health aides, establish certification systems, and build the administrative and clinical infrastructure needed for long-term success. These investments will strengthen CHAP nationally, improve access to care in underserved Tribal communities, advance health equity, and uphold Tribal self-determination in health care delivery. ■

## INDIAN HEALTH PROFESSIONS

**\$174.14 MILLION (+\$89.61 MILLION)**

The Workgroup requests \$174.14 billion for the Indian Health Professions program. Within Indian Country, both the IHS and Tribal communities face persistent challenges in recruiting and retaining qualified medical personnel for their facilities. Rurality and geographic isolation of IHS and Tribal facilities compound this issue, as does chronic underfunding. This issue

underscores the critical need to cultivate AI/AN health professionals from Tribal communities. To address this, broader initiatives to encourage and facilitate entry of AI/AN individuals into health careers must be implemented. Such efforts encompass facilitating access to federal and state-funded scholarships, increasing loan repayment programs, and fostering partnerships with educational institutions to provide necessary support and resources.

IHS and Tribal providers have long contended with provider shortages, significantly complicating the delivery of care to patients. The federal trust responsibility, upheld by the Eighth Circuit Court of Appeals in *Rosebud Sioux Tribe v. United States*, emphasizes the provision of health care as a fundamental obligation. In that case, the Court discussed the duty of the government to provide “competent physician-led health care,” affirming its existence and reinforcement through the Snyder Act and the IHCIA. Appropriations must be made to fulfill this commitment and ensure the availability of “competent physician-led health care” across Indian Country. IHS and Tribal health providers and Tribal Public Health programs continue to struggle to find qualified medical and public health professionals to work in facilities due to being rural and the sole programs serving Indian Country. Nearly half of the public workforce nationwide is considering leaving their positions within the next five years. According to the GAO IHS and Tribes has an “average vacancy rate for physicians, nurses and other care providers of 25%.” Current vacancy rates and providers lack of desire to work in dilapidated facilities with an outdated electronic health record make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners at an all-time high, the situation is unlikely to improve without a substantial investment in staffing.

The federal government must leverage its existing resources towards fighting this problem. We encourage continued use of programs such as the National Health Service Corps (NHSC), during the ongoing Health and Human Services reorganization. The NHSC supports provider placements throughout Indian Country and remain a strong recruitment tool for Tribal organizations. This support is made possible because of the automatic designation of outpatient IHS, Tribal facilities and UIOs that receive funds through Title V of the IHCIA as Health Professional Shortage Areas (HPSAs). Tribes are automatically designated as ‘population’ HPSAs. Automatic HPSA designations do not expire, but the Health Resources Services Administration (HRSA) advises that the designations need to be updated periodically to ensure that the score is accurate. We support the continued use of the auto HPSA to ensure that IHS and Tribal organizations have continued and increased access to providers.

The Indian Health Professions program should be fully funded to increase scholarships and loan repayments to be commensurate with other federal programs such as the VA and HRSA. Additionally, loan repayments and forgiveness programs should be expanded for medical professionals providing care in severely underserved areas, remote, or returning to serve in their respective Tribal communities. These scholarships should include public health professionals, midwives and nutritionists. The Workgroup also requests that the IHS Scholarship and loan repayment program be exempt from Federal Income Tax Withholding, aligning it with other federal programs such as National Service Corp Program, the VA, and HRSA. These Federal Income Tax laws and policies negatively affect students receiving IHS scholarships and loan repayments and discourage them from pursuing careers in IHS and Tribal communities.

### **TRIBAL MANAGEMENT GRANTS** **\$102.82 MILLION (+\$99.83 MILLION)**

The Workgroup recommends \$102.821 million for the Tribal Management Grant (TMG) program in FY 2028. Authorized under the ISDEAA, the TMG program supports federally recognized Tribes and Tribal organizations (T/TO) in planning, preparing for, or deciding to assume all or part of existing IHS PFSAs through an ISDEAA Title I contracts or Title V compacts. The program also assists current ISDEAA contractors and compactors in strengthening and enhancing their management and administrative capacities to deliver quality and culturally relevant healthcare in Tribal communities.

#### **The TMG Program includes four project categories:**

1. Feasibility study
2. Planning
3. Evaluation study
4. Health Management Structure (HMS)

Feasibility, Planning and Evaluation projects are one-year grants, while the Health Management Structure grants support multi-year projects of one to three years.

- **Planning Grants** (up to \$50,000) enable recipients to collect data, set goals, and develop performance measures for PFSAs they intend to assume under a Title I contract.

- **Evaluation Grants** (up to \$50,000) assess program effectiveness and efficiency and identify modifications or new components to improve Tribal health care delivery systems including traditional and cultural healing.
- **Feasibility Grants** (up to \$70,000) support analyses to determine T/TO management of specific programs is practicable.
- **Health Management Structure Grants** (up to \$300,000) fund the design and implementation of systems to manage PFSAs, including electronic health record (EHR) systems, billing and accounting systems, health accreditation activities, and corrective actions related to audit findings.
- While IHS continues to prioritize direct health services over discretionary competitive grant programs, Tribal Nations and Tribal organizations **maintain strong interest in exercising their sovereign right** to manage and strengthen the delivery of health care services in tribal communities. The TMG Program remains an essential resource in advancing Tribal self-determination by equipping T/TOs with tools and capacity needed to assume, manage, and improve the quality of their health care delivery systems, supporting the broader federal initiative to expand self-governance across Indian Country.

The investment to improve and expand the public health infrastructure among the Tribal Nations supports healthier nations. The Workgroup emphasizes the vitality of DHHS to communicate and consult with Tribes for Public Health Infrastructure Grants and direct funding on funding appropriations.

The Workgroup recommends short-term grants up to 5 years for public health workforce capacity building, such as Health Educators, to focus on HIV Prevention and infectious diseases such as TB and STIs. Technical assistance programs for capacity building would assist with local workforce and feeder programs into the PSAFs. This grant opportunity would be in addition to the budget formulation of preventative health, Public Health

Nursing, Health Education, and Community Health Representatives. The Workgroup emphasizes the critical need for Tribal consultation for funding allocations and passthrough between DHHS interagency agreements to make direct funding to Tribal Nations instead of states.

## DIRECT OPERATIONS

**\$130.89 MILLION (+\$27.09 MILLION)**

The Workgroup recommends \$130.89 million for Direct Operations. The Direct Operations budget supports a multitude of services, including health policy formulation at IHS, policy development for self-determination contracting, administration of Tribal grant programs and maintaining the DSTAC.

As Tribal Nations continue to exercise their inherent sovereignty through self-governance and self-determination by contracting or compacting their health programs, under the ISDEAA, funding for Direct Operations has decreased on average by 2 percent per year.<sup>86</sup> Regardless, the federal government maintains responsibility to ensure high-quality services for Tribal Nations that choose to receive health services directly from IHS.

Today, 18 Tribes choose to solely receive IHS direct services,<sup>87</sup> and there are 123 IHS-operated facilities providing direct healthcare operations,<sup>88</sup> in addition to the central oversight and management of personnel required to operate the IHS's facilities and administrative functions. Current resources provide for the direct operations of IHS's system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include:

- **Continuing vital investments** to enhance the IHS's capacity for providing comprehensive oversight and accountability in key administrative areas such as human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- **Improving responsiveness** to external authorities such as Congress, the GAO, and the Office of Inspector General (OIG), and addressing Congressio-

<sup>86</sup> Indian Health Service, FY 2024 Congressional Justification, CJ - 185, available at: [https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display\\_objects/documents/FY2024-IHS-CJ32223.pdf](https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf).

<sup>87</sup> Indian Health Service. (2025). Direct Service Tribes. Retrieved from: [https://www.ihs.gov/odsct/dst/#:~:text=DST%20Areas,\(As%20of%20July%202021\)](https://www.ihs.gov/odsct/dst/#:~:text=DST%20Areas,(As%20of%20July%202021)).

<sup>88</sup> *Id.*

nal oversight and reports issued by the GAO and the OIG to make improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.

- **Addressing requirements** for national initiatives associated with privacy requirements, facilities, and personnel security.
- **Continuing to provide** analysis and timely disbursement of binding obligations for CSC and Section 105(l) Lease Agreements to maintain internal controls and improve the accuracy of annual cost estimates.

Direct Operations funding will continue to remain essential to the IHS's ability to provide direct health care services and fulfill inherently federal functions within the Indian health system. The President and Congress must also, in conjunction, consider Tribally driven long-term solutions for the improved delivery of IHS direct services to Tribal citizens, and the effective and efficient management of federal responsibilities to Tribal Nations.

## **FACILITIES & ENVIRONMENTAL HEALTH SUPPORT**

**\$426.16 MILLION (+\$114.76 MILLION)**

The Facilities and Environmental Health Support (FEHS) programs provide and support a wide range of services. These include real property management, health care facilities and staff quarters construction, maintenance and operation services, community and institutional environmental health, injury prevention, and sanitation facilities construction. These programs directly and indirectly support all IHS facilities' performance measures and improved access to quality health services. The Workgroup requests \$795 million for FEHS programs to staff and support its headquarters, regional, area, district, and service unit activities. FEHS program activities are organized into three main areas:

1. Facilities Support, and
2. Environmental Support, and
3. and Office of Environmental Health & Engineering (OEHE) Support.

Facilities Support provides operations and management staff for facilities and staff quarters, as well as construction management support. Environmental Health Support covers staffing and operating costs for environmental health services, injury prevention, institutional environmental health, and sanitation facility construction staffing. Finally, OEHE support includes IHS headquarters staff, engineering services staff, and direct management of overall facilities appropriation services and activities.

For Environmental Health, the IHS delivers a comprehensive, national, community-based, and evidence-based program with five focus areas that include:

1. Children's environment
2. Safe drinking water
3. Vector-borne and communicable disease
4. Food safety
5. Healthy homes

Additionally, the IHS investigates disease and injury incidents, and provides training to federal, Tribal, and community members. Through the FEHS programs, the IHS works to identify environmental health hazards and risk factors in communities and implement control measures.

## **SELF-GOVERNANCE**

**\$6.31 MILLION (+\$1.3 MILLION)**

The Workgroup requests \$6.31 million to support and expand self-governance training and technical support through the Office of Tribal Self-Governance (OTSG). This request supports an expansion of the IHS Tribal Self-Governance program and funding for Planning and Negotiation Cooperative Agreements to assist Tribes preparing to enter the IHS Tribal Self-Governance program. This line funds Tribal needs across IHS Areas and at Headquarters for any Tribe that has elected to participate in the IHS Tribal Self-Governance program. Additionally, this funding supports the IHS Director's Tribal Self-Governance Advisory Committee, which advises the IHS Director on Self-Governance policy decisions.

The OTSG is responsible for a wide range of critical agency functions to honor the IHS's relationship with

Tribes and their citizens under the authorization of Title V of the ISDEAA. Title V authorizes Tribes and Tribal Consortia to enter into Self-Governance compacts, self-determination contracts, and related funding agreements to assume federal PSFAs and associated Tribal Shares, thereby placing the accountability for PSFA service provision with Tribal Nations. Today, Tribes administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

### ► **Self-Governance Planning and Negotiation Cooperative Agreements**

Title V of the ISDEAA provides the IHS statutory authority to enter into Planning and Negotiation Cooperative Agreements. These agreements assist Tribes in planning and negotiation activities, technical assistance, analysis, and systems review are all part of those negotiation activities. IHS agency lead negotiators, Tribal technical advisors, and financial experts

are required to help Tribes implement self-governance planning successfully. Two types of cooperative agreements are meant to assist Tribal expansions of self-governance programs. The first is the Planning Cooperative Agreement, which provides resources to Tribes entering or expanding Title V compacts. Costs supported by the planning cooperative agreements include legal and budgetary research, internal Tribal government planning, and organization preparation relating to the administration of health care programs. The second is the Negotiation Cooperative Agreement. This agreement provides resources to Tribes to help defray the costs of preparing for and conducting Self-Governance program negotiations. The design of the negotiation process enables a Tribe to set its priorities when assuming responsibility for IHS PSFAs, to observe the government-to-government relationship between the United States and each Tribe, and involves the active participation of both Tribal and IHS representatives, including the OTSG.



## Facilities

### MAINTENANCE & IMPROVEMENT

**\$1.45 BILLION (+\$1.28 BILLION)**

The Budget Formulation Workgroup is proposing \$1.45 billion to fully fund facility Maintenance and Improvement (M&I) in FY 2028. M&I is consistently ranked as a top priority because it ensures that AI/AN patients receive care in facilities that are safe, functional, and compliant with building, life safety, and accreditation standards. M&I supports essential infrastructure systems, including HVAC, plumbing, electrical, roofing, fire protection, medical gas, elevators, and emergency power, that are foundational to safe health care operations. When these systems fail, the consequences directly affect patient care: infection control is compromised, electronic health records and diagnostic equipment are disrupted, medications and vaccines are placed at risk, and services may be delayed or suspended. Deferred maintenance is not cosmetic; it impacts patient safety, continuity of care, and health outcomes.

Chronic underfunding has allowed facility deterioration and maintenance backlogs to grow nationwide. The IHS October 2023 Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) report identified \$792.2 million in unmet needs, though the IHS Facilities Appropriations Advisory Board has indicated this figure likely understates the true backlog due to limited reporting tied to funding expectations. The 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress found that annual M&I appropriations are approximately one-third of industry standard practice, virtually guaranteeing substandard facility conditions. In contrast, other federal health systems, including the Department of Veterans Affairs and the Department of Defense, receive capital investments aligned with industry benchmarks. AI/AN communities should not receive care in facilities that fall below those same standards.

## MAINTENANCE

### ► RISKS FOR DEFERRING MAINTENANCE

**WHEN A FACILITY** is unable to keep up with its maintenance needs, the risk of failure increases. When aging systems are not repaired or replaced proactively, sudden failures often require emergency procurement, temporary closures, patient transfers, and costly restoration of damaged space. Industry analyses demonstrate that reactive replacement following system failure can cost exponentially more than planned maintenance, placing additional strain on the already insufficient funding available to IHS facilities. Inadequate M&I funding also places facilities at risk of noncompliance with standards required by the Centers for Medicare & Medicaid Services, The Joint Commission, the Occupational Safety and Health Administration, and the National Fire Protection Association, all of which jeopardize accreditation, reimbursement, and access to care in already underserved communities. Contemporary, well-maintained facilities are also essential to recruiting and retaining health professionals, as outdated and failing infrastructure undermines workforce stability and morale.



For Tribes operating facilities under self-determination agreements, insufficient federal M&I funding shifts infrastructure costs onto Tribal governments and diverts scarce resources away from direct patient services. This chronic underinvestment undermines Tribal self-governance and fails to uphold the federal trust responsibility to provide safe and adequate health care facilities. Full funding of M&I at \$15.36 billion is not an expansion of services; it is the minimum investment necessary to ensure safe, compliant, and operational facilities. **Chronic underfunding does not save money.** Underfunding drives emergency repairs, disrupts care, increases long-term costs, and perpetuates inequities in the federal health system. Funding M&I at the proposed level represents a necessary correction toward infrastructure parity, fiscal responsibility, and improved health outcomes for AI/AN communities. ■



According to the 2021 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress, annual appropriations for M&I are approximately 1/3 of the industry standard practice, virtually guaranteeing sub-standard facility conditions by intentional Congressional design. Adequate funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations, and satisfy accreditation standards. Investments that improve the quality of patient care improve our health outcomes, increase access, reduce operating costs, and are, therefore, proven to be cost-effective.

### **SANITATION FACILITIES CONSTRUCTION**

**\$1.66 BILLION (+\$1.55 BILLION)**

The IHS Sanitation Facilities Construction (SFC) Program is an integral component of IHS disease prevention activities. The program has brought potable water and constructed or rehabilitated waste disposal facilities for AI/ANs and Tribal communities since 1960. As a result, the rates of infant mortality, the mortality rate for gastroenteritis, and other environmentally related diseases have been dramatically reduced by about 80 percent since 1973. However, the need for adequate sanitation infrastructure remains critical, as many Tribal communities still rely on aging community-based water and sanitation systems (e.g., unpiped water or sanitation). The Workgroup recommends \$1.56 billion for the Sanitation Facilities Construction program in FY 2028. The Workgroup also recommends that IHS create and fund an Operation and Maintenance account to support sanitation and water infrastructure that has already been constructed.

## SDPI

### SPECIAL DIABETES PROGRAM FOR INDIANS

**\$559.23 MILLION (+\$359.23 MILLION)**

The Workgroup recommends the permanent authorization of the Special Diabetes Program for Indians (SDPI), along with codifying authorities that provide Tribes flexibility in choosing how to receive SDPI funds: through ISDEAA contracts or compacts or through direct service provided by the IHS.

In the FY 2026 appropriations package, Congress enacted a significant increase for the Special Diabetes Program for Indians (SDPI), raising the program's annual funding to \$200 million for FY 2026, a \$41 million increase and the first funding boost since 2004. The amount includes \$50,410,959 allocated for the remaining portion of FY 2026. This increase fulfills a long-standing Tribal request to raise SDPI's annual funding to \$200 million.

SDPI remains the nation's most effective federal initiative for combating diabetes in Indian Country. Over nearly three decades, the program has driven a 54% reduction in end-stage renal disease and contributed to an 84% reduction in hospitalizations for uncontrolled diabetes. Today, more than 300 SDPI programs serve approximately 780,000 American Indian and Alaska Native (AI/AN) people. However, despite its proven success, SDPI's funding remained stagnant at \$150 million for two decades. During this time, medical inflation and population growth caused Tribes to lose more than one-third of their purchasing power.

Beyond SDPI, the FY 2026 legislation also extends Medicare telehealth flexibilities, including audio-only services, and increases Community Health Center (CHC) funding to \$4.6 billion. It continues funding for the National Health Service Corps (NHSC) and Teaching Health Centers that operate graduate medical education programs. Many Tribal Health Organizations and Urban Indian Organizations rely on NHSC placements and benefit significantly from CHC funding.

Although Tribes appreciate the recent increase, the absence of permanent funding for SDPI remains a major concern. The recurring short-term extensions create barriers to strategic planning and continuity of care, key components of effective diabetes prevention and management.

# FOOD IS MEDICINE

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**RIBAL COMMUNITIES ARE FREQUENTLY LOCATED IN RURAL AREAS,**

which present unique challenges, including economic hardship and limited access to adequate food resources. The Pascua Yaqui Tribe and the Tohono O'odham Nation reservations are located in a food desert, which exacerbates the scarcity of food within the community.

A food desert is typically characterized by limited access to affordable and nutritious food options. For these communities, this geographic challenge impacts the ability of community members to obtain fresh produce, make healthy food choices, and have essential ingredients for balanced diets. Food affordability represents a significant concern within the community. To ensure communities have access to healthy, affordable food, it is imperative to reconnect these communities to the value of traditional foods that are critical to long-term disease prevention and improve health outcomes in a culturally responsive way. Additionally, it is imperative to emphasize the notion that food is medicine.

To improve access to and affordability of these foods, the Pascua Yaqui Tribe and Tohono O'odham Nation Healthy O'odham Promotion Program (HOPP) have created initiatives to reduce the impact of living in a food desert and reduce the burden of chronic disease.

**CONTINUED ON NEXT PAGE**



Tribal health programs have also faced disruptions caused by sequestration in Fiscal Years 2022 and 2023. Additionally, the current Administration recently announced a mandatory 2% sequestration for the SDPI program in 2027. Tribes strongly recommend that grantees be held harmless from sequestration, as reductions in funding directly harm programs already striving to stretch limited dollars throughout each grant cycle.

Permanent authorization of SDPI would ensure stable, high-quality diabetes outreach, education, and prevention efforts for Tribal citizens. Ongoing uncertainty threatens clinical outcomes if future funding is not renewed, increased, or if reductions occur. No other public health program matches SDPI's record of achievement, and continued, stable investment is essential to sustain life-saving diabetes management and prevention programs. Reducing diabetes in Indian Country leads to lower rates of comorbidities such as renal failure, heart disease, and hypertension, further demonstrating the program's value.

Securing permanent SDPI funding is fundamental to maintaining prevention programs, direct clinical services, and community outreach efforts. Permanent reauthorization represents a commonsense approach to supporting a highly successful program. The most effective path forward includes increasing funding, ending competitive grant cycles for SDPI, providing Tribes with flexibility to receive funds through ISDEAA contracts or compacts or through direct IHS service, and eliminating sequestration practices that diminish resources and disrupt long-term planning. Moving away from piecemeal funding will allow Tribes to fully implement and sustain the comprehensive diabetes programs their citizens need and deserve.

## RECOMMENDATION

IHS must expand funds and recommend advanced appropriations for programs such as the Prescription Produce Pilot Program (P4) and the Special Diabetes Program for Indians (SDPI). This will support food sovereignty initiatives and improve access to local and traditional foods, food education and preparation, and enhance local economic development to reduce food insecurity and prevent diabetes and other chronic diseases impacting our communities.

## FOOD IS MEDICINE

## CONTINUED FROM PREVIOUS PAGE

The Sonoran Desert plant life includes saguaro cactus fruit, cholla cactus, prickly pear cactus, mesquite beans, and wild spinach. These plants are used to make food that is rich in vitamins, fiber, protein and other micronutrients, which have been a traditional diet staple for the O'odham. The HOPP has a strong history of focusing on gardening and has taken various actions to prioritize gardening as a part of a broader effort to promote health, food sovereignty, and cultural revitalization through traditional agriculture. HOPP's mission is to empower Tohono O'odham to live healthy lives by providing diabetes and nutrition education, physical activity, and community outreach, and by cultivating a healthy environment by providing opportunities, such as the gardening initiative, to community members.

This HOPP initiative leverages its partnerships with other programs, such as the San Xavier Co-op Farm, Ramona Farms, Native Seeds, Tohono O'odham Community College, and the Tohono O'odham Recreation Centers, to bring community members together in a healthy environment, as they learn how traditional foods grow and positively impact their health. The garden and harvest programs focus on:

- **TRADITIONAL PRACTICES** Utilizes dryland farming techniques and desert-adapted crops that thrive in an arid environment. Traditional harvesting for foods that grow naturally in the environment and have traditionally been used to sustain the O'odham.
- **HEALTH AND NUTRITION** Promotes the consumption of traditional, healthy foods as a way to combat health issues such as diabetes and other chronic diseases.
- **EDUCATION AND COMMUNITY ENGAGEMENT** Teaching gardening skills, traditional ecological knowledge, and incorporating community members of all ages.

The Pascua Yaqui Tribe has taken several steps to combat the challenges of providing healthy, affordable food to its members by leveraging different resources. To ensure access to healthy foods, the Pascua Yaqui Tribe created a micro-market initiative that aligns with disease prevention and health promotion. The micro-market initiative aims to reduce the incidence and impact of diseases, improving overall public health by providing programs that promote healthy lifestyles, balanced diets, and regular exercise. The micro-market initiative will provide and promote the consumption of wholesome foods, such as fruits and vegetables rich in essential nutrients, and minimize the intake of unhealthy processed foods, thereby significantly reducing the risk of developing chronic conditions such as hypertension, high cholesterol, and diabetes. Additionally, the micro-market initiative activities will foster social, economic, environmental, and personal factors conducive to health by providing a space to promote health education around food as medicine. A learning kitchen, registered dietitians, and food preparation will be pivotal to the initiative which will focus on offering locally grown vegetables and fruits to enhance access to fresh and nutritious produce, and support local farmers and promote community engagement.

The Pascua Yaqui Tribe was one of the five Tribes selected for the Prescription Produce Pilot Program (P4). The focus is to prevent diabetes and other chronic diseases. The aim of P4 is to demonstrate and evaluate the impact of produce prescription programs on AI/AN people and their families. More specifically, the overall goal is to improve health care outcomes by reducing food insecurity and improving overall dietary health by increasing consumption of fruits, vegetables, and traditional foods. This micro-market will allow members to utilize P4 vouchers locally. ■



## 2ND REQUEST CONCLUSION

**I**HS funding is roughly 10 times less than the Workgroup's recommendation. It is time for the United States to uphold trust and treaty obligations to Tribal Nations through the full funding of IHS. Our communities and future generations' health outcomes rely on the sufficient funding levels of the IHS, and we cannot afford to decrease the life span of AI/AN citizens again.

IHS, Tribal, and urban Indian clinics have celebrated the achievement of advance appropriations in FYs 2024, 2025, and 2026 that created sustainability in our operations and services. Indian clinics were able to develop unique services and activities that contributed to strengthening cultural practices and utilizing best practices suited for our people. However, IHS advance appropriations should be expanded to include all IHS accounts and must be sustained until Congress fulfills its duty the way it was intended – as a mandatory obligation in the performance of a bargained-for exchange. Until Congress enacts this solution, the Administration and Congress must prioritize advance appropriations for the IHS through the discretionary appropriations process to ensure funding for healthcare services and

critical facilities activities are not disrupted.

Many IHS programs, such as SDPI, have proven successful and resulted in cost savings for the federal government, yet remain under-resourced and uncertain. This program has proven to be effective at reducing the prevalence of diabetes among AI/AN adults<sup>89</sup> and has also demonstrated an estimated net savings to Medicare of up to \$520 million over 10 years due to averted cases of end-stage renal disease.<sup>90</sup> Indian Country continues to stretch our limited resources. Still, the effects of inflation and the growing population require full and mandatory funding.

The United States can address AI/AN health disparities through the Workbook's funding recommendations. Tribal Nations seek no more than the duties affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. The United States unique obligation to Tribal Nations requires increased investments and full funding for the IHS. The health, safety, and well-being of Indian Country is dependent on the United State's ability to adequately fund the Indian health care system so that we can enhance the quality of life for AI/AN people.

<sup>89</sup> *British Medical Journal: Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017*, available at: <https://drc.bmj.com/content/8/1/e001218>, accessed on: March 11, 2023.

<sup>90</sup> *HHS Assistant Secretary for Planning and Evaluation, Issue Brief: The Special Diabetes Program for Indians Estimates of Medicare Savings*, available at: [https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI\\_Paper\\_Final.pdf](https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf), access on: March 11, 2023.

# 3RD REQUEST

## FULLY FUND Current Services and Binding Obligations

**T**he Workgroup requests \$264.75 million for Current Services in FY 2028. This requested increase accounts for costs associated with maintaining current services at IHS through 2027. The fixed costs used are calculated by IHS, accounting for service population growth, medical and non-medical inflation estimates, and compensation increases for IHS staff. The funding to maintain current services is spread throughout the appropriate IHS budget line items provided by the IHS and included in the Detail of Changes table above.

In recent appropriation cycles, insufficient IHS funding decreased the agency's purchasing power and operations. Despite significant medical inflation and population growth over the last decade, Congressional funding has not kept pace, leaving the IHS struggling to maintain levels of care. By including additional funding for fixed costs through FY 2027, the Workgroup seeks to maintain the variety of programs provided by IHS including clinical services to improve community health and wellness through immunizations, case management, health screenings, and patient education and counseling.

The NTBFW also requests increased funding to ensure the IHS, Tribal, and Urban Indian (I/T/U) health system can recruit healthcare providers and administrative support staff. The IHS has long been understaffed, and IHS data shows an average vacancy rate for physicians, nurses, and other care providers of between 32 and 37 percent. The I/T/U system faces many competitive disadvantages. For example, the IHS has trouble matching local market salaries. Additionally, although Tribally operated sites have more flexibility in compensation

packages and processes, these programs are hindered in recruitment and retention efforts due to funding limitations. These vacancy rates disrupt a patient's care continuum and make running a quality healthcare program nearly impossible.

The I/T/U system also struggles to retain employees. One contributing factor to this is that other federal agencies can provide more generous benefit structures. The Department of Veterans Affairs (VA), for example, currently provides a more generous automatic 8 hours of leave per pay period for its Title 38 employees and has a standardized annual performance bonus for providers.

Future recruitment of healthcare workers, including clinical providers, is anticipated to become more competitive in the next 5-10 years, with anticipated shortages across many categories, including primary care physicians. Perpetual understaffing limits the abilities of the I/T/U system and impairs its ability to provide high quality healthcare services. Increased funding for fixed costs will allow the I/T/U system to maintain current services and better recruit healthcare professionals to ensure adequate service delivery for AI/AN people.

### ► Binding Obligations

The Workgroup requests an increase of \$9.97 billion for binding obligations in 2028, including staffing at newly completed facilities, Health Care Facilities Construction, and an estimate of Contract Support Costs (CSC) and Payments for Tribal Leases, also known as 'Section 105(l) Lease Agreements.' These amounts are included in the Detail of Changes table above and described below.

### ► Staffing for Newly Completed Facilities

The Workgroup requests \$325 million for staffing at newly completed facilities. Construction of healthcare facilities is an ongoing process, with an annually published construction list of future projects and completed projects previously funded for construction. Consistent with annual IHS Congressional Justifications, the Workgroup supports the inclusion of resources for the staffing of newly completed facilities that would otherwise not have the workforce and personnel to operate. These amounts are estimates provided by the IHS for use by the Workgroup and may be subject to revisions of cost estimates at completion.

### ► Contract Support Costs (CSC)

The Workgroup requests such sums as necessary to fully fund statutory and legally obligated CSC and that Congress should appropriate CSC through mandatory spending. This must be done as an interim step until Congress moves the entire IHS budget to mandatory funding. The estimated cost of CSC for FY 2028 by the IHS is \$8.96 billion. This estimate is provided to the Workgroup by the IHS. The Workgroup recognizes that this amount is subject to change based on the actual CSC obligations required by statute and reconciliation requirements of the IHS-CSC Manual.

Approximately 60 percent of the IHS budget is operated by Tribes under the authority of the ISDEAA. The ISDEAA allows Tribes to assume the administration of programs, services, functions, and activities previously carried out by the federal government. The IHS trans-

fers operational costs for delivery of health programs to Tribes through the “Secretarial amount,” which is the amount IHS would otherwise have spent to administer the health programs. In addition, Tribes are authorized to receive an amount for CSC that meets the statutory definition and criteria, which consists of actual administrative costs available to the IHS to support health programs but not available to Tribes within the “Secretarial amount.”

The FY 2028 CSC estimate, as part of binding obligations, includes an estimate of the required amount to administer the full funding request for direct health programs. The Supreme Court has consistently ordered that CSC is a contractual obligation of the IHS. If Congress continues to allocate the IHS budget through annual discretionary appropriations, the Workgroup supports that the appropriation continues in such sums as



may be necessary due to the mandatory nature of CSC legal obligations. However, the inclusion of mandatory accounts under discretionary spending caps has resulted in a net reduction in the amount of funding provided for Tribal programs and, by extension, the ability of the federal government to fulfill its promises to Tribal Nations. ***The Workgroup requests that Congress appropriate all the IHS funds as mandatory spending. CSC and payments for Section 105(l) Lease Agreements must be immediately moved to mandatory because of the impact these payments are having on funding for programs and services. The Workgroup urges this immediate action to ensure that spending for IHS under discretionary caps can prioritize addressing Tribal health disparities made worse by Termination Era budgets.***

### ▶ Section 105(l) Lease Agreements

Section 105(l) of the ISDEAA requires and authorizes the IHS to enter into leases for facility operations and maintenance upon request of a Tribe or Tribal Organization to administer or deliver programs, services, functions, or activities under the Act. The number of Tribes and Tribal Organizations utilizing this has grown significantly recently as the information and benefits spread throughout Indian Country. This has proven to be a very powerful tool to aid not only in the operations and maintenance of the existing facilities but also in the construction of new facilities.

As facilities appropriations continue to be under-funded, this creates additional barriers to patient care:

1. The condition of existing buildings continues to fall as the cost of upkeep increases faster than increases to facilities budgets to maintain the service level needed.
2. The replacement list for new facilities continues to grow at an accelerated rate due to increased construction costs of new facilities and longer time frames to fund these projects fully, which

leads to fewer new facilities being constructed. This problem, combined with the rapid decay of existing buildings needing to be replaced sooner, only further accelerates the rate at which new facilities need to be replaced.

3. Patient services ultimately suffer due to a lack of adequate facilities to provide modern healthcare.

With the help of Section 105(l) Lease Agreements, federal entities can effectively partner with Tribes to bridge the gap between the need and the current level of funding. Tribes can bring in more flexibility with alternative funding and private financing structures. This opportunity not only accelerates the completion of new facilities that are due for replacement but also provides the necessary funding to stop the rapid decay of existing facilities, decreasing the rate at which buildings need to be replaced. These new modern facilities allow for modern healthcare delivery methods to provide a higher level of whole person care.

The Workgroup continues to urge that all the IHS budgets be provided as mandatory spending, and CSC payments for Section 105(l) Lease Agreements are moved to mandatory. The Workgroup urges this immediate action to ensure that spending for the IHS under discretionary caps can prioritize addressing Tribal health inequities made worse by inadequate budgets.

**The Workgroup requests such sums as may be necessary to fully fund statutory and legally obligated payments for Section 105(l) Lease Agreements and that Section 105(l) Lease Agreements should be provided through mandatory spending. The estimated cost of Section 105(l) Lease Agreements for FY 2028 by the IHS is \$581.65 million. This estimate is provided to the Workgroup by the IHS. The Workgroup recognizes this amount is subject to change based on the actual amount and description of leases with obligations in FY 2028.**

# 4TH REQUEST

## PROTECT, PRESERVE, and EXPAND Advance Appropriations for the Indian Health Service

S

ince FY 2023, Congress has taken an important step toward honoring the United States' trust and treaty obligations by providing advance appropriations for the IHS.

This action placed IHS on par with other federal health systems that already receive advance appropriations and marked a meaningful shift in strengthening the nation-to-nation relationship between Tribal Nations and the United States. By providing funding stability, advance appropriations help ensure the federal government can better meet its responsibility to support the health of AI/ANs.

Advance appropriations provide a full-year appropriation one year in advance, allowing the IHS, THPs, and UIOs to plan more effectively for staffing, services, and long-term health care delivery. This stability allows providers to focus on improving health outcomes rather than managing uncertainty caused by federal funding delays or potential government shutdowns. Advance appropriations also improve operational efficiency within the IHS by reducing short-term funding actions and the need for emergency contingency planning tied to unpredictable federal spending outcomes.

Tribal Nations strongly support the continuation of advance appropriations for the IHS as a critical step toward aligning federal funding with the government's trust responsibility. However, advance appropriations do not yet extend to all IHS accounts and line items, leaving several



important programs subject to uncertainty. These include the IHCIF, modernization of electronic health records, sanitation facilities construction, and health care facilities construction—programs that depend on consistent and predictable funding to effectively serve Tribal communities.

To further align federal funding with the trust responsibility and ensure stability across the Indian health system, the Workgroup recommends that Congress maintain advance appropriations for the Indian Health Service in Fiscal Year 2028 and extend advance appropriations to these additional accounts and line items.

# 5TH REQUEST

## RECLASSIFY Contract Support Costs and 105(l) Lease Payments to Mandatory Funding

**T**he Indian Self-Determination and Education Assistance Act (ISDEAA) requires the Indian Health Service (IHS) to compensate Tribes for Contract Support Costs (CSC) and Section 105(l) Payments for Tribal Leases. CSC are the necessary and reasonable costs associated with administering the contracts and compacts through which Tribes assume direct responsibility for IHS programs and services. A 105(l) lease is compensation to Tribes for reasonable operating costs associated with facilities leased or owned by Tribes and Tribal organizations to carry out health programs under the ISDEAA. These accounts are mandatory spending, but Congress currently includes them in the discretionary budget.

Several Supreme Court decisions, such as *Cherokee Nation v. Leavitt*, *Salazar v. Ramah Navajo Chapter*, and *Becerra v. San Carlos Apache Tribe*, have affirmed that

the government must fully fund CSC and 105(l) lease payments, yet Congress continues to place them in discretionary appropriations, where they compete with vital programs within the IHS. The cost to fulfill CSC and 105(l) obligations continue to rise, especially after the 2024 *Becerra v. San Carlos Apache Tribe* decision required the IHS to pay CSC on revenues from Medicare, Medicaid, and private insurance, potentially adding up to \$2 billion annually. This creates an impossible situation under discretionary caps: either Congress cuts core IHS services or finds new discretionary funding, both of which harm Tribal healthcare and undermine the federal government's ability to meet its trust and treaty obligations to provide healthcare for AI/ANs. Reclassifying CSC and 105(l) payments as mandatory would provide stable, predictable, and adequate funding that aligns with long-standing legal requirements and supports Tribal self-determination.

# 6TH REQUEST

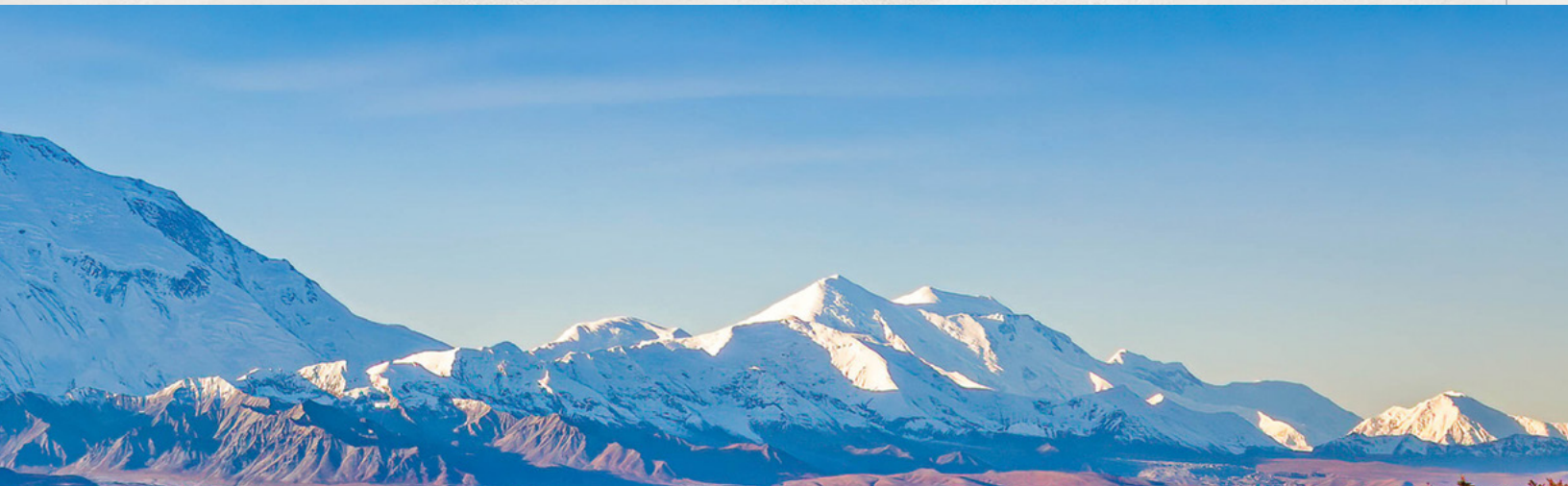
## PERMANENTLY EXEMPT Appropriations for all Indian Health Service, Tribal Organizations, and Urban Indian Organizations from Budget Cuts, Sequestration, and Recissions

**A**s outlined by Tribal leaders throughout the IHS NTBFW's request and supported by numerous federal reports and findings, the IHS is chronically underfunded, with current estimates for full funding being roughly seven times greater than the amounts enacted by Congress. The IHS budget remains so small in comparison to the national budget that spending cuts or budget control measures would not result in any meaningful savings in the national debt but would devastate Tribal Nations and their citizens. This will create the potential for life-or-death consequences in Indian Country. Further, any cuts or elimination of funding and services to Tribal Nations and communities is a violation of the federal government's trust and treaty obligations to provide for AI/AN healthcare.

Under the Budget Control Act of 2011, the IHS was not exempt from the automatic across the board cuts unlike

other federal programs that serve the health of our nation's populations, such as Social Security, Medicare, Medicaid, the CHIP, and the VA. Although the American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2% to 5.1% for FY 2013, even at that revised level, the IHS budget suffered a devastating cut of \$225 million. The is chronically underfunded for decades, and the Indian health system has still not fully recovered from the effects of sequestration, which contributed heavily to the ineffective and insufficient delivery of health services in Indian Country. Now more than a decade later, given high rates of inflation and rising costs on top of those lasting effects from sequestration, further cuts to the IHS budget have the potential to create dire consequences in the Indian health system.

Several members of Congress publicly stated that the 2011 sequestration was clearly an oversight, and that the IHS should not have been held to the full sequester.



Nevertheless, the I/T/U programs were left with an impossible choice: either deny or reduce services or subsidize the federal trust obligation. In fact, many facilities closed their doors for several days per month due to lack of funding. Other facilities were forced to only deliver PRC for Priority 1 essential services. The IHS is one of only four federally funded services providing direct patient care. However, the agency was the only one of the four not exempted from the full amount of sequestration. This oversight, which created an unsafe hardship for Indian patients seeking care, must be permanently corrected. Tribal Nations are requesting Congress and the Administration to amend prior statute or implement further legislation that will permanently and completely protect the IHS from sequestration. Any attempts to reduce the national budget or deficit must hold IHS programs and services harmless. All federal funding for I/T/U programs and services, especially funding for IHS which is charged with carrying out trust obligations, is part of the US' trust and treaty obligations, and thus this funding is legally mandated.

Lost dollars result in the loss of health care practitioners and services through staff reductions and

reduced access to basic health care. Many AI/ANs, especially in rural communities where only one provider serves an entire community, ultimately suffer with the loss of a single doctor, midlevel, or Community Health Aide. For some Tribal Nations, loss of a provider can result in life-or-death consequences for those communities. The trust obligations, which impact the lives and future survival of Indians, must be a priority for funding within HHS, this Administration, and Congress. Until the IHS is fully funded, the promised health care that American Indians and Alaska Natives deserve will not become a reality.

As Congress considers funding reductions in FY 2028 or beyond, the IHS must be held harmless. As we saw in FY 2013, poor legislative drafting subjected our tiny, life-sustaining, IHS budget to a significant loss of base resources, resulting in lasting effects that can still be felt within the Indian health system. Congress must ensure that any budget cuts, sequesters, or rescissions, whether automatic or explicit, hold the IHS and our people harmless. We cannot balance the budget on the backs of Indian Country.



# 7TH REQUEST

## SAFEGUARD Special Tribal Provisions Within Medicaid, Medicare, and the State's Children's Health Insurance Program

### MEDICAID

**A**lmost 50 years ago, Congress authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs to supplement inadequate IHS funding. The House Report stated, “[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to AI/ANs.”

Medicaid plays an integral role in ensuring access to health services for AI/ANs and provides critical funding support for the Indian health system overall through third party revenue. In fact, in many places across Indian Country, reimbursements from Medicaid have enabled Indian health facilities to provide medical services that were previously unfunded by the annual appropriations from Congress.

The Medicaid system is a critical lifeline in Tribal communities. Efforts that decrease already scarce Medicaid resources also jeopardize the ability to cover the cost of care and further restrict the eligible patient population. This puts an unequal burden on the IHS budget, which is dependent upon these resources to make up for funding shortfalls. The unique relationship between Medicaid and the Indian health system means that the Administration has the tools it needs to allow states to design Medicaid programs that best fit non-Indian populations while simultaneously respecting Tribal sovereignty and maintaining Medicaid as a critical source of funds for the Indian health system. Like states, Tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them.

We urge the Administration to work with Tribes and to strengthen its Tribal consultation practices on Tribal priorities so that fiscal strain does not unintentionally fall back to the IHS and Tribal health programs.

#### **Also, important existing Tribal protections in the Medicaid program must be preserved. These include:**

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider (IHCP) or through referral under PRC is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under PRC.
- If an AI/AN elects to enroll in a Managed Care Organization (MCO), they are permitted to designate an IHCP as their primary care provider.
- A state is prohibited from classifying trust land and items of cultural, religious, or traditional significance as “resources” for purposes of determining Medicaid eligibility for AI/ANs. Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery.
- An IHCP must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider.

#### **Other Tribal protections and measures must be implemented. These include:**

- Encourage states to maintain telehealth flexibilities adopted during the Public Health Emergency and

to increase Medicaid telehealth reimbursement for IHCPs to the OMB encounter rate.

- **Shield** IHCPs from state benefit cuts and enrollment limitations using 1115 waivers to protect AI/AN beneficiaries.
- **Establish** standardized oral health care benefits for AI/ANs under state Medicaid programs.
- **Extend** 100% Federal Medical Assistance Percentage (FMAP) for Urban Indian Organizations.
- **Work** with states to help them file Section 1115 waivers to obtain Medicaid reimbursement for traditional practices.
- **Authorize** IHCPs to bill for all Medicaid optional services and services authorized under the IHCIA regardless of whether the State authorizes those services for other providers.

## MEDICARE

**M**edicare plays an essential role in the Indian health system by providing additional coverage for AI/ANs who are elderly or have certain disabilities. Reimbursements from Medicare serve as a critical funding source for IHCPs and have enabled the expansion of services in many areas. Because of this, strengthening and expanding Medicare reimbursements for services can protect the financial health of the Indian health system.

However, many Medicare policies do not align with the trust responsibility or fit the Indian health system, and the program itself lacks the kinds of protections the Medicaid program offers. This must change to provide equitable health care services to AI/ANs, who are owed health care by the federal government.

**Tribal protections in the Medicare program must be enacted. These include:**

- **Ensure** that the IHS Outpatient Encounter Rate is available to all Indian outpatient programs that request it.
- **Exempt** AI/AN beneficiaries from Medicare premiums and deductibles, similar to how Medicaid cost sharing is waived.
- **Permanently cover** all telehealth services permitted during the public health emergency, expand the types of services permitted to be conducted via telehealth, and expand the definition of permitted telehealth to include audio-only telephonic and two-way communication methods.
- **Improve** Medicare Part D by requiring plans to pay IHCPs without unlawfully imposing discounts as a result of an IHCP exercising its right to discounted pharmaceuticals under Section 340B or federal supply schedule.
- **Require** all Medicare Advantage (MA) plans to automatically deem IHCPs as in-network even if they do not enroll in a provider agreement and reimburse IHCPs at the OMB encounter rate. This automatic deeming and rate-setting should not supersede rates that an IHCP has negotiated and prefers over the OMB encounter rate.
- **Require** Medicare to reimburse IHCPs for 100% of the calculated cost of their services.
- **Include** Pharmacists, Certified CHAPs, Behavioral Health Aides/Practitioners, Dental Health Aide Therapists (DHATs), and other providers as eligible provider types under Medicare for reimbursement for all Medicare-covered services that are within the scope of their licensed or certified practice under applicable state, federal, or Tribal laws.
- **Create** a dental benefit under Medicare that does not require enrollment in managed care.

# 8TH REQUEST

## ALLOCATE Special Initiative Funding through Indian Self-Determination and Education Assistance Act Agreements through Contracts and Compacts

**T**ribal Nations are sovereign governments, not grant recipients, and maintain a unique legal and political relationship with the United States as defined by the U.S. Constitution, treaties, statutes, court decisions and regulations. Therefore, federal funding must be delivered in a manner that reflects this relationship: directly, consistently, and predictably. To uphold its trust and treaty obligations, IHS funding must be mandatory rather than discretionary, and Tribal Nations must have the option to accept all federal funding directly via streamlined channels, such as ISDEAA agreements. Reliable and consistent funding is essential to support long-term strategies addressing the complex and chronic needs of AI/ANs. In stark contrast, grant programs are temporary, unreliable, non-recurring, and lack the flexibility necessary to address the ongoing, critical needs of Tribal communities.

Utilizing grant mechanisms to deliver on the United States' trust and treaty obligations undermines the unique priorities and individual responsibilities of each Tribal Nation. It also forces Tribal Nations to compete for limited resources. This creates categories of Tribal Nations: those that have the staffing, technical experience, and financial resources to secure and manage competitive awards, and those that do not. Often, those that do not are the ones that would benefit the most from additional funding. Frustratingly, grant funding typically comes with excessive reporting requirements, means testing, and overall administrative burdens which fail to honor Tribal sovereignty and the unique nature of the federal trust and treaty obligation.

ISDEAA agreements offer a more effective alternative by streamlining administrative processes for both Tribal Nations and the IHS. Funding can be distributed more efficiently, with reduced federal oversight. Tribal Nations operating under ISDEAA agreements remain accountable through the Single Audit Act, which provides comprehensive, independent review of financial management and compliance. These agreements also provide the opportunity for Tribal Nations to recover costs for oversight and management without reducing direct care through contract support costs (CSC) funds. Today, grants only allow for indirect costs, which can reduce direct care and services supported by granting mechanisms.

Despite Congressional directives, agencies like IHS continue to distribute some appropriations increases through grants to “track the outcomes and performance of these funds to demonstrate the effectiveness of critical investments.” The agency has also continued to distribute decades-old funding increases through grant mechanisms, even though Tribal Nations overwhelmingly support streamlined and formula-based distributions in Tribal consultation and public comments. Each grant program creates and supports federal administrative positions that, should distributions be made through ISDEAA agreements, would reduce federal bureaucracy and allow essential programs and services to be more efficient and effective using less resources when administered via ISDEAA agreements.

For example, in its April 7, 2025, Dear Tribal Leader and Urban Indian Organization Letter, IHS announced



that it would be continuing the practice of issuing seven behavioral health programs via the competitive grant funding mechanism. Of the \$59.5 million allocated, only \$43.9 million is provided to Tribes, Tribal organizations, and urban Indian organizations; the remaining amount, or 26% of total annual funding, is used for grant management support at the IHS. This decision forces Tribal Nations to compete against each other for each separate grant, even though all experienced critical behavioral health and alcohol and substance abuse crises. Although IHS has proposed that competitive grants reach the communities of most need, this is not true. Instead, many Tribal Nations in need lack the capacity to apply for such programs.

The federal trust and treaty obligations to fund health-care and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian

Country was never meant to be contingent upon the quality of a grant application. Yet that is the construct that the federal government has forced Tribal Nations to operate under. Tribal Nations are sovereign governments, and funding for Tribal Nations, our citizens, and communities, is provided in fulfillment of legal and historical obligations. As a result, those federal dollars should not be subject to an inappropriate, grant-based mentality that does not properly reflect the diplomatic relationship between Tribal Nations and the federal government.

The NTBFW therefore recommends that United States uphold its trust and treaty responsibilities and distribute funding for all ongoing health services in FY 2028 directly through ISDEAA agreements using a fair and equitable formula. This will ensure sufficient, recurring, and sustainable funding for Tribal Nations, reduce federal administrative costs, and better meet the federal government's trust and treaty obligations to Tribal Nations.

# 9TH REQUEST

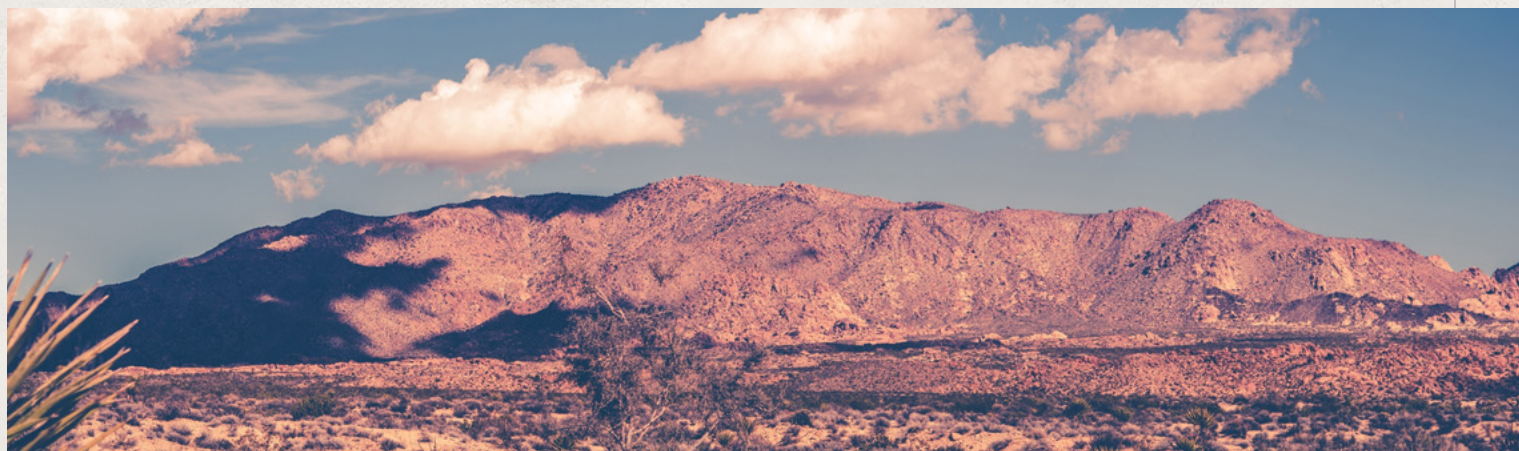
## In Consultation with Tribes, Provide IHS the **AUTHORITY TO REPROGRAM FUNDING** to Efficiently Use Federal Dollars for its Direct Programming

**T**he IHS receives funding through federal appropriations from Congress for the provision of health services. Funds allocated to the agency are then distributed through several different mechanisms, including IHS Area Offices, Tribal self-determination contracts and self-governance compacts under ISDEAA, Urban Indian Organizations, and to federal service unit facilities. At issue is the ability of the federally operated healthcare facilities and IHS headquarters to use federal dollars efficiently and adjust programmatic funds across IHS accounts, especially at the local service unit level.

Current appropriations law often creates a barrier for the IHS to fully utilize authorized annual funding. For FY 2019 and FY 2020, the IHS was granted two-year authority to obligate/re-obligate funding, which has provided some needed flexibility to utilize its appropriation fully

and efficiently. However, additional flexibility is still needed to allow the IHS the ability to reprogram funding if savings are achieved in one fund. For example, programs such as PRC severely lack funds to meet critical health needs, and services are often deferred or denied due to lack of funding. Such programs can benefit from reallocation of savings or reprogramming or transfer of appropriations to provide continued health services.

Fundamentally, the ability to direct resources is one of Tribal sovereignty and self-determination. Just because a Tribe chooses to receive direct services from IHS does not mean it forfeits these rights. The workgroup requests that IHS be granted greater budget flexibility, especially at the local service unit level, to reprogram or transfer appropriations to meet health service delivery priorities, in consultation with the Tribes who receive services from that share of the IHS funding.



# 10TH REQUEST

## Provide Meaningful, Recurring, and non-Competitive **DEDICATED SET-ASIDES** Across HHS for Tribes, Tribal Organizations, and Urban Indian Facilities to Build Tribal Public Health Infrastructure and Expanding Capacity

**A**dvancement in AI/AN health outcomes continues to be limited by the aging and insufficient public health infrastructure available to Tribal Nations. The Workgroup requests recurring funding and flexible authority to support the development and strengthening of Tribal public health infrastructure. Currently, the IHS, Tribes, and Urban Indian facilities do not receive dedicated public health funding from many agencies within the HHS. The IHS can only provide limited public health and emergency preparedness infrastructure funding, and those resources are restricted to IHS and Tribal clinics.

In recent years, flexible supplemental funding to develop and expand public health infrastructure in the Indian health system has demonstrated the importance of allowing Tribal health systems to determine how to best address the needs of their communities. Flexible spending extends the timeline for utilizing

funds and allows the Indian health system to spend dollars where they best see fit. When Indian health systems have the authority to direct resources locally, they can invest in prevention programs, disease monitoring and tracking systems, and other locally tailored public health initiatives. This flexibility enables Tribal clinics to develop unique public health solutions for their local communities that reflect specific geography, governance structures, and health priorities. This unique health care model is so successful that it is often replicated by local and state health jurisdictions to improve prevention and treatment efforts across the nation.

As sovereign governments, Tribal Nations possess inherent authority and responsibility to meet the healthcare and public health needs of their citizens. Federal agencies across HHS, including CDC, SAMHSA, the Administration for Children and Families, and HRSA, must more consistently recognize this status. Too often, we see federal funding opportunities

<sup>91</sup> As of 2021, there are 574 federally recognized Tribes with a Census-estimated population of approximately 7.2 million in 2021. In 2019, the Bureau of Indian Affairs stated that 70.2 million acres are recognized as Tribal lands.

<sup>92</sup> Written Testimony of Patrice H. Kunesh, Director, Center for Indian Country Development, Federal Reserve Bank of Minneapolis, before the United States Senate Committee on Indian Affairs, *Lending Opportunities: opening the Door to Homeownership in Indian Country*, October 16, 2019, accessed on: February 6, 2024, available at: <https://www.indian.senate.gov/wp-content/uploads/10.16.2019%20%20Kunesh,%20Patrice,%20Testimony%20CICD,%20MPLS%20Fed,%20SCIA%20%20-%20Final.pdf>.

<sup>93</sup> *National Congress of American Indians, Tribal Nations and the United States: An Introduction*, updated February 2019, accessed on: February 6, 2024, available at: [https://archive.ncai.org/tribalnations/introduction/Indian\\_Country\\_101\\_Updated\\_February\\_2019.pdf](https://archive.ncai.org/tribalnations/introduction/Indian_Country_101_Updated_February_2019.pdf).

<sup>94</sup> For example, the Jay Treaty of 1794 grants certain tribal citizens on the U.S.-Canada border the right to pass and repass the border.

prioritize state and local governments while excluding Tribes from direct partnerships from grant notices. For jurisdictional comparison:

- Tribal Nations all together would represent the 15th most populous state in the United States with the 8th largest landmass.<sup>91</sup>
- Collectively, Tribes are the 13th largest employer in the United States, employing both Native and non-Native citizens and contributing significantly to regional economic growth.<sup>92</sup>
- Approximately 260 miles of Tribal lands share an international border (for context, about 100 miles longer than California's border with Mexico<sup>93</sup>) and some Tribal citizens maintain treaty rights that permit cross-border travel and related legal rights.<sup>94</sup>
- Tribal governments manage complex transportation and infrastructure systems, including airports, ferry operations, U.S. waterway transportation, international shipping and economic activity.

Despite this scale and responsibility, Tribes are frequently excluded from major federal public health infrastructure investments. For example, in 2024 the CDC awarded \$4.3 billion through the Public Health Infrastructure Grants, one of the largest investments in the national public health capacity. Yet Tribes were left out of this funding opportunity, despite Tribal leaders being informed that these resources would be routed through the IHS. This process continues to reinforce a persistent inequity where states and local governments receive direct support to build public health infrastructure, while Tribal Nations remain excluded despite our sovereign governmental status. Congress and HHS must entirely rethink these funding structures to ensure Tribal Nations are fully integrated as they work to improve the public health of the whole country.

The United States treaty and trust obligations to Tribal Nations are not singularly contained within one federal agency, and the IHS cannot carry that burden

of meeting these obligations exclusively. HHS can meaningfully advance the health status of AI/ANs by ensuring dedicated and recurring resources for Tribal public health capacity and infrastructure development, greater flexibility and Tribal control in public health programs for Indian Country, the conduction of meaningful Tribal Consultation, and direct federal investment in Tribal public health infrastructure that upholds trust and treaty obligations.

#### **EXPANSION OF TRIBAL SELF-GOVERNANCE AT HHS:**

The Department should work with Tribal leaders and the Secretary's Tribal Advisory Committee (STAC) to expand Tribal Self-Governance in Indian Country and across HHS. For decades, Tribes have requested that HHS collaborate with us to craft a strong plan to support and implement Tribal Self-Governance expansion. Advancing this effort would better align federal programs with Tribal sovereignty and improve the effectiveness of programs serving Tribal communities.

#### **TRIBAL FUNDING SET-ASIDES AND DIRECT FUNDING:**

While full Tribal Self-Governance expansion remains the goal, the process may take time. In the interim, we implore the Department to ensure Tribal set-asides are included for all federal programs that serve Indian Country and that Tribes can access this funding directly and not solely through the states. HHS must include broad Tribal access and eligibility to all programs serving Tribal communities.

This also includes key block grants currently administered by states, such as the Community Mental Health Services Block Grant, the Substance Use Prevention, Treatment, and Recovery Services Block Grant, the Preventive Health and Health Services (PHHS) Block Grant Program, and the Title V Maternal and Child Block Grant. Where statutory authority may not exist for direct Tribal funding, we ask that HHS include proposals to authorize such funding to these programs through the A-19 budget recommendation process.

# 11TH REQUEST

## ENSURE the Office of Management and Budget Meaningfully Engages with the Tribal Budget Formulation Workgroup

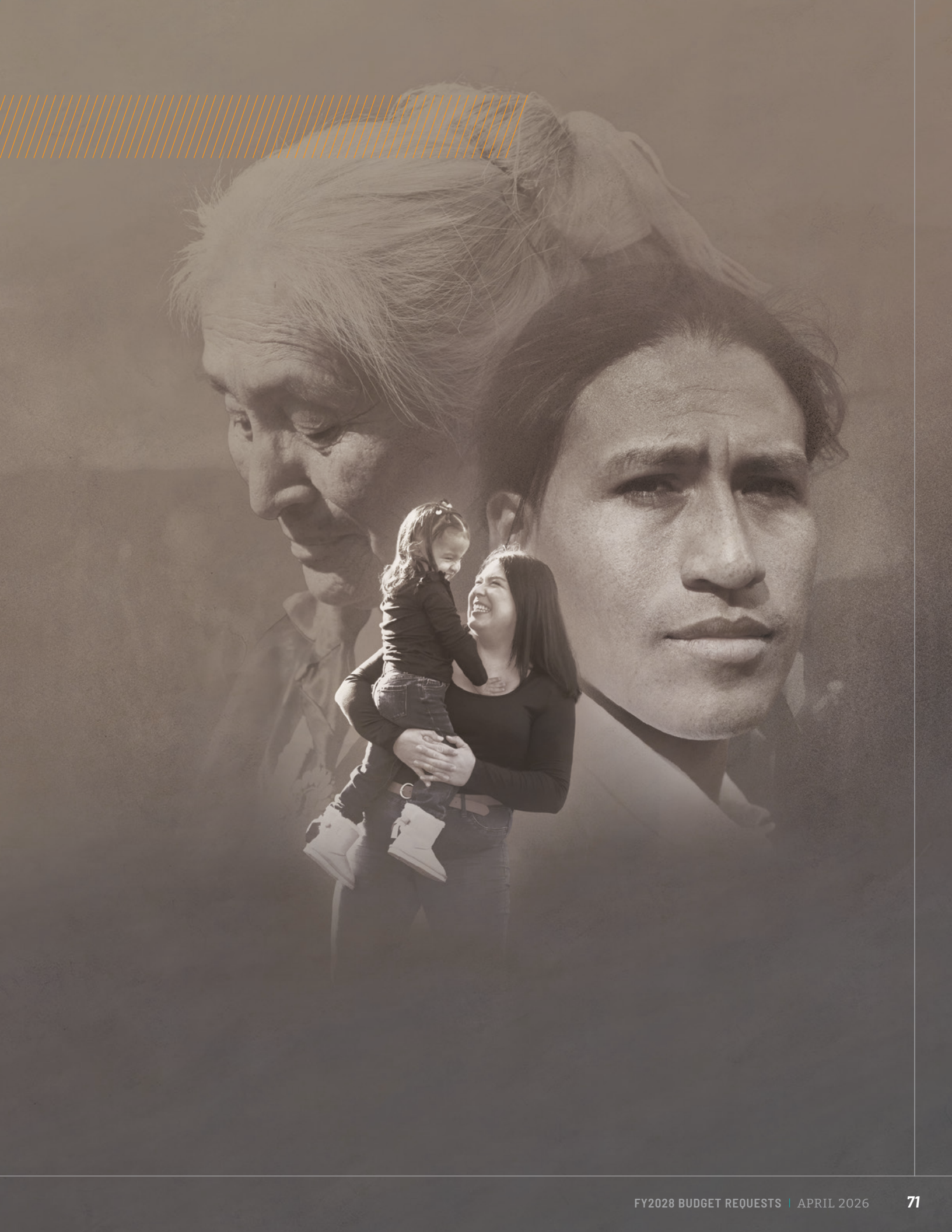
**I**t is necessary for the OMB to honor the government-to-government relationship by engaging directly with Tribal Nations during the Tribal Budget Formulation. Direct and meaningful engagement between the OMB and Tribal Nations can improve transparency and efficiency when developing the Tribal Budget Formulation and ultimately strengthen our partnership.

Under President Trump's first term, the Administration honored Tribes, Tribal sovereignty, the government-to-government relationship, and the federal trust responsibility. OMB should reaffirm the unique treatment, programs, and services to Tribal Nations by working directly with Tribes during the implementation of the Tribal Budget Formulation, based on Tribes' political and legal status as sovereign nations. The Indian health system experiences dire consequences when federal funding is frozen, paused, or eliminated. Improved relationships between OMB and Tribes can help avoid

confusion and disruption in the future.

To improve transparency with Tribal Nations, the Workgroup recommends the OMB maintain the operation of the Tribal Advisor to uplift the funding priorities of Tribal Nations directly to the OMB Director. Both emerging governance issues and ongoing government efficiency underscore the need for permanency in the Tribal Advisor's position to the OMB Director. The Workgroup also recommends that OMB create a Tribal Advisory Committee (TAC) to ensure consistency for Indian policy in all government matters. The TAC would be able to provide a wide-ranging perspective to OMB as they uphold presidential policies that have countless impacts on Tribal Nations and AI/AN people.

The treaty and trust obligations to the Tribes are not, and should not, be compartmentalized. Instead, having OMB expertise present and participating in meaningful national budget formulation is a step toward honoring those obligations.



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AND HOT TOPICS**