DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECRETARY'S TRIBAL ADVISORY COMMITTEE

March 21, 2017

The Honorable Tom Price
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Secretary's Tribal Advisory Committee Follow up items from March meeting

Dear Secretary Price,

On behalf of the Secretary's Tribal Advisory Committee (STAC), we thank you and your staff for the productive meeting that was held from March 7-8, 2017. We appreciate your commitment to Indian Country and recognition of the value of partnership with the Tribes as the Department of Health and Human Services (HHS) moves forward under this new administration. We look forward to continuing to meet with you and agency leadership to hear our concerns and address key issues in a responsive and transparent manner.

The following letter presents the STAC's key priorities for this year and provides more information on some of the topics we discussed in March. We hope to work with you to advance these issues in a collaborative and meaningful way.

Continued Commitment to Tribal Consultation and Nation-to-Nation relationship between Tribes and the United States.

The principles that shape American Indian law are sovereignty, the Federal-to-Tribe (government-to-government) relationship, and the "Trust Responsibility" of the U.S. Government to Indian Tribes. Indian Tribal governments are indigenous governments that possess a unique government-to-government relationship with the United States. Indian Tribes are part of the constitutional structure of government. Tribal authority was not created by the Constitution—Tribal sovereignty predated the formation of the United States and continued after it (Article 1, Section 8, Clause 3 of the U.S. Constitution). "*Indian relations are … the exclusive province of Federal law*." (County of Oneida v. Oneida Indian Nation, 470 U.S. 226, 234 (1989), making the unique status of Indian Tribes and the government-to-government relationship with the Federal Government clear.

The U.S. Supreme Court has repeatedly recognized Tribal sovereignty in court decisions for more than 150 years. In 1831, the Supreme Court agreed, in Cherokee Nation v. Georgia, that Indian nations had the full legal right to manage their own affairs, govern themselves internally, and engage in legal and political relationships with the federal government and its subdivisions. In 1942 Supreme Court Justice Felix Cohen wrote, "*Indian sovereignty is the principle that those powers which are lawfully vested in an Indian tribe, are not delegated powers granted by express acts of Congress, but rather inherent powers of a limited sovereignty which can never be extinguished*."

Tribal governments' special political status is not that of a racial or ethnic group, nor are they associations or affiliations. Accordingly, the federal government has a duty to consult with Indian Tribes on federal policies with implications for the Indian health care delivery system. This consultation requirement, rooted in Tribal sovereignty, treaty rights, the government-to-government relationship, and the Trust responsibility, is reflected in federal policy and is confirmed in the HHS Tribal Consultation Policy.

- Tribes must have timely written notice before the federal government can move forward with new policies that have Tribal implications. Tribal implications refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effect on one or more Tribes, on the relationship between the federal government and Tribes, or on the distribution of power and responsibilities between the federal government and Tribes.
- Consultation must take place prior to the rulemaking process.
- Continue to meet with the STAC and other Tribal advisory committees within HHS to gather feedback and input on the development of policies that impact Tribal communities.
- The White House Council on Native American Affairs should continue to work on Health and Human Service issues and we welcome your support in working with other departments across the federal government to address American Indian and Alaska Native health challenges.

Challenges for Federal Funding for Indian Health Beyond IHS including Administration for Children and Families (ACF)

Tribes and Tribal organizations receive a disproportionately low number of Department of Health and Human Services (HHS) grant awards. For instance, while Tribal children make up 2% of the United States population, Tribes receive less than 0.5% of federal child welfare funds. Several significant obstacles impair Tribes' ability to receive adequate funds for these programs.

First, program funding awards are predominately made by competitive grants, which prejudices against Tribes with less capacity to compete for funds, and requires finite terms in the award of funds that interrupts the delivery of program services and discontinuity in program effectiveness.

Second, programs predominately require large matching contributions of non-federal shares by Tribal governments, ranging from 20% to 50% of the funding award. Many Tribes have limited or no discretionary, unencumbered Tribal funds sufficient to provide the required contribution. Tribes should not be required to contribute such a large amount of its own funds to operate federal programs that are a duty of the federal trust responsibility. For example, the Child Support Enforcement program requires Tribes to contribute up to 20% of the program award.

Third, certain federal programs limit the recovery of indirect costs against program funds to a small percentage that in almost all instances is much less than the Tribes' indirect cost rate percentage that requires full recovery at the federally approved rate or else Tribes must reconcile the shortfalls of recoveries from their own funds. For example, the TANF program "caps" indirect rate recoveries at 20%, when Tribal indirect cost rates are mostly well above this percentage.

Fourth, block grant funds typically flow directly to states who then must pass funding on to Tribes. Sadly, these funds often do not make it to the Tribal level. According to a report issued by the Congressional Research Service (CRS) in June 2013, there are 22 funded block grants. HHS administers 10 of these

programs, but where states must "pass through" funds Tribes are often left out, despite eligibility. For example, Tribes are eligible to receive the Preventative Health and Health Services Block Grant, Administered by the Centers for Disease Control and Prevention (CDC). It funds all 50 states, eight U.S. territories, but only two Indian Tribes. In several block grants, Tribes are not eligible to receive any federal funds, such as the Social Services Block Grant and Community Mental Health Services Block Grant, and few, if any, states actually pass through any funds to Tribes while using their numbers to establish their federal allocation. Without having a state intermediary, Tribes would not only receive more adequate funding but could more easily tailor program needs to their people. Therefore, we request that HHS:

- Provide an administrative waiver of support legislation to remove statutory requirements for competitive grants, Tribal non-federal contributions to program awards, and limits on Tribal direct cost rate percentages against program funds.
- Work with Congress to ensure that health and human services programs throughout HHS have set-asides for Tribes and Tribal organizations, and increase the Tribal set-aside for Child Care.
- Facilitate and require that states receiving federal funds engage in Tribal consultation prior to the submission of state grant proposals to the federal government.
- Despite having some of the worst health disparities in the country, many Tribes are under-resourced to search for and apply for federal grants, whereas states and local governments often employ hundreds of staff to seek funding opportunities. We ask that you take the limited capacity of Tribes into consideration when reviewing grant applications across all agencies at HHS.

Expansion of ISDEAA Self-Determination Agreements and PL 477

The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1974, and 1995 amendments, is the basis for the most successful federal Indian policy of modern times by authorizing Tribal governments' self-governance compacts and 638 contracts of federal programs. While ISDEAA compacts and contracts are mandatory within the Bureau of Indian Affairs (ISDEAA Title IV) and Indian Health Service (ISDEAA Title V), it is discretionary for the Department of Health and Human Services outside of IHS. Similarly, PUBLIC LAW 102-477 allows Federally Recognized Tribes and Alaska Native entities to combine Federal employment and training formula-funded grant funds. Tribes and the STAC have long advocated for HHS interpretations that would add programs to the PL 477 program, such as Low Income Heating Energy Assistance Program (LIHEAP). Therefore, we request that HHS:

- Add ACF programs to ISDEAA compact or 638 contract agreements.
- Add LIHEAP, Head Start and other related programs to the PL 477 program.

Assistance in Treating Opioid Abuse and Addiction

Opioid abuse and addiction is a growing national epidemic in the United States and Indian Country is no different. However, due to the chronic underfunding of the Indian Health Care Delivery system, Indian Country does not have access to the same resources that the rest of the country has to combat this serious epidemic. Drug-related deaths among American Indians and Alaska Natives is almost twice that of the general population.

- Does HHS have a plan to address the opioid epidemic in Tribal communities? If not, STAC would like to work with HHS to develop one.
- How will HHS ensure that funding and resources meant to address the national opioid epidemic reach Tribal Communities? Both for programs where Tribes are specifically authorized as grantees, and ones where they are not.
    - How will HHS require States to consult with and involve Tribes as they work on these issues?
- We suggest that HHS lead an effort with IHS, CDC, SAMHSA, NIH, and Tribes to develop a demonstration project targeted for Tribal communities and addressing opioid abuse and addiction in particular using the consolidation of funding tools established as successful with the 477 program.

Quality Care Challenges at IHS

Several Indian Health Service (IHS) operated hospitals continue to experience serious violations of patient welfare and safety which not only endangers lives of patients but also results in but diminished care and loss of critical third party revenues. In fact, some of these deficiencies have been identified for years, but the situation in certain IHS-operated facilities has not improved. This situation is unacceptable to the STAC and we urge you to do all in your power to see these situations rectified immediately. Recently, Senator Rounds introduced legislation to provide for a comprehensive audit of the Indian Health Service. In addition, the GAO recently released a report adding IHS to the list of high-risk agencies. While we appreciate the federal government's interest in addressing some of the challenges at IHS, we urge strong caution and request that Tribes be consulted in these efforts moving forward so that effective and lasting change occurs.

- What is the plan for HHS to provide leadership to address some of the quality care issues happening at IHS?
- How is IHS working to directly answer questions posed by Tribes and Congress concerning its efforts in the Great Plains Area?
- Tribes in the Great Plains Area have also been asking for a detail breakdown of the Tribal Shares allocation for every facility in the region since early 2016. Each Tribe has provided a request to IHS to release this information. Yet, IHS still refuses to provide this information. As Tribes in this region consider moving to self-governance, it is critical that this be shared immediately
- What are HHS and IHS doing to ensure that the staffing needs of the Great Plains Area are met as soon as possible at both the executive and service unit level?
- While the STAC appreciates the exemptions for some IHS positions from the federal hiring freeze, we request that exemptions also be provided for some of the high level administrative positions including the Area Directors in order to provide stable leadership during this time of reform at the agency. Further the resources required for the Area Directors to conduct Tribal consultation is an important and relevant requirement and should not be diminished.

Continued Support for SDPI

The Special Diabetes Program for Indians (SDPI) was started in 1997 to provide funding to IHS, Tribal health programs, and Urban Indian Programs to implement interventions which reduce risk factors for

diabetes and its complications, including End-Stage Renal Disease. The program has proven a success and today this comprehensive public health-oriented national program has shown great strides in treating the diabetes epidemic and reducing complications from End-Stage Renal Diseases. In January, the CDC released its Vital Signs Monthly report where they found that between 1996 and 2013, among AI/AN adults with diabetes, End-Stage Renal Disease incidence decreased by 54%, which is the biggest driver of Medicare costs. SDPI is a model program that demonstrates the effectiveness of collaboration between Tribes and IHS by being community-driven and culturally appropriate. Its success cannot be denied and its operation should be continued and modeled by other programs.

- SDPI is set to expire on September 30, 2017. We request that HHS work with Congress to ensure that this legislation is renewed.
- SDPI is an example of true Tribal consultation and collaboration and we request that HHS use it as a model for other programs to address the extreme health disparities suffered by AI/ANs.

Maintain Medicaid Payments and Protections for Tribes and American Indians and Alaska Natives

In 1976, Congress amended the Social Security Act to authorize Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated health care facilities, recognizing that the trust responsibility for health was not limited to just the Indian Health Service but extended to the entire federal government. Medicaid reimbursements are critically important in filling the gap created by chronic underfunding of IHS, and are a critical source of funding for IHS, Tribal health programs and Urban Indian health programs. While we understand that any changes to the laws authorizing these health insurance programs are done through Congress, we appreciate the federal government's commitment to honoring its trust responsibility in advocating for American Indian and Alaska Native protections and trust that HHS, as well as CMS, will consult with Tribes on any changes in regulations and policies.

- Retain eligibility under Medicaid to all American Indians and Alaska Natives up to 138% of the Federal Poverty level (FPL).
- Maintain or strengthen affordability of individual market (e.g. Marketplace) coverage for American Indians and Alaska Natives.
- Ensure the trust responsibility for Indian health care remains a federal responsibility and is not shifted to the states.
- Maintain 100% Federal Medical Assistance Percentage (FMAP), plus the reimbursement rates for services at the OMB rates published annually in the Federal Register for inpatient and outpatient facilities and give full effect to CMS's recent State Health Official Letter
- Ensure Medicaid payments to the Indian health care system are not subject to a block grant or per capita cap.
- Preserve American Indian and Alaska Native specific provisions in Medicaid, including protections from premiums and cost sharing, prohibition of classifying trust lands and cultural and religious items as resources for eligibility purposes, and other protections.
- Extend and apply these provisions to urban Indian health care programs (UHPs) whenever permissible under federal law.

Conclusion

In conclusion, we would like to reiterate our appreciation for your willingness to work with us and for your prioritization of issues in Indian Country. We look forward to continuing a strong relationship with you and to hearing your response to these requests.

Sincerely,

Chester Antone
Chairperson
Secretary's Tribal Advisory Committee