April 6, 2018

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

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

Dear Secretary Azar:

On behalf of the Secretary's Tribal Advisory Committee (STAC), we welcome you to your new role as Secretary within the Department of Health and Human Services. We are confident that your background of government service will be a valuable asset in furthering the HHS's mission of providing quality health care services for American families and communities.

By way of introduction, the STAC is an intergovernmental forum intended to facilitate meaningful dialogue between Tribal leaders and federal health officials on the administration of HHS programs. The STAC provides a space for federal and Tribal leaders to exchange ideas, seek consensus, share information, and provide advice on the effective use of federal resources and federal-Tribal partnerships to best serve the needs of Indian Country. Meetings of the STAC are convened on a quarterly basis in Washington, D.C. We look forward to speaking with you and the HHS administration at our next regularly scheduled meeting on May 9-10, 2018.

The following letter presents the STAC's key priorities and provides more information on some of the topics we discussed in January. 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 United States has a unique legal and political relationship with American Indian and Alaska Native Tribal governments established through and confirmed by our Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities. Meetings of the STAC help fulfill these unique obligations to Indian Tribes by reinforcing the Federal Government's commitment to work with Tribes on a government-to-government basis, however meetings with the STAC are also not a substitute for Tribal Consultation. As such, meaningful consultation must take place prior to the development of any policy or rulemaking that has a significant impact on Tribes. We have worked hard to develop cooperative relationships with the agencies and bureaus of the Federal Government and to serve as a reliable partner in the effective management of HHS resources and programs. Over the past decades, Tribes have successfully crafted our own health systems that are innovative and deliver high

quality care. We look forward to continued partnership with the Department to strengthen our health systems and we ask for your continued commitment as well.

- 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.
- Use the STAC and Tribal Nations as a resource to find solutions to the health care needs of American Indians and Alaska Natives.
- Engage with Tribal nations through meaningful consultation early in the development of policy, prior to rulemaking.

Exemption of Indian Health Service Beneficiaries from Work Requirements and Community Engagement Requirements

In a January 17, 2018 Dear Tribal Leader Letter (DTLL) CMS indicated that it cannot exempt IHS Beneficiaries from Work and Community Engagement Activities due to "civil rights concerns." For several years now, dating back to the last Administration, Tribes have had to address vaguely defined "civil rights concerns" that have been raised to block important Tribal policies sought by CMS and other divisions of HHS. Apparently, these concerns have been raised by individuals in the Office of Civil Rights, but those concerns have never been explained or defined, nor has the Office of Civil Rights provided any legal authority in support of that position. There is an entire body of Indian law that recognizes the unique legal obligations of the United States to Indian Tribes, and recognizes that both Congress and the Executive Branch may make special accommodations for American Indians and Alaska Natives without running afoul of civil rights laws or the Equal Protection Clause. When such actions are rationally related to the United States' unique obligations to Indians, they do not constitute impermissible racial classifications and are subject to rational basis scrutiny, not strict scrutiny. We are concerned that by disregarding this authority, and applying what appears to be strict scrutiny, the Office of Civil Rights is disregarding the longstanding legal and political distinction that governs the relationship between Tribes and the United States and which has been recognized by the courts. We continue to request the following:

- Exempt IHS Beneficiaries from Work Requirements and Community Engagement Activities.
- Engage with Tribes and the HHS Office of Civil Rights on these vaguely defined "Civil Rights Concerns."
- Reinforce that the federal government may lawfully carry out its trust responsibility by singling out Indians and Indian Tribes for special treatment.
- CMS and HHS have a duty to accommodate Indian interests in administering federal statutes.
- 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.

Assistance in Treating Opioid Abuse and Addiction

While addressing the opioid epidemic continues to be a nationwide priority, American Indians and Alaska Natives (AI/ANs) are at disproportionate risk of death and complications due to opioid misuse. For example, American Indians and Alaska Natives face opioid related fatalities at three times the rate of

Blacks and Hispanic Whites[1]. In 2011, the CDC reported an opioid overdose rate of 8.4 per 100,000 for American Indians and Alaska Natives, second only to Non-Hispanic Whites[2]. As sovereign nations, Tribes are not systematically included within statewide public health initiatives such as the recent prevention and intervention efforts created through the new state opioid crisis grants.

In order to ensure a truly robust and effective federal, state, Tribal, and territorial public health response to opioid misuse, federally recognized Tribes and Tribal organizations must be directly eligible for these resources. As independent, sovereign nations, Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Tribal Nations are frequently left out of state and local public health efforts, and it is critical that at least a portion of these dollars flow directly to Tribal Nations to ensure that Tribes and their citizens have the resources to create and direct their own prevention and treatment efforts in locally responsive and culturally appropriate ways.

- The IHS established the National Committee on Heroin, Opioids and Pain Efforts (HOPE) in March, 2017. What have been some of the projects and outcomes of this committee, and how has it furthered IHS' efforts in reducing opioid related deaths in Tribal communities?
- The IHS entered into a memorandum of understanding (MOU) with the Bureau of Indian Affairs (BIA) in 2015 to arm BIA officers with opioid overdose rescue kits that contained naloxone. According to the IHS blog dated September 21, 2017, only 284 BIA officers have completed the training. With the unprecedented number of opioid overdose deaths stretching across Indian Country, how, specifically, is the IHS planning on increasing the quantity of trained BIA officers? In addition, how will the IHS plan on expanding naloxone trainings to other first responders, providers and community health workers so that a variety of personnel are able to respond in the case of an overdose?
- As you know, data is the backbone of public health. Without accurate, complete and timely access to data, Tribal Nations and organizations are not able to make a comprehensive assessment of need, determine where resources are needed most, or what sorts of interventions to employ. Lack of data has been especially prohibitive for Tribes' ability to respond to the opioid crisis. In consideration of this, can you shed some light on why Tribal behavioral health data is partitioned off and not included within the EpiData Mart at the IHS National Data Warehouse?
- Gathering and using the best available data can be a challenge for Tribes and Tribally led organizations. Tribes face barriers related to: the multiple systems where data on tribal citizens may be located; the lack of understanding about the status of tribes as governments and public health authorities; the misclassification of AI AN people; and national data sets that leave out tribal people altogether because of the small number of AI AN data, to name but a few barriers. What is CDC doing to assist in ensuring that Tribes have the data they need to make informed decisions and policy?

[1] Am J Public Health. 2014 June; 104(Suppl 3): S470–S480. Published online 2014 June. doi: 10.2105/AJPH.2013.301854

[2] Paulozzi, L. J., MD, Jones, C. M., PharmD, Mack, K. A., PhD, & Rudd, R. A., MSPH. (2011). Vital Signs: Overdoses of Prescription Opioid Pain Relievers --- United States, 1999--2008. Morbidity and Mortality Weekly Report (MMWR), 60(43), 1487-1492. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm

- Tribal governments are in the best position to inform your department on how to properly examine and interpret what is happening in our communities related to these issues and we request direct funding to address this epidemic in our community.

Health Workforce Development

The Indian Health Service and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: Physicians 34%; pharmacist 16%; nurse 24%; dentist 26%; physician's assistant 32% and advanced practice nurse 35%. Current vacancy rates make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners is at an all-time high, the situation is unlikely to improve in the near future. What we do know, is that the IHS has been unable to meet the workforce needs with the current strategy and IHS must improve its ability to address workforce challenges if the care needs of AI/ANs are going to be met.

The current IHS workforce development relies primarily on recruiting non-Indians through the loan repayment program, but those dollars are limited. A much more viable solution is to recruit native youth to enter into medical school. They are much more likely to return to and serve in native communities than non-native counterparts. Additionally, the care provided by Indian medical professionals result in more culturally informed care for all AI/ANs. However, the trend in AI/ANs going to medical school is alarming. In 1977, there were 124 AI/AN applicants to medical school, but by 2011 that number had shrunk to 101 – an almost 20% decrease. Perhaps more alarming is that only 20 out of 18,705 medical school graduates were AI/AN in 2015 – about 0.1%.

- A top priority for Tribes is the recruitment of permanent IHS leadership at Headquarters and regional offices. In the Great Plains Area, they have gone through multiple temporary regional directors, which impairs the administration of quality care to the Area and inconsistent policy making.
- HHS must work with Congress to develop programs targeted at native youth who are interested in becoming Medical professionals
- We request HHS to support proposals to provide medical professionals with more equitable pay and benefits in order to incentivize working for the IHS.
- We request the IHS loan repayment program have the same tax free status as the National Health Service Corps (NHSC).

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 make the following requests to HHS:

- We continue to request the addition of ACF programs to ISDEAA compact or 638 contract agreements.
- We continue to request the addition of LIHEAP, Head Start and other related programs to the PL 477 program.

The Adoption and Foster Care Analysis and Reporting System (AFCARS) Final Rule Support

The STAC supports the 2016 Final Rule: Adoption and Foster Care Analysis and Reporting System (AFCARS) published in the Federal Register on December 14, 2016 (81 FR 90524). The final rule generally requires tribal and state Title IV-E agencies to collect and report data to ACF on children in out-of-home care and who exit foster care to adoption or legal guardianship, The 2016 regulations provide new data elements related to placement of American Indian and Alaska Native children who are in state care and the relationship of those placement activities to implementation of the Indian Child Welfare Act of 1978 requirements. At our January meeting STAC tribal leadership learned that DHHS had started a review process for the 2016 regulations on or before November 2017 to determine if the regulations should be re-opened for public comment. On March 15, 2018 ACF published a notice ordering a two year delay on implementation of the 2016 regulations and an Advance Notice of Public Rulemaking (ANPRM) seeking comments on streamlining the regulations. At the January meeting, STAC leadership urged the DHHS Secretary and ACF to not pursue streamlining of the regulations and to continue with the original implementation schedule.

We are concerned that DHHS did not inform tribes earlier about their intent to review the regulations or re-open them for public comment. Because there was no notice to tribes or attempt to seek tribal input we have serious concerns regarding the direction the proposed policy changes are leading. Significant streamlining of the data requirements for American Indian and Alaska Native families and children would continue a long history of the federal government not collecting important data on this population and enabling the continued disparate treatment of Native families and disproportional placement of Native children in state foster care systems. We strongly urge DHHS to hold regional consultation sessions developed in collaboration with tribal governments in each of the 12 Indian Health Services regions. Tribal governments need these to happen soon so they can provide informed comments to the ANPRM and discuss these issues with their state counterparts.

Conclusion

In conclusion 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