National Indian Health Board

October 26, 2017

John R. Graham,
Acting Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Request for Comments on the Draft Department Strategic Plan for FY 2018–2022

Dear Mr. Graham:

We appreciate the Administration's request for comments on the draft Department of Health and Human Services (HHS) Draft Strategic Plan for FY 2018-2022 but we have concerns over the lack of meaningful Tribal Consultation and request that Tribal consultation take place prior to the completion of a final plan.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self- Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

Background

The United States has a unique legal and political relationship with American Indian and Alaska Native Tribal governments established through and confirmed by the United States 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, including the provision of healthcare to American Indians and Alaska Natives.

Further, Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and permanently enacting the Indian Health Care Improvement Act (IHCIA).[1] In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[2] The Indian Health Service (IHS) was created in 1955 to assist the U.S. to fulfill its obligation to provide health care to AI/ANs. Twenty years later, Congress enacted the Indian Self-Determination and Education

[1] 25 U.S.C. § 1601 et seq
[2] Id. § 1601(1)

Assistance Act of 1975 to enable Tribes and Tribal Organizations to directly operate health programs that would otherwise be operated by IHS, thereby empowering Tribes to design and operate health programs that are responsive to community needs. Title V of the Indian Health Care Improvement Act authorized federal funding for urban Indian organizations to provide health services to AI/ANs, many of whom had been relocated to urban areas by federal relocation programs. Together, this complex healthcare system is often referred to as the "I/T/U" (IHS/Tribal/Urban) or Indian health system. A year later, the Congress authorized IHS and Tribal health programs to bill Medicare and Medicaid, which expanded the resources available to them to carry out the federal trust responsibility.

The I/T/U system utilizes a community-based public health model with many approaches that are not found in typical American medical delivery systems. For example, Indian health programs include public health nursing, outreach workers, prevention services, and even building community water and sanitation services. Many Indian health programs have pioneered new types of providers, such as community health aides and dental health aide therapists, as well as new approaches to delivering services in remote rural areas, including telehealth. Tribal governments manage a wide range of services, such as substance abuse treatment, the U.S. Department of Agriculture nutrition programs for pregnant women, infants and children, Senior Centers and elder nutrition sites, rabies vaccinations, and injury prevention programs, to name just a few. Tribal programs tend to take a more holistic view.

The obligation to provide healthcare to AI/ANs does not extend only to the IHS. The federal trust responsibility is the responsibility of all government agencies, including others within HHS. Agencies like the Centers for Disease Control and Prevention (CDC); Substance Abuse and Mental Health Services Administration (SAMHSA); and Centers for Medicare and Medicaid Services (CMS) all must play a crucial role in ensuring that Indian Country receives both preventative and direct access to health services. As such, NIHB and Tribes request that the HHS Strategic Plan comprehensively supports and track its success in promoting the health and welfare of American Indians and Alaska Natives across the United States.

Need for Meaningful Tribal Consultation

Meaningful Tribal Consultation is consistent with the unique obligations that the United States has with Indian Tribes by reinforcing the Federal Government's commitment to work with Tribes on a government-to-government basis. Tribes 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. As such, Tribes must have proper opportunity and notice to provide consultation and input on policies that have a significant federal impact on Tribes.[3]

In addition, according to sections 8 and 9 of HHS's own Tribal Consultation Policy, upon identification of an event significantly affecting one or more Tribes, HHS will initiate consultation regarding the event. Although, HHS began drafting its recommendations for the Strategic Plan in May, Tribes were never permitted to provide comments or consultation on the plan until after it was published in the federal register on September 27th, which is not consistent with Executive Order 13175 that requires Tribal consultation prior to the promulgation of any proposed rule.[4] Although, the HHS Strategic Plan is not a proposed rule, it will have a significant effect on Tribes across the country.

[3] Executive Order 13175, 65 Fed. Reg. 67249 (November 9, 2000).
[4] *Id.*

In addition, Executive Order 13175 requires agencies to engage in widespread Tribal consultation through timely written notice before moving forward with new policies that have Tribal implications:

> "Policies that have [T]ribal implications" refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian [T]ribes, on the relationship between the Federal Government and Indian [T]ribes, or on the distribution of power and responsibilities between the Federal Government and Indian [T]ribes.[5]

While we do appreciate the agency's attempt to gather Tribal input during two calls, on October 16th and 19th, there was not enough notice about the calls to properly get meaningful participation nor was there adequate notice. As such, we request an extension of the deadline to provide comments on the HHS Draft Strategic Plan or additional opportunities to provide meaningful input before the finalization of the FY 2018-2022 Draft Strategic Plan.

Tribal consultation is an open and continuous exchange of information that leads to mutual understanding and informed decision making between federal agencies and Tribal governments. Tribal consultation should occur at the earliest possible point in the policy formulation process. The HHS Strategic Plan needs to include as a goal or purpose of the plan is to ensure meaningful consultation with Tribes on policy and programmatic issues including, but not limited to eliminating health disparities of Indians and ensuring access to critical health services. The involvement of Tribes in the development of HHS policy allows for culturally appropriate approaches resulting in greater access to CMS programs and positive outcomes for Indian people and the health programs operated by the Indian Health Services, Tribes and Tribal Organizations, and urban Indian organizations.

The Strategic Plan needs to have Stronger Language around its Trust Obligation to Tribes

As discussed, 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[6] 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*

[5] *Id.*

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. As such, every time Tribes must be treated in parity with states. Therefore, every instance where the Strategic Plan speaks to supporting states, the plan must also include Tribal governments. Also of note, "Tribes" are referenced only one time throughout the whole Strategic Plan. When doing a search for "Indians," there are four instances but only one is in reference to American Indians and Alaska Natives. This lack of inclusion of Tribes and American Indians and Alaska Natives fails to account for Tribal priorities and needs and is not aligned with the federal government's trust responsibility. We recommend that Tribes and American Indians and Alaska Natives are referenced throughout the Strategic Plan that is reflective of the unique government-to-government relationship that Tribes have as well as the trust responsivity to provide healthcare for AI/ANs.

Raise the level of IHS engagement across the Strategic Plan

Throughout the Strategic Plan, the Indian Health Service (IHS) is not listed as a contributing OpDiv and StaffDiv to the same extent as other agencies. IHS services are linked to many disparity areas such as economic or social wellbeing, and communicable diseases yet is noticeably missing from agencies referenced on information technology and healthcare communication. IHS participation should be fully involved at all levels of HHS planning, organization, and operation. IHS must be listed as a contributing division in each of the goals and objectives, and especially all goals and objectives that relate to the provision of quality health care to AI/ANs. For example, Objective 1.2 says "focusing on populations at high risk for poor health outcomes." This statement clearly applies to the AI/AN population, but yet IHS is not listed under contributing divisions. There are other numerous places within the Strategic Plan where this is an issue and the Department should reconsider how to include IHS in a way that embodies the federal government's trusty responsibility to Tribes and AI/ANs.

Include modernization of the Health Information System and Telehealth infrastructure serving the Indian health care system as a clear Goal and Objective

The Resource and Patient Management System (RPMS) serves as the IHS electronic health record (EHR), but it has struggled to support the modern health information technology needs and mandates. This system is outdated. While IHS has begun exploring whether to update or replace the system, this process will be a multi-year endeavor. Including modernization of the Health Information system for IHS as a clear objective under goal 1 sends a clear message that this is a priority and is responsive to requests from Tribes.

The successful utilization of a variety of telehealth technologies and services in Indian country is well documented in the Tribal communities where they are being implemented. However, these successes were achieved on a largely regional basis, driven by visionary leaders, with various and not reliably sustainable funding sources. The IHS has not yet been systematically resourced to establish either a sustainable telehealth infrastructure or governance program that would prioritize resources in accordance with identified need, establish and promote best practices, and formally evaluate and report on successes and issues. In communities where it is available, however, telemedicine has allowed Tribal Nations to

dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary medivacs and expand local treatment options. This needs to be reflected as goal in the Strategic plan.

Specifically include objectives to promote the health care workforce for IHS

The Indian Health Service and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. 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%. An objective to recruit more AI/AN into the medical profession needs to be included in the Strategic Plan.

In addition, NIHB requests that the HHS strategic plan incorporate innovative models for superior delivery of oral healthcare services, specifically dental therapy. These midlevel providers, operating within a scope of practice that emphasizes preventative and restorative oral healthcare, have been serving Alaska Native communities since 2004 and have a proven track record of success and sustainability. Tribes over the past several years have increasingly voiced support and enthusiasm for bringing the model to the rest of Indian Country as a way to expand access to care and lessen disparities in oral health outcomes.

The National Indian Health Board's Tribal Oral Health Initiative has gathered qualitative and quantitative data on the causes and solutions to Indian Country's oral health crisis. Tribes across the country are struggling with a provider shortage, lack of resources and employment opportunities, and overall poor oral health outcomes (See Appendix A: Oral Health Comments). Dental therapy addresses each of these problems, and the model should be included in HHS's strategic plan to reform, strengthen, and modernize the nation's health care system.

Include the Tribal Impact in any Change to Centralized Business Practices

Several of the goals in the Strategic plan discuss streamlining business processes for the department. NIHB agrees that there are numerous processes that have become very bureaucratic and unnecessary. One example Tribes have experienced is when new funds are appropriated for the care of AI/ANs, that money is distributed by HHS agencies through grant programs, rather than direct distribution methodology to IHS site and Tribes. Self-Governance is a streamlined model that decreases bureaucracy and leverages federal funding to meet local need. Therefore, NIHB asks that all increases be directly distributed through

some agreed upon methodology to ensure the monies reach the local level so appropriate and enhanced health care can be provided to Tribal communities.

In addition, Tribes and Tribal organizations receive a disproportionately low number of HHS grant awards. One significant obstacle for Tribes to receive adequate funds for these programs is the fact that 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. 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. Without full-time grant staff, applications are often not funded and do not go to the areas with significant needs. 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. Without having a state intermediary, Tribes would not only receive more adequate funding but could more easily tailor program needs to their people. In the Strategic Plan, strategies and objectives need to effectively take into account Tribal capacity and needs when determining funding awards.

One other way to improve efficiency and outcomes is to expand the use of self-government agreements in HHS. For over a decade, Tribes have been advocating for expanding self-governance authority to programs in at HHS. Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level. This proposal was deemed feasible by a Tribal/federal DHHS workgroup in 2011. Therefore, in 2016, NIHB recommends that HHS utilize current administrative authority to expand self-governance within HHS through demonstration projects, and work with Congress to support the permanent expansion of Self-Governance.

Another example HHS may want to consider is encouraging agencies to pool funding between agencies to support health initiatives in Indian Country. IHS has seen success in developing sanitation infrastructure in Tribal communities through partnership with the Environmental Protection Agency (EPA). This interagency agreement could be a way to streamline the funding for other national initiatives like public and behavioral health.

Conclusion

We thank you for this opportunity to provide our comments and recommendations on the HHS Draft Strategic Plan for FY 2018-2022, however we remind the department that the public comment process is not a substitute for Tribal consultation. On behalf of all 567 Tribes, we request that Tribal consultation occur before finalization of the Strategic plan. We look forward to continue working with you to improve

the health of American Indians and Alaska Natives. Please contact NIHB's Director of Federal Relations, Devin Delrow, at ddelrow@nihb.org if there are any additional questions or comments raised in this letter.

Sincerely,

Vinton Hawley,
Chairman, National Indian Health Board

Attachment:

Appendix A: Oral Health Comments, *Dental Therapy as a Tribal Solution*

National Indian Health Board

Appendix A: Oral Health Comments

Dental Therapy as a Tribal Solution

Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System

As in other determinants of health, American Indians and Alaska Natives (AI/AN) rank at or near the bottom of other groups when it comes to oral health. Preschool aged AI/ANs have untreated tooth decay at four times the national average. The Indian Health Service (IHS), the primary agency by which the federal government fulfills its legal responsibility to provide Tribes with healthcare, spends only $99 per year per patient for oral healthcare. The national average is $272 per person per year.[1] While we agree that the need for additional resources to address oral health is necessary, it is also possible to improve oral health care using existing cost-effective models, and the HHS Strategic plan should prioritize this.

Tribes in several areas have utilized their rights as a sovereign nations to employ one of the most promising models for Tribes addressing oral health needs in their communities – dental therapy. These midlevel providers mirror physician assistants and nurse practitioners by bridging the gap in health care provision. Dental therapists perform routine services, with an emphasis on preventative and restorative care. These providers receive the exact same education as dentists do in the operations they are licensed to perform and operate under a dentist's general supervision. Currently, dental therapists operate in 54 countries, the state of Minnesota, and in Tribal communities in Alaska, Oregon, and Washington. Dental therapists will soon operate in Vermont and Maine, as those states have enacted authorizing legislation.

Dental Therapy as a Reliable, Accessible, Effective and Affordable Delivery Model

Tribes in Alaska have used dental therapists since 2004 as part of the Community Health Aide Program (CHAP). Dental therapists fly to the small, hard to access communities in rural Alaska and provide the services they are licensed to perform. Because the majority of patient needs are met by the dental therapist, the dentist can see a higher number of needy patients, practicing at the top of his or her scope and expanding access to dental care. This model's proven success is of particular interest to Indian Country, which suffers from a severe provider shortage. In the United States, a dentist serves 1500 people on average. In Indian Country, a single dentist serves 2800 people.[2]

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[1] The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children (Rockville, MD: U.S. Department of Health and Human Services, Indian Health Service, 2014). These figures refer to IHS fiscal year 2011 data and Medical Expenditure Panel Survey Household Component Data, 2009.

[2] The 1999 Oral Health Survey of American Indian and Alaska Native Dental Patients. Rockville, Md: Indian Health Service, Division of Dental Services; 2002:106
http://dhss.alaska.gov/dph/wcfh/Documents/oralhealth/docs/Oral_Health_1999_IHS_Survey.pdf

Dental Therapy is Reliable. Tribes in Alaska have seen an additional benefit from dental therapy: more of their own people are coming home. Because the curriculum focuses on the most common and simplest procedures that dental therapists provide, the dental therapy education system is able to provide a rigorous curriculum over three academic years (two calendar years), followed by a preceptorship. Dental therapy is more accessible as a profession, and indeed many of the Dental Health Aide Therapists in Alaska, Oregon and Washington come from the communities they serve.[3]

Dental Therapy is Safe and Effective. Dental therapists reduce oral health disparities, and countless studies confirm that they provide safe and effective care. A study from the University of Washington examined the oral health status of Alaska Native communities in the Yukon-Kuskokwim Delta. This study concluded that communities served by dental therapists saw, "More children and adults who received preventive care, Fewer children under age 3 with extractions of the front four teeth, [and] Fewer adults ages 18 and older with permanent tooth extractions" than communities without them.[4] The study concluded that "Increased Dental Therapists treatment days at the community-level in the YK Delta were positively associated with preventive care use and negatively associated with extractions."

Reduced Emergency Room visits. Dental therapy helps alleviate the number of people seeking emergency treatment in a number of ways. More oral health services mean that a patient suffering from a chronic condition can be seen in the near future instead of allowing his or her condition to fester until the pain forces a visit to the ER. Dental therapy, therefore, is exactly the type of modern reform that HHS should emphasize in its strategic plan as a means to reduce the strain on ER facilities.

Dental therapists save money. A dental therapist performing a simple procedure can be reimbursed by his or her employer at a lower rate than a dentist performing the same procedure due to the lower amount of debt associated with their education. Swinomish Tribe in Washington State, which first hired a dental therapist in January 2016, is using the savings to help fund the expansion of its dental clinic so more patients can be seen. The addition of one dental therapist allows for more people to receive services, which increases third party revenue intake, which allows the Tribe to hire more providers, who see more people, and so on. Dental therapists are more they sustainable; they are catalysts for change in Tribal communities.

An alternate solution proposed by oral health provider representatives is to increase Medicare and Medicaid reimbursement rates for oral health services and encourage more dentists to accept Medicare and Medicaid patients. While we also support increased revenue flowing into the Tribal health system, in its absence, Tribes must find other solutions or see their members go without care.

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[3] In Alaska, Reaching Into Remote Corners To Provide Dental Care. Conan Murat, Bethel AK. http://anthc.org/wp-content/uploads/2016/02/DHAT_ConanMuratStory.pdf

[4] Dental Utilization for Communities Served by Dental Therapists in Alaska's Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study (Seattle, WA: University of Washington). http://faculty.washington.edu/dchi/files/DHATFinalReport.pdf

Other models are beneficial but not as effective as dental therapy. Community Dental Health Coordinators (CDHCs) provide educational services and can help navigate the patient through the dental healthcare process. While these services could benefit the patient, a dental therapist can provide actual care. The problem isn't that AI/ANs don't know how to brush their teeth; the problem is they have to wait several months to see a dentist. Thus, HHS should prioritize the comprehensive solution that dental therapy offers over other, less inclusive models.

By modernizing the dental teams to better serve Tribal communities, dental therapists address three issues: dental therapists increase the number of patients receiving oral healthcare, the dental teams employ more people in areas where unemployment is often rampant and persistent, and the Tribes reduce the financial strain placed upon them by an underfunded system. These solutions certainly reform, strengthen, and modernize the way AI/ANs receive oral health care. Tribes have already found a solution and as part of the strategic plan of HHS, we highly encourage you to support models such as Dental therapists to improve care.

Rural Healthcare Needs. Tribal clinics can be the bedrock of healthcare provision in rural communities across America. While Tribal members are often given priority due to the trust responsibility, almost all Tribal clinics also provide services to nontribal members. Often, the third party revenue that comes from providing care to nontribal members represents a crucial source of income for Tribal clinics. HHS should understand and respect this dynamic and not propose paternalistic regulations and policies that discourage Tribally-employed providers from caring for nontribal patients. In rural communities where jobs tend to be scarce, such arbitrary regulations make rural placement unattractive to providers, who may elect not to work at a rural or Tribal facility.

Dental therapy is Tribal sovereignty in action. We believe that the strategic plan should support the ability for Tribes to feel empowered to utilize innovative models to solve health needs in their communities. Dental therapists have a proven track record of quality service, rigorous education, and cultural competence in Tribal communities. It's time for the federal government to remove barriers between Tribes and true oral health for their people. This reality must be reflected in the HHS's strategic plan.