

Submitted via e-mail

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U.S. Department of Health and Human Services
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RE: Review and Evaluation of Tribal Consultation Policy

Dear Ms. Ecoffey,

On behalf of the National Indian Health Board (“NIHB”)ⁱ and the National Congress of American Indians (“NCAI”),ⁱⁱ we write to respond to the Dear Tribal Leader Letterⁱⁱⁱ issued by the Department of Health and Human Services (“HHS” or “the Department”) on October 22, 2018, requesting feedback from Tribal representatives on the HHS Tribal Consultation Policy (“TCP”).^{iv} The HHS TCP applies to all divisions of the Department and is meant to establish principles for how HHS will engage with Tribes, to the greatest extent practicable and permitted by law, on all Department and division policy development.

This letter reiterates NIHB’s previously proposed changes to the current version of the Tribal Consultation Policy,^v since the proposed changes were not adopted during the 2012 comment period. This letter also includes substantive recommendations from the members of NIHB’s Medicare, Medicaid, and Health Reform Policy Committee (“MMPC”)^{vi} to address shortcomings in the Department’s engagement with Tribal populations.

A. RECOMMENDATIONS SPECIFIC TO THE SECRETARY’S TRIBAL ADVISORY COMMITTEE (“STAC”)

According to the HHS website, STAC’s primary purpose is to:

Seek consensus, exchange views, share information, provide advice and/or recommendations; or facilitate any other interaction related to intergovernmental responsibilities or administration of HHS programs, including those that arise explicitly or implicitly under statute, regulation or Executive Order. This purpose will be accomplished through forums, meetings and conversations between Federal officials and elected Tribal leaders in their official capacity (or their designated employees or national associations with authority to act on their behalf).^{vii}

The establishment of STAC brought a new level of attention to the government-to-government relationship between HHS and Indian Tribal governments. Its establishment as a Secretary-level Tribal advisory committee brought a coordinated, Department-wide process to incorporate Tribal guidance on HHS priorities, policies and budget, and improve the government-to-government relationship. Given the significance and importance of STAC to HHS and Tribal governments, we recommend that a role for STAC be established in the HHS Tribal Consultation Policy.

1. We recommend that STAC form a subcommittee to create procedures for incorporating Tribal feedback into the Tribal Consultation Policy.

- Under Section 13, “Evaluation, Recording of Meetings and Reporting,” add *HHS will provide STAC with a copy of the HHS Annual Tribal Consultation Report*. The Annual Tribal Consultation Report will not contain a simple recitation of meeting attendees and minutes; it shall identify Tribal priorities raised during meetings as well as account for responsive activities on behalf of the Department to promote Tribal health priorities and sustainable solutions. This is consistent with the spirit of open, ongoing communication and mutual accountability.
- STAC should provide meaningful input upon review of Tribal comments to the consultation policy, and thereafter develop a draft policy, in coordination with the Department, that is then disseminated to Tribes for further review.
- HHS should develop a similar Tribal consultation process as in 2010, when HHS helped to facilitate a Tribal caucus of leaders to discuss the consultation policy and received feedback from the Tribes. Following that same process today, in collaboration with STAC, would ensure the more deliberate consultation process sought by Tribes, and due to Tribes.

B. NIHB AND NCAI REITERATE PREVIOUS RECOMMENDED CHANGES TO THE HHS TRIBAL CONSULTATION POLICY

1. We recommend that HHS renumber sections of the TCP so that it is easier to reference. There are a number of places in the policy where there are duplicative numbering or numbering that does not follow standard conventions. For instance, in the current version of the TCP, **there appears to be two subsections (A) in Section 8, “Tribal Consultation Process.”** The second (A) should be changed to (B) and the remaining subsections appropriately relisted as (C) and (D). In addition, there is a sequence of numbers before the lettered sections begin. The TCP is a critical tool for Tribes and the Department and should be as easy to use as possible.

2. We recommend that HHS improve Section 8(A)(4), “Receipt of Tribal Comments,” by providing that all Tribal comments submitted will be posted on an HHS webpage unless the commenter expressly requests otherwise. In that case, the identity of the commenter and the date of the comment would be posted with a notation that there was a request that the

comment not be posted. The process would be similar to the way all Federal agencies must deal with comments to proposed regulations, notices, and many other matters. It assures much greater transparency and creates opportunities for better dialogue among Tribal leaders where differences of views may exist. It also makes the reporting of outcomes under Section 8(A)(5), “Reporting of Outcomes,” much clearer.

- **We specifically recommend adding at the end of Section 8(A)(4):**

All comments submitted in writing in response to a request for consultation or a Dear Tribal Leader Letter (“DTLL”) by HHS or any of its Divisions or programs will be posted on an HHS webpage with the expressed consent of the sender. If no expressed consent is given, comments submitted will be included in a final summary of comments received and shared without direct attribution to a specific entity. This summary will be posted on the HHS webpage with the associated request or DTLL.

3. Consultation Follow-Up. We recommend that HHS be specific about the response to the comments received and the timelines for accomplishing tasks or achieving objectives that are identified through Tribal consultations. Section 13(2)(e) of the TCP requires that final, adopted policy decisions be communicated to Tribes in an *Annual Tribal Consultation Report*, yet a mechanism is not in place for following up on Tribal recommendations or creating a process to work through recommendations until a final policy change can be made and *before* the Consultation Report is disseminated. Meaningful Tribal consultation, as contemplated in Executive Order (“E.O.”) 13175, is both cooperative and responsive, and more than an informal roundtable discussion or listening session where Tribes air their grievances.

- **HHS should hold “Follow-up activities” after each consultation session.** Rather than the Department and Tribes returning to consultations year after year without knowing the status of the issues raised in the previous year, forward progress can be made on resolving concerns by direct Departmental response, including, for example: through webinars, listening sessions, teleconferences, or other activities.
- A full Tribal Consultation Report consisting of every single item or issue raised by individual Tribal leaders, followed by an explanation as to whether the identified issues were addressed or incorporated into the final consultation report, and the entirety of the Department’s response.^{viii}
- HHS should develop a description of the format of the DTLL as issued by different agencies within the Department; and a process for initiating Tribal consultation on various topics.
- A DTLL, which would include the proposed policy change, anticipated Tribal impact from HHS’ perspective, a timeline for providing feedback, and locations for in-person consultations, should be issued not less than 30 days before the initial consultation.

- **HHS is accountable for facilitating a continuous cycle of consultation.** This could take the form of status updates or check-in calls with STAC to provide them any updates as a result of consultation activities. Many times, Tribes have participated in excellent consultation meetings, only to return the following year to learn there was ultimately little to no progress on certain issues, and those issues resurface again requiring the same concerns to be raised by Tribal leaders anew.

Consultation can be a very effective tool for learning where there needs to be improvement or coordination, but there must be a process in place to thereafter ensure that the improvement or coordination can and will be addressed.

4. Definitions and Use of Terms. At Section 17, “Definitions,” many of the definitions are duplicative and should be consolidated and used consistently throughout the policy to avoid unnecessary confusion. **We have the following specific recommendations:**

- **Federally Recognized Tribal governments.** This term is used only in the definition of “Joint Tribal/Federal Workgroups and or/Task Forces.” We think the term should be replaced with “*Indian Tribes*” – as that term is defined in the policy (subject to our proposed amendments found below) – and the term “Federally Recognized Tribal governments” be deleted from the definitions section.
- **Indian.** Because of our recommendation below for revising the term “Indian Tribe,” a change would need to be made for consistency to the definition of “Indian.” Further changes are needed to assure that the TCP does not exclude individuals in its coverage who are “Indians” for other purposes related to HHS activities. Rather than referencing the definition of Indian Tribe at 25 U.S.C. § 5130, we recommend that the reference be to the definition of Indian in the Indian Self-Determination and Education Assistance Act at 25 U.S.C. § 5304(e) and to other conditions under which individuals are considered by HHS to be Indian. The definition of “Indian” should be redrafted as follows: “*A person who is a member of an Indian Tribe, as defined at 25 U.S.C. § 5304(e) or is otherwise considered by the Secretary to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native or is determined to be an Indian under regulations promulgated by the Secretary. Throughout this policy, “Indian” is synonymous with “American Indian/Alaska Native.”*”
- **Indian Organizations.** This term should be replaced throughout the TCP with the term “*Tribal Organization*,” as defined in Section 17(24) of the TCP, consistent with how that term is used in the Indian Self-Determination and Education Assistance Act, at 25 U.S.C. § 5304(l). The term “Indian Organization” could then be deleted from the definitions.
- **Indian Tribe.** We think the definition of “Indian Tribe” should be consistent with the Indian Self-Determination and Education Assistance Act, as is the case in the

Indian Health Service (“IHS”) Tribal Consultation Policy. The definition should read, “*Any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village, or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians [25 U.S.C. § 5304(e)].*”

- **Tribal Government.** We read the term “Tribal Government” as being synonymous with “Indian Tribe.” We suggest the Department replace the term “Tribal Government” throughout the policy with “*Indian Tribe*” and then delete the definition of “Tribal Government” from the definitions.
- **Tribal Officials.** We recommend the term “Tribal Officials” be revised to be consistent with how that term is defined by the Indian Health Service and E.O. 13175 to state, “*A duly elected/appointed Tribal Leader or official delegate designated in writing by an Indian Tribe or Tribal Organization.*” We note that the current definition uses the term “inter-Tribal organizations” which is not defined or used in the policy at all. The use of the term “Tribal Organization” is consistent with our advice regarding that term as described above.

5. Standard for Action. We recommend that HHS adopt a standard that it will take various actions addressed by the TCP *unless it is prohibited by law* from doing so. The phrase “practicable and permitted by law” is used many times as a benchmark for whether HHS will take action.^{ix} HHS should adopt a standard that it will take various actions addressed by the TCP *unless it is prohibited by law* from doing so. This would improve the frame in which the relationship between HHS staff and legal counsel would undertake analysis of requests. We recommend that everywhere the phrase “practicable and permitted by law” is used, it be changed to “*practicable and not prohibited by law.*”

6. Section 10, “Joint Tribal/Federal Workgroups and/or Task Forces.” We recommend that HHS clarify that the joint workgroups or task forces formed under the consultation policy are not subject to (or in the alternative are formed to be exempt from) Federal Advisory Committee Act (“FACA”) requirements. For many years IHS, for example, has used Tribal workgroups and task forces as a practical means of consulting with Indian Tribes and Tribal Organizations, and this practice needs to be able to continue unhindered. We understand this is possible because courts have interpreted the definition of an “advisory group” under FACA narrowly, so as not to include every formal and informal consultation between an agency and a group rendering advice.

To the extent this could be clarified by the Department in its Tribal Consultation Policy, we think it would be helpful to ensuring that Tribes can continue to unreservedly participate in workgroups and task forces to address critical issues of Departmental policy, and can freely determine who it is they wish to represent them. Additionally, in Section D, “Recommendations

and Policy Implementation,” of Addendum 1 of the HHS TCP, we suggest that “*and Tribal Organizations*” be added to the end of the paragraph.

C. SUBSTANTIVE RECOMMENDATIONS TO HHS TRIBAL CONSULTATION POLICY

1. We recommend that the HHS Tribal Consultation Policy emphasize the Federal trust responsibility to American Indians and Alaska Natives (“AI/ANs”). The United States (“U.S.”) has a unique legal and political relationship with American Indian and Alaska Native Tribal governments established through and confirmed by the U.S. 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 health care 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”) [25 U.S.C. § 1601 et seq.]. 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” [25 U.S.C. § 1601(1)]. IHS was created in 1955 to assist the U.S. to fulfill its obligation to provide health care to AI/AN citizens. Twenty years later, Congress enacted the Indian Self-Determination and Education 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 IHCIA 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. A year later, 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 obligation to provide health care to AI/ANs does not extend only to IHS. The Federal trust responsibility is the responsibility of all government agencies, including others within the Department. As such, **NIHB, NCAI, and Tribes request that the HHS TCP provide a preamble statement or Introduction that details the Federal trust responsibility to provide health to American Indians and Alaska Natives and the Department’s commitment to Tribal consultation in carrying out that responsibility.**

2. We recommend enhancing the language in the TCP related to the government-to-government relationship between the U.S. and Tribes:

- After the sentence in Section 4(D) under “Policy,” which currently states, “[E]ach Division shall make all practicable attempts where appropriate to use consensual mechanisms for developing regulations, including negotiated rulemaking,” the

Department should add *“Each Division shall use or develop a Tribal consultation policy in accordance with the HHS Policy, which assumes a Tribal consultation process to create health policy in Indian Country.”*

- At Section 14, “Conflict Resolution,” we recommend including: *“Tribes shall have the opportunity to raise issues outside of the consultation process and will be treated as sovereign nations when doing so.”*

3. We recommend that HHS refer to STAC throughout the policy as having a role that is supportive of HHS, and also include STAC in the Definitions and Acronyms sections.

4. We recommend that HHS revise the policy to include evaluation and accountability measures in the position description for the agency contact person who will liaison with Tribes. We recommend that HHS incorporate language into the policy that will ensure that representatives to Tribes are properly trained and culturally sensitive to the needs of Tribal communities. Specifically, at Section 9(B)(1) under “Consultation Procedures,” which currently states at subsection (a): “An Indian Tribe(s) has the ability to initiate consultation, i.e. meet one-on-one with an HHS Division Head or *designated representative* to consult on issues specific to that Indian Tribe,” we recommend that the Department add:

- *HHS shall support maximum participation of the HHS Division Head or designated representative under this policy.*
- *HHS will ensure that its representatives who participate under this policy will be legally informed, culturally sensitive, and respectful of American Indian and Alaska Native cultural values and protocols, and will be knowledgeable about American Indian and Alaska Native Tribes, values, rural or remote village ways of life and challenges, and governance differences.*
- *HHS representatives participating shall demonstrate willingness to collaborate with Tribal participants.*

HHS must ensure that individuals who participate on its behalf under this policy shall have sufficient decision-making authority or delegated authority to engage in consultation.

5. We recommend enhancing the role of the Office of Intergovernmental Affairs at Section 4(A) under “Policy,” which currently states:

Each HHS Operating and Staff Division (“Division”) shall have an accountable process as defined in Sections 8 and 9 of this policy to ensure meaningful and timely input by Indian Tribes in the development of policies that have Tribal implications. If Divisions require technical assistance in implementing these sections, the Office of Intergovernmental Affairs (“IGA”) can provide and/or coordinate assistance.

by adding:

- *HHS/IGA shall educate Division and departmental staff on the statutory and regulatory authorities for Tribal consultation and best practices.*
- *HHS/IGA shall continuously strive to improve the Tribal consultation process between Tribes and HHS agencies within.*

6. We recommend that the HHS policy emphasize regional Tribal consultation responsibilities by adding to Section 1, “Purpose”: *Each office, center, operating unit and regional office within HHS shares in the responsibility to consult with Indian Tribes and to comply with this policy.*

7. We recommend that HHS strengthen agency evaluation, reporting, and accountability procedures by reporting Tribal interactions in a more public forum. Right now, HHS operational divisions provide an annual report on consultation to STAC in the form of a thumb drive containing data from multiple agency divisions. Going forward, **the annual consultation reports should be published by HHS in a more visible, public, or user-friendly manner.** Specifically, to Section 12, “Tribal Consultation Performance and Accountability,” we recommend adding:

HHS is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of HHS to incorporate Tribal recommendations, HHS will assess its performance on an annual basis and provide Tribes with whom consultation activities took place a copy of an Annual Tribal Consultation Report. The Report shall summarize the consultation activities occurring in the prior year, in addition to follow-up measures and solutions to problems identified. The issuance of the report shall correspond with the Federal Government Fiscal Year calendar.

8. We recommend that HHS improve Section 8(A), “Communication Methods.”

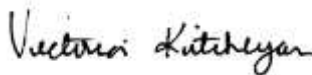
- **Current mechanisms aren’t working or are underutilized.** HHS communication mechanisms, as identified in the policy, are not used to the extent they should be. Better communication mechanisms include, for example, an accessible, up-to-date website for each HHS division. This would minimize disruption in communication, especially with constant staff turnover at the Department or in Tribal organizations.
- **At Section 8, “Tribal Consultation Process,” we recommend adding:** *Communication to Tribal Leaders should be targeted.* If HHS issues a notice of consultation through the official channel, the Federal Register, HHS representatives or Tribal Liaisons must make individual contact with Tribal leaders to notify each leader of the consultation opportunity. This can be easily accomplished by issuing a DTLL to each Indian Tribe’s designated leadership, as listed in the most recent BIA Tribal

Leader Directory housed within the Department of the Interior (DOI). Tribes must receive ample notice (not less than 30 days) before consultation, or as soon as a critical event is identified.

9. We have recently become aware that the Department intends to consolidate 3 or more regional consultations to complete the process more quickly and efficiently. We strongly disagree with this practice. Regional consultation mechanisms are as unique as the Tribes themselves. Currently, regional consultations occur over the course of 2 days; the first day consists of several one-on-one 15 minute sessions and the second day consists of dialogue with the regional Department offices. The consolidation of regional consultation sessions as a result of Departmental reorganization is problematic for Tribes. It would make regional consultation sessions more difficult than they are now by providing even less time for dialogue and one-on-one consultations, in contravention of the government-to-government relationship. Ample time is needed for each Tribe at each regional level.

We appreciate the opportunity to provide input into the review of the Department's Tribal Consultation Policy. Should you have any questions about our comments as set forth in this letter, please contact Devin Delrow, NIHB's Director of Policy, at ddelrow@nihb.org. We look forward to providing comments to the Department on revisions to the policy before any changes are finalized and implemented in the future. We also look forward to continuing to work together closely with the Department and its various divisions into the future.

Best regards,



Victoria Kitcheyan
Chair, National Indian Health Board



Jefferson Keel
President, National Congress of American Indians

ⁱ Established in 1972, the National Indian Health Board ("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. 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, or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

ⁱⁱ Founded in 1944, the National Congress of American Indians is the oldest, largest and most representative American Indian and Alaska Native organization in the country. NCAI advocates on

behalf of tribal governments and communities, promoting strong tribal-federal government-to-government policies, and promoting a better understanding among the general public regarding American Indian and Alaska Native governments, people and rights.

ⁱⁱⁱ HHS, Dear Tribal Leader Letter (Oct. 22, 2018),

<http://files.constantcontact.com/a3c45cb9201/84cbe4d9-0b19-4ac4-8298-ca5700fe7733.pdf>.

^{iv} HHS, Tribal Consultation Policy (2010),

<https://www.hhs.gov/sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf>.

^v NIHB, Comment on DHHS Tribal Consultation (Dec. 7, 2012),

<https://www.nihb.org/tribalhealthreform/wp-content/uploads/2013/01/NIHB-comments-on-DHHS-Tribal-Consultation.pdf>.

^{vi} MMPC is a standing committee of the NIHB. The primary purpose of MMPC is to provide technical assistance to the Tribal Technical Advisory Group to the Centers for Medicare and Medicaid Services (“TTAG”).

^{vii} HHS, Secretary’s Tribal Advisory Committee, <https://www.hhs.gov/about/agencies/iea/tribal-affairs/about-stac/index.html>.

^{viii} See Bureau of Indian Education, Strategic Direction Tribal Consultation Report (Mar. 2018),

https://bie.edu/cs/groups/xbie/documents/site_assets/idc2-086442.pdf.

^{ix} See Sections 1, 4, 4.B, 4.C, 7.5, 8.A.3 [Communication Methods: Meetings], 9.B.3 [Consultation Procedures: States], 11, 11.B, 12, 15, and 17.20.