National Indian Health Board

August 25, 2021

The Honorable Rochelle Walensky, MD, MPH
Director
Centers for Disease Control and Prevention
Agency for Toxic Substances and Disease Registry
1600 Clifton Road NE
Atlanta, GA 30329–4027

Re: CDC/ATSDR Tribal Consultation Policy

Dear Dr. Walensky:

On behalf of the National Indian Health Board (NIHB),[1] we are responding to your call for Tribal Consultation regarding the Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR) Tribal consultation policy. We applaud CDC/ATSDR for taking this step towards reaffirming and strengthening the Government-to-Government relationship that exists between Tribal Nations and the Federal Government. CDC/ATSDR has a central role in fulfilling the United States' federal Indian trust responsibility. Therefore, the agency must have a policy that ensures that Tribal Consultation is meaningful, thorough, and consistent with the other operating divisions throughout HHS.

CDC/ATSDR must update their Tribal Consultation policy to increase accountability, acknowledge and honor the Tribe's right to call for Tribal Consultation, and provide meaningful engagement in policies that impact American Indian and Alaska Native (AI/AN) Nations during the policy development process. First, Tribal leaders need to know that the agency is hearing them and that their recommendations are accepted and implemented to the greatest extent possible. To that end, we want to ensure that the agency respects the government-to-government relationship. The current consultation policy does not provide a mechanism for Tribal leaders to verify whether the agency considered their feedback, making it difficult to hold the agency accountable for the consultation results. **We ask that, at minimum, the CDC/ATSDR issue a Dear Tribal Leader Letter (DTLL) 30 days after every consultation that outlines what participants discussed, enumerates Tribal recommendations and requests, and reports what the federal government is doing with that information and input.** We also urge CDC/ATSDR to facilitate accountability with other agencies, particularly when the actions of those agencies impact its policies. Meaningful consultation is similarly compromised when the agency fails to give Tribal leaders adequate time

[1] Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments to provide quality health care to all American Indians and Alaska Natives (AI/ANs). A Board of Directors, consisting of a representative from each of the twelve Indian Health Service (IHS) Areas, governs NIHB. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas with no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. NIHB advocates for all tribes, whether they 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 continues to rely on IHS for delivery of some, or most, of their health care.

to prepare. Additionally, the agency is not providing support to the organizations that Tribal leaders rely on for technical assistance with consultation preparation and participation.[2] Due to the COVID-19 pandemic, many agencies have recently come to rely on rapid consultations, which Tribal leaders do not find helpful as a regular course of action. **For meaningful consultation to occur, Tribal leaders must have adequate time to prepare.**

Tribal leaders look forward to working with CDC/ATSDR in ways that respect and affirm their Tribal sovereignty. We believe that the steps outlined in this letter will be beneficial as CDC/ATSDR is considering ways to make their consultation policy more responsive to the government-to-government relationship.

CDC/ATSDR and the Federal Trust Responsibility

Beginning with first contact and ending with the decision by the United States to cease Tribal treaty making in 1871, the United States and its predecessor European sovereigns and sovereign Tribal Nations signed over 350 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises – which exist in perpetuity - collectively form the basis for what we now refer to as the federal trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared 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*."[3]

This trust responsibility, was highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

> Importantly, the Federal Government has a unique legal and political government to- government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[4]

The trust responsibility establishes a clear relationship between Tribes and the federal government.

This responsibility must inform the federal government's work with Tribal nations and Tribal people. **Tribal consultation is the primary means of respecting and being a necessary part of that relationship.** The executive branch affirmed Tribal Consultation by Executive Order in 2000 and through Presidential Memoranda in 1994, 2004, 2009, and most recently by President Biden in 2021.

CDC/ATSDR is one of the federal entities charged with addressing health disparities among AI/AN Tribal Nations and Peoples. However, every branch and agency of the federal government

[2] *See* discussion *infra* "Tribal Technical Assistance"
[3] 25 U.S.C. § 1602
[4] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html

must honor and uphold the trust obligations for health and public health to sovereign Tribal Nations and Peoples. These trust obligations are owed to AI/AN people and do not have an expiration date.

AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher poverty rates, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. As the US Civil Rights Commission addresses so effectively in Chapter 2 of its 2018 Broken Promises Report, Tribal communities are at substantial health risk since the efforts of the federal government to uphold its trust responsibility for Tribal health care have been so ineffective.[5] On average, AI/ANs born today have a life expectancy of 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy.[6] For example, in South Dakota in 2014, whites' median age at death was 81, compared to 58 for American Indians.[7]

According to the CDC, in 2019 AI/ANs had the second highest age-adjusted mortality rate of any population of 767.3 deaths per 100,000 people.[8] In addition, AI/ANs have the highest uninsured rates for adults aged 18-64 (32.9%) and children under the age of 18 (16.7%)[9]; higher rates of infant mortality (2.7 times the rate for whites)[10]; higher prevalence of diabetes (2.3 times the rate for whites)[11]; and significantly higher rates of suicide deaths (20% higher than non-Hispanic white)[12]. AI/ANs also have the highest Hepatitis C mortality rates nationwide[13], and the highest rates of type II diabetes, chronic liver disease, and cirrhosis deaths.

The core of the federal trust responsibility to Tribal Nations is that the federal government is supposed to ensure the health and welfare of AI/AN peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold its obligation in a way that is perhaps unparalleled in modern American history. However, systemic barriers are increasingly impeding Tribes' ability to receive help from the federal government—slowing or even outright denying access to aid.[14]

As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were left behind by the federal government during the nation's development of its public health infrastructure and systems continue to be chronically underfunded. As a result, the capacity of many Tribal public health

[5] U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.
[6] Id., 65.
[7] South Dakota Department of Health. *Mortality Overview*. Retrieved from https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf
[8] CDC National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released 2021.
[9] National Center for Health Statistics. *Percentage of angina for adults aged 18 and over, United States, 2019*. National Health Interview Survey. Generated interactively: Aug 12 2021 from https://wwwn.cdc.gov/NHISDataQueryTool/SHS_2019_ADULT3/index.html
[10] CDC 2020. *Infant Mortality Statistics from the 2018 Period Linked Birth/Infant Death Data Set*. National Vital Statistics Reports. Table 2. https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf
[11] CDC 2021. *Summary Health Statistics: National Health Interview Survey: 2018*. Table A-4a. http://www.cdc.gov/nchs/nhis/shs/tables.htm
[12] CDC 2021. National Vital Statistics Report, Vol. 69, No. 13. Table 10. https://www.cdc.gov/nchs/data/nvsr/nvsr69/nvsr69-13-508.pdf
[13] CDC 2020. *Viral Hepatitis Surveillance — United States, 2018*. Table 3.7. https://www.cdc.gov/hepatitis/statistics/2018surveillance/pdfs/2018HepSurveillanceRpt.pdf
[14] CDC 2021. *National Vital Statistics Report*, Vol. 69, No. 13. Table 10.

systems remains far behind most state, territorial, city, and county public health entities. Many Tribal public health systems lack core services, such as disease surveillance and reporting, emergency preparedness and response, public health law and policy development, and public health service delivery. To address the chronic health disparities and lower life expectancy of AI/AN peoples, HHS must commit the resources, and CDC/ATSDR must continue its meaningful and sustainable direct investments into Tribal communities for public health.

The agency must keep these striking health disparities in mind when considering the CDC/ATSDR Tribal Consultation Policy. This policy can strengthen the government-to-government relationship and help facilitate meaningful progress towards the goal of eliminating AI/AN health disparities.

Strengthening the Government-to-Government Relationship

Tribal Consultation is considered a necessary part of the federal trust responsibility. As President Biden stated in Section 1 of the Presidential Memorandum on Tribal Consultation, "*[m]y Administration is committed to honoring Tribal sovereignty and including Tribal voices in policy deliberation that affects Tribal communities. The Federal Government has much to learn from Tribal Nations, and effective communication is fundamental to a constructive relationship*."[15] He also called on agencies to engage in "***regular, meaningful, and robust consultation with Tribal officials in the development of Federal policies that have Tribal implications***."[16]

Tribal leaders seek to improve the government-to-government relationship between Tribal Nations and the federal government. While we recognize that federal agencies regularly conduct consultation, we reject the notion that the consultation requirements are achieved by merely scheduling a time and sending personnel to hear concerns. Proper consultation and government-to-government engagement exceeds that limited scope. The engagement must allow for the heads of governments to come together, share concerns, generate ideas and solutions, negotiate their roles and responsibilities, and agree on a course of action. Consultation policy requires recognizing a Tribal Chairperson to be first to speak among Tribal representatives – yet no parallel construct exists for the federal government. That needs to change. Comparable heads of State from the federal government must meet with heads of State from Tribal governments.

Moreover, we recommend that HHS recognize a uniform definition of "Tribal Consultation" to be used through the Department. The absence of such a uniform definition creates confusion throughout the various HHS departments, such as CDC/ATSDR, and the Tribes. Additionally, Tribal consultation as a tool for intergovernmental relations must include the principles of free, prior, and informed ***consent (FPIC)*** if it is to be meaningful, respectful, and ultimately successful. Therefore, the uniform definition should incorporate the principles of FPIC that is consistent with the **United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) that was affirmed by the United States.[17]**

[15] *See* "Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships," https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/26/memorandum-on-tribal-consultation-and-strengthening-nation-to-nation-relationships/, January 26, 2021.
[16] Id.
[17] https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

The CDC/ATSDR plays a critical role in how the United States government honors its trust and treaty obligations. The government has tasked the agency to help eliminate the many health disparities faced by Tribal nations and ensure access to essential health and public health services. The CDC/ATSDR is a direct representative of the United States government, and it provides critical funding and services to AI/AN people in furtherance of the trust responsibility. **The CDC/ATSDR must be mindful of this relationship, and the agency should ensure that respect for the sovereignty of Tribal Nations frames every interaction.** CDC/ATSDR cannot be effective if the concerns of Tribal leaders do not inform their policies.

Improving Accountability

Tribal leaders require accountability from all agencies tasked with addressing the health disparities plaguing Tribal communities. **The agency and its Tribal Consultation Policy must assure Tribal leaders that any federal action that impacts Tribes or may impact how Tribes govern their citizens are subject to consultation.** These actions include, but are not limited to program development, promulgated rulemaking, executive or administrative policy directions, budget formulation, or any other efforts by the agency that has the potential to impact Tribes or Tribal citizens. We acknowledge that quantifying "when" the agency should initiate engagement can be complicated. However, just as federal "notice and comment" has been established for most federal government actions, so too should the opportunity be afforded for Tribal leaders to weigh in and effectuate outcomes that impact their governments.

CDC/ATSDR Tribal Consultation policy should make it clear to Tribal leaders that they have a right to ask for consultation whenever they desire. The policy should prescribe a method of contacting the agency and any timelines for a response from the agency. Providing Tribal leaders with prescribed steps on initiating a Tribal consultation and making that clear in their policy will go a long way towards facilitating accountability.

Tribal leaders require affirmative actions demonstrating that their concerns are being heard, considered, and adopted. We acknowledge that Sections 3(G) and 3(E) of the CDC/ATSDR Tribal Consultation Policy provides “Performance Measures and Accountability” and “Evaluation and Reporting” guidance. However, these sections lack any actual substance and only point to the corresponding section of the HHS Tribal Consultation Policy. The current policy does not go far enough in mandating a thorough review of the consultations with Tribal leaders and does not provide a mechanism for Tribal leaders to track how the agency uses their recommendations. To facilitate accountability, CDC/ATSDR should, at minimum, issue a DTLL after every Tribal consultation that details what participants discussed, what Tribal leaders requested, and follow-up actions in response to those suggestions.

Other mechanisms should be explored and utilized that will allow improved communication and accountability in addition to a follow-up letter. For example, having federal agency partners report out in every meeting about prior recommendations could increase accountability and improve transparency. Similarly, the agency should provide a written report of all consultation and CDC/ATSDR Tribal Advisory Committee (TAC) activity to the CDC TAC, CDC/ATSDR Director, Secretary of HHS, and the Secretary's Tribal Advisory Committee. This report should also be published on the CDC website and distributed via a DTLL.

Further, **the Tribal Consultation Policy should require that CDC/ATSDR address why the agency did not implement certain suggestions**. In any follow-up mechanism used, the agency must include a way for Tribal leaders to inquire further about why their request or proposal was not incorporated or to suggest alternative approaches that may be mutually beneficial. Far too often, Tribal leaders make suggestions but never hear back. Instead, they are left to wonder if their request was received, understood, and considered. This often leads to a decrease in Tribal leader participation. Therefore, we urge the agency to survey Tribal leaders who attend the consultation to see if they were effective and how the agency can improve future Tribal Consultations. Additionally, the agency should track participation to ensure that there is sufficient representation and input. **Meaningful consultation is not possible without meaningful consideration, communication, implementation, and follow-up.**

Informed Tribal Decision Making

We urge CDC/ATSDR to move towards a consultation model that encourages informed Tribal decision-making by giving Tribal leaders ample time to prepare so the consultation can be engaging and meaningful for both sides. Although some situations call for quick decision-making, the agency must still honor the trust responsibility and consult with Tribes. These inherent Tribal rights must stand even during national emergencies. Additionally, rapid consultations should only be used in all but the most urgent situations, such as the case throughout the COVID-19 crisis. A rushed effort does not produce superior results for Indian Country. We believe that such consultations do not give Tribal leaders enough time to research and discuss the issue at hand. The lack of preparation time often results in consultations that feel like they exist to allow CDC/ATSDR to "check a box" and not learn about Indian Country's concerns. Tribal leaders are leaders of sovereign nations; therefore, the agency should not expect them to be ready for a consultation on short notice. While one might argue that a rapid consultation meets a minimum technical threshold to be called a "Tribal Consultation," such meetings do not allow for informed and meaningful discussions with Indian Country.

Further, we urge CDC/ATSDR to adopt a uniform notice requirement that ensures that every federally recognized Tribe can participate in Tribal consultations. It often takes time for notice of these meetings to arrive at the desk of Tribal leaders, who the agency then expects to turn their attention towards getting ready for the meeting with little time to prepare. Tribal leaders should have some degree of predictability regarding Tribal consultations to operationalize preparation and have a mechanism to ensure that they have ample time to prepare. We are also concerned that Tribal leaders may not receive the invitation on time and cannot attend or have time to prepare. Tribal leaders are leaders of sovereign nations and often have competing priorities. It is unrealistic to expect them to be ready on short notice. **We urge the agency to adopt a policy requiring at least a 30-day notice for consultation, with limited exceptions for emergency items.** There is currently no prescribed timeline in the policy. We believe that a uniform requirement will allow for a degree of predictability and adequate time for Tribal leaders to prepare.

On Thursday, August 5, 2021, CDC/ATSDR held a formal Tribal Consultation on the agency's Tribal Consultation Policy. **To our knowledge, there was no DTLL issued for this consultation**

and notice only appeared in the Federal Register on July 2nd, 2021. This is unacceptable and is a failure by the agency to provide adequate, informed, and timely notice to Tribal leaders. Unfortunately, this is not the first time the agency has failed to provide proper notice. Currently, there are no requirements in the agency's Tribal Consolation Policy around *how* the agency should communicate Tribal consultations to Tribal leaders. The policy states that the "CDC will initiate consultation regarding the event through communication methods as outlined in the HHS Tribal Consultation Policy." Section 8(A) of the HHS Department Policy on Tribal Consultation merely provides an open list of communication methods. There needs to be a uniform means of reaching Tribal leaders. **We urge the agency to, at minimum, adopt a uniform requirement to send a DTLL for every consultation and mandate that the letter include any pertinent information (such as a Federal Register notice).**

The agency must also expand the methods through which Tribal leaders can participate in Tribal consultations. As we learned during the COVID-19 pandemic, it is possible for the agency to conduct Tribal Consultations remotely and for Tribal leaders to be engaged in that format. While the agency should resume in-person consultations, they must continue to ensure that Tribal leaders can participate remotely. Many Tribes are small and do not have the resources to pay for travel for their leadership to participate in consultations. The ability to participate remotely expands the number of Tribal leaders who can participate, which helps to ensure that the agency is hearing from a broad cross-section of Tribal leaders.

We also urge the agency to consider expanding the usage of listening sessions during these early stages of policy development to hear directly from Tribal leaders. If CDC/ATSDR engages Tribal leaders from the start, it should make for a more fruitful consultation process. The agency should not wait until they have formulated a policy or regulation before asking for feedback from Indian Country.

Tribal Technical Assistance

The CDC/ATSDR Tribal Advisory Committee (TAC) and Tribal technical assistance from National, Regional, and Inter-Tribal organizations can be essential tools in the consultation process. But note, discussions with a TAC are not a substitute for Tribal consultation. TACs should be utilized by CDC/ATSDR when they are formulating policies because TACs are the best conduit through which CDC/ATSDR can receive technical assistance that is Tribally informed and representative of the various regions. CDC/ATSDR currently has a very active advisory committee that the agency can utilize to inform the different policy areas that their programs touch. We urge CDC/ATSDR to begin engaging the TAC early in the policy and regulatory making process so any proposed policies can be Tribally informed from the start, prior to initiating formal consultation. Additionally, we request that the agency support the TAC's desires for the Tribal Public Health Work Group, a vital means for technical assistance and expert guidance for the TAC.

To have meaningful consultation with the CDC/ATSDR TAC, the agency must prioritize completing the CDC/ATSDR TAC charter revision process and prioritize the TAC's input on all changes to the charter. **We support the TAC's request that the CDC/ATSDR responds to the proposed charter edits by October 15, 2021.** We also ask that any revisions or edits

CDC/ATSDR makes be marked and that the agency provide detailed explanations for any changes they rejected.

We recognize that only the primary TAC delegates can speak during official TAC meetings to maintain compliance with the statutory exemption to the Federal Advisory Committee Management Final Rule (FACA) found in the Unfunded Mandates Reform Act (UMRA). During the meetings, the TAC member must yield their seat to allow authorized representatives, technical advisors, or guests to talk. This requirement is contrary to traditional Tribal ways and customs, which allow for interactions where everyone involved can contribute equally to the discussion. We encourage the CDC/ATSDR to consider how these restrictions impact the quality of conversations. We implore the agency to explore meeting formats that conform with the UMRA while allowing for the least burden and inconvenience.

We also have concerns about support for technical assistance for Tribal leaders from Tribal organizations. Tribal organizations, such as NIHB, are routinely consulted by Tribal leaders in preparation for TAC meetings and Tribal consultations. However, there is little support for this work. **We urge CDC/ATSDR to support the work of Tribal organizations, who are vital in ensuring that Tribal leaders have access to the subject matter expertise that helps them prepare to offer meaningful feedback to the agency.** We believe that this technical assistance is vital to full and meaningful consultation.

Conclusion

Thank you for your attention to the Biden Administration Memo and efforts to address its Tribal consultation policy. Rededication to government-to-government relationship presents an opportunity to improve the processes that maintain and strengthen these sacred relationships. Given the status of Tribes as pre-existing sovereigns and their unique position in the American legal framework, Tribal consultation must be robust and meaningful. There must be accountability from CDC/ATSDR. Thank you again for taking this first step, and we look forward to an ongoing dialogue on how to make Tribal consultation more respectful and responsive to the needs of Tribes.

Sincerely,

Stacy A. Bohlen
CEO
National Indian Health Board