National Indian
Health Board

November 18, 2021

Daniel Tsai
Deputy Administrator & Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Montana HEART Section 1115 Demonstration Waiver.

Dear Mr. Tsai:

On behalf of the National Indian Health Board (NIHB),[1] I write to you in support of Montana's proposed Healing and Ending Addiction through Recovery and Treatment (HEART) waiver. This 1115 Demonstration Medicaid waiver will benefit many American Indian/Alaska Native (AI/AN) people with substance use disorders and mental illness in Montana. Inclusion of evidence-based stimulant use disorder treatment, tenancy support, and pre-release care management along with a focus on better coordination of behavioral and physical health care will be of great benefit to AI/ANs. However, we advocate for a few adjustments to the waiver to ensure it will provide the maximum benefit possible to AI/ANs in Montana and serve to uphold the federal trust responsibility.

Trust Responsibility

The United States owes a special duty of care to Tribal Nations which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[2] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people." This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

---

[1] 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 (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.

[2] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

> 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.[3]

The trust responsibility establishes a clear relationship between Tribes and the federal government.[4] The Constitution's Indian Commerce Clause, Treaty Clause, and Supremacy clause, among others, provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs and support for the Indian health system that provides their care.

Recommendations

With the federal trust responsibility in mind, we extend the following recommendations for improving Montana's proposed HEART waiver:

1) **Pre-release services should be expanded beyond state prisons to include Tribal, federal, and Bureau of Indian Affairs (BIA) correctional facilities.** These services are desperately needed for people in these facilities as well as the Montana state prison system. Facilities serving AI/AN people should be included in the waiver *from the beginning* as needed transformative systems changes are being made, and not neglected or added later as an afterthought.

   Pre-release services would arguably provide even greater benefit and cost-effectiveness in Tribal and BIA prisons and jails than for the state prisons. AI/ANs in Montana suffer significantly higher rates of substance use disorder, serious mental illness, and suicide than the general population. About one-third of all people booked into Tribal jails are arrested on drug- or alcohol-related charges. The BIA has also acknowledged the need to connect justice-involved Native people who have substance use disorders to treatment opportunities[5]. The proposed pre-release behavioral health services will more effectively reach a population greatly in need of them if the proposal is expanded to include Tribal and BIA facilities. Providing additional behavioral health services to these justice-involved AI/ANs would be a significant step in fulfilling Montana's and the federal government's commitment to health equity.

   Furthermore, expanding this waiver's proposed pre-release services to include Tribal and BIA correctional facilities would be a step towards fulfilling the long-neglected federal trust responsibility for the health and wellbeing of justice-involved AI/ANs. Multiple

[3] Introduction, "Cross-Agency Collaborations". Feb. 2018.
[4] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.
[5] Darren Cruzan, "Native Communities Drugs – 3.31.15," Testimony Before the Senate Committee on Indian Affairs, U.S. Department of the Interior, March 31, 2015.

investigations by news outlets[6] as well as the Office of the Inspector General[7] for the U.S. Department of the Interior have found such pronounced neglect and disrepair in these facilities as to lead to a substantial number of preventable deaths for incarcerated AI/ANs. The 2004 Inspector General report[8] found facilities that "were egregiously unsafe, unsanitary, and a hazard to both inmates and staff alike. BIA's detention program is riddled with problems and, in our opinion, is **a national disgrace**…our assessment found evidence of a continuing crisis of inaction, indifference, and mismanagement throughout the BIA detention program" (emphasis added). Since 2004, progress to address these grievous ills has been insufficient. Such malicious neglect is a violent failing of the federal trust responsibility.

While systemic reforms are clearly needed across the BIA justice system and facilities, expanding Medicaid behavioral health supports to include those in BIA and Tribal facilities would represent a show of good faith, that the AI/ANs incarcerated in these facilities are not still subject to the crisis of inaction and indifference that has already led to so many unnecessary deaths.

2) **Add specific support for development of more treatment facilities operated by Indian Health Care Providers.** Facilities that serve the entire family (both parents and children) are especially needed as are culturally sensitive treatment, aftercare, and sober living alternatives. There are few evidence-based treatment models for AI/AN people. We believe that Montana can become a leader in developing a treatment model that is developed by AI/AN people for AI/AN people that honors our resiliency and traditional values while incorporating the best of western models of care. Such a hybrid model will also benefit AI/AN people outside of Montana.

Furthermore, the only facilities who would benefit from the proposed waiver of the Medicaid exclusion of Institutions of Mental Disease (IMD) are both in southern Montana, far from most of Montana's reservations. More investment is needed for community-based services on the reservations so that AI/AN people do not have to be cut off from their communities to receive necessary treatment, and to ensure that services provided are culturally appropriate.

3) **When creating the implementation plan, the state should work with Montana Tribes and IHS/Tribal providers** to ensure the following:

- Adoption of the most liberal definitions of "services" possible so all services provided by Tribal providers are eligible for 100% FMAP.
- New services should be tailored for cultural appropriateness.

---

[6] Hegyi, N. "Indian Affairs Promised to Reform Tribal Jails. We Found Death, Neglect, and Disrepair." *NPR.* Jun 2021.

[7] Office of the Inspector General, US Department of the Interior. "Bureau of Indian Affairs Funded and/or Operated Detention Programs." Feb 2016.

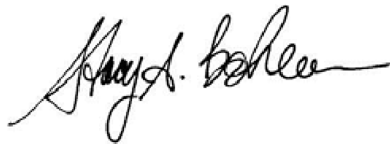
[8] Office of the Inspector General, US Department of the Interior. "Neither Safe nor Secure: An Assessment of Indian Detention Facilities." Sept. 2004.

- Innovations in the waiver should benefit those living on reservations as much as those living in urban areas.

Conclusion

We urge CMS to approve Montana's HEART Section 1115 Demonstration waiver, with a few modifications. To ensure the waiver achieves the maximum benefit, CMS should work with Montana Department of Public Health and Human Services to expand pre-release services to federal, Tribal, and BIA incarceration facilities; expand culturally appropriate community-based services for AI/ANs, including on reservations; and collaborate closely with Montana's Tribes in designing the implementation plan for this waiver.

Sincerely,



Stacy A. Bohlen, *Sault Ste. Marie Chippewa*
Chief Executive Officer
National Indian Health Board