

September 10, 2020

RADM Michael D. Weahkee  
Director, Indian Health Service  
U.S. Department of Health and Human Services  
Mail Stop: 08E37A  
5600 Fishers Lane  
Rockville, MD 20857

**RE: Indian Health Service Technical Assistance to Congress on Special Diabetes Program for Indians**

Dear RADM Weahkee:

Following in depth discussions with the National Indian Health Board's Board of Directors, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally-recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, I write to express our urgent and deep concerns with technical assistance (TA) Indian Health Service (IHS) provided to Congress on the future of the Special Diabetes Program for Indians (SDPI). NIHB finds that IHS's TA constitutes a complete and utter disregard for Tribal consultation, Tribal Leaders Diabetes Committee recommendations, Tribal guidance, policy, and resolutions concerning the future of SDPI. We request that you immediately re-engage with Capitol Hill and correct the TA so far provided so that the Agency's assistance is in keeping with, reflective and respectful of Tribal positions and guidance.

**Background**

On July 24, 2020, IHS submitted TA in response to a request from members of Congress regarding the SDPI Reauthorization Act of 2020. Congress specifically requested TA around recommended changes to SDPI's structure; specifically, the legislative proposal seeks to authorize Tribal Nations and Tribal organizations to elect to receive SDPI awards through existing Title I or Title 5 contracting and compacting agreements. These changes are strongly supported by Tribal Nations and Tribal organizations. The Tribal Self Governance Advisory Committee, NIHB and many regional Tribal health organization have standing policy supporting this change to allow contracting and compacting under P.L. 93-638, the Indian Self Determination and Education Assistance Act (ISDEAA), and we have been working to advance this position for more than a decade. Astonishingly, the IHS TA opposes the Tribal position and includes multiple exaggerated, fear-mongering and misleading statements about the consequences such a change would bring.

We are equally alarmed by comments IHS provided to Congress advising legislative strategy regarding SDPI reauthorization. Specifically, IHS posits that separating SDPI from other "health extenders" with which the program has historically been reauthorized with could negatively impact legislators' support for the program, and undermine "powerful advocates" who are "especially vocal in their support" of SDPI because of its connection to other programs. We fail to understand how this political and advocacy advice relates whatsoever to the assistance Congress asked of IHS and we are alarmed by the Agency insinuating itself into this arena. Even if it were appropriate

for IHS to offer political strategy TA to Congress when Congress did not request it, the Agency's actions again run afoul of Tribal strategy.

To that end, and given IHS's repeated public showing of commitment and support for SDPI, we would think that IHS would be focused on working with Tribal advocates and Congress to achieve reauthorization and capitalize on legislation that would do so – not act strategically to undermine it.

### **Response to IHS Technical Comments**

Below we have inserted the comments provided by IHS in the TA document, and our corresponding statements in response.

**IHS TA:** The agency would have to run a hybrid program (part-grant, part-direct ISDEAA transfers). This would result in a number of challenges, such as difficulties with equitable division of funds as the funding formula would no longer be able to adjust funds as AI/AN populations shift across IHS Areas and as new tribes enter, and as the needs of awardees change.

This statement is a complete mischaracterization. Tribes are not recommending to change the distribution formula or the methodology through which funds are currently distributed. The mechanism to implement the Act is already in place. No new infrastructure would be required. IHS may need to coordinate with other divisions within IHS to ensure that implementation occurs smoothly and that is a responsibility IHS should take on with enthusiasm. We hold that IHS should boldly support and cooperate with Tribes to bring SDPI into 638 contracting and compacting, an action that would advance the priorities of sovereign Tribal Nations rather than IHS undermining Tribal priorities and creating the perception with lawmakers that this is an unsolvable challenge.

Please include correction of this mischaracterization when you communicate with lawmakers to correct the IHS TA.

**IHS TA:** Elimination of the grant requirement to submit data on diabetes treatment and outcomes. National data on diabetes has been key to demonstrating SDPI's progress and helped to ensure its continued authorization success. This data would not be readily available if the funds are distributed pursuant to the ISDEAA.

This comment is entirely off the mark. Not a single Tribe has requested the authority to receive awards through contracting and compacting agreements in order to gain exemption from data reporting requirements. Tribes are requesting ISDEAA authority for SDPI because self-determination and self-governance are integral to Tribal sovereignty, and empower greater local Tribal control over program operations so that services are best tailored to the unique needs of each Tribal community.

Tribes are not opposed to providing data about their SDPI programs. In fact, Tribes are leaders in the capture of data and utilizing data in management and operations, dedicating limited resources to maximizing their impact. More importantly, Tribes also want to highlight the incredible successes of SDPI.

Tribal objections around SDPI data collection are about duplicative, unnecessary, and overly burdensome data gathering and reporting requirements. Tribal leaders are also concerned that

IHS's use of funds regarding data collection are fiscally irresponsible and that the Tribes, themselves, could do a better and more fiscally responsible job of data collection. There is absolutely no reason to think that Tribes won't agree to provide that data if the SDPI funds are transferred to Tribes in ISDEAA agreements.

Please provide Congress with correct information on this point.

**IHS TA: Ability under ISDEAA for awardees to re-budget and reprogram their funds so that funds intended for diabetes can be used for any other healthcare purpose.**

This comment is also a complete red herring. Unfortunately, it also harkens back to entrenched bureaucratic paternalism and anti-Tribal self-determination sentiments that have existed since ISDEAA was authorized over four decades ago. Tribes are not proposing to eliminate the grant structure of SDPI; rather, Tribes are requesting the authority to receive their SDPI awards through the ISDEAA mechanism. This means that by receiving SDPI awards through ISDEAA agreements, the services and activities Tribes implement will remain focused on the prevention, treatment, and management of diabetes.

This is precisely why the legislative language is crafted as "*Delivery of Funds*." By maintaining the grant structure overall, it ensures that Direct Service Tribes and urban Indian organizations continue to have access to this life-saving program.

We need you to set the record straight with lawmakers who received onerous TA from IHS on this point, as well.

**IHS TA: Elimination or limitation of routine grant performance monitoring, which is not required under ISDEAA.**

SDPI has been in existence for over two decades. During its tenure, Tribes have mobilized SDPI into becoming the most successful public health program ever implemented in Indian Country for the prevention, treatment, and management of type II diabetes.

SDPI is responsible for a 54% reduction in rates of End Stage Renal Disease, a 50% reduction in rates of diabetic eye disease, and for the first reduction in rates of diabetes among AI/AN adults in over a decade. SDPI is also largely responsible for saving Medicare expenditures by \$52 million per year.

It is beyond time to respect SDPI and the Tribes that created and continue to operate it, for the evidence-based and foundational program it is. SDPI significantly improves the quality of life and improves the health status of American Indians and Alaska Natives and saves millions of dollars.

Again, please set the record straight with lawmakers.

### **Conclusion**

In summary, the Agency is well aware that the vast majority of Tribes are working to gain the authority to accept SDPI funding through existing Title I or Title 5 contracting and compacting agreements. We are fighting for this program every day and it is not at all assured to be reauthorized, even as is, during this session of Congress. The Indian Health Service, in SERVICE

to the Tribes, should be advancing the Tribal priorities, positions and perspective regarding the future of SDPI – not providing Congress with alarmist, false, paternalistic and patronizing information regarding the Tribal position on SDPI. As well, IHS should not be in the business of providing unsolicited political strategy advice to Capitol Hill, particularly when that advice subverts and undermines the work of Tribal Governments.

We urge IHS to retract its misleading TA immediately and work with Tribes to advance the proven method of self-determination and self-governance in furtherance of federal Treaty obligations to Tribal Nations and AI/AN Peoples.

Should you have any questions about our letter, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Bill Smith".

Bill Smith  
Acting Chairman  
National Indian Health Board

cc: NIHB Board of Director