USET
SOVEREIGNTY PROTECTION FUND

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Melanie Fontes Rainer
Acting Director
Office for Civil Rights
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Dear Acting Director Rainer,

We write on behalf of United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) in response to the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) Tribal consultation on its Notice of Proposed Rulemaking (NPRM) revising implementing regulations for Section 1557 of the Patient Protection and Affordable Care Act (Section 1557) related to Nondiscrimination in Health Programs and Activities, 42 U.S.C. § 18116. While we understand and appreciate HHS' interest in expanding the scope and reach of Section 1557 outside of the Indian Health System, we remind the Department of its unique diplomatic and political relationship with Tribal Nations, as well as its trust and treaty obligations to uphold and promote Tribal sovereignty. With this in mind, Tribally operated health care facilities, with our discrete and limited patient population, should not be subject to this rule.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.[1] USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues.

The NPRM is inappropriate for the Indian Health System

The NPRM applies nondiscrimination standards to all health programs and activities receiving federal financial assistance from the Department; State and Federally Facilitated Exchanges; and all HHS health programs and activities, including the Indian Health Service (IHS). However, what it fails to recognize is the unique nature of the Indian Health System and the diplomatic, nation-to-nation relationship between Tribal Nations and the United States.

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe–Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mi'kmaq Nation (ME), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Monacan Indian Nation (VA), Nansemond Indian Nation (VA), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), Upper Mattaponi Indian Tribe (VA) and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Tribal Nations are inherently sovereign governmental entities that have the recognized right and authority to exercise our inherent sovereign governmental powers to create our own laws and requirements for our people, land, and enterprises. The federal financial assistance that Tribal Nations receive is delivered in accordance with the United States' trust and treaty obligations. Health care facilities operated under the Indian Health Determination and Education Assistance Act (ISDEAA) are overseen and regulated by the sovereign Tribal Nations they serve. The federal government, through ISDEAA, other laws, court cases, and treaties, recognizes our sovereignty and has taken on an obligation to promote and protect it. Furthermore, by and large, our facilities are not open to members of the public, but rather only to patients who are eligible beneficiaries because of their political status as citizens of Tribal Nations.

The NPRM does not currently reflect our distinct circumstances and relationship with the United States. As currently written, it would inappropriately apply regulations clearly meant for health care facilities open to the general public to Tribal Nations.

Tribally Operated Facilities should be Exempt from the NPRM

Tribal Nations' status as inherently sovereign political entities and our unique relationship with the United States permits the United States to treat us differently from others. *See Morton v. Mancari*, 417 U.S. 535 (1974). Thus, the federal government need not apply laws and requirements of general applicability that it creates for the public to Tribal Nations. Accordingly, there are numerous examples of similar laws and regulations exempting or otherwise not applying to Tribal Nations.

Efforts must be made to ensure that all federal department and agency actions are consistent with the President's expectation that Tribal sovereignty is respected to the fullest extent. We have consistently called upon the Biden Administration to begin its consideration of whether to apply any laws and other requirements that are generally applicable to the public to Tribal Nations by first assuming they do not and should not apply to Tribal Nations. For more information, we draw your attention to a letter on this issue we recently transmitted to the White House Council on Native American Affairs.

We are urging that same approach to the application of the NPRM. Although we understand that as federally operated facilities, IHS hospitals and clinics may be subject to the NPRM, it is critically important that it not be applied to Tribal Nations. In addition to its impingement on Tribal sovereignty, it contains a number of requirements, such as reporting, language assistance, and others, that are likely to be administratively burdensome and costly for Tribal Nations at a time when the Indian Health System continues to be chronically underfunded.

Conclusion

HHS must ensure that the NPRM is not inappropriately applied to Tribal Nations or our health facilities. Instead, the Department should defer to Tribal Nations to exercise our inherent sovereignty in choosing whether to institute such requirements for our people, land, and enterprises. We appreciate the opportunity to provide comment to HHS prior to the implementation of the rule and expect that our sovereignty and diplomatic relationship will be better reflected as rulemaking proceeds. Please count USET SPF as a partner in your efforts to deliver upon the federal government's sacred trust responsibility and obligations to Tribal Nations. Should you have any questions or require additional information, please do not hesitate to contact Ms. Liz Malerba, USET SPF Director of Policy and Legislative Affairs, at (615) 838-5906 or by e-mail at lmalerba@usetinc.org.

Sincerely,

Chief Kirk E. Francis, Sr.
President

Kitcki A. Carroll
Executive Director