National Indian Health Board

Submitted via email: Secretary@HHS.gov

March 7, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of the National Indian Health Board (NIHB) and the 574 federally recognized American Indian and Alaska Native (AI/AN) Tribes we serve, we write to strongly urge you to implement the recommendations outlined in this letter to ensure Tribes, Tribal organizations, and urban Indian organizations quickly receive necessary resources to prevent, prepare, and respond to the domestic presence of the 2019 novel coronavirus (COVID-19).

Indian Country is pleased that Congress included, and the President signed into law, $40 million in direct funding to Tribes, Tribal organizations, and urban Indian organizations under H.R. 6074, Coronavirus Preparedness and Response Supplemental Appropriations Act. We are also pleased that H.R. 6074 authorizes reimbursements to federal agencies like the Indian Health Service (IHS), and to Tribes, Tribal organizations, and urban Indian organizations that have expended funds since January 20, 2020 on COVID-19 preparedness and response activities.

On Thursday March 5, 2020, NIHB held a national All-Tribes call with over 200 Tribal leaders and health officials participating. NIHB held the call to seek input and guidance on how the set-aside funding for Indian Country under H.R. 6074 for COVID-19 response efforts should be managed. We write today to outline Indian Country's priorities and perspectives on how these funds should be delivered to Tribes, Tribal organizations, and urban Indian organizations and we stand ready to work with you to achieve the full implementation of these recommendations.

To that end, Indian Country puts forth the following recommendations to ensure a robust and comprehensive response to COVID-19 in Tribal and urban Indian communities:

1. **Authorize an interagency transfer of the $40 million in set-aside funds for Tribes, Tribal organizations, and urban Indian organizations from the Centers for Disease Control and Prevention (CDC) to the Indian Health Service (IHS) for dissemination**
2. **Triple the set-aside funds for Tribes, Tribal organizations, and urban Indian organizations to $120 million**
3. **Provide additional funds to cover related Tribal and urban Indian expenses for COVID-19 outside of strictly clinical care**

4. **Minimize deployments of Commission Corps officers stationed at IHS, Tribal and urban Indian sites**
    - **<u>We urge you to deem all IHS Commission Corps officers as mission critical</u>**
5. **Clarify the process by which Tribes, Tribal organizations, and urban Indian organizations can receive reimbursements authorized under H.R. 6074**

<u>Background</u>

Each department and agency of the United States federal government has trust and treaty responsibilities to AI/AN Tribes and Peoples. These responsibilities were established through over 350 Treaties between sovereign Tribal Nations and the United States, and reaffirmed in the United States Constitution, Supreme Court case law, federal legislation and regulations, and presidential executive orders.

Congress further reaffirmed the federal trust responsibility under the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) when it 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 to effect that policy*."[1] It is essential to remember that these obligations exist in perpetuity. As such, the federal government must honor its obligations to Tribes and AI/AN Peoples in the COVID-19 response and we believe the best way to do that in this scenario is to transfer the $40 million in Tribal and urban Indian COVID-19 funds to IHS for immediate distribution.

Further, Section 601 of IHCIA established IHS as an agency under the U.S. Public Health Service (USPHS), making it an integral part of the federal public health emergency response apparatus. Relatedly, Section 218 of IHCIA authorizes IHS to award funds to Indian Country for communicable and infectious disease prevention, control, and elimination measures. This is important, as the Indian health system has a large federal footprint nationwide with 605 hospitals, clinics, and health stations managed by IHS, Tribal, and urban Indian health programs (the I/T/U system) stretching over 37 states. IHS also has the most efficient mechanism in place to ensure funding swiftly reaches the I/T/U system with the added strength of the statutory authority under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) to award funds to Tribes under self-determination or self-governance contracts and compacts.

Despite the large footprint of the Indian health system and inclusion of IHS as an agency under the USPHS, the Service is frequently excluded from federal public health emergency response efforts. In addition, IHS is not even included in the White House Coronavirus Task Force led by the Vice President – a situation which Tribes would like to see corrected. IHS also is not able to directly access pharmaceuticals, supplies, and other medical countermeasures (MCMs) from the Assistant Secretary for Preparedness and Response (ASPR) Strategic National Stockpile (SNS). This needs to be corrected, as well.

[1] 25 U.S.C. 1601 et seq.

The most recent version of CDC's report on how state, local, and Tribal entities can access SNS resources acknowledges that, "…*Many planners mistakenly believe that* [AI/AN] *communities will receive MCMs from the Indian Health Service (IHS) or another federal agency. However, CDC's guidance calls for state and local health departments to coordinate with these communities, develop written agreements, and ensure those living on tribal lands will receive MCMs.*[2]

It is entirely unacceptable that IHS has to face restrictions in accessing SNS resources, and that the only recourse for sovereign Tribal governments to access SNS resources is by working with local and state entities when the trust responsibility lay solely with the federal government, and not with the states. It is equally unacceptable that a state governor must request a presidential disaster declaration on behalf of a Tribal Nation under the Stafford Act in order for a Tribe to directly access resources. In light of the COVID-19 health emergency, these federal structural failures are once again placing AI/AN lives at increased risk of disease and death.

AI/AN Health Disparities and Increased Risk for COVID-19

AI/AN Tribal and urban Indian communities are disproportionately impacted by health conditions that the Centers for Disease Control and Prevention (CDC) has specifically identified increase the risk of a more serious COVID-19 illness. Among these are heart and lung disease, diabetes, and respiratory illnesses.[3] Among AI/ANs 18 years of age and over, rates of coronary heart disease are 1.5 times the rate for Whites[4], while rates of diabetes among AI/ANs in the same age group are nearly three times that of Whites.[5] Studies have shown that AI/ANs are also at increased risk of lower respiratory tract infections,[6] and in certain regions of the country are twice as likely as the general population to become infected and hospitalized with pneumonia, bronchitis, and influenza.[7]

Health disparities in Indian Country are exacerbated by the chronic underfunding of the Indian health system, and statutory restrictions in access to federal public health funding streams. For instance, per capita medical expenditures within Indian Health Service (IHS) in FY 2017 were $4,078, compared to $9,726 in national per capita spending that same year. Tribes, Tribal organizations, and urban Indian organizations remain ineligible to apply for CDC Public

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[2] Centers for Disease Control and Prevention. Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 11. Retrieved from https://www.orau.gov/sns/v11/ReceivingDistributingDispensingSNSAssets_V11.pdf

[3] *See* https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html

[4] CDC 2020. Summary Health Statistics: National Health Interview Survey: 2018. Table A-1a. http://www.cdc.gov/nchs/nhis/shs/tables.htm

[5] CDC 2019. Summary Health Statistics: National Health Interview Survey: 2018. Table A-4a. http://www.cdc.gov/nchs/nhis/shs/tables.htm

[6] Santiago Manuel Cayetano. Lopez, MD, Zachary Weber, Medical Student, Geralyn Palmer, Medical Student, Travis Kooima, Medical Student, Fernando Bula-Rudas, MD, Archana Chatterjee, MD, PhD, Archana Chatterjee, MD, PhD, 2615. Increased Severity of Lower Respiratory Tract Infection Among Native American Compared with Non-Native American Children, *Open Forum Infectious Diseases*, Volume 6, Issue Supplement_2, October 2019, Pages S909–S910, https://doi.org/10.1093/ofid/ofz360.2293

[7] Groom, A, et al. Pneumonia and influenza Mortality among American Indian and Alaska Native People, 1990-2009. Am J Public Health. 2014 June; 104. Supplement 3: S460–S469. Published online April 2014. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035860/.

Health Emergency Preparedness (PHEP) grants, and historically receive very little CDC funds for public health.

In fact, the $21 million per year Good Health and Wellness in Indian Country (GHWIC) program is the largest source of dedicated public health funding for Indian Country, and it has been proposed for elimination in the last three President's Budget requests. This is a compelling reason why Indian Country does not believe CDC has the organizational commitment to champion and protect public health resources for Tribal and urban Indian organizations. Further, CDC has historically expressed very little cultural competency to address Tribal and urban Indian needs, and the current COVID-19 emergency requires swift and appropriate action. That is why Indian Country is asking for their set-aside emergency COVID-19 funding to be administered through IHS, which possesses both cultural and structural competency to ensure these resources reach Indian Country in alignment with Tribally informed methods.

In conclusion, to effectuate more robust and comprehensive access to COVID-19 prevention, control, and response efforts across Indian Country, we ask that the following recommendations be implemented:

1. **Authorize an interagency transfer of the $40 million in set-aside funds for Tribes, Tribal organizations, and urban Indian organizations from CDC to IHS for immediate dissemination**
    - The IHS has direct access to and relationships with Tribes, Tribal organizations, and urban Indian organizations in a way that CDC does not.
    - Authorizing an interagency transfer of funds from CDC to IHS would assist in guaranteeing that the entire Indian health system is included in response efforts.
    - In addition, transferring the funds to IHS would allow funds to be distributed according to IHS rules and regulations, thus allowing self-governance Tribes to receive COVID-19 funds under P.L. 93-638 self-determination or self-governance contracts and compacts.

2. **Triple the set-aside funds for Tribes, Tribal organizations, and urban Indian organizations to $120 million**
    - Tribes, Tribal organizations, and urban Indian organizations urgently need COVID-19 funds. If the $40 million in set aside funds were to be equally distributed across all of Indian Country, it would amount to only $65,000 per Tribal Nation and Urban Indian Organizations, which is entirely inadequate.
    - H.R. 6074 established $40 million as the baseline Tribal set-aside, with the opportunity to receive additional funding. We urge you to consider tripling the set-aside to $120 million for Tribes, Tribal organizations, and urban Indian organizations to ensure that Indian Country is more appropriately resourced.
    - We urge the federal government to identify additional resources and reallocate them to Indian Country for this purpose.

It would be wholly unacceptable for the federal government to fail to sufficiently fund all 50 states in the COVID-19 response – why then should it be acceptable to fail to sufficiently fund all of Indian Country, to which the federal government holds trust and treaty obligations?

3. **Provide additional funds to cover related Tribal and urban Indian expenses for COVID-19 outside of strictly clinical care**
    - Most IHS and Tribal facilities lack the necessary laboratory infrastructure to test for COVID-19, and also lack the supplies and resources to isolate or quarantine patients experiencing symptoms, provide personal protective equipment to providers and first responders, and connect patients to care services. As a result, Tribal and urban Indian entities have faced additional ancillary expenses such as for transportation, lodging, patient referrals, and other expenditures.
    - While H.R. 6074 authorizes reimbursements for activities directly related to coronavirus preparedness and response, it does not explicitly outline reimbursements for related expenditures such as transportation and other expenses.

4. **Minimize deployments of Commission Corps officers stationed at IHS or Tribal sites**
    - **<u>We urge you to deem all IHS Commission Corps officers as mission critical</u>**
    - The Indian health system faces severe and chronic provider shortages. In a 2018 Government Accountability Office (GAO-18-580) report, provider vacancies across eight IHS Areas with substantial direct care responsibilities were at an average 25%, but stretched as high as 31%.
    - The Indian health system relies on Commission Corps officers to fill its widespread provider vacancies. In fact, the IHS is the largest recipient of Commission Corps officers nationwide.
    - IHS and Tribal sites have reported that dozens of Commission Corps officers have already been deployed, and an additional 100 have been authorized for deployment.
    - Taking Commission Corps officers from IHS, Tribal and urban Indian sites not only adversely impacts patient care, <u>it also poses a significant financial burden on the I/T/U system</u>. This is because I/T/U sites are still required to cover salary and benefits of Commission Corps officers, *even when they are on deployment*.

5. **Clarify the process by which Tribes, Tribal organizations, and urban Indian organizations can receive reimbursements authorized under H.R. 6074**
    - It remains unclear how Tribes, Tribal organizations and urban Indian organizations can submit reimbursement requests for expenditures related to COVID-19 between January 20, 2020 and the date of enactment of H.R. 6074.

- We ask that you work with IHS and CDC to issue guidance to all Tribes and urban Indian health entities clarifying the process for itemizing and submitting reimbursement requests.

As more and more cases are announced and as availability of medical supplies remains scarce, we urge your prompt consideration of these requests to ensure that necessary COVID-19 resources are delivered to Indian Country as expeditiously as possible. We stand ready to work you to ensure the Indian health system is fully prepared to address this health emergency.

Yours in Health,

Victoria Kitcheyan

Victoria Kitcheyan
Chairwoman
National Indian Health Board

cc: Robert R. Redfield, Director, Centers for Disease Control and Prevention
RADM Michael D. Weahkee, Principal Deputy Director, Indian Health Service
The Honorable Roy Blunt, U.S. Senate
The Honorable Patty Murray, U.S. Senate
The Honorable Rosa DeLauro, U.S. House of Representatives
The Honorable Tom Cole, U.S. House of Representatives
The Honorable Lisa Murkowski, U.S. Senate
The Honorable Tom Udall, U.S. Senate
The Honorable Betty McCollum, U.S. House of Representatives
The Honorable David Joyce, U.S. House of Representatives