

# National Indian Health Board



November 16, 2021

The Honorable Xavier Becerra  
Secretary  
United States Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave SW  
Washington, DC 20201

Sent via email: [consultation@hhs.gov](mailto:consultation@hhs.gov)

***Re: NATION-TO-NATION DIALOGUE ON COVID-19 RESPONSE***

Dear Secretary Becerra:

On behalf of the National Indian Health Board (NIHB),<sup>1</sup> I write to provide follow-up comments, input, and recommendations on the recent Nation-to-Nation Dialogue on COVID-19 Response. We applaud the White House Council on Native American Affairs (WHCNAA) Health Committee for taking this step towards developing an interagency plan to improve health systems and infrastructure to better address the ongoing COVID-19 Public Health Emergency and to prepare for future Public Health Emergencies in Indian Country. We also commend Secretary Becerra and the U.S. Department for Health and Human Services (HHS) for leading this effort.

The COVID-19 Public Health Emergency has elevated many of the health disparities that plague Indian Country. Moreover, the response has exemplified many issues related to funding, public health infrastructure, workforce development, and the lack of respect for Tribal sovereignty. This Public Health Emergency has shown how important it is for Tribes to have the agency and funding to address the health concerns of their communities.

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<sup>1</sup> Established in 1972, the [National Indian Health Board \(NIHB\)](http://www.nihb.org) 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.



Tribal leaders look forward to continuing this conversation and working with all federal agencies in ways that respect and affirm Tribal sovereignty. We believe that the comments in this letter will be beneficial as the WHCNA Health Committee considers ways to improve health systems and better prepare for future Public Health Emergencies.

## **I. Trust Responsibility**

Over the course of a century, sovereign Tribal Nations and the United States 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.”

The Indian Health Service (IHS) is the principal federal entity charged with fulfilling the federal trust responsibility for healthcare; however, every branch and agency of the federal government is required to honor and uphold the trust obligations for health to sovereign American Indian and Alaska Native (AI/AN) Tribal Nations and peoples. These trust obligations are owed to AI/AN peoples because of their status as American Indian and/or Alaska Native, and do not have an expiration date.

## **II. Tribal Sovereignty and the Nation-to-Nation Relationship**

Inherent in the government-to-government relationship between Tribal Nations and the federal government is that the United States work directly with Tribes as sovereign equals in all governmental functions, including emergency preparedness and response. At no point should the federal government use the states as intermediaries. The federal government fails to respect this sovereign relationship when it forces Tribal Nations to depend on state governments for funding or access to essential emergency supplies. Tribes are sovereign nations with the authority and responsibility to exercise the right to protect their citizens and Tribal lands.

Having to work through the states during the public health emergency created numerous barriers that delayed access to supplies and vaccines, ultimately costing lives. When the federal government distributed supplies, vaccines, or emergency personnel indirectly to Tribes, using states as middlemen, this added a layer of unnecessary complexity that created confusion in communications and logistics.

The relationships between Tribal Nations and state governments vary significantly across the United States. As Tribal leaders discussed during the Dialogue, there is often lingering conflict at the state and local levels. Under the stressful and highly politicized conditions of the public health emergency, some of these relationships only deteriorated further. For example, Vice President Alicia Mousseau of the Oglala Sioux Tribe described how the current public health emergency exacerbated pre-existing tensions when the governor took issue with the Tribe’s decision to put up monitors along the reservation’s borders to help mitigate the spread of COVID-19. As a result, the governor was temporarily banned from Tribal lands.

Under such conditions, it is unreasonable to expect the roll-out of emergency response and supply distribution to go smoothly if it relies on the beneficence and cooperation of state governments. Furthermore, some governors used this access to emergency medical supplies as political leverage against Tribes. It is unacceptable and amoral for Tribes to be placed in such a position, and an alarming violation of the Federal trust responsibility. Moreover, the federal government should direct funding of all kinds directly to Tribes and not funnel funding through states. We have repeatedly seen that pass-through funding does not work and is not efficient.

Removing states as an intermediary in all these instances would be a significant step forward in affirming the sovereignty of Tribal Nations. We appreciate the assurance from federal officials at the Dialogue that honoring the government-to-government relationship is a priority. Morgan Rodman, Executive Director of the WHCNAA, promised more information to come on this topic; we look forward to hearing more from the Council on this issue. With robust consultation, Tribal Nations can work with WHCNAA and other federal agencies to create policies and processes that are more efficient and respect the sovereignty of Tribes.

### **III. Creation of a Tribal Workgroup on Emergency Preparedness and Response**

Tribes are most knowledgeable about their community emergency preparedness and response capabilities. The diversity of Tribal communities and geographies require significant Tribal knowledge to ensure effective responses. There should be an Interagency Tribal Workgroup formed to provide recommendations on improving emergency preparedness and response policies and protocols. These recommendations should then be taken through a robust Tribal Consultation process. In addition, these affected agencies should develop a plan of implementation – and effective budget requests – for these recommendations.

### **IV. Remove Barriers to Funding and Implement Direct Funding Mechanism Across All HHS Agencies**

Like state and territorial governments, Tribes have the rights and responsibilities to provide vital public health services for their communities. To do this, they must also have the tools to carry out these functions, including funding. The federal government must improve current funding mechanisms to make them more effective and efficient.

Wherever possible, agencies should prioritize direct funding to Tribes through fair, established formulas. As Tribal leaders discussed during the Dialogue, agencies need to step away from treating Tribes as non-profits and instead use a self-governance model. Agencies must use allocation and distribution methods that allow for all federally recognized Tribes to get funding.

We request the creation of Tribal set-asides and non-competitive funding for Tribes across all funding opportunities throughout HHS. All agencies should integrate Tribal health needs and priorities throughout their programs.

In respect of Tribal sovereignty, Centers for Disease Control and Prevention (CDC) and other agencies should ease funding restrictions that limit how Tribes can use certain funding. Tribes know best what works for their communities, and the agencies should honor that knowledge and allow Tribes the flexibility to utilize funding in the ways they see fit.

In situations where funding restrictions cannot be eased, agencies must provide clear and timely guidance to Tribes. Often, direction given to Tribes on funding conditions is unclear and fails to

acknowledge the unique need and requirements specific to Tribes. Failure to provide clear guidance that is specific to Tribes causes confusion and conflict. Many Tribes do not have access to legal counsel that can guide them in the absence of clear federal directives. Too often, Tribes have found themselves in the position of having to return funding due to conflicting or unclear guidance.

Whenever possible, agencies, such as CDC, should partner with IHS through an interagency agreement to pass funding to Tribes through IHS, so that Tribes can compact and contract the funding if they so choose. Note that this does not reduce the responsibility for agencies to provide training, technical assistance, and other support in the same manner that they would for grants through their own offices.

As discussed by Chairwoman Andrews-Maltais during the Dialogue, one step that could make significant progress on this issue would be a Secretarial Order to coordinate funding to Tribes across the HHS. So many grants to Tribes come through different agencies within HHS, all with different rules, reporting, and timelines – resulting in immense administrative burden for Tribes. Streamlining processes and coordination across the entire agency and building in agency-wide exemptions for Tribes wherever possible will help stop this hemorrhage of Tribes’ resources.

We appreciate the efforts the federal government has made at improving inter-agency coordination. The development of shared inter-agency calendars like those mentioned by Fatima Abbas in the Treasury Department is a step in the right direction. We ask that you continue to build on those efforts. When practices are effective, work to institutionalize those successful practices and policies so progress is not lost when the administration changes.

## **V. Tribal Public Health Capacity and Infrastructure**

Contemporary Tribal public health systems, shaped by a history of colonialism, epidemics, government policy, and a lack of funding, evolved along a different trajectory than their local and state counterparts and hence they are often overlooked and not appropriately recognized in the U.S. governmental public health system. Although Tribes have worked hard to build capacity, many systems require long-term investments to bridge gaps.

The COVID-19 pandemic has highlighted the need for strong public health infrastructure in Indian Country. According to the latest data from CDC, AI/AN people are 1.7 times (70%) more likely to be diagnosed with COVID-19. Even more astonishing, they are 3.4 times (340%) more likely to require hospitalization and 2.4 times (240%) more likely to die from COVID-19-related infection when compared to non-Hispanic white people.

The last 18 months have also highlighted Tribes’ abilities to lead successful community-grounded efforts to protect their people, such as through the imposition of widespread health and safety restrictions, and the launch of successful vaccination campaigns. Federal agencies must help Indian Country build upon these successes.

The government must prioritize Tribal public health infrastructure and capacity and provide appropriate resources. The pandemic has further devastated Tribes through the depletion of their General Funds, as they must fill in gaps left by insufficient services and resources from the federal government. Like state and territorial governments, Tribes have both the rights and responsibilities to provide vital public health services for their communities. To do this, they must also have the tools to carry out these functions, including funding. The funding required to build this infrastructure will be greater than the funding needed to merely maintain existing infrastructure

and will involve agencies and offices across HHS and other federal departments, such as the Department of Agriculture and the Department of Housing and Urban Development.

There are several recent bills passed or currently in Congress that utilize Tribal set asides. We request a minimum 5% set aside for Tribes and Tribal organizations across all of CDC's centers, institutes, and offices. This will ensure Tribal public health needs and priorities are integrated across the entire CDC and its programs. In addition, when funding is transferred from the CDC to the IHS to administer or to pass through to Tribes, CDC should still provide technical assistance, training, and other resources to Tribal recipients.

***a. Emergency Preparedness***

The CDC provides funding to build preparedness and response capabilities. Currently the CDC has Public Health Emergency Preparedness (PHEP) cooperative agreements with all 50 states, in addition to 4 cities and 8 U.S. territories. This program should be adapted to ensure Tribes are eligible for and may directly access this funding.

In addition, a Tribal Public Health Emergency Fund should be established to provide for Tribes for future emergencies. As Tribal leaders discussed during the Dialogue, accessing Federal Emergency Management Agency (FEMA) funds through the emergency declaration process involved complicated administrative processes and emergency plan updates. This was a heavy lift for Tribes, even when FEMA provided technical assistance. Tribal leaders observed that FEMA has a system that works well for states, but not for Tribes. One reason for this is that states receive annual emergency management program funding. As a result, they have the infrastructure and administration in place already to streamline receipt of Public Assistance or other funding under their emergency declarations. For these reasons, FEMA should set aside annual funding for Tribal emergency management programs.

***b. Tribal Public Health Workforce Development***

Under the American Rescue Plan (ARP), the Biden Administration invested \$240 million for public health workforce activities in Indian Country to recruit and retain additional public health professionals in the Indian health system. Further, the Biden Administration also announced a separate plan to invest \$7.4 billion from the ARP in the public health workforce, directed toward the CDC, focusing on high-risk communities, and creating a diverse pipeline for the public health workforce.

The \$7.4 billion plan includes a \$4.4 billion investment in surge staffing to state and local health departments and \$3 billion to prepare for future pandemics. Recruiting individuals from the communities they will serve and from backgrounds underrepresented in critical public health professions is a priority. Yet, there is no mention of AI/ANs or the Indian health system.

Although the ARP provided an initial investment in Indian Country's public health workforce, the CDC should include the Indian health system and AI/AN people as they create any programs intended to diversify the national public health workforce. The CDC must also include AI/AN public health experts to inform the design and focus of the new CDC grant program that will modernize the public health workforce that supports public health infrastructure in lower-income and underserved communities. The CDC should develop measures to assess and track governmental public health workforce capacity to ensure gaps in workforce capacity and development are lessened and not widened over time.

### ***c. Provider Shortages***

Essential resources in need of federal investment also include training, technical assistance, and policies that prioritize the development of sustainable, local Tribal workforce capacity.

The Indian health care system is experiencing a dramatic shortage of providers due to the surge of the COVID Delta variant. The entire system had already experienced a serious provider shortage which was exacerbated by the COVID-19 pandemic. This shortage has led to burnout in providers, but the number of rising COVID-19 cases has now stretched the Indian health care system to crisis levels.

With a surge in cases, not only are there not enough providers, but our remaining providers are experiencing more severe burnout and our providers with children are also having to miss work when their children must isolate due to COVID exposures in school.

The Indian health care system needs more timely access to health professionals to come on site and help fight during the pandemic. HHS must work to coordinate across agencies, departments, and organizations to address these shortages and provider burnout as the public health emergency continues to impact our provider levels. The Indian health care system should have the same access as other facilities to receive emergency staffing support and should receive technical assistance to help facilitate the request.

We also ask that Health Resources and Services Administration (HRSA) continue its support for National Health Service Corps (NHSC) placements within the Indian health system and work to expand the reach of the program into Indian Country. To assist Tribes and IHS in addressing provider shortages, we request HRSA to develop a Tribal set-aside within the Teaching Health Centers Graduate Medical Education program for IHS and Tribal medical residency programs.

### ***d. Infection Prevention and Control***

On Friday, September 17, 2021, the Biden Administration announced an investment of \$2.1 billion to protect patients and healthcare workers from COVID-19 and future infectious diseases. The Administration is working through the CDC to provide state, local, and territorial public health departments, and other partner organizations with resources to fight current and emerging infectious diseases and infections in healthcare facilities. There should be at least a 5% set-aside for Tribal public health departments so they can work with Tribal healthcare facilities to improve infection prevention and control and increase capacity to detect infectious disease threats. Some of the \$2.1 billion will be used to support state efforts to improve the National Healthcare Safety Network data collection from healthcare facilities. This includes expansion in reporting and providing technical assistance to facilities reporting. We ask that Tribes have access to technical assistance and data, including funding to improve Tribal data collection efforts.

### ***e. 21st Century Health Technology***

The COVID-19 pandemic has highlighted the importance of telehealth and the need for updated health IT, including electronic health records, in Tribal communities. Yet, broadband and other technologies are lacking in Tribal communities. Likewise, interoperability is a challenge in Indian Country for the interface of electronic health records as well as emergency communications systems.

Past COVID-19 funding has authorized the use of broadband funding for telehealth use and there is additional funding in the bi-partisan infrastructure bill for broadband, including telehealth. The federal government must ensure that budgets fully fund interoperability and technological needs in Indian Country, including electronic health records, health IT, and emergency communications systems, with the funding being provided directly to Indian Tribes, not through grants.

In addition, Medicare should permanently move the telehealth reimbursement rate to the OMB rate so that providers in the Indian health care system can collect the true cost of providing that health care for our patients. We learned a lot because of COVID, and telehealth is here to stay; we've seen the benefits in our ability to better serve our patients during the pandemic. The rate should be adjusted accordingly.

#### ***f. Tribally-Tailored Pandemic Guidance and Recommendations***

The CDC has created and released guidance and recommendations for COVID-19 prevention and response throughout the Public Health Emergency— usually without ever gathering feedback from Indian Country. Although these recommendations may work well for non-Tribal populations, in some cases they undermine the efforts of Tribal leaders and governments in addressing problems relative to the COVID-19 pandemic. For example, when the CDC released guidance that loosened the mask mandates, some Tribal Nations were still experiencing a rise in cases. So, when Tribal governments were requiring their citizens to remain masked indoors, the CDC was promoting messaging that contradicted the practices that were needed to keep Tribal citizens safe.

If CDC considered the impact these recommendations might have on Indian Country before issuing guidance, messages could be more carefully tailored and unintended consequences could be avoided. Feedback from Indian Country should be sought and incorporated early in the process of developing guidance, so that the guidance is carefully tailored and does not inadvertently undermine the efforts of Tribal governments or provide conflicting messaging.

To further support Tribes, we ask that the CDC communications team also get feedback from Indian Country on Tribal-specific guidance and images used in that guidance. Culturally appropriate and easy to understand educational materials should be made available to Tribes, in addition to Tribal clinics, that consider the diverse needs of Tribal Nations.

The federal government could also play a useful role in providing guidance to state and local governments on effective collaboration with Tribes during public health emergencies.

#### ***g. Consideration for Distribution of Medical Materiel in Tribal Communities***

Tribes should be included in planning the distribution of personal protective equipment (PPE), pharmaceuticals, and other essential supplies. Not all Tribes have Tribal clinics, so many are left out of the opportunities to receive PPE. All Tribes, not just clinics, should have access to these kinds of supplies from the federal government. In addition, any distribution model using retail pharmacies to distribute medicines or vaccines should include Tribal pharmacies. Tribes are often in rural and geographically isolated areas and not in proximity to retail pharmacies.

All Tribes, especially those in rural or isolated areas, should be engaged in planning for any medical equipment, supplies, PPE, or testing distribution. Tribes have a better understanding of the land and communities and can be invaluable partners as agencies determine the best and most effective means of distribution. Moreover, consulting with and involving tribes in this planning

and distribution process can help determine how to make distribution through the emergency supply chain faster and more efficient.

In addition, Tribal companies are ready, willing, and able to be part of the supply chain. It would be beneficial to have federal policies to buy Native American whenever possible.

## **VI. Tribal Public Health Data and Research**

Dependable data systems are a key element of strong Tribal public health systems. This includes both during times of emergency, such as this ongoing pandemic, and routine operations of essential public health services.

For example, according to the Public Health in Indian Country Capacity Scan, syndromic surveillance occurs in only 24% of Tribal health organization service areas. Conversely, according to the 2019 ASTHO profile, 86% of states and the District of Columbia (44/51) report performing syndromic surveillance activities. Tribal health organizations also reported a lack of epidemiologists and statisticians and cited a need for technical assistance and training related to epidemiology, data analysis, and public health informatics.

Data access is essential for research and response efforts but remains a challenge for many Tribal Nations. In a September 2020 letter, former CDC Director Robert Redfield and CSTLTS Director Jose Montero indicated that data was being shared with Tribal Epidemiology Centers on a bi-weekly basis. During the August 2021 CDC/ATSDR Tribal Advisory Committee meeting, the Center for Surveillance, Epidemiology, and Laboratory Services shared their work supporting COVID-19 data collection, surveillance, and communication for AI/AN populations. In both instances, there was no information on any regular data sharing between the CDC and Tribes or Tribal health departments. As sovereign governments with public health authority, it is critical that Tribes receive timely, relevant data and support about their people.

As we work to establish critical improvements in research, data capacity, and networks for Tribes, we must also continue to address the general mistrust in research common among AI/AN peoples. This mistrust is rooted in historic and current cases of ethical violations. In any National Institutes of Health (NIH) research involving data about Tribes or Tribal members, NIH should take steps to ensure Tribes are ethically and meaningfully engaged in the development of the research project. Each Tribal Nation must have full oversight and authority over the control, storage, and use of any data associated with their Tribal Nation. Furthermore, Tribal Nations must provide individual consent for the use of such data.

In addition, the NIH should end the competitive grant process, which pits Tribes against each other for essential health research funding. This process does not honor the trust obligation the federal government has to Tribes. Further, Tribes often must compete against more established research entities for significant federal dollars, often losing out on those opportunities.

## **VII. Infrastructure**

For centuries, public health officials have known improvements to infrastructure are vital in improving the public's health. The COVID-19 pandemic has again confirmed this reality: there can be no control of infectious diseases without adequate investment in infrastructure. Water, sanitation, roads, housing, energy, healthcare facilities, and broadband are essential in achieving and maintaining good health in every community, no matter how remote. Chronic underinvestment



in such infrastructure created the vulnerabilities that left Tribal communities so exposed to the devastating impact of COVID-19.

We appreciate the additional federal resources provided during the pandemic, and those that were shared with us during the Nation-to-Nation Dialogue; however, the reality remains that these are insufficient. As Councilman Nate Tyler said during the Dialogue, we have faced significant issues with water, broadband, and other critical infrastructure for years and years. In addition, many of the programs mentioned by officials during the Dialogue, like the joint venture program and small ambulatory program, do not always benefit Tribes in the long term.

It is simply unacceptable that IHS annually receives only 10-20% of sanitation funds needed, as reported by James Ludington, Director of Office of Environmental Health and Engineering. Or, similarly, that the list of facilities highlighted for replacement in 1992 is not yet complete. The need has only grown during the decades since, and the consequences of this neglect have compounded.

In addition to the need for significantly increased dollar amounts, other barriers to infrastructure improvement need to be addressed. For example, in some areas, no contractors are available to implement new broadband access even if funding became available. The funding mechanisms must also be appropriate for Tribes to reasonably be able to access funding meant to be available to them. Much infrastructure funding passes through states to reach Tribes, but this does not benefit Tribes in the long term.

#### **VIII. Conclusion**

Thank you for providing Tribal leaders the opportunity to have a dialogue around the COVID-19 response in Indian Country. We hope this is the first of many conversations on how to support Tribal public health infrastructure and emergency preparedness. We hope this letter serves as a helpful reminder of the request and feedback shared during the session. Thank you in advance for your consideration of these comments and we look forward to further engagement with the Health Committee of the White House Council on Native American Affairs.

Yours in Health,

A handwritten signature in black ink, appearing to read "Stacy A. Bohlen". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Stacy A. Bohlen, *Sault Ste. Marie Chippewa*

Chief Executive Officer

National Indian Health Board