

# National Indian Health Board



Submitted via email: [Secretary@HHS.gov](mailto:Secretary@HHS.gov)

April 3, 2020

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

Dr. Robert R. Redfield  
Director  
Centers for Disease Control and Prevention  
1600 Clifton Road  
Atlanta, Georgia 30333

Dr. Elinore F. McCance-Katz  
Assistant Secretary for Mental Health and Substance Use  
Substance Abuse and Mental Health Services Administration  
5600 Fishers Lane  
Rockville, MD, 20852

Mr. Thomas J. Engels  
Administrator  
Health Resources and Services Administration  
5600 Fishers Lane  
Rockville, MD, 20852

Dear Secretary Azar, Assistant Secretary McCance-Katz, Director Redfield, and Administrator Engels:

On behalf of the National Indian Health Board (NIHB), which was founded by Tribal Leaders almost 50 years ago, and which serves all federally recognized American Indian and Alaska Native (AI/AN) Tribes on all matters of health services and public health, we write to strongly urge you to implement the recommendations outlined in this letter to ensure critical COVID-19 relief funds are delivered according to the guidance of elected Tribal leaders as expeditiously as possible.

First, we would like to express appreciation to the Department of Health and Human Services (HHS) for your efforts towards securing an additional \$40 million in public health funding for Indian Country through the Centers for Disease Control and Prevention (CDC) under the *Coronavirus Preparedness and Response Supplemental Appropriations Act*. We also applaud

HHS for authorizing the transfer of an additional \$70 million to the Indian Health Service (IHS) from the Public Health and Social Services Emergency Fund. These are critically needed dollars that will help stem the tide of the pandemic in Indian Country.

Furthermore, we are pleased that the Coronavirus Aid, Relief, and Economic Security Act (or CARES Act) includes meaningful direct funding for IHS and Tribal health systems. These include over \$1 billion for the IHS Services Account; a minimum \$125 million set-aside for public health through the CDC; a minimum \$15 million set aside for mental and behavioral health services through the Substance Abuse and Mental Health Services Administration (SAMHSA); and a minimum \$15 million set aside for health surveillance through the Health Resources and Services Administration (HRSA). This is an important start, and we remain committed to working with the Administration and with Congress to secure additional direct resources for Indian Country.

We write today to outline Indian Country's priorities and perspectives on how these funds should be delivered to Tribes and Tribal organizations and we stand ready to work with HHS, CDC, SAMHSA and HRSA to achieve the full implementation of these recommendations.

### **Background**

As of April 1, 2020, the IHS has reported 268 confirmed COVID-19 cases in Indian Country. However, given barriers to testing, actual cases may be substantially higher. Moreover, challenges with the IHS electronic health record system (EHR) are also creating barriers to disease surveillance and data sharing.

There is no question that the Indian health system is especially hurting under this pandemic. Unlike state and local governments, Tribes do not have a local tax base to supplement their revenue streams. And because of social distancing and quarantine protocols, many Tribal businesses and enterprises are closing down, further constraining availability of funds to cover healthcare and public health needs.

Countless Tribes have reported that their personal protective equipment (PPE) has run out, placing both healthcare workers and patients at increased risk. Before the pandemic, IHS and Tribal hospitals already had starkly limited intensive-care unit (ICU) capacity. Current space capacity in IHS health care facilities is only about 52% of that required based on the size of the AI/AN population, meaning the Indian health system is woefully unprepared to respond to a surge of COVID-19 cases.

As of March 30, over 1,000 Commission Corps officers have been deployed to address COVID 19, with a sizable percentage of those officers coming from their duty stations at IHS or Tribal sites, leaving Indian Country with even fewer health providers than it had before the pandemic began. Further, because Tribal governments have historically been left out of public health funding streams, and IHS is still reliant on an archaic health information technology (IT) infrastructure, large swaths of Tribal lands are without basic capabilities to conduct disease surveillance, engage in quarantine and isolation, or rapid emergency response.

### **Tribal Feedback**

Earlier this month, NIHB released a national survey to assess the needs and priorities of Tribal governments in response to the COVID-19 emergency, collecting responses from 197 Tribal Nations. The results were alarming. Less than one fifth of Tribal respondents indicated receiving any supplies or technical resources from state (18%) or federal (16%) entities. Only 7% of Tribal respondents reported receiving durable medical equipment (DME) from federal agencies, and only 4% reported receiving PPE. Tribes reported even fewer direct resources from state entities – with only 2% of Tribes indicating that they received either DME or PPE from their state governments. These issues must be urgently addressed in order to protect and preserve life.

On Tuesday March 31, 2020, the National Indian Health Board (NIHB) hosted a national All-Tribes Listening Session call with Tribal leaders, technical experts, and Tribal health officials to seek their guidance on how the CDC set-aside funding for Indian Country under the CARES Act should be disseminated. Over 600 Tribal leaders and representatives joined that virtual session. On Wednesday April 1, 2020, NIHB hosted a second national All Tribes listening session with Tribal leaders, technical experts, and Tribal health officials to seek their guidance on how the SAMHSA and HRSA Tribal set-aside funding from the CARES Act should be disseminated. Over 400 Tribal leaders and representatives joined that session.

### **Recommendations**

With feedback gathered on these listening session calls, through the survey to Indian Country, and through other Tribal leader engagement, we have outlined several recommendations that we urge you to implement to assist Indian Country in COVID-19 preparedness and response efforts.

#### **Formula Funding/ Make Funding Non Competitive**

- All Tribal Nations are facing this COVID 19 crisis.
- **ALL** Tribal Nations need baseline funding to support our COVID-19 response. Funding should not be competitive and should not pit Tribes against each other.

#### **Provide Additional Funding Above and Beyond the Tribal Set Aside**

Our entire nation is facing unprecedented hardships in light of this pandemic, and Indian Country is no exception. However, the chronic and pervasive underfunding of the Indian health system makes IHS and Tribal facilities significantly less prepared than their state or local government counterparts to respond to this public health emergency. Our hospitals and clinics are rapidly experiencing severe financial, staffing and materials shortages. At the same time Indian Country experiences the highest rates of chronic conditions which make our populations especially vulnerable to the most acute cases of COVID 19.

- The 3<sup>rd</sup> COVID 19 legislative language made clear that additional funds above the tribal set aside could be directed to Tribes.
  - We have a higher level of need, and we ask that you provide additional funding to Indian Country above and beyond Tribal set aside amounts.

#### **Flexible Funding is Needed**

- Tribes know best what their needs and priorities are. In acknowledgement of the government to government relationship, and to honor Tribal sovereignty, this funding

should be as flexible as possible under the law, to allow Tribes to design their response activities and determine their own priorities.

#### Retroactive Payments Should Be Supported with This Funding

- Many Tribes could not wait on the federal government to provide funding to address this crisis. Many Tribes have expended their own funds to address the current COVID-19 needs. These funding streams should allow for retroactive payments for expenditures that Tribes have undertaken since January.

#### Get Information out to All Tribes

- In the past, not all Tribes have gotten information on available funding. HHS and its relevant operating divisions must ensure **ALL** Tribes get this information so they know these funds are available. We need you to use multiple channels, multiple platforms, and multiple partnerships to ensure every federally recognized Tribe has information about the funding available, and the tools to apply for the funding.

#### Distribute Funding Quickly

- Tribes are very concerned with a situation that is evolving quickly and that is bringing exponential challenges day by day. Tribal leaders ask that the agencies get funding out as quickly as possible.

#### Facilitate Interagency Transfers from CDC, SAMHSA and HRSA to IHS

- Many Tribal leaders have expressed a preference for inter-agency agreements which would transfer the available CDC, SAMHSA and HRSA funding from the 3rd COVID 19 legislative package to IHS. Once this funding is at IHS, IHS would be able to distribute the funding according to existing formulas and mechanisms. These formulas and mechanisms have been vetted through prior Tribal consultation.

#### Funding Mechanism and Distribution

- If interagency transfers to IHS are not legally permissible, we recommend that existing funding mechanisms be used where possible to help expedite distribution, keeping in mind that **ALL** Tribal Nations need baseline funding. Additionally, we recommend the Agencies adopt existing IHS funding formulas where it is possible to do so, since those formulas have been subject to Tribal consultation.
- SAMHSA designed the Tribal Opioid Response program using formula funding for all Tribes. Unfortunately, not all tribes applied for this money. If SAMHSA uses this mechanism, the Agency must ensure ALL tribes can receive this funding.

#### Cut Administrative Burden

We urge you to cut down the administrative burdens involved in getting out the funding to Indian Country. We urge you to make the application and reporting requirements as **simple** as possible and ensure that Tribes can receive funds as **quickly** as possible. This is especially important if interagency transfers to IHS are not possible.

- We ask for this consideration in all aspects of the distribution of funding, monitoring and reporting– and especially with regards to initial distribution.
  - Tribal leaders and health directors are in the midst of a crisis. Indian Country is not able to devote the time and resources to grant writing when preparation and response activities must be prioritized to save lives in the days and weeks ahead. Also, many Tribes do not have dedicated grant writers on staff.
  - If funding must go out in grants and/ or cooperative agreements, the Agencies should create and distribute tools to help. For example, to help alleviate the administrative burden of applying for grant funding, agency staff should create and disseminate templates so that Tribes can quickly adopt and adapt those templates to support their applications.
  - Tribes should be able to get funding without all of the normal red tape, including streamlining the registrations that are normally required, on many different administrative sites.
  - Funding should *not* be competitive, and as such, agency staff should be able to provide any needed assistance to Tribes applying for the funding.

#### Braiding Funding

- Tribes are putting together funding from many different places to address this crisis. We need federal agency partners to recognize that this is a necessary practice, and we ask that you provide assistance to make this process smoother.
- Wherever legally permissible to do so, funding from IHS, CDC, SAMHSA, and HRSA should be allowed as matching funds, where matching funds are required (for example as part of required FEMA matching funds)
- Federal agencies need to be working together, along with working with Tribes, to streamline reporting processes, when funding from different agencies is combined to address the overall COVID 19 response.

#### Agencies need to provide an explanation and justification for their distribution plans

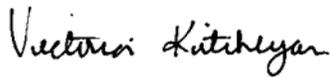
- We request that HHS make very clear how they incorporated Tribal leader input and include a justification if Tribal recommendations were not incorporated.

#### In conclusion

The federal government has trust and treaty obligations to Tribal Nations and Peoples in perpetuity for healthcare and public health. We stand ready to work with HHS and its Operating Divisions to ensure the Indian health system is prepared to address this health emergency.

Yours in Health,

The Executive Committee of the National Indian Health Board



Victoria Kitcheyan,  
Chairwoman



William F. Smith Jr.,  
Vice Chairman



Lisa Elgin,  
Secretary



Samuel Moose,  
Treasurer



Marty Wafford,  
Member-at-Large

cc:

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