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Transmitted Electronically to
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Rear Admiral Michael Weahkee
Director
Indian Health Service
5600 Fishers Lane
Rockville, MD 20857

Dear Rear Admiral Weahkee,

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we write to provide comment to the Indian Health Service (IHS) in response to its Tribal consultation on its COVID-19 Pandemic Vaccine Draft Plan (Draft Plan). As viable COVID-19 vaccines are developed and deployed, it is critical that Indian Country is prioritized during each phase of distribution, given the federal trust obligation and the high rate of the disease in our communities. In addition, the federal government must acknowledge and uphold the sovereignty of Tribal Nations in vaccine distribution and allocation. As the federal government continues to pursue emerging options, Tribal Nations must be consulted on all deployment strategies and guidelines, as well as fully briefed on the results of clinical trials and other testing. Given its participation in Operation Warp Speed (OWS) and as the primary federal agency charged with the provision of health care to Tribal Nations and Native people, IHS must advocate to ensure the trust obligation to Tribal Nations is upheld during the vaccine allocation process, by ensuring we receive equitable allocations of vaccine during all phases of distribution, and that the sovereign decision-making exercised by Tribal Nations in this process is honored.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of 30 federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico[1]. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our patients receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), 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), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), 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), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Honor Tribal Sovereignty and Trust Obligation in Prioritization, Distribution, and Administration
There are three sovereigns in the United States: Tribal governments, the federal government, and state governments. The U.S. Constitution recognizes Tribal Nations as distinct political entities, vested with the same powers of self-government as state and federal governments. While Tribal Nations are subject to federal law, states have no authority over Tribal Nations unless expressly authorized by Congress. When it comes to sovereignty, Tribal Nations and states are on equal footing. Accordingly, the federal government must recognize and uphold our sovereign status in all aspects of vaccine allocation and distribution.

This means ensuring that Tribal Nations must have the same equitable access to vaccine, from its earliest stages of availability, as state jurisdictions. Just as the federal government is working to create a plan for allocating vaccine on an equitable basis to the 60 "jurisdictions" in Phase 1, this plan should necessarily include direct allocations to Tribal Nations who choose to receive vaccine from IHS. We stand firm in asserting that no Tribal Nation should be left out of any phase of vaccine allocation. IHS, along with OWS, must account for this in the federal government's national allocation strategy or risk violating the trust obligation to Tribal Nations. Indian Country further expects that IHS will be our advocate at the table during any private meetings of OWS.

In addition to advocating for Tribal Nations during the national allocation process, IHS and the whole of the federal government must defer to Tribal sovereignty during the prioritization process. We note that the IHS Vaccine Draft Plan contains little information about what methodology will be used to distribute vaccine within Indian Country. A 'with-in Indian Country' strategy must be developed in consultation with Tribal Nations. On page 7 of the Draft Plan, IHS indicates that it "will identify [American Indian and Alaska Native] priority groups based on available information from the [Centers for Disease Control and Prevention] and the [Advisory Committee on Immunization Practices]." We assert IHS cannot unilaterally define priority groups; these must be developed in consultation with Tribal Nations. In addition, Tribal Nations themselves should determine how the vaccine will be allocated in Tribal communities, including to our non-Native community members and employees. No other unit of government should make this choice. While we welcome the development of a model Tribal vaccine allocation plan, in consultation with Tribal Nations, we should not be required to utilize any particular allocation plan or guideline. Only we can determine how best to utilize a limited supply of vaccine or therapeutic within our communities.

The IHS Vaccine Draft Plan also speaks to vaccinating Health Care Professionals during Phase 1, but is silent on other vulnerable populations that should be prioritized as the earliest doses become available. This focus may be appropriate for IHS-operated Service Units and their employees, but it does not acknowledge or support the sovereign right of Tribal Nations to determine how to allocate vaccine within our own communities. While first responders, including Health Care Professionals, are certainly part of the high-risk population in Tribal communities, Tribal Nations are charged with caring for and protecting all of our community members, including IHS beneficiaries, their families, and our employees (first responder and not). It is our duty to ensure vaccine is allocated first to all of our most vulnerable or high-risk community members.

Tribal Nations are the Final Arbiter of Population Counts
As you are likely already aware, many federal sources of data on Tribal populations, especially datasets that rely on census counts, are inaccurate and do not reflect Tribal enrollment numbers. In some cases, this includes IHS user population counts. Moreover, none of these datasets are likely to fully capture those living and working within our communities. With this and Tribal sovereignty in mind, we insist that Tribal Nations be the final arbiters of our own population counts.

Support for Self-Governance Tribal Nations
As noted above, the IHS Draft Vaccine Plan appears to have a strong focus on the allocation and distribution strategy for IHS-operated Service Units while providing few details on how the agency will support self-governance Tribal Nations. This includes a focus on unilateral IHS decision-making in many places throughout the Draft Plan. As the National Academies of Sciences, Engineering, and Medicine Committee on Equitable Allocation of Vaccine for the Novel Coronavirus' *Preliminary Framework for Equitable Allocation of COVID-19 Vaccine* states, "for Tribes that exercise their right of self-determination and self-governance through a compact [or contract] with IHS to provide services for their population, vaccine administration could be coordinated through the IHS Office of Self-Governance. This would respect the government-to-government relationship between the U.S. and federally recognized Tribes."

However, we are concerned that neither the Office nor the concept of self-governance is included in the Draft Plan. Certainly, it is our expectation that representatives from the Office of Self-Governance are serving on IHS' Vaccine Task Force. However, IHS must clearly delineate in its final Vaccine Plan how the approach outlined in the Draft Plan will apply to self-governance Tribal Nations and how the agency will support Tribal self-governance as the vaccine is allocated, distributed, and administered.

Vaccine Costs Should be Covered by the Federal Government
It should be understood and confirmed that the cost of vaccine allocated to Indian Country be borne by the federal government. This includes costs associated with the administration and storage of any vaccine, as well as related supplies. The Draft Plan notes the possibility of administration fees. While these fees should absolutely be charged to any private or public (Medicaid, Medicare, Veterans Affairs) insurance that an individual holds, it is wholly inappropriate to bill IHS beneficiaries or Tribal Nations. In accordance with federal trust and treaty obligations to provide health care, Tribal Nations and Native people must be able to access and administer any COVID-19 vaccine at no cost. In addition, though we recognize that information on necessary supplies for vaccine administration is not complete at this time, IHS should include in its final Plan confirmation that it will provide these supplies to Tribal Nations without charge.

Streamline Reporting Requirements
USET SPF is aware that any jurisdiction in direct receipt of vaccine from the federal government will be subject to certain reporting requirements. However, we note that these requirements have not been developed in consultation with Tribal Nations, nor with Indian Country in mind. In an effort to promote Tribal self-determination and support those Tribal Nations who opt to exercise our sovereign right to access the vaccine directly, reporting requirements should be streamlined to include those data elements that are absolutely necessary. Additionally, though we are pleased to see that IHS is already considering issues around lack of access to broadband, electronic health records and other IT infrastructure as part of the Draft Plan, USET SPF reminds the agency that these issues must not be barriers to the exercise of our sovereign right to access and administer the vaccine. IHS must provide and/or accept appropriate workarounds for any lack of infrastructure without adding additional administrative burdens to Tribal Nations.

Communications Must Include Transparency in Vaccine Approvals
While Indian Country must receive some of the very first doses of vaccine as they become available, any vaccine or therapeutic must only be approved after scientifically rigorous vetting and clinical trials. While we appreciate the issuance of appropriately stringent guidelines for Emergency Use Authorization from the Food and Drug Administration, many in Indian Country (and beyond) remain concerned that in an effort to speed the deployment of viable vaccines, research supporting their safety and efficacy may be insufficient. Prior to deployment in Indian Country, Tribal Nations must be assured that approved vaccines are safe and

effective through the transparent sharing of results of clinical trials and other testing. As IHS develops its communications plan on COVID-19 vaccines, it must ensure that the science behind the federal approval of these vaccines is included and shared in a clear and easy-to-understand manner.

Ongoing Tribal Consultation Required

The public health emergency caused by COVID-19 is likely the greatest national crisis we will face in our lifetimes. Given its gravity and profound impact on Tribal Nations, any federal vaccine allocation framework, guideline, or plan, including the Draft Plan, must receive meaningful and ongoing Tribal consultation. We expect that ongoing Tribal consultation will occur on this and any other strategy for the deployment of limited supplies of vaccine and therapeutics, including as vaccines are approved and new information is received.

Conclusion

It is critical that the trust obligation to Tribal Nations and Native people be prioritized as essential to any federal distribution plan. And as the primary agency charged with the provision of health care to Tribal Nations, IHS is uniquely positioned to ensure that the trust obligation is delivered upon as vaccine is allocated, distributed, and administered. This includes upholding and supporting our sovereign right to receive vaccine directly from the federal government, along with other jurisdictions among the U.S. family of governments. While we understand the United States has a duty to each of its citizens, its obligation to Indian Country is unique. A failure to deliver upon this obligation as a vaccine is allocated will be detrimental to Indian Country and the nation as a whole. We encourage you to keep this in mind, as you craft and finalize a federal allocation and distribution strategy in the coming months. Should you have any questions or require further information, please contact Ms. Liz Malerba, USET SPF Director of Policy and Legislative Affairs, at LMalerba@usetinc.org or 615-838-5906.

Sincerely,

Kirk Francis
President

Kitcki A. Carroll
Executive Director