USET
SOVEREIGNTY PROTECTION FUND

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Transmitted via consultation@ihs.gov

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Elizabeth Fowler
Acting Director
Indian Health Service
5600 Fishers Lane, Mail Stop 08E86
Rockville, MD 20857

Dear Acting Director Fowler,

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) on the allocation of $6.1 billion in COVID-19 resources authorized under the American Rescue Plan Act of 2021 (ARP). At a level nearly equal to the entire Fiscal Year 2021 appropriation for IHS, these funds have the potential to facilitate enormous change in the Indian Healthcare System, during the COVID-19 public health emergency and beyond. It is with this in mind that USET SPF urges IHS to take both a short- and long-term approach to the use of these dollars, and as we have previously advocated, utilize methodologies that will ensure rapid distribution to our communities that is equitable, flexible, and reflective of our sovereign governmental status.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of 33 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 Native people. 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.

As the COVID-19 pandemic enters its second year, Tribal Nations are feeling hopeful, as vaccine deployment continues across our communities. However, in seeking to respond to this once-in-a-lifetime public health threat, our staff and resources have also been severely taxed and in many cases, depleted. While Tribal Nations have seen some relief in previous legislative packages, in my cases, access to these

[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), 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).

resources has been uneven, with allocation amounts frequently insufficient to truly respond to the impacts of COVID-19 on our health systems. USET SPF celebrates and welcomes the $6.1 billion authorized for the Indian Healthcare System. However, it is critical that these resources be distributed in a manner that recognizes both the trust obligation, as well as current and ongoing inequities.

General Comments

Rapid, Equitable Funding Distribution that Upholds Tribal Sovereignty

For over a year now, USET SPF member Tribal Nations, as well as Tribal Nations across the country, have been fighting to respond to COVID-19 in our communities. As IHS well knows, not a single Tribal Nation has been spared from the impacts of this pandemic—public health and otherwise. Therefore, it is critical that IHS ensure that all 574 Tribal Nations have access to a sufficient level of funding from the ARP in a rapid, expeditious, and equitable manner. This can only be accomplished using existing funding mechanisms, including Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts.[2] Additionally, we continue urge IHS to avoid competitive mechanisms for this COVID-19 funding. Forcing Tribal Nations to compete for federal dollars in the midst of a pandemic would be an abrogation of the federal trust responsibility.

Further, IHS must strongly consider what mechanisms should be in place to ensure smaller Tribal Nations have access to sufficient funds from the COVID-19 authorization. As the agency is likely aware, when funding allocation methodologies like user population are utilized in the absence of other leveling mechanisms (a Tribal size adjustment or minimum level of funding, for example), smaller Tribal Nations frequently find themselves with a vastly inadequate share of funding. Recognizing, again, that all Tribal Nations have been and continue to be impacted by COVID-19, the agency must ensure that all Tribal Nations receive funding sufficient to benefit from these provisions.

Flexibility in Use of Funds and Reporting Requirements

Broadly, Tribal Nations must have maximum flexibility in the use of all funding allocated under the ARP, as intended by Congress and the Biden Administration. This includes ensuring Tribal Nations have broad authority in allowable costs and activities, unless expressly prohibited by law. Flexibility in use of funds will ensure Tribal Nations have the ability to utilize COVID-19 funds in manner that best suits our individual circumstances and communities. Further, in recognition of our sovereign status and the trust obligation, as well as the current strain on resources posed by COVID-19, Tribal Nations must not be subject to burdensome administrative requirements for use of these funds, particularly the $2 billion for lost revenue. This includes reporting, audit, or other types of compliance requirements. Any reporting requirements mandated by law must be streamlined and only the minimum required that Tribal Nations may continue to focus on COVID-19 prevention, mitigation, vaccination and recovery. Any absolutely necessary reporting should, to the extent possible, be reserved for the Annual Report only.

Comments on Specific Funding Lines

In addition to the broad guidance above, we provide additional thoughts related to the specific allocation methodologies and various other considerations for each funding line under ARP within IHS' purview.

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[2] USET SPF further notes that ARP prohibits the collection of Contract Support Costs where this funding is received through ISDEAA contracts and compacts. Recognizing this and in light of the enormous influx of COVID-19 relief and recovery funding that Tribal Nations have and will receive, USET SPF would like to work with IHS and the Biden Administration on guidance to ensure Tribal Nations have the option to exclude this funding from future Indirect Cost rate calculations.

$2 Billion for Lost Revenue
For nearly the entirety of the COVID-19 public health emergency, Tribal Nations have been reporting steep declines in 3rd party reimbursements for care provided to our patients. With our clinics operating at a staffing deficit, along with the cancelation of non-essential procedures and visits, revenue generated by federal and private insurance has fallen drastically short. This shortfall represents an existential threat to continuity of operations, given the role that third party billing (especially Medicaid and Medicare) plays in providing further resources in the face of chronic underfunding on the part of the federal government. For some Tribal Nations, 3rd party reimbursements comprise 50-60% of total operating budgets.

In spite of this, Tribal Nations have not had sufficient access to the Provider Relief Fund (PRF) under the Department of Health and Human Services, with only a very small amount being dedicated to Indian Country—approximately 0.28% of funding available. Although Tribal health care providers have been eligible for other streams of PRF funding, access has been inconsistent and insufficient across the Indian Healthcare System.

It is with this in mind that we underscore the importance of thoughtfully and equitably distributing the $2 billion in dedicated funding for the Indian Healthcare System to address this shortfall. As far as USET SPF is aware, all Tribal Nations have experienced third party revenue loss in some form. While some Tribal Nations have been able to address these losses via PRF resources, many have not. At the same time, we anticipate ongoing shortfalls as Indian Country works to address and recover from the virus.

To this end, USET SPF recommends a dual approach in allocating this funding. First, set a floor. All 574 federally recognized Tribal Nations should have access to an equal amount of base funding from a portion of the total distributed immediately. Next, Tribal Nations with actual revenue loss over and above this base should have access to additional resources, less any resources received from the PRF. There should be standard criteria for assessing what constitutes lost revenue developed in consultation with Tribal Nations.

$500 Million for Health Care Services, Including Purchased/Referred Care
USET SPF recommends that this funding be distributed using the existing methodologies for non-recurring program increases. As IHS seeks to distribute this funding across existing lines, Purchased/Referred Care should be given particular weight in this space, as it is the only IHS line item specifically identified in the statute.

$140 Million for Health IT, Telehealth, and EHR
IHS is well aware of the digital and technological divide that exists in Indian Country due to ongoing and historic federal neglect. This divide has become especially stark during the COVID-19 pandemic. Telehealth has become an invaluable resource to Tribal Nations as we seek to provide healthcare services to our people in the safest way possible. This is something that will likely continue long past the pandemic. We also note the historic and ongoing lack of access to functional electronic health records for Tribal Nations. Whether users of the Resource Patient Management System or a commercial off-the-shelf system (COTS), all Tribal Nations have been impacted by the federal government's failure to provide a 21st century electronic health record. These funds should be equitably distributed to Tribal Nations via existing mechanisms. The purchase of COTS (both retro- and prospective) should be an eligible expense.

$600 Million to Plan, Prepare for, Promote, Distribute, Administer and Track COVID-19 Vaccines, and other Vaccine-related purposes
USET SPF recommends that IHS utilize the same distribution methodology it relied upon to distribute vaccine funding under the Coronavirus Response and Relief Supplemental Appropriations Act. We also agree that these funds should be combined with those identified for Testing/Contract Tracing and Public

Health Workforce in a flexible manner, so that Tribal Nations may determine their most appropriate use at the local level.

We would also like to take this opportunity to highlight the continued inequities in the distribution of vaccines. It has recently been reported by national news outlets that some Tribal Nations are vaccinating individuals with virtually no ties to their Tribal communities whatsoever. In the Nashville Area, due to limited supply, many Tribal Nations have yet to fully vaccinate our Tribal citizens and other members of our communities. While we acknowledge a recent increase in Area allocation, we urge IHS to continue to work to rectify these inequities.

$1.5 Billion for Testing, Contact Tracing, and Related Activities
USET SPF recommends that IHS utilize the same distribution methodology it relied upon to distribute funding from the Public Health and Social Services Emergency Fund under the Coronavirus Response and Relief Supplemental Appropriations Act.

$240 Million for Public Health Workforce and Related Activities
USET SPF recommends that a majority of this funding be distributed to Tribal Nations utilizing existing methodologies for program increases. We also note the importance of public health work performed by Tribal Epidemiology Centers, with the full support of the Tribal Nations they serve, and encourage IHS to consider how this funding may further augment and compliment these responsibilities. Additionally, given the historic and ongoing difficulties attracting public health professionals to Indian Country, we also encourage increases to the student loan repayment program, as well as the beginnings of an ongoing recruitment effort for public health professions in the Indian Healthcare System. We recognize that IHS wants to avoid a funding cliff. At the same time, however, without action, a lack of public health workforce and other public health infrastructure will persist in Indian Country long after the conclusion of the COVID-19 public health emergency. Now is the time to begin addressing these long-standing inequities and IHS should be requesting additional appropriations to sustain any necessary new programs.

$420 Million for Mental Health and Substance Abuse Prevention and Treatment Services
Again, USET SPF recommends that existing methodologies for program increases be used for these funds, with a majority distributed directly to Tribal Nations. However, the Nashville Area has an ongoing lack of access to culturally-competent treatment services—for both youth and adults. This disparity has only been compounded by the pandemic. We also recommend exploring possibilities around construction of additional treatment facilities in our Area, as well as expanded resources for existing facilities.

$600 Million for Construction, Maintenance, Equipment, and Related Activities Necessary for COVID-19 Response
USET SPF recommends that these funds be distributing using the existing formula for Maintenance and Improvement. Given historic and ongoing inequities in access to facilities funding, this formula will provide for the most equitable distribution of these dollars. In addition, we agree with IHS' suggestion that it would be inappropriate to allocate these funds among the various purposes up front. Rather, IHS should to defer to Tribal Nations for decisions on the use of these dollars within the confines of the ARP.

$10 Million for the Delivery of Potable Water
USET SPF recommends that this funding be distributed via the existing Sanitation Facilities Construction Formula.

Conclusion

Due to the federal government's chronic failure to fully fund the Indian Healthcare System, as well as ongoing failures to provide necessary resources, Tribal Nations continue to operate with limited and diminishing resources as we work to address the impacts of COVID-19. While the $6 billion of funding allocated to the Indian Healthcare System provides hope in both the short- and long-term, IHS needs to work with Tribal Nations to ensure this funding is distributed as equitably as possible and in full recognition of Tribal sovereignty. We appreciated hearing some of IHS' thought process around these themes on the consultation call and urge an expeditious, but thoughtful, distribution of these resources. This will allow our health systems to both address and recover from the COVID-19 pandemic. 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