USET
SOVEREIGNTY PROTECTION FUND

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Transmitted Electronically
To 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 funding from the American Rescue Plan Act (ARPA), the Infrastructure Investment and Jobs Act (IIJA), and the Build Back Better Act (BBBA). We appreciate IHS taking proactive steps to consult with Tribal Nations early in order to ensure funding is distributed quickly. However, Tribal Nations have remaining questions about IHS proposed allocation plans, and these should be addressed before final decisions are made. As always, IHS should ensure that funding is distributed without unnecessary delay and is equitable, flexible, and reflective of our sovereign governmental status.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.[1] USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues.

As IHS well knows, the COVID-19 pandemic has underscored the chronic underfunding of the Indian Health System and its devastating consequences. Now, as we look toward recovery from the global pandemic and to "build back better" for Indian Country, IHS and the whole of the federal government must work to ensure each Tribal Nation is prioritized for recovery resources. We note that while an historic level of funding has been allocated to Indian Country as a result of these three bills, this remains insufficient to address centuries of unmet obligations for Tribal Nations. With each Tribal Nation facing at least some

[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).

deficits in health care infrastructure and resources, IHS should first focus on ensuring each Tribal Nation benefits in some way from this funding. In the longer-term, IHS should work with Tribal Nations to advocate for funds sufficient to address the unmet health care obligations of the federal government, including full and mandatory funding for IHS.

General Comments

Rapid, Equitable Funding Distribution that Upholds Tribal Sovereignty

It is critical that IHS ensure that all 574 Tribal Nations have access to funding from these bills 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. Additionally, we continue urge IHS to avoid competitive mechanisms for this funding. Forcing Tribal Nations to compete for federal dollars is 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 these bills. 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 and chronic underfunding, 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 these bills in fulfillment of trust and treaty obligations. 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 recovery funds in manner that best suits our individual circumstances and communities. Further, as underscored in the President's recent Executive Order on *Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government*, Tribal Nations must not be subject to burdensome administrative requirements for use of these funds. This includes application, 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 recovery and rebuilding. Any absolutely necessary reporting should, to the extent possible, be reserved for the Annual Report only.

ARPA Public Health Workforce Funding

USET SPF appreciates the additional allocation of $210 million in Public Health Workforce funding from the Department of Health and Human Services (HHS) following the issuance of the Administration's COVID-19 Health Equity Task Force report. As you are aware, due to chronic underfunding and federal neglect, the Indian Health System lacks the public health infrastructure from which other communities in the United States currently benefit. This contributed to an inability to fully respond to COVID-19 in Indian Country.

While we agree that Public Health Workforce funding is critical, HHS and IHS should have consulted with Tribal Nations prior to identifying the spending breakdown below. While USET SPF provides comment on each funding line, we remind the Administration that it is critical to seek Tribal guidance on all matters that would impact our Nations and people.

BIE Nurses: $92 million

We agree that all Bureau of Indian Education-funded schools, including Tribally-controlled schools, should have a nurse and/or public health personnel on staff. Priority should be given to those

schools that currently lack a nurse entirely and/or have insufficient public health staff. School nurses and public health staff provide critical public health services to our youth—our next generation of leaders. Our students should have public health and mental health protections and services as they resume their education following the shutdowns of 2020.

Public Health Capacity: $67 million
As IHS heard from several Tribal leaders on its December 14th virtual Tribal consultation, there are lingering questions as to how IHS arrived at its proposed allocation for this funding, including a proposal to reserve $20 million for an IHS Emergency Preparedness Team. While we note that more than two-thirds of the $67 million total would be distributed directly to Tribal Nations, organizations, and Urban Indian Health Programs under this proposal, it would be helpful to have greater detail on the allocation of these funds. While we agree, for example, that IHS Service Units should have Emergency Management staff and training, it's not clear what level of funding will be dedicated toward this purpose, versus how much will be retained at Headquarters. Further information on this proposal will allow Tribal Nations to provide our best guidance to IHS.

Loan Repayments: $45 million
As stated in our March 19th comments to IHS on ARPA funding, USET SPF strongly supports the dedication of additional funding toward IHS' Student Loan Repayment Program in order to build public health capacity within the Indian Health System. We further encourage IHS to expand the types of professions that are eligible for loan repayment, including those in business administration, health administration, hospital administration, and public health. Attracting and retaining these professionals, as well as clinical staff, will be key to greater preparedness and better administration within the Indian Health System.

Core Surveillance and Epidemiology: $6 million
While we can understand the need to develop IHS capacity to monitor and prepare for vaccine-preventable diseases, as well as update natality and mortality reporting, it is unclear whether and how these activities will benefit Tribally operated programs or Tribal Epidemiology Centers (TECs). Although we note the additional funding for TECs in the BBBA, passage of this legislation in its current form or at all is far from guaranteed. IHS should provide Tribal Nations will greater information as to how these activities will support our work. In addition, USET SPF reminds IHS that our organization assisted with the development of the vital statistics package (via Cimmaron) within the Resource Patient Management System for mortality data. As IHS updates natality and mortality reporting, it should utilize existing resources rather than reinventing the wheel and the information shared via existing systems should be kept up to date.

IIJA Sanitation Facilities Construction Funding
USET SPF is pleased to know that the $3.5 billion allocated to IHS under the IIJA for Sanitation Facilities Construction Funding is sufficient to address all current projects in the Sanitation Deficiencies System (SDS) today. Given our Area's historic issues with determining SDS prioritized projects, we generally support the proposed project allocation methodology. However, we suggest that Goals 2 and 3 should be achieved concurrently. We understand the desire to address as many shovel-ready projects as possible in the early years of this funding but want to be sure that those Tribal Nations without shovel-ready projects receive equitable access to funding and support. We agree that IHS should continue to make every effort to work with Tribal Nations to identify alternate funding for ineligible costs.

Build Back Better Act Funding
As stated above, USET SPF notes that the BBBA remains under consideration by Congress. While we appreciate IHS' swiftness in initiating consultation on this funding, we know that we are far from having final

legislative text. We further urge the agency to join Tribal Nations in supporting any increases to the BBBA's direct funding to Tribal Nations in accordance with trust and treaty obligations. In addition, we ask that IHS join us in supporting a provision found at Section 30701 of the bill providing for closure of the Medicaid coverage gap in states that have not yet expanded the program.

Health Care Facilities Construction Priority List: $1 billion
While the facilities of USET SPF member Tribal Nations do not appear on the Health Care Facilities Construction Priority List, we see the need to address all the facilities on this list once and for all, so that aging facilities in the Nashville Area, and other Areas, can be addressed. Going forward, we urge IHS to consider an Area Allocation methodology for Health Care Facilities Construction Funds, so that all Tribal Nations may benefit from these dollars.

Maintenance and Improvement: $945 million
Historically, Maintenance and Improvement (M&I) funding is the only way Tribal Nations in the Nashville have been able to renovate our aging facilities. BEMAR and the funding formula work well for our member Tribal Nations, and so we continue to support the distribution of these dollars using the existing M&I formula.

Small Ambulatory Program: $40 million
The Small Ambulatory Program has been another opportunity for Nashville Area Tribal Nations to address facilities deficiencies in our region. We continue to urge IHS and other federal agencies move away from any competitive grants. However, if this funding must be competed, we urge that IHS do so over multiple cycles, so that Tribal Nations have multiple opportunities to receive this funding.

Facilities and Environmental Health Support: $113 million
Through this consultation, IHS is seeking comment on whether funding for Facilities and Environmental Health Support should be allocated to only IIJA and BBBA projects. USET SPF disagrees with this approach. There are likely deficits across Indian Country in the programs, activities, and supplies funded by these dollars. Tribal Nations should not need to seek project approval in order to access funding meant for all of us.

Behavioral Health Services and Facilities: $124 million
As this funding is allocated, IHS should keep in mind behavioral health has been severely and chronically underfunded, despite the enormity of unmet obligations in this space. Providing for the most equitable access to and flexible use of these funds should guide IHS in their deployment. USET SPF recommends that this funding be distributed via ISDEAA contracts and compacts and/or Area Allocations to ensure each Tribal Nation is able to determine the best use of these dollars in response to local priorities.

Tribal Epidemiology Centers: $25 million
We strongly support additional funding for TECs, given the importance of their public health work, as well as their enormous, yet unrealized, potential due to underfunding. Rather than providing an overly prescriptive list of public health enhancements as it distributes this funding, IHS should ensure that TECs have the flexibility necessary to respond to the public health priorities of the Tribal Nations they serve.

Conclusion

We appreciate the opportunity to provide guidance to IHS on the distribution of this critical funding. We urge IHS to ensure the distribution of these dollars results in meaningful access and benefit across Indian

Country, and it upholds Tribal sovereignty and self-determination in how they are directed at the local level. As we look toward recovery from the global pandemic, USET SPF asks that you join us in working toward a legacy of change for Tribal Nations, Native people, and the sacred trust relationship. This involves the enactment of policies that uphold our status as sovereign governments, our right to self-determination and self-governance, and honor the federal trust obligation in full—including achieving full and mandatory funding for IHS. 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