

**National Indian Health Board Written Testimony
Submitted to the United States Commission on Civil Rights
July 17, 2020 Briefing
COVID-19 in Indian Country:
The Impact of Federal Broken Promises on Native Americans**

On behalf of the National Indian Health Board (NIHB) and the 574 Federally Recognized Sovereign Tribes we serve, we thank you for inviting us to participate in this critically important session examining the impacts of COVID-19 on Tribal Nations and communities.¹ Founded by the Tribes in 1972, our organization serves all Tribes, both American Indian and Alaska Native. NIHB works to strengthen Tribal sovereignty and ensure the federal government upholds its Trust and Treaty obligations to the Tribes for the improvement of health care, health outcomes and systems and public health infrastructure and capacity in Indian Country.

The US Commission on Civil Rights invited us to participate in today's briefing to discuss COVID-19 in Indian Country: The Impact of Federal Broken Promises on Native Americans.

Today we are bearing witness to and experiencing the alarming changes to our everyday lives resulting from this unprecedented crisis. In a matter of weeks, COVID-19 reshaped the very fabric of our economy, our society, the way we conduct business, relationships and our personal livelihoods – in some ways, permanently.

These are profoundly uncertain and challenging times. These are also times of profound opportunity to achieve redress of hundreds of years of injustices, which are the children of colonization. Today, our nation is confronted by the dual epics of the Black Lives Matter movement coming to fruition in the face of the intolerable deaths of Black citizens at the hands of police...and the COVID-19 pandemic that continues to disproportionately ravage the most marginalized among us: and Indian Country is right at the center of the Pandemic. But in order to understand how to address and overcome these trials and realize the opportunity for change before us, we must first insist on an honest reckoning of our history for what we see today are the fruits of colonization – a system of exploitation, violence and opportunism that is the foundation on which this Nation was constructed.

For colonization is like Foucault's Pendulum created in 1851 by the great French physicist Leon Foucault...once set in motion, it operates into perpetuity on the Earth's geo-magnetic force - with

¹ Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes 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 continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

only slight encouragement needed to keep going. Colonization's constructs proceed the same way – once set in motion, they marching through history perpetuating exploitation, injustice and marginalization of Indigenous Peoples and Peoples of color with a seemingly invisible hand spurring on its progress. It is the very construct that makes it so. Despite the poor social determinants of health most frequently found in the Indigenous and other communities of color, circumstances that proceed from hundreds of years of colonization, we are often blamed for our poor circumstances. What our communities are experiencing during this COVID-19 pandemic is simply the expected outcome of this historical truth.

It has to change.

This is not a time of incremental change – the dual, convergent crisis of racism and COVID-19 create the circumstances for lasting, profound, systemic and meaningful change. We are in a time when the unthinkable is now the possible – we are in a place of rightfully questioning what and who we glorify and honor as our history and how we will make history. We are in a time of great opportunity to heal from our sordid history through honest and complete reflection, and to collectively make manifest a future in which all of us can experience the bounty of America's founding principles of equality and liberty. There is a great African proverb that states - until the lions have their own historians, the history of the hunt will always glorify the hunter. It is time to hear our stories and include our truths in our history. It is time to be courageous in policymaking...to think and act in a new way and forge a new future and stand on new ground. And it is a time when courage is expected and honored – when valor is not uncommon.

We see the ripple effects of colonization continue to underpin the institutional and structural disparities Our Peoples endure, and the devastating similarities between Our People's struggle, and the struggles of the Black community. The fact that Native and Black communities are carrying the greatest burden of this pandemic is not by accident, but a logical outcome of a very old design.

Centuries of genocide, oppression, and simultaneously ignoring our appeals while persecuting Our People's ways of life persist - now manifest in the vast health and socioeconomic inequities we face during COVID-19. The historical and intergenerational trauma our families endure, all rooted in colonization, are the underpinnings of our vulnerability to COVID-19. Indeed, we tell our stories of treaties, Trust responsibility and sovereignty here – over and over – and it often appears the listeners are numb to our historic and current truths. But the truth does not change: that is the ground we stand on.

Across the country, we hear heart wrenching accounts of Our People experiencing racism at the hands of our neighbors while battling a pandemic that continues to lay bare how under resourced our Indian health system is and how vulnerable are our economies. We hear baseless stories about how “dirty Indians” are causing the outbreaks, or how private hospitals are refusing to accept referrals to treat Our People. These same sentiments echoed across all previous disease outbreaks that plagued Our People from Small Pox to HIV to H1N1. This begs the painful question: what has changed?

We may have reached a place where the underpinnings of colonization may finally be loosening as a consequence of the exposed neglect, abuse, bad faith and inequities American Indians and

Alaska Natives are experiencing during this pandemic. But it did not start with COVID-19. This pandemic and the way it is ravaging our Peoples is exposing the consequences of hundreds of years of US policy predicated on broken promises with the Indigenous Peoples of this land.

Please allow us to share the context from which the impacts of broken promises are felt afresh during the COVID-19 pandemic of 2020.

Treaty Rights and Inherent Tribal Sovereignty

When the first European powers arrived on the shores of what we now call the American continent, they encountered a land that, much like their own, was home to a multitude of civilizations and cultures. However, the Europeans who arrived at our shores did not share an interest in traditional diplomacy, they sought conquest. Shortly after Christopher Columbus's return to Spain after his voyage to the Americas in 1492, the European powers sought legal justification for their future colonization. In 1493, Pope Alexander VI issued a papal decree that authorized Spain and Portugal to take control of the Americas and rule over its people, the first invocation of what would become known as the Doctrine of Discovery. This decree was followed in 1494 by the Treaty of Tordesillas, which formally split newly discovered lands in the Americas between Spain and Portugal. The foundation of both of these documents and the power that they assert are both derived from the idea that a Christian nation can assert their sovereignty over their non-Christian counterparts. This idea would form the basis of the Doctrine of Discovery, which would form the underpinning of colonization over the coming centuries. This method of engagement continues to have ramifications into the present day.

The Doctrine of Discovery was the instrument undergirding the colonization of this Continent. While some argue that it's an antiquated document lost to the annals of history, Our People still bear witness the ruthlessness with which it was used, even in the way the COVID-19 response played out in Indian Country.

As the centuries passed, European powers continued their unrelenting march across the Americas. Native peoples were displaced, often by force or by the introduction of European diseases to which they had little resistance. Some Tribal nations were able to negotiate treaties before their lands were taken from them. While many of these treaties were negotiated under duress and often at the barrel of a gun, they are perhaps the earliest examples of the existence of a government to government relationship between the European powers and Tribal Nations.

The successor to these initial European powers was, of course, the United States of America. The United States Constitution established a firm place for Native peoples in the American legal system. Article I, Section 8, Clause 3 of the United States Constitution provides that Congress may have the power "to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes." However, by including Tribes as separate from foreign nations, the Framers also made it clear that Tribes occupied a third, legally ambiguous realm. Through their displacement of the English, the United States of America claimed land from the Atlantic Ocean to the Mississippi River, including Tribes with whom they had yet to engage. By virtue of "discovery," the United States was asserting a form of sovereignty over peoples with whom they had never actually engaged in formal relations.

In 1823, Supreme Court Chief Justice John Marshall authored the majority opinion of *Johnson v. M'Intosh*, in which he codified the notion that the Doctrine of Discovery was the basis of initial European settlement of the Americas. The Court affirmed the idea of Indian title, which stated that Tribes could only sell their lands to the United States and not to private actors. By virtue of having been “discovered” by the predecessor powers to the United States, Tribes were only able to sell their lands to them. Marshall is careful however to mention that the United States inherited the land as the successor sovereign to England, who themselves had used the Doctrine of Discovery in order to claim the land. The Doctrine of Discovery is never implicated as current United States policy but rather framed as a historical policy of the European powers, who used it to claim sovereignty over lands that passed to the United States.

Just over a decade later, Marshall further clarified the position of Tribal Nations in the American legal framework when he stated that they were “domestic dependent nations.” The logic trail that started in the Constitution, that Tribes were not “foreign” but not entirely domestic, had reached one of its logical conclusions.

The early approach to Indian affairs by the United States could perhaps be best described as remarkably antagonistic. The early placement of the predecessor of the Bureau of Indian Affairs in the Department of War is perhaps best emblematic of the fact. Most are also familiar with the Indian Removal Act, which was signed into law by President Andrew Jackson in 1830. The Act also provides the backdrop for an example of perhaps the most egregious flaw in American treaty making, the lack of care to ensure that they were negotiating with those who were authorized to negotiate. In the Treaty of New Echota, the Cherokee Nation allegedly ceded their claims in the Southeast and agreed to “voluntarily” relocate to modern day Oklahoma. However, the treaty was not signed by a party that was authorized to make such a concession. That fact however mattered little to the United States, who now had all of the legal justification they needed to forcibly remove the Cherokee people from their homelands.

Lack of sincerity in treaty making would be a hallmark of the United States. Over the next few decades, they signed treaties with Tribal Nations and virtually all of them were eventually broken. You may also be familiar with the Treaty of Fort Laramie, signed in 1868 between the United States and Tribes in the Great Plains. In this treaty, the United States renounced their claims to the entirety of the Black Hills. Within a decade however, the United States violated the treaty and claimed control of the Hills, including “Six Grandfathers,” a sacred site for the Lakota people, which we now know as “Mount Rushmore.” The treaties signed between the United States of America and Tribal Nations included promises of continued educational, medical, and financial support. We are still waiting for this promise to be fulfilled.

In 1871, the United States formally ended treaty making with Tribal Nations. And pursuant to their outlined duties in the Constitution, Congress began to exert more control over Indian Country. In the late 19th century, the eradication of Tribal Nations and Indian culture became the policy of the United States government. Congress was not shy about passing laws that diminished Tribal sovereignty and enhanced their own power over Native people. They passed laws that divided communal Tribal land and banned our traditional religious practices. The Bureau of Indian Affairs

even established boarding schools that sought to assimilate our children and prevent the generational spread of our cultures, traditions, religions and language.

Congress also interfered with our rights to assert sovereignty over our own peoples. In 1883, the Supreme Court ruled in *Ex parte Crow Dog* that the United States could not prosecute Native people for crimes committed against other Native people in Indian Country. Congress responded by passing the Major Crimes Act, which placed certain crimes under the jurisdiction of the United States government. However, in 1978 in *United States v. Wheeler*, the Supreme Court affirmed that Tribes could still punish Tribal citizens for offenses included in the Major Crimes Act. However, they also ruled that being tried and convicted under both Tribal and federal law do not constitute a violation of the Double Jeopardy Clause of the 5th Amendment.

Congress also asserted their right to unilaterally break the treaties that they had previously ratified. The Supreme Court upheld this power in 1903 with *Lone Wolf v. Hitchcock* when they ruled that the ability to abrogate treaties was an element of Congress's power over Tribal Nations. However, as we would learn in *McGirt v. Oklahoma*, which was decided just a week ago, Congress has to expressly signal its intent to violate a treaty and diminish Indian land.

McGirt is important to discuss because it's the confluence of two major issues in Indian legal history, jurisdiction and treaty abrogation. *McGirt* strengthened the distinction in *Lone Wolf* by stating that Congress has to expressly diminish Tribal land, inference is not sufficient. As noted by Justice Neil Gorsuch in his majority opinion, "*Because Congress has not said otherwise, we hold the government to its word.*" At its core, the Supreme Court declared, unequivocally, that despite the passage of time, despite the unsanctioned efforts to chip away at Treaty rights, and despite the willful, collective amnesia on the part of so many previous and current federal elected officials regarding the obligations of the United States to Tribal Nations in perpetuity – those obligations remain intact: they are not null and void. They remain relevant. They remain true. But as with most Indian Law decisions and actions, this news came with a bittersweet reminder: Congress can unilaterally break these treaties, as long as they expressly declare their intent to do so.

Congress's power over Tribal Nations has resulted in a legal history that is perhaps best described as inconsistent. The era of cultural assimilation was followed by the Indian Reorganization Act in 1934, which sought to preserve Tribal sovereignty by asking Tribes to adopt Western style governments. However, this era was followed by the Termination Era, which sought to end Tribal governments entirely. And again, that was followed by the Indian Civil Rights Act in 1968 and the Indian Self Determination Act in 1975. Because of Congress's power over Tribal Nations, we are subjected to the whims of Congress's shifting politics, priorities and conveniences.

The Supreme Court's role in the diminishing of Tribal sovereignty also cannot go unnoticed. In 1978, the Supreme Court ruled in *Oliphant v. Suquamish Indian Tribe* that Tribes lack jurisdiction to prosecute non-Indians for offenses committed on Tribal land. In 1990, this decision was extended further in *Duro v. Reina*, when the Court held that Tribes could not prosecute non-member Indians. Congress acted quickly however to resolve this issue and allow non-member Indians to be prosecuted by Tribes but did not extend it even further to non-Natives. While the

Violence Against Women Act of 2013 allowed Tribes to assert jurisdiction over non-Indians in domestic violence cases, we are awaiting a full fix that allows Tribes to act as any other sovereign entity and enjoy jurisdiction over any crimes committed by any persons within their territory.

As our sovereignty has been eroded, Native people have long had to contend with the notion that we are strangers in our own homeland. In 1884, the Supreme Court ruled in *Elk v. Wilkins* that the voting privileges granted under the 14th Amendment did not extend to Native people. Further, it was not until 1888 when Native women married to White United States Citizens were afforded citizenship, and in 1890 land-owning and taxpaying American Indian men were extended the right to citizenship under the Indian Territory Naturalization Act. It would take another 30 years until the right to citizenship was extended to include Native veterans of the First World War. However, full enfranchisement would remain scattershot for Native peoples until the passage of the Indian Citizenship Act (ICA) of 1924 – nearly 150 years after the founding of the United States. Yet while the ICA granted citizenship, voting rights were left to the discretion of states. For example, Southern States excluded American Indian voters by virtue of Jim Crow laws. It is perhaps poetic that Virginia passed the “Racial Integrity Act” in 1924, which simply classified Native peoples in the state as “colored,” thus denying them the right to vote. Such tactics were not limited to the South, of course. South Dakota denied Native peoples the right to vote by claiming that individuals residing in “unorganized counties” – which was essentially a euphemism to describe South Dakota’s Indian reservations – were ineligible to vote. It would not be until the passage of the Voting Rights Act in 1965 that Native people were able to have full voting rights in the United States.

This testimony cannot provide a full accounting for the federal government’s legal history with Native peoples. It is a legal history fraught with encroachments on Tribal sovereignty, lack of respect for our traditions and cultures, including government programs designed and implemented to destroy Native language, tradition, religion, culture and identity. Also, rapidly shifting federal policies toward Native peoples subject us to the whims of a fickle and unpredictable sovereign. The devastating impacts of this history should perhaps be obvious to even the most uninformed observer. As sovereigns, we do not enjoy the full rights enjoyed by other sovereigns. For example, we do not have full criminal jurisdiction over our lands. Also, our lands have been diminished by acts of Congress. It was only recently that we received the slight reprieve in that such abrogation must be explicit and intentional. The legal history of the United States of America rests on the idea of the Doctrine of Discovery, primarily used to support decisions invalidating or ignoring aboriginal possession of land in favor of colonial or post-colonial governments. Using the Doctrine of Discovery, Europe and later the United States unduly asserted sovereignty over us with neither our consent nor knowledge. From the start to date, it is clear that our continued relationship with the United States is animated by a series of broken promises and treaties.

Reality of Broken Treaties

The solemn legacy of colonization is epitomized by the severe health inequities facing Tribal Nations and AI/AN Peoples. When you compound the impact of destructive federal policies towards AI/ANs over time, including through acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and

outlawing of traditional ways of life, religion and language, the inevitable result are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country.

The clear consequence of the disparities outlined below in terms of healthcare access and quality, housing, food security, and other social determinants of health are laid bare by the statistics outlining the disproportionate impact of COVID-19 on AI/AN People and communities.

It is said that a government's budget is a reflection of its priorities. One must look no further than the severe and pervasive underfunding of all federal Indian programs to observe, unequivocally, that the United States does not prioritize fulfillment of its obligations under the over 350 treaties it signed with sovereign Tribal Nations.

Chronic Underfunding of Indian Health Service and Indian Health Programs

The Indian Health Service (IHS) is the only federal healthcare system created as the result of treaty obligations. It is also the most chronically underfunded federal healthcare system, and the only federal healthcare system not exempt from government shutdowns or continuing resolutions. Compared to the three other federal health care entities – Medicare, Medicaid, and the Veterans Health Administration – IHS is by far the most lacking in necessary support. In 2018 the Government Accountability Office (GAO-19-74R) reported that from 2013 to 2017, IHS annual spending increased by roughly 18% overall, and roughly 12% per capita. In comparison, annual spending at the Veterans Health Administration (VHA), which has a similar charge to IHS, increased by 32% overall, with a 25% per capita increase during the same time period. Similarly, spending under Medicare and Medicaid increased by 22% and 31% respectively. In fact, even though the VHA service population is only three times that of IHS, their annual appropriations are *roughly thirteen times higher*.

Over the past two decades, only once – in FY 2006 – has the Interior, Environment, and Related Agencies appropriations bill, which has jurisdiction over IHS funding, passed on time. In every other year there were delays in passage of an enacted IHS budget due to unrelated congressional negotiations on federal spending. In FY 2018, per capita medical expenditures at IHS were at only 40% of national health spending (\$3,779 vs \$9,409).

Chronic and pervasive health staffing shortages – for everything from physicians to nurses to behavioral health practitioners – stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 GAO report found an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two-thirds of IHS Areas (GAO 18-580). In addition, many Tribes do not have adequate housing for health care professionals, which further complicate recruitment efforts. Numerous reports from GAO and the HHS Office of Inspector General (OIG) have documented how IHS and Tribal facilities struggle to keep providers when competing with mainstream healthcare entities that can easily offer higher wages and better working conditions. It should then come as no surprise that the Indian health system has largely failed to make meaningful strides towards reducing provider vacancies.

For instance, as reported by the HHS OIG, IHS and Tribal administrators have noted that staffing shortages have forced IHS hospitals and clinics to turn patients away due to limited capacity. In other instances, staff shortages have caused facilities to fail to meet compliance standards for waiting rooms and medical transfers. These issues reduce staff's ability to meet performance standards, lowers staff morale, and ultimately leads to less quality patient care. Chronic underfunding of the Indian health system means that hospitals and clinics have less money to hire qualified physicians at competitive salaries. Further, limited funding for personnel can delay the physician hiring process as overburdened staff juggle multiple competing priorities and responsibilities. At the end of the day, these challenges harm the patient most – many of whom encounter long delays in scheduling appointments and are potentially traveling hundreds of miles just to access their closest health center.

Lack of providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective and culturally inept. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Further, because of how often IHS and Tribal facilities cycle through contracted providers, it also raises concerns around provider oversight and accountability.

Limited funding and access to specialty care resulted in nearly 80,000 Purchased/Referred Care (PRC) services (an estimated total of \$371 million) being denied in FY 2016 alone. Deferral of care is particularly consequential when it applies to pain treatment. Moreover, lack of access to non-opioid therapies for pain such as traditional medicine and other alternatives leaves IHS and Tribal providers and patients with few options. In fact, rates of prescription opioid deaths increased 10.8% among AI/ANs from 2016-2017 – the highest percentage increase of any demographic. Lack of access to providers and limited funding for health services reinforces the endless cycle of deferral of care and lower health outcomes in Tribal communities.

Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that – at 37 years. In 2013 alone, funding shortfalls for facilities maintenance and upgrades created a \$166 million backlog. Basic medical devices and equipment are largely outdated, as hospital administrators express strong concerns that use of the equipment may increase one's risk for hospital-acquired infections. A 2016 OIG report found IHS and Tribal trauma centers lacking necessary computerized tomography (CT) scans, or missing essential medicines. Use of antiquated equipment also deters new medical graduates from working in the Indian health system, most of whom are trained on advanced technologies and thus unable or unwilling to use outdated equipment.

In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care. The OIG noted that more than two-thirds of IHS hospitals have insufficient space including for exam rooms, diagnostic services, and even pharmacies. Similarly, water and sanitation infrastructure in Indian Country is significantly underdeveloped.

Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide. In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of “honey buckets” that are disposed in environmentally hazardous sewage lagoons.

Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households roughly 71 times higher than the cost of water in urban areas with municipal water access. In a 2018 report to Congress, IHS estimated that in order to bring all IHS and Tribal sanitation systems to a Deficiency Level 1 criteria, the agency would need \$2.67 billion.

IHS Chief Medical Officer Dr. Michael Toedt has repeatedly stated publicly that the dilapidated IHS health information technology (IT) infrastructure are severely hindering agency efforts to engage in effective and comprehensive COVID-19 disease surveillance. Further, expansion of telehealth has been restricted by significant broadband connectivity issues across Indian Country, as outlined in a 2019 Federal Communications Commission (FCC) report detailing that 46.6% of homes on Tribal lands lack broadband access at standard speeds. As a result, Tribes have been unable to take full advantage of recent federal regulatory flexibilities in use of telehealth under Medicare. Because the new flexibilities would sunset at the conclusion of the public health emergency, it is economically and financially unfeasible for many Tribes to make costly investments into telehealth infrastructure and equipment for a short-term authority.

So while mainstream hospital systems have largely made a seamless transition to telehealth, Tribes once again remain behind due to lack of historical investment. In addition, IHS and Tribal providers have been unable to receive adequate reimbursement under Medicare for telehealth, receiving roughly \$14 per patient visit, which is significantly below the reimbursement rate for these services under Medicaid.

The Indian health system continues to face immense challenges in health IT modernization, with very little dedicated funding within the IHS budget to meet this need. In fact, the FY 2020 IHS budget included \$8 million for Electronic Health Records (EHR) – the first time the IHS had dedicated funding for this need. The Resource and Patient Management System (RPMS) – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and is partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA).

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribal governments have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system which are negatively impacting

interoperability and continuity of care for AI/ANs. When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue.

However, Congress has largely failed to ensure parity in funding between VHA and IHS for health IT, despite the reliance of RPMS on the VA system. For example, while Congress gave IHS \$8 million for health IT in the FY 2020 enacted budget, the VHA received roughly \$1.5 billion. Similarly, Congress has not provided comparable emergency funding to IHS compared to VHA in response to the COVID-19 pandemic. For instance, the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act invested \$15.85 billion into medical care at the VHA, including \$3.1 billion specifically for health information technology (HIT) and telemedicine; but only \$1.032 billion for IHS, of which only \$65 million was allocated for HIT support.

Tribal Nations are also severely underfunded for public health, and were largely left behind during the nation's development of its public health infrastructure. As a result, large swaths of Tribal lands lack basic emergency preparedness and response protocols, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response. And despite the fact that Tribal governments and all twelve Tribal Epidemiology Centers (TECs) are designated as public health authorities in statute, they continue to encounter severe barriers in exercising these authorities due to lack of enforcement and education.

Health Inequities and Vulnerability to COVID-19

When you compound the impact of broken treaty promises, chronic underfunding, and endless use of CRs, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. **These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do.** Indeed, AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.²

In 2016, 26.2% of AI/ANs were estimated to be living in poverty, compared to the national average of 14.0%. Just under a fifth of AI/ANs lacked health coverage in the same year, while nationally only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is marred by undercounting of AI/ANs in the U.S. Census, rates of overcrowded housing clearly indicate a significant shortage of available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally.³ AI/AN

² South Dakota Department of Health. Mortality Overview. Retrieved from <https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf>

³ U.S. Department of Housing and Urban Development. 2017. Housing Needs of American Indians and Alaska Natives in Tribal Areas: A Report From the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs. Retrieved from <https://www.huduser.gov/portal/sites/default/files/pdf/HNAIHousingNeeds.pdf>

communities also face high rates of food insecurity, which can increase risk for future chronic diseases such as diabetes, obesity, and other ailments. While majority-AI/AN counties represent less than 1% of counties nationwide, as high as 60% of them are classified as food insecure.⁴ In California, just under 40% of AI/AN families with incomes under 200% of the federal poverty line (FPL) were food insecure⁵; in Oklahoma, 1 in 4 AI/ANs were reported to be food insecure in 2015⁶; and in Montana, an analysis of 187 AI/AN households found 43% to be food insecure.⁷

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.⁸ In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)⁹; higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

CDC reported that the presence of underlying health conditions such as type II diabetes, obesity, cardiovascular disease, and chronic kidney disease significantly increase one's risk for a severe COVID-19 illness. AI/AN populations are disproportionately impacted by each of these chronic health conditions. For instance, type II diabetes incidence and death rates are three times and 2.5 times higher, respectively, for AI/ANs than for non-Hispanic Whites. Despite significant improvements in rates of End Stage Renal Disease (ESRD) as the result of the highly successful Special Diabetes Program for Indians (SDPI), AI/AN communities continue to experience the highest incidence and prevalence of ESRD.

Increased physical distancing and isolation under the COVID-19 pandemic have led to recent and alarming spikes in drug overdose deaths, suicides, and other mental and behavioral health challenges. Population-specific data on increased drug overdose and suicide deaths during the pandemic are currently unavailable; yet if trends prior to the rise of COVID-19 are any indicator of risk, it is safe to assume that AI/AN People are experiencing serious challenges. One of the major drivers of increased mortality rates among AI/ANs overall has been significantly higher rates of drug overdose and suicide deaths than the general population. Alarming, rates of prescription opioid deaths among AI/ANs increased 10.8% from 2016 to 2017 – the highest

⁴ Feeding America. 2017. Map the Meal Gap: Highlights for Overall and Child Food Insecurity. Retrieved from <https://www.feedingamerica.org/sites/default/files/research/map-the-meal-gap/2015/2015-mapthemealgap-exec-summary.pdf>

⁵ Iue Bird Jernigan V, Garroutte E, Krantz E, Buchwald D. Food insecurity and obesity among American Indians and Alaska Natives and whites in California. *J Hunger Environ Nutr.* 2013;8:458–471

⁶ Blue Bird Jernigan V. Healthy makeovers in rural tribal convenience stores as part of the Tribal Health and Resilience in Vulnerable Environments (THRIVE) Study. Paper presented at: 143rd APHA Annual Meeting and Exposition, October 31–November 4; New Orleans, LA. Washington, DC: American Public Health Association; 2015.

⁷ Brown B, Noonan C, Nord M. Prevalence of food insecurity and health-associated outcomes and food characteristics of Northern Plains Indian households. *J Hunger Environ Nutr.* 2007;1(4):37–53.

⁸ Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. *National Vital Statistics Reports*; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.

⁹ Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

percentage increase of any demographic, and this happened despite national and IHS efforts to crack down on unnecessary opioid prescribing.

The opioid epidemic triggered significant increases in rates of infectious diseases such as Hepatitis C (HCV) among AI/ANs – raising from 1.8 to 3.1 acute cases per 100,000 from 2015 to 2016. In 2014, 9% of AI/ANs over the age of 18 had a co-occurring mental health and substance use disorder – more than 3 times the rate of the general population. In 2015, suicide rates among AI/ANs in 18 states were more than 3.5 times higher than the lowest rates recorded. All of these determinants of health and poor health status could be dramatically improved with sufficient and sustainable federal investment into the health systems, health care, public health systems, and infrastructure in Indian Country in accordance with federal treaty obligations.

So, into this neglected and stunted health system on which American Indians and Alaska Native rely...into this system which is, collectively, the living expression of how seriously the federal government takes Treaty obligations and the Trust responsibility that requires the provision of full and quality health care for American Indians and Alaska Natives...into all of this theatre of failure comes COVID-19.

Impact of COVID-19

As of July 13, IHS has reported 25,000 positive cases, with roughly 63% of positive cases being reported out of the Phoenix and Navajo IHS Areas alone. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribally-operated health programs, which constitute roughly two-thirds of the Indian health system, are voluntary. According to data analysis by APM Research Lab, AI/ANs are experiencing the second highest aggregated COVID-19 death rate at 51.3 deaths per 100,000. The Centers for Disease Control and Prevention (CDC) reported on July 4, 2020 that age-adjusted COVID-19 hospitalization rates among AI/ANs are higher than any other population, at a rate of 270.5 per 100,000. Reporting by state health departments has further highlighted disparities among AI/ANs.

- In New Mexico, AI/ANs represent roughly 8% of the population, yet account for over 44% percent of all COVID-19 cases.
- As of this writing, the Oyate Health Center in Rapid City, South Dakota has conducted 839 COVID-19 tests, with 114 confirmed positive case results (13.5%). In Pennington County, the second-largest county in South Dakota, AI/AN People account for 53% of all COVID-19 cases despite representing less than a fifth of the county population. Statewide, AI/ANs account for nearly 17% of all cases despite representing only 10% of the population.
- In Wyoming, AI/ANs account for over 22% of all COVID-19 cases statewide despite representing only 2.9% of the state population.
- Similarly, in Montana, where AI/ANs constitute about 6.6% of the state population, over 11% of confirmed COVID-19 cases are among AI/ANs.

- In South Dakota, AI/ANs are experiencing the second highest case rates by race at 26.3 cases per 10,000 compared to 7.1 per 10,000 for Whites.

In a data visualization of COVID-19 case rates per 100,000 by Tribal Nation created by the American Indian Studies Center at the University of California Los Angeles, it was found that if Tribes were states, the top five infection rates nationwide would all be Tribal Nations.

Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS¹⁰, Tribal governments have innovatively found ways of maximizing third party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third party collections can constitute up to 60% of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third party reimbursement shortfalls ranging from \$800,000 to \$5 million per Tribe, per month. In a hearing before House Interior Appropriations on June 11, 2020, IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30-80% below last year's collections levels, and that it would likely take years to recoup these losses.

These funding shortfalls have forced Tribes across the lower 48 and Alaska to furlough hundreds of workers, curtail available healthcare services, or close down clinics entirely. For example, Tribes in the Bemidji Area reported that nearly 20% of their healthcare system and 35% of their government services staff were forced to be furloughed due to revenue shortfalls. Meanwhile, Tribal business closures have compounded the devastation of the COVID pandemic in Indian Country. According to the Harvard Project on American Indian Economic Development (HPAIED), before COVID-19 hit, Tribal governments and businesses employed 1.1 million people and supported over \$49.5 billion in wages, with Tribal gaming enterprises alone responsible for injecting \$12.5 billion annually into Tribal programs. During the six week period (through May 4, 2020) whereby all 500 Tribal casinos were closed in response to COVID-19 guidelines, Tribal communities lost \$4.4 billion in economic activity, with 296,000 individuals out of work and nearly \$1 billion in lost wages.¹¹

Extrapolated across the entire U.S. economy, collectively \$13.1 billion in economic activity was lost during the same time period, in addition to \$1.9 billion in lost tax revenue across federal, state and local governments. In a new visualization created by NIHB, over 193,000 AI/ANs have become uninsured as a result of COVID-19 job losses, with the vast majority of these individuals (72%) lacking access to IHS as well.¹² Such astronomical losses in Tribal healthcare and business revenue are exacerbating the already disproportionate impact of COVID-19 infections in Indian

¹⁰ Per capita spending at IHS in FY 2018 equaled \$3,779 compared to \$9,409 in national health spending per capita; \$9,574 in Veterans Health Administration spending per capita; and \$13,257 per capita spending under Medicare.

¹¹ Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from <http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming>

¹² National Indian Health Board. Estimating Covid-19 caused increases in Uninsured AIANs due to job loss. <https://public.tableau.com/profile/edward.fox#!/vizhome/EstimatingCovid-19causedincreasesinUninsuredAIANsduejobloss/EstimatingIncreaseinAIANUninsuredduetoCOVID-19JobLoss>

Country, and are further reducing available resources for Tribes to stabilize their health systems and provide critical COVID-19 and related health services to their communities.

Federal Paternalism

The treatment of Tribal Nations by the federal government can be best described as a form of paternalism where insufficient aid is often given but no power is delegated. This is commonly seen in the large programs that the Tribes are often beneficiaries of. The inference by the federal government in these instances is that Tribes are not capable of administering these programs and need the assistance of either the federal or state governments in order to do so.

The aura of paternalism often dictates how federal legislation impacting Tribes are written and enacted, and the strings attached with federal funding of healthcare and public health in Indian Country. For instance, Tribal governments have repeatedly advocated for government-wide expansion of Tribal self-determination and self-governance. Self-determination and self-governance policies honor the inherent sovereignty of Tribal Nations by affording local Tribal control over program and policy implementation, thus allowing for the creation of tailored programs uniquely developed to address community priorities. Not only does this improve the efficiency and effectiveness of program operations, it is a proven method that leads to better health and socioeconomic outcomes for Tribal communities. Yet Tribes have continually encountered resistance from lawmakers, administrators, and even non-Tribal external stakeholders who paternalistically call into question the authority and competency of Tribes to govern independent of state or federal intervention.

For instance, Tribal leaders and advocates faced fierce opposition from external groups when Tribes advocated for the authority to administer Supplemental Nutrition Assistance Program (SNAP) funds through self-determination or self-governance contracting or compacting. This opposition is not new, nor is it exclusive to Tribal administration of SNAP. The recurring motif behind these baseless and dismissive claims is an underlying assumption about the inferiority of Tribal systems of government to that of Western systems. These racist and genocidal assumptions have existed since the arrival of European colonizers in the early 1600s, and over time have become entrenched in United States' Anglo-Saxon hegemony, informing the manner in which the federal government negotiates and engages with sovereign Tribes – grounded in a sense of presumed Western ideological supremacy, and guided by a doctrine of presumed Tribal incapacity. From the example of Chief Justice Marshall declaring Tribes to be “domestic dependent nations” over a century ago to Congress first requiring pilot projects to test the ability of Tribes to independently operate health programs across HHS, the underlying message is the same – Tribes cannot be trusted to govern on their own. They must be “civilized” under Western social rule, and indoctrinated under Western law.

Perhaps the best example of this is the Medicaid program, which is a federal and state partnership, and forms a substantial portion of third party revenue into the Indian health system. Congress has acknowledged that states have no government to government relationship with Tribes by assigning them no financial role in the administration of Medicaid through IHS and Tribal facilities. The federal government pays a 100% Federal Matching Assistance Percentage (FMAP) for care

provided to American Indians and Alaska Natives (AI/ANs) through IHS and Tribal health care facilities.

Despite this, Tribal members still have to abide by the terms and conditions of state Medicaid programs. Medicaid is a program that can vary widely, depending on the state and for states that cross state lines, this can be a bureaucratic nightmare. The variance between Medicaid programs also applies to different initiatives that state Medicaid programs may seek to enact. Tribal members have to contend with work requirements, managed care, and other state enacted programs that force them to abide by requirements enacted by a sovereign that has no financial stake in providing them health care. While there are mandated Tribal consultation requirements, the state is under no obligation to incorporate what Tribes ask for. The checkboard of Tribal exemptions from work requirements is perhaps the best symbol of this.

Tribes are also subject to the whims of federal agencies, particularly around grant making. As we have seen with COVID-19, many federal agencies have no idea about Indian Country, resulting in grant opportunities that are often ill-fitted for Tribal Nations. Competitive grant making is perhaps the best example of this. Tribes are forced to compete against each other, and sometimes even non-Tribal actors, to access funding for emergency items. A formula based allocation of funding directly to Tribes would be the best way to honor the trust responsibility and ensure that all Tribal nations, not just the ones who have access to the resources needed for competitive grant writing, are able to access funding.

Formula based funding is often the preferred mechanism for distributing aid to the states. The federal government doesn't ask New York or Massachusetts to compete with Mississippi or Alabama because that would be inherently unfair to lower resourced states. Why then is it acceptable to force Tribes to compete with one another? There are examples that we can point to for how this could work. Under the Stafford Act, Tribes are able to directly make disaster declarations to FEMA in order to receive direct aid.

Paternalism has even affected our ability to assert sovereignty over our lands. Much of the discussion around Tribes asserting criminal jurisdiction has revolved around the perceived inability of Tribal courts to adequately hear such claims. The reason for these dubious claims is a fundamental misunderstanding of federal Indian law, and a blindness towards federal trust and treaty obligations to sovereign Tribes. But more poignantly, the undercurrent behind such claims is an inherent prejudice towards Tribal legal systems and a mistrust of Native People. More directly put, they are a regurgitation of the same age-old racist sentiments about the alleged inferiority, incompetence, and untrustworthiness of Tribal Nations and Native People that were used to justify some of the most heinous acts of genocide and oppression this country has ever perpetrated. Back then these arguments were used to justify the theft of Native lands. In the present day, they were used to justify not returning that land to their rightful sovereign.

The legacy of paternalism has been the erection of systemic barriers to accessing benefits and programs that should be afforded to us through the United States government's trust and treaty responsibilities. Tribal nations and people should be trusted to manage our participation in these programs.

Systemic Barriers in COVID-19 Response

At the core of the federal trust responsibility to Tribal Nations is the fact that the federal government is supposed to ensure the health and welfare of Native peoples. The COVID-19 pandemic has given the federal government an opportunity to uphold their end of the bargain in a way that is perhaps unparalleled in modern American history. However, Tribes are increasingly running into systemic barriers that impede their ability to actually receive help from the federal government and this is slowing or even outright denying access to aid.

One reason is because the federal government decided to use competitive grant making as a means of distributing funds to Tribes. To apply for competitive grants, you need staff to put together an application. Tribes that were lower resourced found themselves having to use a skeleton staff to put together applications in order to have access to funds that they needed in order to provide care for their people. If Tribes could not pull together these resources, they were excluded from being able to apply for these pots of money.

Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. **The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon the quality of a grant application – yet that is the construct that the federal government has forced Tribes to operate under.** That is unacceptable.

Instead, a more effective way to distribute aid to Tribes would be through a fixed funding formula that ensures sufficient, recurring, sustainable funding reaches all Tribal Nations. Doing so would allow Tribes to know that the funding was coming to them, how much they were getting, and be able to plan to utilize that money to help their citizens. It would have also alleviated the burden on Tribes to use their staff to apply for grant funding and allowed them to use their limited resources to treat the issue at hand.

Another issue was the insufficient notice of funding opportunities. Many Tribes were not told what opportunities were available or how they would be able to access the funding. Given the Trust Responsibility, we would expect HHS to take special care to ensure that Tribes know of these opportunities and are able to submit any required documentation within a timely manner. As mentioned above, many Tribes were operating with skeleton crews. Insufficient manpower to track grant opportunities and then gather and submit paperwork for grants created a necessity for HHS to work more closely with Tribes to make sure that they were able to take advantage of these opportunities. We feel that HHS failed in this manner.

Tribes were also forced to deal with agencies with whom they had little experience or knowledge. For example, in the initial funding allocations, aid to Tribes was distributed through the CDC and not IHS. This, in turn, created a delay in receiving funding as the CDC had to create a mechanism to either distribute the funding themselves or transfer the money to IHS. On April 9, 2020, the National Indian Health Board submitted a letter to the Secretary of Health and Human Services asking him to utilize existing funding streams where possible in order to minimize delays in getting funding to Tribes, and to ensure that a baseline level of funds reached all Tribal governments.

Utilizing existing funding mechanisms would have solved multiple problems. First of all, Tribes would have known where their money was coming from, they likely would have received it more quickly, and they would have been able to work with agencies with whom they have experience working. While we respect the work of agencies such as HRSA or the CDC, we do not feel that they have sufficient experience working in Indian Country and this lack of experience resulted in multiple issues including a delay of funding or the fact that Tribes were forced to receive funds through competitive grants.

Before COVID-19 hit, the Good Health and Wellness in Indian Country (GHWIC) GHWIC program, funded at \$21 million in Fiscal Year (FY) 2020, was both the ONLY and largest Tribally-specific funding stream available at CDC – for an agency with an over \$7 billion operating budget. Because of a lack of meaningful Tribally-specific programs throughout CDC over the years, the vast majority of agency officials have little direct engagement or understanding of how to be a good partner to the Tribes. In the Coronavirus Preparedness and Response Supplemental Appropriations Act, Congress outlined \$40 million in set-aside funding for the Tribes through CDC to respond to the pandemic – a woefully insufficient amount given the decades of chronic underfunding of Tribal public health. Yet when that bill became law, it provided the largest Tribal set-aside in CDC history, even though it amounted to a drop in the bucket compared to CDC's overall budget. The issues that ensued with dissemination of those funds – lack of consultation or engagement with the CDC Tribal Advisory Committee to inform how funds should be allocated; or the arbitrary selection of grantees when Tribes repeatedly urged the agency to ensure a baseline level of funds reached all Tribes – are a direct result of the agency's lack of experience working with Tribes.

We feel deeply troubled by the systemic barriers that impeded the federal government's response to this crisis. As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. However, Tribes were largely left behind during the nation's development of its public health infrastructure, and Tribal health systems continue to be chronically underfunded. As a result, many Tribal public health systems remain far behind that of most state, territorial, and even city and county health entities in terms of their capacity, including for disease surveillance and reporting; emergency preparedness and response; public health law and policy development; and public health service delivery. Historically, CDC has failed to make meaningful and sustainable direct investments into Tribal communities for public health – thus contributing to the higher health disparities, lower health status, and lower life expectancy of American Indians and Alaska Natives (AI/ANs) compared to the general population.

In addition, despite the fact that Tribal governments and all twelve Tribal Epidemiology Centers (TECs) are designated as public health authorities in statute, they continue to encounter severe barriers in exercising these authorities due to lack of enforcement and education. Currently, Tribes and TECs are being routinely denied access to CDC public health surveillance systems, and are actively thwarted from receiving Tribal data from state health departments. Both CDC and state officials have incorrectly cited potential HIPAA violations if they were to share data with the Tribes and TECs, while states have imposed pay-to-play restrictions for Tribal access to public

health data, or have limited the type of data Tribes and TECs can receive to only certain diseases. These measures infringe on Tribal sovereignty, run contrary to federal law, and further deny Tribes the ability to build their public health infrastructure.

The lack of investment into Tribal public health continues. Tribal leaders have repeatedly requested budgetary information from CDC on how much funding each Center, Institute, and Office (CIO) at CDC has provided directly to Tribal governments and Tribal organizations. The CDC has largely failed to provide this information. When it has, it is clear that nearly every CIO is failing to adequately fund Tribal public health with investments hovering around 1% or less of total program dollars. Over the years, Tribal leaders have continuously requested that each CIO work to establish direct funding set-asides for Tribes and Tribal organizations. Only the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) has truly followed through on this request, most notably exemplified by the Good Health and Wellness in Indian Country (GHWIC) program.

For instance, during a recent listening session with the Interdepartmental Council on Native American Affairs (ICNAA), CDC officials responded to a Tribal leader's question about HIV funding to Tribes with the statement that while no Tribes were directly funded in FY2017 or FY 2018, that some funding reached Tribes through the states. It is unacceptable for CDC officials to respond to such an inquiry with statements about how funding has reached the Tribes "through the states." The partnership and government-to-government relationship is strictly between Tribes and the federal government, not state governments.

All federal public health programs should not only include Tribes as eligible entities, but also include direct Tribal funding set-asides. Tribal set-asides further the fulfilment of the federal trust obligation for health; but also, without a set-aside, Tribes will more than likely not receive meaningful public health funding. Many Tribal public health departments do not have the capacity to compete with state and local governments for competitive public health grants. The consequence is that Tribes are routinely left behind in development of public health infrastructure.

For instance, a 2019 U.S. Department of Health and Human Services report found that, from FY 2014 to FY 2018, Tribes received 0.06% of funds under the Preventive Health and Health Services Block Grant (\$0.5 million out of \$729.2 million). During that same time period, Tribes received only 0.03% of all Substance Abuse Prevention and Treatment Block Grant dollars (\$3 million out of \$8.8 billion). These are just two examples of how Tribes are largely left behind when direct Tribal set-asides do not exist in statute.

Civil Rights Issues Impacting American Indians and Alaska Natives

Political Status of Tribes

Indian Tribes are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States, and since its founding the United States has recognized them as such. As the Supreme Court explained in 1876, "from the commencement of its existence [and following the practice of Great Britain before the revolution], the United States has negotiated with the Indians in their Tribal condition as

nations.”¹³ The United States entered into the first treaty with an Indian tribe in 1778. Once the Constitution was ratified, President George Washington worked with the Senate to ratify treaties in the late 1780s, thereby establishing that treaties with Indian Tribes would utilize the same political process that treaties with foreign nations must go through. Although treaty making with Indian Tribes formally ended in 1871, the federal government has continued to interact with Indian Tribes as political entities through statutes and administrative actions. Early Supreme Court decisions also confirmed the status of Tribes as political entities operating within the confines of the United States.

Through treaty making and its general course of dealings, the United States took on a special and unique trust responsibility for Indians and Indian Tribes. In entering into those treaties, Indian Tribes as political entities had exercised their sovereignty by bargaining for what they could in exchange for portions of their land or other concessions—all with the goal of providing for their people under the circumstances they faced. In turn, treaty promises made by the federal government helped to shape the young country’s view of its responsibilities to Indians and Indian Tribes. As the Supreme Court recently noted, although the federal trust responsibility to Indian Tribes is not the same as a private trust enforceable under common law, “[t]he Government, following a humane and self-imposed policy . . . has charged itself with moral obligations of the highest responsibility and trust.”¹⁴

Indigenous Civil Rights

The impacts of this current COVID-19 health crisis are far-reaching and, as we gather today, continue to unfold across the United States with exponential rise in cases and deaths, with no unified system of intervention that has proven effective at containment. For Tribal communities, the impact has been severe already, and the prospects for the future are troubling at best. As the US Civil Rights Commission addresses so effectively in Chapter 2 of its 2018 *Broken Promises* Report, Tribal communities are already at substantial health risk, since the efforts of the federal government to uphold its trust responsibility for Tribal health care has been so ineffective.

Alaska Native villages and Tribal governments, which together form the structure of “federally recognized Tribes” under federal law, have political systems, customs and traditions that predate the United States and the passage of the Constitution. Tribes never agreed to any of the terms in the US Constitution, including the Bill of Rights. Tribal governments are inherently sovereign nations. Congress recognized this unique status when it passed the Indian Civil Rights Act in 1968, extending many, but not all, of the civil rights protections of the original Bill of Rights to Tribes and Tribal governments. Tribal civil rights have to be understood within the specific landscape and history of federal Indian law.

As separate sovereigns, when Tribal nations, for example, have passed their own laws governing workplace civil rights, the Supreme Court has recognized that such laws do not touch upon “racial” civil rights issues, but rather are within the political rights of Tribes to self-governance. This

¹³ *United States v. Forty-Three Gallons of Whiskey*, 93 U.S. 188, 196 (1876).

¹⁴ *United States v. Jicarilla Apache Nation*, 564 U.S. 162, 176 (2011) (omitting internal quotations) (*quoting Seminole Nation v. United States*, 316 U.S. 286, 296–97 (1942)).

concept of self-governance is the primary theme I want to stress today. In the face of a global pandemic, Tribal communities' capacity to survive and be resilient is only as strong as their right to self-govern is supported by the federal government. And what we are seeing during the COVID crisis, is deeply troubling, as the federal government has shirked its trust responsibility to promote and protect Tribal health in favor of granting to state governments the true right to self-governance.

Congress passed the Indian Self-Determination, Education and Assistance Act (ISDEAA) in 1975, ushering in an era of Tribal self-determination and self-governance within Indian Country. That has brought about, along with the passage and implementation of the Indian Health Care Improvement Act, a renaissance within Indian Country for well-planned and developed health care systems. These health care systems lack the funding necessary to meet 100 percent of need, but have been hugely successful in bringing health care to rural and often extremely remote Tribal communities. But, in a pandemic, this health care system has little capacity to implement protective measures without close coordination with other local, state, and federal agencies. Where we are seeing threats to American Indian and Alaska Native civil rights, during this COVID-19 response, is in the outsize role that state governments are playing to determine whether health care is a priority, and if so, whether the state recognizes the need to protect Tribal communities.

State governments have a long history of direct opposition to Tribal sovereignty and self-governance, battling land rights, fishing and subsistence rights, civil, criminal, and taxation jurisdiction. In Alaska, my home state, we have seen the State government make decisions since the COVID-19 crisis broke that directly impact our Tribal communities, negating their right to self-determination, self-governance, and threatening the efficacy of the Tribal health care system.

The Bristol Bay region provides a cautionary tale. Home to the world's largest wild run of sockeye salmon, in March of this year, the Tribal governments from that region banded together with their regional Tribal health provider—Bristol Bay Area Health Corporation (BBAHC)—to ask the State of Alaska to shut down the fishery for the year. This remote region of villages is inundated with tens of thousands of seasonal fisheries workers each year, coming from across the globe. The Governor, while allowing other villages to shut themselves off from outsiders in other parts of the state without a commercial fishery, instead prioritized the fishing season and allowed it to move forward, granting the fishing industry itself the right to self-regulate and monitor the health of its workers.

We are now seeing in the hub of the Bristol Bay region—Dillingham—huge spikes in COVID-19 positive cases, all initially connected to the fishing industry. From a Tribal perspective, this could have been prevented. If Bristol Bay Tribal communities had full self-determination and self-governance, there would have been a closure to outsiders until more resources and information were available about how to control or eliminate the pandemic from impacting the region. Instead, the State of Alaska decided for the region that it was more important to harvest fish and bring in tens of thousands of people from around the globe in order to do so.

The attack on Tribal civil rights by the State was not accidental. BBAHC, when faced with the State's decision to value a commercial fishing season over the health of its Alaska Native villages, filed a complaint on May 13 with the Alaska State Commission on Human Rights, which is

responsible for investigating actions of state government that impact the civil and human rights of Alaska residents. The Alaska Commission responded on May 22 that it would not undergo an investigation and that because Alaska Natives have a political, not racial, status under existing law, that there is essentially no such thing as “racial” discrimination against Alaska Natives. The Alaska Commission indicated it was more concerned about the health implications of the fishery opening for non-Alaska Natives than for Alaska Natives.

This is the very embodiment of systemic racism, and this example from Alaska is one that we leave the US Commission on Civil Rights with to consider. Each state in the US is making daily, if not hourly, COVID-19 response decisions that impact the health and civil rights of its citizens. But state governments are not well suited to deal with sovereign Tribal governments, and in many states, are confrontational and act against those Tribal interests. The federal government, by allowing states to override Tribal rights to self-governance and self-determination, puts these Tribal communities further at risk, in violation of its separate trust responsibility to Tribes. Tribal communities have been disproportionately impacted by global pandemics historically, so in order for our communities to be resilient, healthy, and carry forward, we need entities like this Commission to understand our separate and unique history, and to help us advocate for true self-governance.

The effects of systemic racism are apparent even outside of Indian Country. The recent story about the Washington football team name change is a reminder of how deep and embedded into our national conscience the erasure and degradation of Native people actually is. The Washington football team name can trace its lineage back to the early 1800s and the decision of Tammany Hall, what would become the driving force behind New York politics, to use a Lenape chief as their symbol. Over a hundred years later, the Washington football team was named after the Boston Braves, a baseball team that was the primary tenant of their first home, Braves Field. The Boston Braves received their name because their owner James Gaffney was a member of Tammany Hall.

The Washington football team adopted their most recent name when they moved to Fenway Park, the home of the Boston Red Sox, but wanted a way to keep their logo and branding. The name stuck when they moved to Washington, DC a couple of years later. The fact that a symbol of a political machine in New York City found its way to a football team in Washington, DC is a symbol of how deeply embedded these symbols are. These mascots are harmful to our people. Studies have shown that they negatively impact the self-confidence of young Native people and how they view themselves in society. Being reduced to a caricature is harmful for anyone and is a creator of further health care issues. Systemic racism and infringement on the civil rights of Native people is problematic on multiple fronts.

Recommendations

As the U.S. contemplates how it will respond to the findings of the Broken Promises report, it must reexamine the fundamentals of its approach to fulfilling its trust and treaty obligations to Tribal Nations. Anything less than a willful intent to make a sustained strategic investment into Indian country will ensure for the continued failure to achieve the necessary outcomes and results that we should be mutually seeking.

The U.S. must honor its trust and treaty obligations in its response to COVID-19. Thus far, the IHS has secured roughly \$2.4 billion in emergency aid from Congress and through inter-agency transfers from HHS. **These were necessary, but nowhere near sufficient**, investments to stem the tide of the pandemic. The House-passed HEROES Act included another \$2.1 billion in funding for IHS which Tribes and NIHB strongly support. However, NIHB alongside its national and regional Tribal partners have collectively requested over \$8 billion in aid for the Indian health system. As such, congressional relief has fallen significantly short of what Tribal Nations and Tribal organizations have outlined must be invested in furtherance of treaty obligations and in recognition of the disproportionate impact of COVID-19 in Indian Country.

Our recommendations are stated below:

COVID-19 Specific

1. **Expansion of Self-Governance:** Replacement of competitive grant funding mechanism with full expansion and implementation of Tribal Self-Determination and Self-Governance across all federal agencies and departments, including within the Department of Health and Human Services
2. **Water and Sanitation Funding:** Immediate emergency funding of at least \$1 billion for water and sanitation infrastructure across all IHS and Tribal facilities
3. **Immediate Emergency Funding for IHS:** Immediate, emergency appropriation of at least \$8 billion for Indian Health Service to pay for expansion of healthcare service delivery, replenish lost third-party revenue, construct of shelters of opportunity, purchase and deliver personal protective equipment (PPE), cover services under Purchased/Referred Care (PRC), etc.
4. **Permanency of SDPI:** Permanent reauthorization and full funding in perpetuity of the Special Diabetes Program for Indians, with annual funding increases matched to medical inflation and statutory authority for Tribes and Tribal organizations to receive awards through Indian Self-Determination and Self-Governance contracts and compacts
5. **Medicaid Priorities:** Enactment of technical fixes to federal Medicaid law to expand the quality and accessibility of health services, and to maximize third party collections within the Indian health system. These include:
 - Authorizing Indian Health Care Providers to bill Medicaid for the full suite of medical services authorized under Medicaid and the Indian Health Care Improvement Act – called “Qualified Indian Provider Services”
 - Permanent fix to the so-called “four walls” billing restriction under Medicaid
 - Extension of 100% FMAP to urban Indian organizations
6. **Telemedicine-Ready Indian Country:** Immediate and sufficient direct funding to Tribes and Tribal organizations for implementation of broadband connectivity across all of Indian Country, including dedicated, recurring, and sustainable funding for expansion and streamlined implementation of telehealth across IHS and Tribal facilities

7. **Addressing Mental/Behavioral Health:** Immediate and emergency funding to I/T/U facilities to address worsening mental and behavioral health challenges during the COVID-19 pandemic including substance use, suicide, depression, and other health conditions

Honoring Treaties

Financing Fulfilment of Treaty Obligations: Up to 1% of closing costs associated with all private and commercial real-estate transactions to be reserved for a trust fund to pay for healthcare, education, housing, public safety, and other services as required under the trust and treaty obligations of the federal government to sovereign Tribal Nations and American Indian and Alaska Native People. Those funds can, in part, be directed towards the following:

1. Full, permanent, and mandatory funding of the Indian Health Service as an entitlement program funded at levels outlined by the IHS National Tribal Budget Formulation Workgroup
 - Full funding for construction and renovation of all IHS and Tribal healthcare facilities across all twelve IHS Areas
 - Full funding to eliminate chronic and pervasive healthcare provider shortages across all IHS Areas
2. Addressing the epidemic of Missing and Murdered Indigenous Women (MMIW) through the creation of a permanent fund to cover all necessary medical and social service needs for American Indian and Alaska Native women, children and families; and through full federal and state recognition of inherent Tribal sovereignty by extending full civil and criminal jurisdiction over non-Indians to Tribal Nations
3. Full, permanent, sustainable and recurring funding for public health infrastructure development across Indian Country including for emergency preparedness and response, preventive health services, epidemiology, workforce, and health education
4. Creation of a permanent endowment to pay for post-secondary and graduate education for American Indian and Alaska Native youth to enter the medical and public health field

Conclusion

Our treaties stand the test of time. They are the Supreme Law of this land. If a nation's honor and exceptionalism is a measure of its integrity to its own laws and creed, then one must look no further than the United States' continued abrogation of its own treaties to recognize that its honor is in short supply. James Baldwin once said "I love America more than any other country in this world, and, exactly for this reason, I insist on the right to criticize her perpetually." Every square inch of this nation is Our People's land. It is our ancestor's land. It will be our children's land, and their children's for seven generations and into perpetuity. We are forever committed to its success, and demand that it hold itself to its highest ideals. As the sole national organization committed to advocating for the fulfilment of the federal government's trust and treaty obligations for health,

we will always be dedicated to bringing into fruition the day where Our People can state with dignity that the United States held true to its solemn word.

Ideally, fulfillment of trust and treaty obligations should be without debate and the U.S. should honor its promises. It should recognize that the cost of fulfilling these promises are miniscule compared to the vast wealth that it has accumulated from Indian Country lands and natural resources, or our U.S. GDP. These lands and natural resources, most often acquired from us shamefully, are the bedrock of U.S. wealth and power today.

One final thought on how America might make a commitment to advance sweeping policy reform toward American Indians and Alaska Natives. This is an innovative and sweeping idea that would reverse significant portions of US policy toward American Indians and Alaska Natives: an American Indian recovery and reinvestment project modeled after the Marshall Plan. This successful post World War II European Recovery Program was a large scale economic recovery program and infrastructure rebuilding project. Recognizing the European economic devastation that resulted from the war, the United States sought to assist in the rebuilding of several European sovereign economies. It was a strategic investment by the U.S. with the specific intent to modernize and strengthen the participating European economies to increase the likelihood of their rapid recovery and long-term success. The Marshall Plan was in place for 4 years and was subsequently replaced by the Mutual Security Plan. Combined, these two plans lasted roughly 15 years, cost nearly \$1Billion dollars (in current dollar value), and represented a significant percentage of overall U.S. GDP.

Similar to the fact that European economies were devastated by the war, Tribal Nation economies have been devastated by federal policies of assimilation and termination over the decades and centuries. As the 2003 Quiet Crisis Report and 2018 Broken Promises both reports, the U.S. has failed to honor its trust and treaty obligations to Tribal Nations. As a result, Tribal Nations and AI/AN suffer from some of the highest health, economic, and social well-being disparities found in the U.S. Additionally, our Tribal Nation economies continue to rebuild after years of targeted U.S. destruction as part of its efforts to diminish our sovereign governmental rights, authorities, and powers.

Similar to the European Marshall Plan, the time is long overdue for an Indian Country Marshall Plan. A new and modern approach, rooted in diplomacy like the Marshall Plan, must be considered with the understanding that such a domestic investment into to the economic recovery and success of Tribal Nations is in the best interest of the U.S. Strong sovereign-to-sovereign relations, and strong Tribal Nation economies, are paramount to the success and strength of the U.S. A Marshall Plan for Indian Country, created and administered with Indian Country, would create new ground on which we could stand, together, and reset the course of history. From this place, the United States Government can chart a new course to fully honor the sacred trust and treaty obligations that exist in perpetuity with the indigenous peoples of this land.

Thank you for inviting us to share this information with you and we look forward to answering any questions you may have.