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EVALUATING THE RESPONSE AND MITIGATION TO THE COVID–19 PANDEMIC IN NATIVE COMMUNITIES AND S. 3650

HEARING

BEFORE THE

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ONE HUNDRED SIXTEENTH CONGRESS

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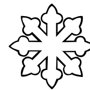

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EVALUATING THE RESPONSE AND MITIGATION TO THE COVID–19 PANDEMIC IN NATIVE COMMUNITIES AND S. 3650

WEDNESDAY, JULY 1, 2020

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:36 p.m. in room 562, Dirksen Senate Office Building, Hon. John Hoeven, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN HOEVEN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. Good afternoon. We will call this oversight and legislative hearing to order.

Before we begin, I want to remind those members who are connecting with us remotely to please mute your microphone. This will cut down on the static feedback in the hearing room.

The Committee will receive testimony today from two Administration and two tribal witnesses on evaluating the response and mitigation to the COVID–19 pandemic in Native communities. The Indian Health Service witness will also provide testimony on S. 3650, the Coverage for the Urban Indian Public Health Providers Act. This bill will get us to a total of eight bills in two weeks that we have taken testimony on in Committee . I certainly look forward to marking up these bills and moving them to the Floor in the coming weeks.

Today, tribal communities are experiencing some of the highest rates of infection for COVID–19 in the Country. The Indian Health Service recently reported more than 19,000 positive cases in the 12 service areas. Data also shows that at least five Indian tribes such as the White Mountain Apache, the Pueblo of Zia, the Pueblo of San Felipe, the Navajo Nation, and the Kewa Pueblo, have had higher cases per capita, outpacing States like New York, New Jersey, Massachusetts and some others.

Additionally, the Centers for Disease Control and Prevention states that American Indians and Alaska Native are in a racial and ethnic minority group at an increased risk of contracting COVID–19 or experiencing severe illness, regardless of age. American Indian and Native American persons have a hospitalization rate five times that of non-Hispanic White persons.

Because of these higher rates, Native communities have taken needed measures to limit exposure and protect their people, instating curfews, or shelter in place orders. Opening drive-through testing locations, closing non-essential businesses, ceasing tourism and other revenue-generating activities and switching schools to virtual platforms to provide necessary education to students are examples of how tribes are taking action and limiting the spread of infection from reaching more into their communities.

In my home State of North Dakota, the first reported case of COVID–19 was on March 11th, 2020. I can say that all the communities across the State have taken measures to protect their residents against the coronavirus. One of the larger reservations in my home State is the Mandan Hidatsa and Arikara Nation. They have provided a live community impact dashboard that updates COVID–19 cases found on their lands.

This community ahs experienced 42 confirmed cases, causing the tribe to take protective measures, such as devising a policy that penalizes members for violating quarantine orders. We should take a moment to acknowledge those law enforcement, first responders, and medical personnel risking their health to protect and care for those affected by the pandemic. Thank you all for your tireless work that is helping so many.

As the Country knows, there is no vaccine to protect a person against this respiratory illness. But work will continue toward finding one. Congress will continue to fulfill the trust and treaty obligations to Indians. Through various funding authorized by Congress so far the Indian Health Service has allocated approximately $2.4 billion to address COVID–19 needs.

Today's hearing will provide the Committee with an understanding of what both the Indian Health Service and Federal Emergency Management Agency is doing to mitigate and prevent more cases of COVID–19 appearing in Native communities. Specifically, I am interested to learn what is working well and where improvements can be made by reaching more rural communities, especially the tribal communities, who have less access to resources than may be available in urban areas.

We are also interested in what lessons have been learned from both IHS and FEMA during this pandemic. The Committee is committed to understanding how the interactions between the IHS and FEMA are being coordinated during the COVID–19 pandemic response.

I am also pleased to see Mr. Scott Davis, Executive Director of the North Dakota Commission on Indian Affairs here today, testifying on panel two. Scott works tirelessly for the five Indian tribes in North Dakota, and is a former All-American marathon runner at Haskell Indian School. He was also a great basketball player. I have watched him play basketball. He was very good at that. Good athlete. And he is an outstanding Commissioner for Indian Affairs in North Dakota.

Moving on to the legislative agenda of today's hearing, on May 7th, 2020, Senators Tina Smith and James Lankford introduced S. 3650, the Coverage for the Urban Indian Health Providers Act. Senators Udall, McSally, Harris, Feinstein, Sinema, Moran, Tester, and Warren also have joined as co-sponsors. This bipartisan bill

amends the Indian Health Care Improvement Act to provide parity to the Indian Health System, which is made up of the Indian Health Service, tribal health programs, and urban Indian organizations.

S. 3650 expands the Federal Torts Claim Act coverage to Urban Indian Organizations. More than 70 percent of American Indians and Alaska Natives live in urban areas throughout the Country. Urban Indian Organizations are able to provide culturally competent care to Natives living in these urban areas.

Currently, Urban Indian Organizations are not offered protections that are already provided to the IHS and tribal health program employees. UIOs spend critical dollars on malpractice liability insurance for employees and volunteers, rather than putting these resources toward health care.

Before we move to our witnesses, I want to turn to Vice Chairman Udall for his opening statement.

STATEMENT OF HON. TOM UDALL, U.S. SENATOR FROM NEW MEXICO

Senator UDALL. Thank you, Chairman Hoeven, for calling today's hearing.

Over the last several months, our Nation has faced a convergence of major and seemingly unprecedented challenges; a global pandemic and economic crisis and flagrant systemic injustice. In examining the Federal response to these crises, it is clear that the Administration ignored the warning signals.

But for Indian Country and other communities of color, the lack of Federal public health preparedness and the resulting economic freefall were not unprecedented. In fact, they were predictable and they were avoidable. We know that Native populations in the U.S. experience morbidity and mortality rates four times greater than non-Native populations in previous pandemics.

Tribal economies are particularly vulnerable to economic shocks and downturns in that in matters of housing, health care, education, and justice, American Indians, Alaska Natives and Native Hawaiians were too often left behind. We know this because for years, tribal leaders, Native organizations and witnesses have testified before this Committee that Federal policies and failures have exacerbated health disparities, economic barriers, and institutional inequities.

I understand that this is an uncomfortable truth for us to grapple with. But we in Congress should not be surprised by reports that the Indian Health Service, tribe and urban Indian clinics have faced challenges securing personal protective equipment and testing supplies when we knew that they did not have access to the Strategic National Stockpile, and that they were excluded from most Federal public health emergency preparedness planning.

We should not be surprised by testimony that Indian Country has struggled to navigate the bureaucratic maze of COVID–19 programs when we knew that many agencies had little to no meaningful engagement with tribes prior to this pandemic. And we should not be surprised that tribes' ability to access Federal assistance and resources depends largely on how good their relationship is with their State government, which Federal official they are work-

ing with, or which agency region they are located in, not when we knew that Federal practices lack consistency and policies favor State pass-through models.

I have been fighting alongside tribes to address these very same issues since I first arrived in Congress. Many of you on this Committee have been fighting right alongside with me. But as we have been so humbly reminded by this pandemic, there is much yet to be done. That is why today's hearing is so important. Congress and the Administration must take a good, hard look in the mirror and see where we are still falling short. That includes the Treasury Department, which has barely got critical tribal CARES Act funding out the door, 50 days beyond the statutory deadline. That is twice as long as Congress intended, causing what a court determined to be irreparable harm to tribal governments in their fight against coronavirus. Whether it is the IHS or Treasury, the Administration must do better.

Admiral Weahkee and Administrator Fenton, I hope you will commit to taking the feedback you receive back to your departments and work with your leadership to act on it. And I hope that this Committee can work together to address these statutory barriers and resource gaps for Native communities without further delay.

Senator Smith's bill, which we are considering today, is an excellent example of the type of practical, bipartisan solution we should all be pushing. This bill not only creates parity with the IHS system, but also helps urban Indian health programs reduce operating costs due to COVID–19 related budget shortfalls. I am proud to be co-sponsor of her work on this front.

I will close by saying that despite the challenges that remain before us, I am dedicated to standing with all American Indians, Alaska Natives and Native Hawaiians. I am hopeful that the Senate will be able to work together and replicate the historic wins we have achieved for Native communities in the first set of coronavirus relief packages.

Thank you again, Mr. Chairman, for this hearing. Thank you to our witness for joining us for this very important discussion.

The CHAIRMAN. Thank you, Vice Chairman Udall. We do have some opening statements. We will begin with Senator Barrasso.

STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

Senator BARRASSO. Thank you very much, Mr. Chairman, for holding this important hearing today.

As you know, when I was chair of this Committee , I frequently spoke about my friends in Wyoming, the Wind River Reservation, the Northern Arapahoe, and the Eastern Shoshone Tribes. Yesterday I had a chance to visit at length with the leadership of the Northern Arapahoe Tribe. As Senator Udall said, there was a delay in getting some of the money out. There was an initial 60 percent went out, but it took a long time to get that second amount. The Northern Arapahoe have gotten that $27 million to which they say they are grateful for what we have done as part of the CARES Act.

As both of you have said, the impacts of this disease on our tribes is disproportionately high. In Wyoming, we have had 20

deaths, half of them from the Northern Arapahoe Tribe. So when you take a look at those numbers and this disproportionate price that they have paid, I think it is very important for us to have this hearing today and to hear from our experts and continue to ask probing questions and see what more we can do.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Barrasso.

Senator Tester will give an opening statement remotely.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thanks for having this hearing, Chairman Hoeven. Look, Indian Country, it has already been said today, has been disproportionately impacted by COVID. They face unique challenges in this pandemic in their communities. That is why it is so very critical that the Federal Government uphold their trust and treaty responsibilities and provide Native communities the resources they need to address this crisis.

As a result, quite frankly, of underfunding and lower reimbursement levels, many Indian health facilities across Indian Country have limited their services for caring, and even individuals impacted by COVID. So being able to refer patients to another facility during this pandemic has been critical for Indian health care providers, to be able to provide adequate care to Native folks.

Having increased revenues as a result of things like Medicaid expansion has been critical for Indian health care and the facilities that serve them. Yet quite frankly, the Trump Administration is moving full steam ahead to dismantle the Affordable Care Act.

The bottom line is this: there is a big problem in Indian Country. In Montana, they are seeing COVID infection at about twice the rate they should, and quite honestly, we need to step up to make sure that the money we have appropriated is getting to them, and making sure they have what they need to be able to come back from this horrible virus.

With that, I look forward to the testimony. I look forward to the questions thereon.

The CHAIRMAN. Thank you, Senator Tester.

We will turn to Senator Murkowski.

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman, and to our Vice Chairman, thank you for a very important hearing. I think we look to the impacts of COVID–19 on different sectors. We have certainly had many hearings in the Energy Committee on how this pandemic has impacted different parts of our economy and the people. There is probably nothing more important that we can be doing here in this Committee than looking to the impacts to our American Indians, Alaska Native and Native Hawaiians, on vulnerable populations, and as the statistics have been shared, they are troubling in terms of how we see the health disparities reflected when you have something like a COVID virus impacting.

In Alaska, we have been, I won't say lucky, because luck has nothing to do with the fact that we have been able to keep our

number of cases very low. What we have done in many of the communities, primarily our Alaska Native remote communities, is they have voluntarily shut themselves off from the rest of the world. They have said, we do not want travelers in here, we do not want the mail plane to come in here, we don't want the plane that is going to be delivering fresh goods for the grocery store, because we are so concerned about how this virus may repeat history, do a repeat from the 1918 flu, the Spanish flu, that wiped out many Alaska Native villages. Natives around the state today remain fearful of just that impact.

So the efforts that have been made to keep the virus out have been considerable. They have been aggressive, and they have been expensive. So the funding for the CARES Act to help offset this is very, very important.

I do think it is also important to recognize that we all want to see these funds dispersed to the villages, to our tribes, and do so in a manner that is consistent with what we outlined in CARES, but also quickly. It was unfortunate that we saw litigation delay the initial distributions of these funds, and are still delaying some portions of the CARES Act funding, all over a dispute that we felt we had made very, very clear when we enacted CARES, that those who would be eligible for this CARES Act funding would be our tribes, and the tribes would include, in Alaska's case, our Alaska Native Corporations.

With the recognition of the complexity of the laws and impacts with how Alaska Natives are addressed and treated under ANSCA, and our Federal laws, we do not have reservations in Alaska. Our statuses are different when it comes to Alaska Native peoples. And it is an overlay of organizations, tribal health organizations, our tribes, our Native villages, our Native corporations. It is complex. And I think it is important to understand how all of these entities together, working together, are pulling the weight to respond to this impact of COVID.

I didn't intend, Mr. Chairman, to make more than a minute statement, but I felt it was important to outline to colleagues that yes, we all share the same goal here. We want to get this much-needed funding out to our tribes across the Country. We will do so. But we have to ensure that they are done in a fair way so that those costs that have been associated with this pandemic are reimbursed and reimbursed fairly and fully.

With that, I am looking forward to the testimony this afternoon, and to direct some questions, primarily about where we are with water and wastewater when it comes to Admiral Weahkee.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski. Now we will turn to Senator Schatz.

STATEMENT OF HON. BRIAN SCHATZ, U.S. SENATOR FROM HAWAII

Senator SCHATZ. Thank you, Mr. Chairman, and Vice Chairman, for scheduling this hearing. I want to follow up on what Senator Murkowski said. It is important for us all to take a breath and to remember the tradition of the Committee on which we all serve. It has a tremendous, decades-long tradition of bipartisanship. But not

only about bipartisanship, but a sense that all Native peoples hang together, that Alaska Natives, American Indians, and Native Hawaiians hang together.

With the unfortunate situation of the deployment of the funds to Alaska being delayed as a result of litigation and a misinterpretation of the statute, we also need to remember that in the final throes of the negotiation over the CARES Act, that the dollars we are actually talking about were characterized as a sort of Democratic ask, something that had to be negotiated for, on behalf of Democrats. I don't think that is the tradition of this Committee. I don't think that is the way we want to move forward.

So as we look at July and we look at another traunch of Federal funding for keeping people alive and keeping some semblance of an economy going, including Native people everywhere across the United States, we should remember that we all must hang together, Democrat and Republican, Native Hawaiian, Alaska Native, and American Indian. I am very, very hopeful that with the Chairman's leadership, we are going to be able to do just that.

Thank you very much.

[The prepared statement of Senator Schatz follows:]

PREPARED STATEMENT OF HON. BRIAN SCHATZ, U.S. SENATOR FROM HAWAII

Thank you Chairman Hoeven and Vice Chairman Udall for scheduling this hearing. Bipartisan and bicameral efforts to support native communities are more important than ever. The COVID–19 outbreak continues to rage and it's disproportionately impacting the lives of American Indians, Alaska Natives, and Native Hawaiians.

Today we will receive testimony from the administration, a national native health organization, and a state commission on Indian affairs. We are seeking to understand two things:

First, whether the authorizations and supplemental funding provided to tribes and native communities in previous coronavirus response bills were effective.

And second, what additional legislative actions are needed to improve implementation, address urgent needs, and speed recovery.

Chairman Hoeven, I request that the remainder of my opening statement be entered into the record so that we can move forward to the witness panels more quickly.

The disproportionate health, economic and social burdens faced by native communities are not new. But the COVID–19 pandemic is shining a light on funding deficits and glaring shortcomings in access to health care, clean water, sanitation facilities, safe housing, and other basic necessities.

Native Hawaiians are at risk:

- They have the shortest life expectancy of the major ethnic groups in Hawaii;
- They are more likely to have an underlying medical condition, such as coronary disease, diabetes, asthma or COPD, making COVID–19 a greater health threat; and
- Native Hawaiians also make up half of the homeless population on the island of Oahu alone. They are also more likely to live in overcrowded housing conditions, making compliance with social distancing guidelines difficult.

I have attached several documents produced by the Office of Hawaiian Affairs and Papa Ola Lokahi as an addenda to my remarks to provide additional data on the status of Native Hawaiians. *

As one of the United States' indigenous peoples, who formed a government prior to our own and exercised sovereignty over lands that are now part of the state of Hawaii, we accord Native Hawaiians a unique legal and political status. The U.S. has a trust responsibility to Native Hawaiians and more than 200 laws have been enacted in furtherance of the special trust relationship.

* The information referred to is in the hearing appendix.

I fully support S. 3650, a bill introduced by Senator Smith and other SCIA colleagues to extend Federal Tort Claims Act (FTCA) coverage for urban Indian health providers, and I also support parity in treatment for Native Hawaiian Health Care Systems (NHHCS) providers.

Just as the Congress passed the *Indian Health Care Improvement Act* to authorize funding and programs for the Indian Health Service, tribes, and to extend health care services for Native Americans living in urban areas, the *Native Hawaiian Health Care Improvement Act* was enacted to authorize funding and programs for Native Hawaiians. Extending FTCA coverage to the Native Hawaiian Health Care Systems would ensure that these health care centers can focus all of their scarce resources on providing patient care.

According to the American Community Survey of 2017, the Native Hawaiian population in Hawaii was approximately 300,000, and the American Indian and Alaska Native population was approximately 36,274. Given a prospective service population this large, the Native Hawaiian Health Care Systems need relief from paying expensive insurance premiums so that they can grow their capacity to serve the health care needs of more Native Hawaiian families.

The CHAIRMAN. Thank you, Senator Schatz. And we will turn to Senator Smith.

STATEMENT OF HON. TINA SMITH, U.S. SENATOR FROM MINNESOTA

Senator SMITH. Thank you, Mr. Chair and Ranking Member. I am really glad to have this hearing today.

It is a good time for us to take a look at what has happened with COVID–19 in Indian Country. I very much appreciate Senator Schatz's comments as we think about how we work in a bipartisan way to make sure that our treaty and trust responsibilities as the Federal Government are upheld carefully.

Mr. Chair, I have to say that I note, based on the witnesses that we have today that we won't have an opportunity to speak with anybody at Treasury today about Treasury's implementation and disbursement of the funds. I know that this is an issue that I can tell has been a concern for both my Republican and my Democratic colleagues. So I hope that we will have an opportunity to talk with somebody at Treasury and understand better what happened and how we can make sure that it doesn't happen in the future, as our American Indians and Alaska Natives and Native Hawaiians had to wait so long for these funds that they needed so desperately.

I want to lift up one issue which is very important to Minnesota tribes, which is as grateful as they are to have this CARES Act funding, as I know everybody on this Committee understands, these dollars cannot be used to displace the lost revenue that tribes have experienced because of their voluntary decision to shut down tribal enterprises. This has resulted not only in dramatic increase in unemployment on tribal nations, but also dramatic decreases in government revenue, as a result.

So I hope this is something that we can all work on together in this Committee , Republicans and Democrats together. Because this issue would haunt tribal nations and people everywhere in this Country unless we are able to address it.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Smith.

Now we will turn to our witnesses, beginning with the——

Senator MORAN. Mr. Chairman?

The CHAIRMAN. Yes?

Senator MORAN. It is Senator Moran.

The CHAIRMAN. Oh, Senator Moran. Would you like to make an opening statement? Go ahead.

STATEMENT OF HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. I would, thank you. Chairman Hoeven and Vice Chairman Udall, thank you for conducting this important hearing. You were kind enough to allow me to make opening remarks, because I chair the Senate Veterans Affairs which will begin when I get there, I guess, but begin at 3:00. I did not want to miss the opportunity to express my view of how important this hearing is, and how important the topic is to make certain that we are doing what we should be doing in regard to tribes and Native Americans.

I also would commend Senator Tina Smith and our colleague Senator Lankford for the bill that is being discussed today. I am a co-sponsor of that bill, and I look forward to seeing it pass the Senate and become law.

I mentioned that I am on my way to chair a Veterans Affairs committee, and I wanted to highlight the role the Department of Veterans Affairs plays in regard to Native American health care, both because many Native Americans are veterans themselves, but also the fourth mission of the Department of Veterans Affairs is to assist the rest of the Country, non-veterans, in times of health care crisis. Senator Tester, the ranking member of the Committee that I chair, and I have had weekly telephone conferences with Dr. Stone, the Director of Health Care at the VA, and the Secretary of the Department, Secretary Wilkie. In almost every weekly phone call, the conversation has involved the role that the Department of Veterans Affairs is playing in caring for the health care and well-being of Native Americans.

The tribes in Kansas certainly have not been without their challenges related to COVID–19. But I am greatly concerned by what is happening in places outside my State as well. I have advocated to ensure that our tribes are remembered in the relief packages that are passed by Congress, and I intend to be active and engaged in the efforts as we look at what a Phase four package might entail as well.

Mr. Chairman, I will not be here to ask the necessary questions, but I will pay attention to the results of this hearing, because it will inform what direction we should proceed in that regard. If I was present, I would highlight the importance of broadband and internet for delivering services on tribal lands and to Native Americans, but to all Americans, as we have seen COVID–19 demonstrate the importance of tele-health and tele-education.

I also am remiss in not being able to hear the testimony of the North Dakota Executive Director of the Indian Affairs Commission. You highlighted that he is a Haskell graduate. Haskell of course is in Lawrence, Kansas. Every time I meet or hear of a Haskell grad, I take great pride in their success and the time that they spent in my home State.

Mr. Chairman, thank you for the opportunity to join you for this brief moment. I look forward to hearing the results of your hearing, so that we can act appropriately on behalf of tribes and Native Americans.

Thank you.

The CHAIRMAN. Thank you, Senator Moran. I will pause for just a moment, if there is anyone else who is attending remotely who wants to give an opening statement.

Hearing none, then we will go forward with our witnesses. First, we have the Honorable Rear Admiral Michael D. Weahkee. He is the Director of the Indian Health Service, U.S. Department of Health and Human Services. After he testifies, he will be followed by Mr. Robert Fenton, Jr., Regional Administrator, Region 9, Federal Emergency Management Agency, U.S. Department of Homeland Security, Washington, D.C.

With that, Rear Admiral Weahkee, please proceed.

STATEMENT OF HON. REAR ADMIRAL MICHAEL D. WEAHKEE, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. WEAHKEE. Good afternoon, Mr. Chairman, Vice Chair Udall, and members of the Committee . Thank you for the opportunity to testify on the Indian Health Service's efforts to respond to and mitigate the coronavirus pandemic, as well as on S. 3650, Coverage for the Urban Indian Health Providers Act.

Let me start with a few comments on S. 3650. I am pleased to mention that the IHS endorses the policy to extend Federal Tort Claims Act coverage to UIOs, which is consistent with our fiscal year 2021 budget request. However, IHS does prefer formulating the coverage extension as part of the statutory section of the Public Health Service Act, where the other various similar extensions are located. This is noted in my written statement.

Now I will transition to our COVID–19 response. Over the past several months, the IHS has worked closely with our tribal and urban Indian organization partners, with State and local public health officials, and with our fellow Federal agencies to coordinate a comprehensive, all of government, public health response to this pandemic.

Throughout our efforts, our number one priority has been the health and safety of our IHS patients and our staff. While the Indian health system is large and complex, we realize that preventing, detecting, treating, and recovering from COVID–19 requires collaboration and local expertise. We continue to participate in regular conference calls with our tribal and Urban Indian Organization leaders from across the Country to provide updates, answer their questions, and to hear their concerns and engage in rapid tribal consultation in Urban Confer sessions, so that we can inform our COVID–19 funding distributions and meet the needs of Indian Country.

I am grateful to Congress for supporting our efforts through several supplemental appropriations that have enabled the Indian Health Service to allocate $2 billion to our IHS, tribal, and urban Indian health program partners to prepare for and respond to the Coronavirus. We are detecting COVID–19 through screening and state of the art lab testing.

Through White House-led testing initiatives, we have distributed, or are in the process of distributing, a total of 470 Abbot ID NOW test analyzers, and hundreds of thousands of testing supplies for

various testing platforms. Our IHS National Supply Service Center has distributed over 60 million units of personal protective equipment and other Coronavirus related supplies, including 1.7 million testing swabs and transport media.

In my written testimony, I provided data on our resting statistics as of June 7th, in which we had performed 157,980 tests, which equaled 9.5 percent of our user population, exceeding the U.S. all races testing rate. But we do have up to date information that we can provide to the Committee as these numbers do change on a daily basis.

We are treating each and every patient with culturally competent, patient-centered, relationship-based care as we look to recover from COVID–19. The IHS is supporting the emotional well-being and mental health of our workforce and the communities we serve, providing services that draw from a long history of cultural resilience among our American Indian and Alaska Native communities.

In June, the IHS announced a new critical care response team of expert physicians, nurses, and other health care professionals. This mobile team is providing urgent, life-saving medical care for COVID–19 patients and conducting hands-on clinical education.

HHS has also provided the Indian Health Service with access to 20,000 doses of remdesivir, that is being supplied to patients in both our Federal and tribal hospitals across the Country. Remdesivir is an investigational anti-viral medicine that has shown progress in shortening the recovery time in some people.

In April, the IHS expanded use of an agency-wide video conferencing platform that allows for tele-health on almost any device and in any setting, including in our patients' homes. Since this expansion, the IHS has experienced a greater than 11-fold increase in the use of tele-health from roughly 75 visits to week to now an average of over 907 visits per week. Our health care professionals are also providing a great deal of care over the telephone.

We look forward to continuing our work with tribal and Federal partners as the Country moves forward toward phased reopening and recovery. We strongly encourage everyone to continue to follow CDC guidelines and instructions from their local, State, and tribal governments, to prevent the spread of COVID–19 and protect the health and safety of our communities.

Before I close, I just wanted to highlight a few recent trips that I have made to the Navajo, Bemidji, and Phoenix areas, where I observed powerful and uplifting examples of collaboration during my visits to several area health facilities. I met with Navajo Nation President Jonathan Nez, and Oneida Nation Tribal Chairman Tehassi Hill, to hear directly about their challenges combating COVID–19. I am grateful for the strong leadership displayed by our tribal partners in working alongside Federal and State partners to ensure the safety and well-being of American Indian and Alaska Native communities.

In closing, I want to acknowledge and thank our entire Indian Health Service team, including those on the front lines treating our patients, and others in supportive roles that have demonstrated profound commitment in raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the

highest level during this unprecedented time. I am extremely proud of their hard work to combat COVID–19. I consider myself fortunate to work alongside such a truly committed and dedicated workforce.

Thank you again for the opportunity to speak with you here today. I appreciate your continued partnership and engagement while we work together to combat the Coronavirus epidemic.

Thank you.

[The prepared statement of Rear Admiral Weahkee follows:]

PREPARED STATEMENT OF HON. REAR ADMIRAL MICHAEL D. WEAHKEE, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon Chairman Hoeven, Vice Chairman Udall, and Members of the Committee. Thank you for the opportunity to testify on the Indian Health Service's (IHS) efforts to respond to and mitigate the Coronavirus pandemic, as well as on S. 3650, Coverage for the Urban Indian Health Providers Act.

Responding to and Mitigating the Coronavirus Pandemic

Over the past several months, the IHS has worked closely with our tribal and Urban Indian Organization (UIO) partners, state and local public health officials, and our fellow Federal agencies to coordinate a comprehensive public health response to the pandemic. Throughout our efforts, our number one priority has been the safety of our IHS patients and staff.

While the Indian health system is large and complex, we realize that preventing, detecting, treating, and recovering from COVID–19 requires local expertise. We continue to participate in regular conference calls with tribal and UIO leaders from across the country to provide updates, answer questions, and hear their concerns. In addition, IHS engages in rapid Tribal Consultation and Urban Confer sessions in advance of distributing COVID–19 resources to ensure that funds meet the needs of Indian Country.

I am grateful to Congress for supporting our efforts through the passage of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Economic Security (CARES) Act; and the Paycheck Protection Program and Health Care Enhancement Act. These laws have provided additional resources, authorities, and flexibilities that have permitted the IHS to administer nearly $2 billion to IHS, tribal, and urban Indian health programs to prepare for and respond to Coronavirus. These resources have helped us expand available testing, public health surveillance, and health care services. Moreover, they support the distribution of critical medical supplies and personal protective equipment in response to the pandemic. In addition, the $500 million distributed by the Department of Health and Human Services (HHS) from the Provider Relief Fund to IHS, tribal, and urban Indian health programs will help providers in American Indian and Alaska Native communities recover lost revenue, and provide Coronavirus-related health care services. All of these resources make a real difference in helping to fulfill our IHS mission as we continue to work with tribal and UIO partners to deliver crucial services during the pandemic.

The IHS continues to play a central role as part of an all-of-nation approach to prevent, detect, treat, and recover from the COVID–19 pandemic. We are partnering with other Federal agencies, states, tribes, tribal organizations, universities, and others to deliver on that mission. We protect our workforce through education, training, and distribution of clinical guidance and personal protective equipment. We also protect our tribal communities through supporting tribal leaders in making their decisions about community mitigation strategies that are responsive to local conditions, and to protect the health and safety of tribal citizens as those communities make plans to safely return to work.

We are detecting COVID–19 through screening and state-of-the-art lab testing. Through White House-led testing initiatives, we have distributed, or are in the process of distributing, a total of 350 Abbot ID NOW rapid point-of-care analyzers, as well as hundreds of thousands of testing supplies for various testing platforms. The IHS National Supply Service Center has also distributed over 60 million units of personal protective equipment and other Coronavirus response related products, including 1.7 million testing swabs and transport media. As of June 7, we have performed 157,980 tests in our American Indian and Alaska Native communities, which equates to 9.5 percent of our user population, exceeding the U.S. all-races testing

rate, and the testing rate of most states and foreign nations. Of those tests, 13,165 (9.3 percent) have been positive, with large geographic variation from as much as 23.3 percent in the hard-hit Navajo Area, to less than 0.3 percent in the Alaska Area.

We are treating each and every patient with culturally competent, patient-centered, relationship-based care. As we look to recovery from COVID–19, the IHS is supporting the emotional well-being and mental health of its workforce and the communities we serve, providing training, education, and access to treatment that draws from our faith and traditions and a long history of cultural resilience among American Indians and Alaska Natives.

Earlier this month, the IHS announced a new Critical Care Response Team of expert physicians, registered nurses, and other health care professionals that will be available on an as needed basis.

This team will provide urgent lifesaving medical care to COVID–19 patients admitted to IHS or tribal hospitals. These expert medical professionals will conduct hands-on clinical education while treating patients and expanding capacity. They will also train the frontline health care professionals on the most current information available for the management of COVID–19 patients, and other critically ill patients. The critical care response team can be mobilized and at the bedside of the patient within 24–48 hours' notice.

Earlier in May, we began distributing remdesivir to IHS federal and tribal hospitals based on requests and current burden of patients with COVID–19 who are hospitalized or in an ICU. Remdesivir is an investigational antiviral medicine that has been used under an emergency use authorization to treat certain people in the hospital with COVID–19. Remdesivir was shown in a clinical trial to shorten the time to recovery in some people, although the data was not sufficient to determine if the drug was associated with lower mortality. HHS has provided the IHS with access to 8,000 vials of remdesivir, and it is being supplied to patients at 15 of our IHS and tribal hospitals across the country.

In April, the IHS expanded use of an Agency-wide videoconferencing platform that allows for telehealth on almost any device and in any setting, including in our patients' homes. Since April's telehealth expansion, the IHS has experienced a greater than eleven-fold increase of telehealth visits, from roughly 75 telehealth visits per week on average to now 907 videoconferencing telehealth visits per week on average. This number does not include other telehealth modalities such as care provided over the telephone, which is common in the bandwidth-constrained environments of Indian country.

We look forward to continuing our work with tribal and federal partners. As we work towards recovery, we are committed to working closely with our stakeholders and understand the importance of working with partners during this difficult time. For instance, we are currently working with other federal partners to provide assistance to the National Indian Gaming Commission as they work to provide guidance to tribally owned casino facilities that want to ensure they are doing all they can to keep employees and customers safe. We strongly encourage everyone to continue to follow CDC guidelines and instructions from their local, state, and tribal governments to prevent the spread of COVID–19 and protect the health and safety of our communities.

I want to share an update on a trip that I made to the Navajo Area IHS at the end of May. During my trip, I visited the Navajo Area Office and Emergency Command Center in Window Rock, Arizona. I met with Navajo Nation President Jonathan Nez and joined him in the Navajo Nation's virtual town hall meeting on COVID–19. I am grateful for the strong leadership displayed by our tribal partners in working alongside federal and state partners to ensure the safety and well-being of American Indian and Alaska Native communities. I observed powerful and uplifting examples of collaboration during my visits to the Gallup Indian Medical Center, the Shiprock-Northern Navajo Medical Center, and the Crownpoint Health Care Facility. I would like to thank our entire Navajo Area IHS team for their continued dedication to our patients. I also want to acknowledge the rest of our IHS team, including those on the front lines, and others in supportive roles that have demonstrated profound commitment to raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level during this unprecedented time. I am extremely proud of their hard work to combat COVID–19, and I consider myself fortunate to work alongside a truly talented and dedicated team.

S. 3650, Coverage for the Urban Indian Health Providers Act

This bill would amend the Indian Health Care Improvement Act (IHCIA) to extend Federal Tort Claims Act (FTCA) coverage to UIOs as coverage is currently au-

thorized for Indian Self-Determination and Education Assistance Act (ISDEAA) contractors.

Congress must specifically authorize, in statute, the extension of federal tort coverage to certain groups or individuals. Currently, Federal law extends FTCA coverage to ISDEAA contractors' employees and personal services contractors [25 U.S.C.§ 5321(d)]. Federal law does not provide tort liability coverage for injuries to Urban American Indian and Alaska Native patients that result from the negligent acts of employees at UIOs providing health and medical services pursuant to a contract with or a grant from the IHS.

The IHS enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. In calendar year 2017, 35 UIOs provided 653,614 health care visits for 75,194 American Indians and Alaska Natives, who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation.

UIOs are purchasing liability insurance with resources that could be better utilized to expand services available to Urban American Indian and Alaska Native patients. The rising cost of liability insurance and the general cost of providing health care services adversely impact the ability of UIOs to provide needed services. As a result, certain kinds of staff and health services, such as dental services, have been substantially reduced or eliminated. UIOs are an integral part of the IHS health care system. They provide high quality, culturally relevant health care services and are often the only health care providers readily accessible to Urban American Indian and Alaska Native patients.

IHS endorses the policy to extend FTCA coverage to UIOs, which is consistent with the FY 2021 Budget request. However, IHS prefers formulating the coverage extension as part of the statutory section in the Public Health Service Act where the other various similar extensions are located.

Thank you again for the opportunity to speak with you today.

The CHAIRMAN. Thank you, Admiral Weahkee.

Now we will turn to Administrator Fenton.

STATEMENT OF ROBERT J. FENTON, JR., REGIONAL ADMINISTRATOR, REGION 9, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. FENTON. Good afternoon, Chairman Hoeven, Vice Chairman Udall, and distinguished members of the Committee . My name is Robert Fenton. I am the FEMA Region 9 Regional Administrator.

I want to thank you for this opportunity to discuss the actions taken by FEMA to support Native American communities during the COVID–19 pandemic. But before I begin my remarks, I would like to provide my condolences to the families and relatives of the 126,000 Americans who have lost their lives from COVID–19. Given the scope of this hearing and the disproportionate impact of the pandemic on Native American communities, I would like to express my particular condolences to the families and relatives of Native American victims of COVID–19. My thoughts and those of FEMA's employees are with you.

For the first time in FEMA's history, there are 57 concurrent major disaster declarations, encompassing every inch of our Country and impacting all 574 federally-recognized tribal nations. This is truly a Whole-of-America response.

The scale of this historic event has required FEMA to adapt its response practices in order to both respond to COVID–19 and simultaneously to maintain mission readiness for other disasters, such as wildfires or hurricanes. As you are aware, the challenges facing tribal nations are as diverse as the United States itself. Regardless of the unique obstacles, all tribal nations face widespread challenges in mitigating the impacts of this pandemic.

To address these challenges, FEMA headquarters, FEMA's regional offices, and their tribal liaisons are available to provide dedicated support to tribes. As previously stated, I am the Regional Administrator of FEMA's Region 9, which encompasses 400,000 square miles and includes some of the most culturally and economically diverse communities in the United States. Our region includes 157 federally recognized tribes within California, Arizona, and Nevada.

In Region 9, as well as in other regions, we have dedicated tribal liaisons and deploy staff to tribes when additional coordination is needed. An example of one tribe that FEMA Region 9 has worked with closely during the pandemic is the Navajo Nation. The Navajo Nation faces particular unique challenges as it borders three States with higher mobility in and outside of its borders.

Many Americans are not aware the Navajo Nation experienced the fastest rate of spread in the Country. I would like to highlight some of FEMA's experiences in supporting the Navajo government as well as other Federal agencies.

To address the historic challenges facing the Navajo Nation, a unified command group was formed by President Jonathan Nez. It included FEMA and multiple HHS components, including IHS, to ensure that the right Federal assets are mobilized at the right time to save lives. Following emergency declarations, I sent our Type 1 National Team members to the Navajo Nation to establish a unified command and an incident action plan to provide interagency coordination at all levels. This structure remains in place today and it continues the partnership.

Just yesterday, I visited the Navajo Nation, where I participated in the Nation's uniformed command meeting and joined President Nez in a virtual town hall in support of the messaging on the importance of adhering to mitigation. President Nez has taken great steps to limit mobility, highly encouraged the use of masks, enacted curfews, and stay-at-home orders, and continues to champion ways to leverage CARES Act funding in a manner that best serves the Navajo Nation.

While the Navajo Nation has faced some unique challenges in their fight to lessen the impact of COVID–19, they have also experienced challenges common to all tribal governments. One area of focus has been intricacies with FEMA's Public Assistance grant program. There are three paths in which tribal governments may become recipients of the PA program, as a direct recipient, as a subgrantee on other States' declarations, or they may request their own major declaration from the President.

The Public Assistance program reimburses emergency protective measures taken by a tribe. FEMA has developed a process to advance 50 percent of a project's funding to applicants before the project is completed.

Our office has performed outreach to tribal nations to explain this process, and continues to work with tribal governments interested in seeking the expedited reimbursement. In some cases, we have dedicated FEMA staff who assist tribal nations in the application process.

I want to highlight some strong partnerships with some of our State partners that we have worked with to support the tribes. For

example, California sat up a tribal affairs desk in the State Operations Center to assist tribes and coordinate a routine weekly conference call with Federal, State and local agencies as well as any health clinics and has provided deployment personnel, equipment and commodities to meet emergency needs of tribal communities.

The State of Arizona has also participated closely with tribes, including providing a significant number of personal protective equipment, and delivered specific aid to specific IHS and 638 facilities, including the use of rotary aircraft to help expedite PPE, medical training, and other components such as Strategic National Stockpile clean ventilators.

These are just a few of the efforts FEMA is participating in with the tribes to respond to COVID–19. I and the entire FEMA team are committed to ensuring we address the critical needs of the tribal governments during this challenging time. The historic response and our preparations for the future will continue to require a Whole-of-America effort. FEMA looks forward to coordinating closely with Congress as we work together to protect the lives of Native Americans.

I would like to thank the Committee for providing FEMA with the resources to meet these complex mission requirements. I look forward to answering your questions today.

Thank you.

[The prepared statement of Mr. Fenton follows:]

PREPARED STATEMENT OF ROBERT J. FENTON, JR., REGIONAL ADMINISTRATOR, REGION 9, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY

Good afternoon, Chairman Hoeven, Vice Chairman Udall, and distinguished Members of the Committee. My name is Robert Fenton, and I am the Region Nine Administrator of the Federal Emergency Management Agency (FEMA). Thank you for the opportunity to discuss FEMA's response and the actions underway to protect tribal nations during the coronavirus (COVID–19) pandemic.

I would like to begin today by acknowledging and providing my condolences to the families and relatives of the 126,000 Americans who have lost their lives to COVID–19. My thoughts, and those of the men and women of FEMA, are with you.

For the first time in the United States' history, there are 57 concurrent Major Disaster Declarations encompassing every inch of our country and impacting all 574 federally recognized Indian tribes: from the native villages of Alaska, to the pueblos of the Southwest and the tribal communities of the Northern Plains, Mississippi Valley and Eastern Seaboard. The scale of this historic event has required FEMA to adapt its response practices and workforce posture in order to both respond to COVID–19 and simultaneously maintain mission readiness for more common disasters such as hurricanes, earthquakes, floods, or wildfires.

Regardless of the challenges that FEMA continues to confront, the bedrock of our mission remains constant: helping people before, during, and after disasters. Although—and indeed because—COVID–19 has changed our daily lives and the scope of its impact is unprecedented, the Nation is counting on us to accomplish our mission and we will do so in accordance with our core values of compassion, fairness, integrity, and respect. FEMA will continue to leverage the Whole-of-Government response to serve all of America.

Engaging with sovereign tribal nations is a key component of this Whole-of-America response, and overcoming the unique challenges confronting tribes has been a strategic prioritization for FEMA from the beginning of the response to the pandemic. Many tribes are in locations with limited transportation, medical, and communications infrastructure which can complicate response efforts during any disaster. Within the context of COVID–19, social determinants of health and disproportionate percentages of chronic illnesses combined with these infrastructural limitations to create particular challenges for potentially at-risk tribes.

In direct reflection of the magnitude of this historic event, FEMA's unprecedented support for tribal governments is measured beyond financial support or the distribu-

tion of personal protective equipment (PPE). FEMA's response has served to stabilize lives in the most fundamental ways. For example, when the shelves of grocery stores became barren and members of two tribes in New York were unable to purchase scarce supplies, FEMA's emergency food distribution services were able to fill that critical void. This is one simple example of FEMA's understanding that emergency management is about putting people first—both the disaster survivors we serve and those who serve them.

FEMA Headquarters and FEMA Regional Offices have provided expanded services in support of tribal governments across the country in response to the pandemic since the National Emergency Declaration was declared on March 13, 2020. Each of the ten FEMA regional offices have dedicated Tribal Liaisons within their workforces to coordinate with tribes located in that respective region. Regional Tribal Liaisons and Regional Administrators serve as the primary point of contact regarding FEMA assistance, and serve as the conduit to connect tribes with FEMA leadership and program subject matter experts, as needed, for information sharing, technical assistance and resource coordination. As part of these efforts, FEMA Regions, with the support of our federal partners, have hosted weekly meetings and conference calls with tribal leaders and tribal emergency managers to answer any of their questions during this pandemic response. In Washington, D.C., FEMA has a dedicated, permanent National Tribal Advisor Desk that further supports coordinated federal response efforts to support tribes during any major disaster or emergency activation within FEMA's National Response Coordination Center (the NRCC)—which is located in FEMA Headquarters. The NRCC has served as the fulcrum for coordinating the federal interagency response to the COVID–19 pandemic. The NRCC Tribal Desk, as is commonly referred to, was activated on March 15th and has been staffed every day to support response and recovery efforts.

Today's testimony will offer an overview of FEMA's response efforts and strategies for COVID–19, the types of assistance we have provided, and the ways in which FEMA has augmented the leading efforts of our federal partners at Health and Human Services (HHS), including the Indian Health Service (IHS), to protect the lives of tribal citizens.

Overview of FEMA's Support for Tribal Partners

Public Assistance Category B

On March 13th, 2020, President Trump declared a nationwide emergency pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). As a result, FEMA's involvement in the federal response was vastly expanded. As part of this unprecedented nationwide declaration, all state, local, tribal, and territorial (SLTT) partners became immediately eligible for FEMA Public Assistance (PA) Category B, emergency protective measures as authorized by section 403 of the Stafford Act and funded by the Disaster Relief Fund. Such assistance includes, but is not limited to, funding for tribal medical centers, Alternate Care Facilities, non-congregate sheltering, community-based testing sites, disaster medical assistance teams, mobile hospitals, emergency medical care, and the transportation and distribution of necessary supplies such as food, medicine, and personal protective equipment (PPE).

Subsequent to the President's emergency declaration, all 50 states, five territories, the District of Columbia, and the Seminole Tribe of Florida have been approved for Major Disaster Declarations. As a direct result of every single state receiving a Major Disaster Declaration, every single tribal government in the country became covered by a Major Disaster Declaration.

To provide flexibility, tribal governments have parallel paths through which they can seek assistance from FEMA. They can either request to be direct recipients under the nationwide emergency declaration, or they can seek assistance as a direct recipient or subrecipient under a State's Major Disaster Declaration. Tribal governments also have the option to request a specific Major Disaster Declaration directly to the President through FEMA. Regardless of the way in which tribal governments pursue FEMA assistance, FEMA Regional Offices and their Tribal Liaisons are available to provide technical assistance.

In total, FEMA is working directly with 85 tribes under this framework including partners such as the Hidatsa and Arikara Nations of North Dakota, the Choctaw Nation of Oklahoma, and the Mashpee Wampanoag Tribe of Massachusetts. In keeping with the Stafford Act, FEMA allocates funding to cover 75 percent of costs, and tribal governments are responsible for the remaining 25 percent.

Cost Share Adjustments for Public Assistance Category B

Many state and tribal governments have requested adjustments to the 75:25 cost-share ratio due to the economic hardship and loss of tax revenue associated with

the COVID–19 pandemic. As of June 25th, 42 states and 28 tribes have requested a cost share waiver. The Stafford Act authorizes the President of the United States to make cost share if warranted.

Tribal government recipients may request cost share adjustments from the President through their FEMA Regional Administrator.

FEMA will then make a recommendation to the President regarding the request and the President has the authority to make final cost share adjustment determinations.

When federal obligations meet or exceed $149 per tribal member FEMA will recommend the President increase the federal cost share from 75 percent to not more than 90 percent. As part of this calculation, FEMA will use a tribal government's population on or near tribal lands, as reported by a tribal government, to determine per capita obligations for each tribal government that makes a request. FEMA also considers qualitative factors such as the historical context of recent disasters within the specified area.

CARES Act Funding for Cost-Share Considerations

To help tribal governments affected by COVID–19, the Department of Treasury recently announced that Coronavirus Relief Fund dollars, provided under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, may be used to pay for FEMA's cost share requirements under the Stafford Act. This is yet another example of increased flexibilities offered to tribal governments to nimbly respond to and recover from COVID–19.

Managing Critical Shortages: FEMA Resource Distributions to Tribal Partners

On March 19th, FEMA's role in the pandemic response changed. Under the direction of the White House Coronavirus Task Force, FEMA moved from playing a supporting role in assisting the U.S Department of Health and Human Services (HHS), which was designated as the initial lead federal agency for the COVID–19 pandemic response, to leading the Whole-of-Government response to the COVID–19 pandemic.

From the outset, a key element of FEMA's response has been managing shortages of medical supplies needed to combat the pandemic, such as PPE, ventilators, swabs, and the chemical reagents required for testing. This effort alone has presented a historic challenge for FEMA and its federal partners such as IHS and HHS. COVID–19 has been a global crisis-leaders across over 150 countries have simultaneously been competing for the exact same medical supplies. We have been further challenged as most of the manufacturing for PPE occurs in Asia, where the virus significantly slowed down private sector production capabilities.

Concurrently, American medical professionals on the front lines of the pandemic have required an exponentially greater volume of PPE and other medical supplies. On average, the United States began consuming a year's worth of PPE in a matter of weeks. FEMA worked closely with HHS to ensure that locations in danger of running out of supplies within 72 hours received lifesaving equipment from the Federal government's reserve within the Strategic National Stockpile (SNS), as administered by HHS.

Many of the earliest shipments to tribal governments and IHS originated from HHS's SNS. From the beginning, FEMA and HHS understood and acknowledged that the SNS alone could not fulfill all our Nation's requirements. The SNS was never designed or intended to fully supply every state, territory, tribe and locality in the United States concurrently, and cannot be relied upon as the single solution for pandemic preparedness. It was principally designed as a short-term stopgap buffer to supplement state and local supplies during an emergency.

Expedited international shipments within Project Airbridge facilitated by FEMA's Supply Chain Stabilization Task Force helped to supplement IHS and tribal nations' PPE or medical needs until global supply chains could begin to stabilize. Once flown in via the Air Bridge, 50 percent of the supplies on each plane were sent by distributors to customers in areas of greatest need, such as hotspots within the Navajo Nation.

Although FEMA was never intended to be the primary source of supplies for any entity, our Agency was able to augment the vast donations and supplies distributed through our partners at HHS and IHS. In addition to our federal partner donations, FEMA facilitated the distribution to tribal governments of 19,400 boot covers. 13,755 coveralls. 65,204 face shields. 1,276,800 gloves. 32,000 goggles. 15,000 KN90 masks. 139,670 KN95 Respirators. 397,030 N95 Respirators. 107,911 gowns. 1,825 Powered Air Purifying Respirators. 1,506 surgical gowns. 120,450 surgical masks and 1,200 Tevek headcovers.

In addition, FEMA distributed more than 26,880 meals and 17,136 bottles of water to tribal communities and constructed five Alternate Care Facilities, in part-

nership with the U.S. Army Corps of Engineers, to assist the San Carlos Apache Tribe, Hualapai Tribe, and Navajo Nation.

An Example: FEMA Support for the Navajo Nation

I do not need to remind the Members of this Committee that the breadth of challenges facing Indian tribes and Alaska Native Villages are as diverse as the United States itself. For example, certain tribes within the Yukon territory of Alaska must deal with the difficulties of being entirely inaccessible by roads and overcome the consequential challenges of receiving medical aid by small boats or aircraft. Conversely, other tribes in the continental United States must adapt to the difficulties of being directly accessible by major highways, and the exponentially increased risk of exposure to COVID–19 brought by international travel. To best exemplify the ways in which FEMA has been able to assist tribal governments and their wide variety of needs, I would like to share our experiences in supporting one of most impacted tribal nations within my jurisdiction: the Navajo Nation.

Similar to the challenges faced by other tribal nations across the country, limited medical infrastructure and high rates of chronic illnesses combined to create a vulnerable demographic amongst the Navajo Nation. To further complicate matters, the Navajo Nation is spread out across Arizona, New Mexico, and Utah. Consistent with other aspects of the COVID–19 response, a key component of FEMA's efforts to protect the lives of the Navajo Nation was close coordination with our federal and state partners as part of the Whole-of-Government response.

To address the immediate shortages of PPE needed to support medical workers on the front line in the Navajo Nation, FEMA and HHS worked together to deliver critical PPE such as 159,000 N95 masks, 111,000 gloves, 30,000 face shields and 18,000 Tyvek suits. As part of the Whole-of-America response, FEMA and HHS were able to further augment these shipments to the Navajo Nation by facilitating donations of 102,967 gowns and an additional 30,500 gloves. To address ventilator shortages, FEMA and HHS also facilitated the delivery of 50 ventilators to Navajo Area IHS and 100 ventilators to the State of Arizona, to be available to tribal nations, as needed.

Experience has demonstrated that emergency management is most effective when federally supported, state or tribe managed, and locally executed. As such, FEMA and Arizona State Health mission sent a Disaster Medical Task Force to Tuba City Regional Health Care, which provided subject matter expertise and other assistance. Furthermore, FEMA has deployed an incident management assistance team to support the Navajo Nation led response through joint planning, operations and logistics at the Navajo Nation Health Command Operations Center.

Testing is also an important aspect of the strategy to combat COVID–19 within the Navajo Nation. In keeping with lessons learned elsewhere in the country, FEMA supported HHS efforts to prioritize rapid testing for at-risk populations within the Navajo Nation. Prioritizing the limited number of rapid tests for populations with underlying health considerations was key to facilitating a rapid response and the strategic distribution of scarce supplies. COVID–19 diagnostic platforms with longer turnaround times were found to be more appropriate in situations with lower risk of rapid spread and escalation. Rapid testing, as supported by HHS, IHS, and FEMA, has allowed for increased diagnostic screenings above the national average.

In addition to FEMA's traditional role, we worked in nontraditional ways as well. Through our relationship with the Department of Homeland Security HQ, we deployed a "Tactical Technical Assistance Strike Team" into the Navajo Nation during the peak of the crisis there. This team not only helped with the traditional response, but also vectored nontraditional NGO partners like The World Central Kitchen and Community Organized Relief Effort into the Navajo Nation.

Lastly, understanding that emergency management practices must put people first, FEMA deployed a six-person Incident Support Base (ISB) team to support staged commodities, if needed or requested by the Navajo Nation. FEMA staged four 52-foot trailers with cots, blankets, water, and meals.

I commend our partners at HHS and IHS for working with the Navajo Nation and using this experience to prepare for future emergencies. For example, IHS is working with the Centers for Disease Control and Prevention, also within HHS, and the Navajo Nation to recommend solutions, identify resources and begin implementing plans to expand water access on the Navajo Nation. These actions will potentially assist in reducing the spread of the illness and lessen the burden on the Navajo Nation's health care delivery infrastructure.

Conclusion

As the Regional Administrator of an area that serves 157 tribal governments, including the Navajo Nation, I am acutely aware of how critical FEMA's work is to

the lives of Indian tribes, and I, and the entire FEMA team, am committed to ensuring we address the critical needs of tribal members during this challenging time.

Finally, I would also like to recognize the men and women of FEMA, as well as our partner departments and agencies for their adaptability, hard work, and endurance during this unprecedented response and express our appreciation to Congress and the President for providing FEMA with the necessary resources to meet very complex mission requirements and conditions.

This historic and unprecedented response will continue to require a Whole-of-America effort, and FEMA looks forward to closely coordinating with Congress as we work, together, to protect the health and safety of the American people during the COVID–19 pandemic.

Thank you for this opportunity to testify. I look forward to answering any questions that you may have.

The CHAIRMAN. Thank you, Administrator Fenton.

And we will proceed to five-minute rounds of questions. I am going to begin with Admiral Weahkee. I know that you have been using the tele-health services, following CDC guidelines. I guess my first question for you, Admiral, at IHS, is when do you see returning to normal operations, and then when you do, will you still have that tele-health service available?

Mr. WEAHKEE. Thank you, Chairman Hoeven. I appreciate the question. We are very excited to have the flexibilities that have been provided by CMS, both in terms of licensure and the increased reimbursement for those services. We are very hopeful that many of those will continue, even beyond the pandemic. I think that we tested the possibility of that occurring and by far, our providers have taken to it, our patients have taken to it. So I really think it is going to be a sea change for the way that patient care is delivered from this point forward.

That being said, we have a lot of challenges in Indian Country with broadband access. Not all of our communities have the ability to obtain services through that mechanism. We have turned to hand-held telephones. Most Americans have a telephone available to them. So we are trying to use that platform as a potential.

In terms of when we will return to normal, I think that is going to be different for different parts of the Country. We have operations in 37 different States, 605 different facilities across that system of care. Some of the locations will be ready to return back to normal much sooner than others, just depending on local situations, hospital capacity, local infection rates.

But we do have a very defined, phased plan to return back to some semblance of normalcy.

The CHAIRMAN. Also, you have lost a lot of third-party reimbursements. What do you see as far as recouping some of those third-party reimbursements for procedures that have been put off because of COVID?

Mr. WEAHKEE. Thank you, Chairman.

We have assessed within our Federal family and with tribal entities who are willing to share their information, and our urban partners, what the third-party losses have been. We have heard everything from 30 percent to 80 percent. We have good insight into our Federal operations and what those numbers are. But depending on the size and type of facility, if you are only providing residential treatment, alcohol and substance abuse, those services are for the most part taking a major hit. Dental services is another line that has taken a significant hit.

But hospital size, part of the Country that you are in, there is some broad variation. We have been very fortunate beneficiaries of the Provider Relief Fund. So we thank Congress for that. But the funding that we have received is not reaching the entire need out there.

I visited the Phoenix Indian Medical Center this week. They are projecting a $14 million deficit by the end of this fiscal year if current situations continue.

The CHAIRMAN. IHS has been allocated $2.4 billion from the CARES Act. How much of that is allocated, and do you anticipate being able to allocate all of it? Are you going to have some returned? If so, why?

Mr. WEAHKEE. Thank you, Chairman. The vast majority of those funds have been allocated. In fact, all the funding is out at the area offices. The first three supplements of funding are in the front lines already in the coffers and being used to purchase testing equipment, and to continue to pay those salaries from that lost third-party revenue.

One set of funds that is taking a little bit longer to get out is the Paycheck Protection Program and Healthcare Enhancement Act funds. That is $750 million worth of the funding. We are undergoing bilateral modifications to the annual funding agreements to ensure that we have testing plans developed in partnership with the tribes and we have a good understanding of their needs, estimated testing supply needs, in the future.

The CHAIRMAN. You indicated testing, more than 150,000 tests, 9.5 percent of the IHS user population. That is a rate that exceeds most States, a lot of them, and most foreign countries, too. What is your target? That is good. What is your target for testing?

Mr. WEAHKEE. Well, Senator, our target, and I will probably lean back on Dr. Toedt here, the target is to assess at least 10 percent of your population.

Dr. TOEDT. [Remark off microphone] testing the positivity rate.

Mr. WEAHKEE. The positivity rate. So our current number is now 272,935 tests that have been completed. That represents 16.4 percent of our user population. So in less than three weeks' time now, we have seen substantial increases in our testing rates. We have a high, in Navajo and Phoenix, right at about 20 percent of their population is being tested. I think positivity rates for places like Alaska where we have been able to test 46,772 patients, they have a positive rate of only a 0.3 percent, which is very good.

But we feel like we are doing a great job in terms of testing capacity and meeting the needs of testing in Indian Country. That being said, supplies deplete and hot spots persist in large metropolitan areas and it will be difficult to get those testing supplies.

The CHAIRMAN. For those hot spots, for example, in the Southwest, including tribes in White Mountain, the White Mountain Apache, also the Navajo Nation, what are you doing in terms of coordinating with other agencies to try to make sure you are meeting their service needs?

Mr. WEAHKEE. Yes, sir, and that goes to the heart of the all-of-government approach. It is vitally important that we are working with the States where our tribes exist. The State of New Mexico has been a fabulous partner. Governor Lujan Grisham has done a

lot of great work in ensuring that we have testing capacity. She has contracted isolation sites. But it is important that we utilize all the resources available to us.

We talked about government support a lot. We have also had a lot of support coming from non-governmental organizations and from universities. Johns Hopkins is engaged in both of those locations, White Mountain and Navajo.

So we are taking advantage of all the resources available to us in this all-of-nation approach.

The CHAIRMAN. Thank you, Admiral Weahkee. We will turn to Senator Udall.

Senator UDALL. Thank you, Mr. Chairman.

Admiral Weahkee, you should know better than anyone that COVID–19 is hitting Indian Country particularly hard, especially in the Navajo service area in Arizona and New Mexico, and you should agree that as doctors and medical professionals across the Country work on the front lines to battle this deadly virus, the least we can do is ensure that they have the right personal protective equipment. That is a bare minimum.

So you can understand why I am deeply troubled by recent reports about hundreds of thousands of substandard KN95 respirator masks supplied to IHS hospitals serving the Navajo Nation on New Mexico and Arizona. I mentioned this concern in a brief phone call with you in May. I followed up with a May 27th letter asking for a full report, and posing very targeted questions to you about what happened there on the circumstances of the IHS' $3 million Federal procurement contract with Zach Fuentes LLC.

First, let me state the obvious. It is outrageous that substandard masks were sent anywhere, let alone to a COVID–19 hotspot. In its haste, IHS contracted for faulty PPE and failed its responsibility to its patients and caregivers, period.

I understand that the IHS did not use the faulty masks, and by a stroke of luck, none were actually distributed for use in IHS facilities. That does not take away from the fact that IHS potentially put patients and medical personnel in harm's way by failing to do its due diligence.

To make matters worse, yet another report has surfaced indicating that the contractor has refused to terminate the contract, and has demanded his $3 million payment.

Admiral, you are in a world of hurt. How about we start with your explaining how this happened, for the record?

Mr. WEAHKEE. Thank you, Vice Chairman. I just want to state for the record that this situation is procurement sensitive. We are still working with contract acquisition professionals and attorneys to go back and forth with this particular vendor on this purchase.

It wasn't a stroke of luck that kept those supplies from getting to our front line staff, it was the systems and controls in place at our area offices and in our receiving, to ensure that those materials were not distributed to our health care professionals.

So I am happy that we have been able to identify the situation and now, because of non-conformance of this particular vendor in meeting the needs of our PPE, we have the ability to send those supplies back. There are options available to him. He can make it good by providing us with masks that meet the FDA standards and

certifications. Or he can try to come up with a different way of fulfilling his end of the contract.

He has not been paid. Those masks are all sitting in a warehouse in Mexico. They are clearly identified that they are not to go to any of our locations.

In terms of how this occurred, we used Federal acquisition regulation requirements and the flexibilities that have been provided to us by the CARES Act. We identified and looked at seven different vendors for that particular procurement. He had the best pricing and the delivery options available at the time. But since you have identified the needs that persist, and they do, we do need masks, not only in Navajo but throughout the Country, we are looking at other vendors to help meet that need.

Our National Supply Service Center immediately shipped 100,000 N95s, not KN95s, but actual N95s, to that location as this is being resolved.

Senator UDALL. I expect a full response to my May 27th letter with written answers to all my questions. And a staff briefing is not enough. Your response letter last night I received at 11:36 p.m. It didn't answer any of the questions.

So I want to ask one of those, or two of those questions today. What protocols are in place to guard against IHS procuring substandard PPE?

Mr. WEAHKEE. Thank you, Senator. The protocols that are in place are controls and systems for any procurement. So we do have a receiving that is conducted by procurement professionals. They review, according to the order, to ensure that we have received what it was that we ordered. We also have quality assurance reviewers that sometimes include infection control nurses. So those items that a materials management person may not have as much familiarity with as a front line health care service worker, there would be multiple points to be able to check and ensure that we are using what it is that we need to be using in each setting.

So there are multiple checks and balances built into our system to ensure that the PPE being used meets the quality control standards in place.

Senator UDALL. Will you commit to me to answer my questions in my May 27th letter to you?

Mr. WEAHKEE. We will, sir.

Senator UDALL. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Udall.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Admiral Weahkee, you heard me mention in my short opening the impact that we have seen in Alaska as a result of the pandemic, the tribal providers being forced to shut down elective procedures in the clinics. The negative financial consequences I don't think can be overstated.

It is estimated that third-party collections have dropped by 80 percent in some States. We recognize that the need is considerable, and you certainly know that.

One of the things that really has helped shine a spotlight during this time of COVID–19 is when you are telling people to follow certain safety protocols, like washing your hands frequently, and you

are from a village where you don't have safe drinking water, you don't have running water in your home, you don't have the means, really, to keep yourself and your family clean. This is very, very, very hard. It just highlights again how essential adequate sanitation is for our communities.

We are seeing not only this play out in our communities, but we know that other forms of disease also come with lack of safe drinking water, lack of the ability to clean and disinfect. Of the 190 Alaska Native communities, 32 are still not served with in-home water and sewer. Typically, these communities have a washeteria where you can go and you can wash your clothes, take a shower, get clean. But in many, many of these communities, and you know because you have seen them, it is simply inadequate.

I was out in Wales this past year. Wales has been working for years now to get their washeteria back. Beyond just one shower, there is no washing machines that work. It is a Federal effort to get a washeteria in place.

Not only a Federal effort, it then becomes a media event when that story is not only played in the Anchorage daily news but in news publications around the Country. So it speaks to the issue that so many rural communities lack access to adequate water. This comes when you have extraordinarily high construction costs in those communities. IHS has established cost caps per home that when approached, both decrease the priority of the project in the scoring system, and limit the amount of funding available.

So my question to you, Admiral, is whether or not IHS would be willing to eliminate or at least to raise the cost caps for projects that provide piped water and sewer into these unserved communities. We have to be figuring out how we can do more to be more responsive, to get water and sanitation out there.

Mr. WEAHKEE. Thank you, Senator Murkowski. I join you in having seen Wales and Shishmaref myself, and the dire need for these services. That has been in my conversation with President Nez on the Navajo Nation, they have a lot of very similar issues with a lack of available water systems.

Even before the pandemic, we had identified a need of $2.7 billion across our system of care for sanitation and facilities construction needs. But these problems are now exacerbated as a result of the pandemic and the inability to wash hands, as you say, which is one of the public health measures we need to put in place.

With regard to the caps, we do have three different tiers in the State of Alaska. As we all know, it costs much more to construct. We have to barge equipment in and supplies and condense your construction time frame. All of those add to the cost.

We are currently collecting actual data to identify whether or not the caps that are currently in place are meeting reality. We know that we now have some additional flexibilities that have been provided to us. President Trump also put in place an executive order that has enabled us to waive certain regulations and policies that may be impeding our construction projects or other infrastructure projects.

So I am definitely open to looking at what flexibilities we may have available to us to make changes and get these built once and for all.

Senator MURKOWSKI. I think it is important, you mentioned the flexibility there and the opportunity to perhaps waive. We have also seen the need for community public health measures in terms of how we deal with community contributions in Indian communities for sanitation projects.

So looking, having the IHS again look to waive the non-Indian contribution requirements in the Indian communities is, I think, something that could be helpful. So I would urge you as you are looking to those authorities that you have, what has recently been laid out in this executive order.

But I think we have known that we have had this problem for far too long. When we had Dr. Eastman up to the State just about six weeks ago or so, his eyes were opened. Even though this was not something that was in his bailiwick or jurisdiction, he was starting to think outside the box, how can we work with FEMA to perhaps use emergency funds. Because this is an emergency. It has been an emergency for a long, long time. That has been part of the problem and what has stalled us out.

So know that we are going to keep working aggressively with you. While it might not be something that we can direct funding to now, I think there are flexibilities that we can look to. I think also when you see the disparities in so many of our Native villages, our Native communities, following from this pandemic, there needs to be a greater sense of urgency as to our purpose and how we address it together.

So I look forward to doing that with both the agencies here. Thank you, Mr. Chairman.

I do have questions that I will be submitting for the record if I may.

The CHAIRMAN. Very good. Thank you, Senator Murkowski.

Senator Cantwell.

STATEMENT OF HON. MARIA CANTWELL, U.S. SENATOR FROM WASHINGTON

Senator CANTWELL. Thank you, Mr. Chairman, and thank you, Vice Chairman Udall, for holding this important hearing.

The Urban Indian Healthcare facilities in Seattle and the Indian Health Board and the Native Project provide critical service for Native Americans and Alaska Natives throughout the Pacific Northwest. The Seattle Indian Health Board serves around 6,000 patients annually, and at least two-thirds of those being Native Americans or Alaska Natives. The Native Project in Spokane also provides a wide array of services to more than 300 tribes.

However, chronic underfunding of our trust and treaty obligations across the Indian Healthcare system, in addition to the deadly COVID pandemic, is threatening Indian health and wellness of Native Americans and Alaska Native communities. So this is especially the case in a large percentage of American Indians and Native Alaskans who live in urban areas. Currently, Urban Indian health programs typically receive less than 1 percent of the IHS budget, even though approximately 70 percent of American Indians and Alaska Natives live in urban areas. So the inequity of Urban Indian health care just has to stop.

The situation is not helped by the fact that the Urban Indian health programs receive a lower Federal Medical Assistance Percentage, or FMAP, as other Indian health care facilities. To me, this inequity does not even make sense. These providers must have parity, particularly as they have needed to close their doors, reduce services, stop medicine delivery due to the lack of resources and capacity of COVID–19.

So Rear Admiral, what are the benefits of extending 100 percent FMAP parity to Indian health programs, and how can we get that done? How would it impact the IHS budget?

Mr. WEAHKEE. Thank you, Senator Cantwell. I agree that we do have many of our American Indian and Alaska Native brothers and sisters living in metropolitan areas now. You quote 70 percent living there. Active user counts, individuals using our Urban Indian programs, is about 71,000 per year, last check. So that contributes partially. Many of our funding formulas are based on the active users of the programs. That being said, we know that there are many urban centers across the Country who really want to participate in that program.

The 100 percent FMAP would benefit those locations, because then 100 percent of the funding going to those locations is coming out of the Federal coffers, as opposed to the match required by the States. So there is a funding amount that States would need to come up with in that current system that would all be paid by the Federal Government if 100 percent FMAP were provided to the Urbans in the same way it is for our IHS tribal and community health centers.

Senator CANTWELL. I am glad you mentioned that part. So now we are talking about an Indian Health Service facility somewhere, let's pick Montana, or what have you, they get 100 percent, right?

Mr. WEAHKEE. Yes, ma'am.

Senator CANTWELL. Okay. So if you actually had a physical hospital facility in downtown Seattle that was on a tribal land, you would also get 100 percent?

Mr. WEAHKEE. Depending on the structure of that facility, if it was true tribal, tribal 638, through a tribe directly running it or tribal resolutions. I think Phoenix Area Medical Center is a good example of that, where there are six service unit tribe and they so get 100 percent FMAP.

Senator CANTWELL. So we are only just talking about the structure of the building, not the obligation to meet Indian health. So my point is, this is an inequity, we have to fix it. There is no reason—do you know of a reason for the inequity?

Mr. WEAHKEE. Other than historical structure, and the manner that the programs came about.

Senator CANTWELL. Right. So I am saying, with so much of the population in Urban Indian Health, and the fact that it is in dire pandemic and needing resources, to me, obviously States are coming to us too and saying, let's have full FMAP, because of their underwater nature in health care. Now seems the perfect time to fix this and to move forward.

I don't think that there is any difference, other than the structure and the building, as you say, in the code. But in reality, we

are talking about serving Indian health. That is all we are talking about. So to me, we should meet this obligation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cantwell.

At this point we will turn to Senator McSally remotely.

STATEMENT OF HON. MARTHA MCSALLY, U.S. SENATOR FROM ARIZONA

Senator MCSALLY. Thank you, Mr. Chairman, I appreciate it.

It is good to see you gentlemen today. Arizona is home to 22 federally recognized tribes and more than 300,000 Native American constituents. When the Coronavirus hit, I have been a tireless advocate for our Native Americans in Arizona, fighting for the tribal stabilization fund, that $8 billion, also for tribal parity and engaging with the Administration to ensure the execution of many parts of the CARES Act was within Congress' intent in order to help our Native American communities.

This pandemic has devastated Native American communities and economies. But I do want to recognize the incredible response by our tribal leaders, of the health care heroes, of the first responders. Tribal members and their families have shown incredible resilience and strength and innovation and just service to others in this incredibly challenging time. They are doing an incredible job and we are here to make sure that they have the resources that they need to fight and defeat this virus. We will defeat this virus together.

Mr. Fenton, it is good to see you remotely. The Navajo Nation has garnered national attention and international attention as one of the hardest hit communities in the world. While FEMA aid has been flowing since early days, the 25 percent cost share requirement has proven to be burdensome and seems to unwisely divert funds away from where they are really needed locally.

On April 2nd, the Navajo Nation formally requested a waiver for the 25 percent tribal cost share requirement. FEMA acknowledged receipt of the letter and reported the request was under review at FEMA Region 9 headquarters. Since nearly three months have passed since the Navajo Nation submitted the request, when can President Nez expect a response?

Mr. FENTON. Yes, Senator. There are a couple of different ways that cost share can be changed. As you know, one is by the President. So that letter is in process.

In the interim, what has happened is the Administration has made CARES Act funding available to be used as a cost share match. So that 25 percent, along with our 75 percent to cover the whole 100 percent. Then we can also look at a change if they reach the 90–10 per capita number, which is $149 per capita.

So no State, tribal nation or territory has received a cost share change, primarily because of all the funding that is out there now and trying to leverage that together to provide the need. I talked to President Nez yesterday, and he understands that there hasn't been a response yet. That doesn't mean that there won't be one. And of course, Congress can do that through a change, too.

Senator MCSALLY. Got it. So just to be clear, they have got no response yet, but where is it in the process of working its way up the Administration? So the answer is not no. I know there are dif-

ferent ways to address this, and one could be in additional legislation. But through the Administration's process, where are they in the process and when will they get an answer?

Mr. FENTON. It is within FEMA, and typically we don't address cost share waivers until there it goes over $149 per capita, which we are far short of right now. So that is what triggers the 90–10 change.

So we have that, we are tracking their cost share right now, and their spend and need. The majority of the assistance we have given to the Navajo Nation has been in direct Federal assistance. So until we build them, there is no cost share for that. We have reimbursed them less than a million dollars at this point. So the cost share would be small amounts that they have been impacted which they can use CARES Act funding, or non-profit in lieu of that, too.

So there hasn't been a significant impact to them yet from that cost share. We continue to monitor it and work closely with them.

Senator MCSALLY. So just to be clear, when you say CARES Act coming as a second mechanism, are you talking about using some portion of the Tribal Stabilization Fund, the $8 million?

Mr. FENTON. Of the Treasury money, I think it was $600 million provided to Navajo.

Senator MCSALLY. To them, that was their portion of the $8 billion, is what you are getting at. Okay, thanks.

So I want to talk about just the tribal initiative. Early on, many tribes in Arizona expressed frustration about indirect accessibility structure between FEMA, States, and tribes. This was in the early days. So how has FEMA worked to improve the working relationships with the tribes in a way that respects tribal sovereignty and also improves efficiency?

Mr. FENTON. There are many different mechanisms that coordinate with the tribes. One is each region has tribal liaisons that work with the tribes. I have two in California, for northern and southern California, and one in Arizona and one in Nevada. In addition to that, during this event, I have deployed personnel to specific tribes that are heavily impacted, so I have a team up in the Navajo Nation, I have sent people over to the White Mountain Apaches. And then I have individuals within each State that are also coordinating that, along with the States that are communicating.

There's a number of mechanisms to ensure the communication. In addition to that, I have dedicated people to help them with the public assistance reimbursement.

Senator MCSALLY. Okay, great. I can't totally read the clock; I think I might be over my time. Admiral Weahkee, I am going to submit some questions for the record specifically about testing. I am concerned the White Mountain Apache Tribe now has the highest infection rate per capita in Arizona and are in need of mobile testing sites. So please look for those questions for the record on testing.

Mr. WEAHKEE. Thank you, Senator.

Senator MCSALLY. Thanks.

The CHAIRMAN. Thank you, Senator McSally.

We will turn to Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman, Ranking Member Udall.

My first question is for Director Weahkee. I wanted to follow up on Chairman Hoeven's question regarding tele-health. Some of the loosening of restrictions that just happened in the CARES Act are actually temporary and only apply for the period of the pandemic. I would like you to speak to the utility of these changes, the additional flexibility you have now, and increasingly I hear from patients, from tribal governments, from Native Hawaiian health care organizations, from providers, that not only is tele-health working, but it is sort of hard to imagine going back to the old way. What Congress hasn't quite realized is that a lot of the changes that we have made statutorily only apply during this pandemic.

So could you speak to the need to making some of these changes permanent?

Mr. WEAHKEE. Yes, and thank you, Senator Schatz, for this opportunity to speak to tele-health. Definitely, it is a mode of care that we have turned to in Indian Country for quite some time. We have seen rapid growth, rapid expansion, an 11-fold increase in only a short three or four months. We know that that pales in comparison to many other health systems who have increased their tele-health hundred-folds.

We have had conversations within HHS. I have heard both Administrator Verma from CMS and Secretary Azar as the Secretary speak to the desire to maintain these tele-health flexibilities long-term. So I am hopeful that we will see that come to fruition. Again, the challenges in Indian Country are really around broadband access and our rurality. We have many of the broadband services that go right around our reservations. So individuals who may be able to access tele-health in a neighboring rural city or county can still not access it on the reservation proper.

So having partnership opportunities with the FCC and the vendors who provide tele-health services are going to be vitally important as we move forward. Of course, the necessary resources to build the cabling and other lines of support.

Senator SCHATZ. So a couple of other questions. First of all, I want to make a specific point about tele-health. People think of as similar to this WebEx where you need a really high-speed connection. That is certainly true, and it is certainly the case that we all need to do better about broadband connectivity in Native communities. But I think it is important to remember that some of tele-health is storing forward technology, it is remote patient monitoring technology, which does not require super-fast bandwidth. Those are the kinds of things that do not depend on our ability to deploy infrastructure, but rather depend on our willingness to extend the flexibility that exists in the CARES Act into the future.

Second question that I have, Director, is, have you seen any quality of care problems now that some of these services are being delivered by tele-health rather than in person?

Mr. WEAHKEE. Thank you, Senator. I have personally not seen any quality of care items. Let me turn to my chief medical officer, Dr. Toedt. Anything you have seen or heard?

Dr. TOEDT. [Remarks off microphone.]

Mr. WEAHKEE. Thank you. We have not.

Senator SCHATZ. And a final question, there was a fair amount of good conversation in the opening remarks around the need to help health care providers in order to deliver direct patient care and not spend too much money on costly malpractice insurance. I think that is true for Alaska Natives, for American Indians, and Native Hawaiians. I am wondering if you could just let us know how important you think it is from a standpoint of your providers.

Mr. WEAHKEE. Thank you, Senator Schatz. I think that any time that you can have the backing of the Federal Government in an ever-increasing litigious society that it would be beneficial to our providers. It would buy them a sense of support.

Any time that you have to take away from precious few resources to pay malpractice insurance, you are making decisions, those funds could better be spent additional providers or nursing support, or other pieces of the health care system, if you didn't have to pay those high insurance rates.

Senator SCHATZ. Thank you very much.

The CHAIRMAN. Thank you, Senator Schatz. We will turn to Senator Daines.

STATEMENT OF HON. STEVE DAINES, U.S. SENATOR FROM MONTANA

Senator DAINES. Thank you, Chairman Hoeven, and Ranking Member Udall.

Admiral Weahkee, welcome. As we look at what is happening in Montana and across our Nation, disasters always seem to hit harder in Indian Country. This one is no different, with the current Coronavirus pandemic. That is why I fought alongside Senator McSally to secure $8 billion, we worked together on that, to be set aside for tribal governments to respond to this crisis.

Additionally, we were able to secure tribal eligibility for an additional $803 billion in grants and loans. This has provided tribes in Montana with some important tools and funds needed to help combat this global pandemic.

We have also worked hard to facilitate getting more PPE out to Montana's tribes, working with the vendors, making sure they have the resources to purchase the amount necessary.

A question, Admiral, is that not enough seems to be the most common phrase I hear in regard to PPE in the health care system. What steps has IHS specifically taken to ensure that tribes in Montana have enough PPE and testing kits to accurately and safely track the Coronavirus?

Mr. WEAHKEE. Thank you, Senator Daines. I appreciate your question. Specific to both PPE and testing supplies there are similar processes used to fulfill the needs for both. Early on in the pandemic, we, just like every other health care system across the Country, were really scrambling to meet the needs. Everybody needed the same materials at the same time, and manufacturing supply was just not where it needed to be to meet those needs.

We worked closely with FEMA and the Assistant Secretary for Preparedness and Response in HHS in the early days to fulfill any supply needs that we couldn't meet through our regular channels, through the Strategic National Stockpile. We all know that at some

point that Strategic National Stockpile was depleted and probably, according to many, earlier than it should have been.

So we have a lot of work to do to prepare for the next pandemic and the potential second wave coming to ensure that we are ramping up the par levels and the supplies that we have, not only in the Strategic National Supply, but within our agency stockpiles as well. We have within the Indian Health Service a National Supply Service Center. It is located in Oklahoma City. It is a warehouse full of supplies as well as three regional supply centers, one in Anchorage, Alaska, Gallup, New Mexico, and Nashville, Tennessee. We have had internal discussions in the same way that they have at the national about increasing our S and S, about increasing our stockpiles and potentially even the need to increase by some additional regional centers, perhaps in the Great Lakes and the Pacific Northwest.

Senator DAINES. In Mille Lac, if I can interject for a moment, we are seeing an increase in the number of COVID–19 positive test results in Montana, significant spikes and some of the hot spots have been right there in Indian Country in Montana. So I think we all need to make sure we don't rest on our laurels and assume that the storm has passed. It seems like it is regaining some strength. We just have to keep our eyes on this very, very dynamic situation going forward.

So I want to thank you for that response. We look forward to continuing to work together on this to make sure that our Montana Tribes have enough resources to effectively respond to this pandemic. Because we are not out of the woods yet. We have a ways to go.

Mr. WEAHKEE. Thank you, Senator.

Senator DAINES. I want to shift gears, before my time runs out, Admiral Weahkee. That is, when asked a question about permanent infrastructure, in Indian Country there seems to be a lack of that in many of our reservations. Tribes lack emergency shelters and quarantine facilities to provide shelter and care for those displaced by the pandemic. Many tribal members live in multigenerational housing, where social distancing and isolation are virtually impossible.

My question is, could you elaborate on the effects the lack of permanent facilities are having on your agency's ability to effectively respond to this pandemic?

Mr. WEAHKEE. Thank you, Senator Daines. I would probably start the response in terms of social determinants of health, and adequate, stable housing being an item that we have lacked within Indian Country for many, many years. Many locations across the Country have the luxury of turning to vacated hotels as an isolation site. We typically don't have many hotels on our Indian reservations to be able to use in that way.

So as you note, we have been turning to vacated Bureau of Indian Education or tribal schools for those isolation sites. But the kids will need to go to school at some point.

Senator DAINES. In terms of doing better, what can IHS and FEMA be doing to better protect our tribes, and what more can Congress be doing to support you in these efforts?

Mr. WEAHKEE. Yes, sir. I feel strongly that in addition to the housing, we have a queue of health care facility construction sites, $2 billion on the current grandfathered list, and $14 billion overall. But if we could open up the opportunity to enable tribal programs to request other facility types, outside of hospitals and health centers, they really want to build residential treatment centers, they want to build long-term care facilities for their elders. Those are authorized currently in the Indian Health Care Improvement Act, but there has not been any funding identified to be able to pursue those opportunities.

Senator DAINES. Admiral Weahkee, I have already run out of time. Thanks for your responses.

Mr. WEAHKEE. Thank you, sir.

The CHAIRMAN. Thank you, Senator Daines. We will turn to Senator Cortez Masto.

STATEMENT OF HON. CATHERINE CORTEZ MASTO, U.S. SENATOR FROM NEVADA

Senator CORTEZ MASTO. Thank you, Mr. Chairman. Thank you, gentlemen, for coming today to talk about this important issue.

Let me just start off with Rear Admiral Weahkee. Back in April, I had sent you a request on behalf of the Duck Water Shoshone in Nevada. They were seeking an ambulance. I just have to say thank you because you fulfilled their request very quickly. You were attentive, and it made a difference for the tribe. So we really appreciate your response to our tribes in Nevada.

Let me follow up on the line of questioning from Senator Daines, that this is really focused on the aging health infrastructure at IHS. I know, you talked about how you had allocated the CARES Act money already, about $2.4 billion. My question is, are you using some of those dollars in the CARES Act for the infrastructure investment to ensure that tribal members are well served, with respect to the concerns that I see, on IHS's aging health infrastructure?

Mr. WEAHKEE. Thank you, Senator Cortez Masto. As part of the four waves of funding that we received, we did specifically target some of the CARES Act funding for infrastructure related purposes, both sanitation facility construction and some of the needs within our facilities. So we have been able to put aside some of the Coronavirus supplements for this purpose specifically. But we of course have many more needs out there that can be met with these resources.

On the BEMAR, our Backlog of Essential Maintenance and Repair, we currently have about $767 million of need in that one particular line item. Of course, equipment is a big piece of that as well. We need to continuously update our equipment, so our providers have the latest and greatest tools to be able to care for and treat our patients.

Senator CORTEZ MASTO. I would appreciate your sharing al of that with the Committee . I think particularly we are looking to go to into another stimulus package to assist our tribes as we address the health care crisis of COVID–19. We want to make sure that you have all the resources and you have the infrastructure

that is set up to provide the support that is necessary through this health care crisis.

I also want to jump back to the traunch of funding that you did receive. You talked about you still had $750 million from the CARES Act to allocate to PPE and health care enhancement. What is your time frame for getting that money allocated?

Mr. WEAHKEE. Thank you, Senator. The $750 million of the Paycheck Protection Program and Health Care Enhancement Act has been 100 percent allocated, we have just not had the opportunity to obligate all those funds yet. About 40 percent of that fund is currently obligated. We are working directly with tribes to pursue these bilateral modifications to the annual funding agreements, which is taking the time. Tribes are putting together their tribal-specific testing plans and identifying the resources that they need, because the detailed budget was a requirement. We are actually managing this pot of funding on behalf of HHS. The funds were appropriated to them, yet we are managing them.

So we weren't able to, in the same way we did supplement one and put it out through a unilateral modification, and the process is just taking us a little bit longer.

We do anticipate, just as quickly as we can get signatures on both sides of the paperwork, having those funds obligated. It is underway across the Country as we speak.

Senator CORTEZ MASTO. Thank you. I appreciate that.

Mr. Fenton, welcome, and thank you so much for your good work in Region 9, which is a region that is very important to the State of Nevada. I have heard from the FEMA's Crisis Counseling Program, which provides emotional support, crisis counseling, and connection to community support systems, as being hugely helpful through this pandemic. Do those counselors that serve greater Nevada also serve the tribes? The question I have along with that is, or does FEMA have a process for providing more culturally competent services to Indian Country?

Mr. FELTON. I couldn't hear the second part of your question, the last sentence, ma'am, if you could repeat it.

Senator CORTEZ MASTO. Sure. Do you serve the tribes, and if you do, do you provide culturally competent services for our tribes?

Mr. FENTON. With regard to our crisis counseling programs, there are currently right now, within Region 9, we don't have any tribes that have their own declaration. So those crisis counseling programs are run through the State. Definitely they could go ahead and provide assistance to tribal governments through that mechanism and their resources.

Navajo Nation is in the process of requesting their own declaration, and if they want to use their resources through their own declaration and submit a crisis counseling grant, they could go ahead and do that.

Then as far as, I think the second part of your question, do we have competent——

Senator CORTEZ MASTO. Culturally competent. Culturally competence sensitive to our tribes and their needs.

Mr. FENTON. So one of the things that we is we provide not only training to our staff to work with tribal governments, but also our territorial partners on the cultural needs, and have a specific cadre

within FEMA that works with our tribes, so that we build relationships and have leveraged people from the tribal community that participate within that cadre to help with communications and better understand the cultural needs.

Senator CORTEZ MASTO. Thank you. I know I have gone over my time. Thank you very much, Mr. Chairman. Thank you, gentlemen.

The CHAIRMAN. Thank you, Senator Cortez Masto.

We will turn to Senator Lankford.

STATEMENT OF HON. JAMES LANKFORD, U.S. SENATOR FROM OKLAHOMA

Senator LANKFORD. Mr. Chairman, thank you very much. To both our witnesses, I really appreciate your engagement for being here today and for all the work that you continue to do. You have had very, very busy schedules here of late, with a lot that is going on. I very much appreciate that.

Admiral Weahkee, I also wanted to be able to thank you for some of your technical assistance and your help as we have gone through this process. Senator Smith and I have a bill, The Urban Indian Health Providers Act, that helps provide some quality on tort reform, and trying to deal with the basics to make sure that all our of our tribal health facilities are treated the same.

As you know full well, some Urban Indian Health care providers have a different level of malpractice coverage than others. Senator Smith and I are trying to be able to fix that, to make sure everybody has quality in this coverage. We have several Senators that are on board on this Committee , and others that are welcome to be able to join. We are grateful for the help and the insight that you have. We look forward to trying to get that passed and get that implemented in the days ahead. I just wanted to be able to say thank you specifically to you, Admiral, for your help through this process as we go through.

Can I ask a question? We have been through a lot at this point. And there is a lot that is happening. For every single one of us, this is on the job training, because none of us has been through a pandemic before. Are you collecting a kind of a lessons learned as you are going through this process to make sure if we have weakness, if we had strength in this area, this is something that needs to be fixed in the future, so while the heat of the battle is going on right now, we are able to serve as many places as you can, is there an ongoing list that you have in your office of things to fix long-term, or lessons to be learned for next time?

Mr. WEAHKEE. Thank you, Senator Lankford. I appreciate your leadership in Congress. We have stood up a structure, an incident command structure, within the agency. We have a headquarters team. Dr. Michael Toedt, who is behind me, is the Operations Section Chief. But we also have a planning section chief, which is headed by our Quality Director, Jonathan Merrell. We are compiling all the lessons learned as we progress. We have a revised concept of operations, which is updated on a regular basis.

Most recently, as a result of some of my visits to Navajo and Phoenix and Bemidji, we have identified the need for health care team support. Many of our caregivers are very much fatigued. They are facing death on a daily basis, not only at work, but also at

home in their communities with friends and family members impacted.

So looking to resources through the UNM TeleECHO program to provide caregiver fatigue training, and other mental health and behavioral health services, is just one example of, as we learn these lessons, implementing them into our response. We will be sure that our pandemic response documents are updated in the hot wash when we get to that point.

Senator LANKFORD. That would be very helpful.

Quickly, I want to be able to mention this to you as well. There is sometimes inequity among tribes as well. Some tribes are very well organized and have good connections, are able to read the documents and know where to be able to get help. Some smaller tribes do not have the same structure to be able to know where to get help. That help is available to them, they just don't know to be able to ask for it and where that is.

What is your office doing at this point to make sure we are reaching out to smaller tribes to make sure they are very aware of the help that is available to them?

Mr. WEAHKEE. Thank you, Senator. One of the things that we are doing is focus on communications. We do have a weekly call with tribal and Urban Indian Organization leaders. We have actually decreased that tempo to once every two weeks. But that is a call in which we have been bringing together our partners from across the Federal agency. White House Intergovernmental Affairs is brokering and facilitating along with HHS Intergovernmental Affairs.

We brought in the BIA, we have brought in FEMA, we brought in various other partners from VA to really speak to the Coronavirus-specific resources they have available to them. Our partners at the Department of Interior in the Bureau of Indian Affairs does have the capacity to help tribes develop tribal-specific emergency response plans. So that is something that we have connected many tribes to. We are happy to continue to do that work.

Senator LANKFORD. Thank you. I just wanted to make sure no one is overlooked in this process, that we have opportunities for help, and they just don't know who to call or where to dial in and get that.

Mr. Fenton, let me ask a quick question as well. Is there any administrative flexibility or form that you see at this point just to streamline tribes' interaction with FEMA? Specifically I am thinking about things like the Public Assistance Administrative Claim requirements, other areas that as we go through this you see, we need some reforms, we need some streamlining?

Mr. FENTON. I appreciate the question, Senator. One of our goals in our strategic plan is to lessen the complexity at FEMA. One of those areas that we have been working on is the Public Assistance program.

One of the things we have done in this event has been able to, up front, 50 percent of the cost for projected costs, and being able to expedite that. Usually we are turning those around in two to three weeks. So we continue to get better. We have the after action process that focuses on these events. We have already had calls with not only our tribes, State and territories to talk about SNS

2.0, and get ready for the fall, and other events, whether it be hurricanes or the fires that will come as we get later into the summer and into this fall.

Senator LANKFORD. Okay. Well, if there are ways that we need to help in that process, this Committee stands ready to be able to help in that. Obviously, Homeland Security, if we can do more, it would be great to be able to great to help. I am also on that committee, and so if there are ways that we need to help in streamlining we are glad to be able to do that to make it more effective and less paperwork in the process.

Thank you both very much.

The CHAIRMAN. Thank you, Senator Lankford. We will turn to Senator Smith.

Senator SMITH. Thank you, Chair Hoeven and Vice Chair Udall. Thanks to our folks here today testifying before us.

I want to start where Senator Lankford started, which is to just talk a little bit about the FTCA coverage for urban health clinics. It is great to have so many of our colleagues on the Committee supporting this proposal. I am glad to have the endorsement that you have provided, Admiral Weahkee.

I am wondering, this is just such an inequity between organizations serving Urban Indian populations versus IHS facilities and tribal health programs that we are trying to correct here. It can make a big difference in terms of the amount of money that Urban Indian Organizations have to provide the services needed so badly.

So Admiral Weahkee, would you just comment for me briefly about the role that Urban Indian Organizations are playing right now in the COVID pandemic, and why this is such an important issue to address?

Mr. WEAHKEE. Yes, thank you, Senator Smith. Definitely, our Urban Indian Organization partners are the third leg of our Indian health system stool, along with our IHS federally operated and our tribally operated programs. We have 41 urban programs located across the Country. Many of those providing vital ambulatory health care services.

One of the earliest hit locations was San Jose, California, our Santa Clara Health System. As noted earlier, our Seattle Indian Health Corps program, they were early in the response to COVID–19, as the Country's first cases really emerged there on the West Coast.

So we have had the opportunity to learn from their response efforts, not only the treatment protocols and the supplies that were going to be needed, but as things progressed and they were further along in their journey in combatting Coronavirus, having the regular calls so that those best practices can be shared to tribal leaders and other urban programs was vitally important.

We have been able to see and hear how they have patched together funding, not only from Indian Health Service but from other Federal agencies and States, to be able to meet the needs of their communities. So I really can't over-stress the value and importance, as we have many of our American Indian and Alaska Natives living in metropolitan areas, my own family included, down in the Phoenix area, where we have family members obtaining services from an organization called Native Health.

So definitely valuable partners in our approach to providing care and treatment.

Senator SMITH. Thank you for that. I have seen the same thing. In the early days of the pandemic I convened a conversation with the urban indigenous community in Minneapolis and heard a lot about the struggle that they are having to provide health care to elders, particularly in the community. We talk a lot about broadband and access to technology being an issue in rural tribal communities. But it is also an issue in urban tribal communities, where there is so much poverty and lack of ability to pay for broadband, or even to have the technology. The phone that you held up earlier, even lacking that technology. If you can't go to the local library or café to get your tele-health, then you are in a world of hurt when you are trying to get access to care. So I think these issues apply to urban Indian populations as well.

I want to, before I run out of time, I want to just follow up on this testing question that several of my colleagues have asked about. In Minnesota, my staff and I are part of a weekly conversation with Minnesota's tribal nations. Every week they ask, where are those testing dollars? They are so concerned about this. They are quite concerned about managing outbreaks on tribal lands.

Of course, being able to do the occupational and surveillance testing that is so important to be controlling the spread of the virus as they reopen tribal enterprises is extremely important right now. So what should I tell my tribal leaders in Minnesota about when they can expect to see those testing dollars, so they can move forward with what they know they need to do?

Mr. WEAHKEE. Thank you, Senator Smith. I think that the best response would be to take a look at the Paycheck Protection Program and Healthcare Enhancement Act. That traunch of funds was specifically meant to increase testing capacity, contact tracing, and surveillance. So as they receive the request to negotiate that bilateral modification, that those funds are specifically meant to meet that need that you just articulated.

Senator SMITH. What they are telling me is that it is extremely hard to figure out how to get access to the kids to get connected. So can I just ask if we can follow up separately to try to resolve this problem for them? It is one of the biggest issues that they have right now.

Mr. WEAHKEE. Yes, ma'am, happy to do so.

Senator SMITH. Thank you.

The CHAIRMAN. Thank you, Senator Smith. And I do have a few more questions for Administrator Fenton. The Vice Chair may have some questions as well.

Senator UDALL. I have more.

The CHAIRMAN. So, Administrator Fenton, FEMA spent a considerable amount of time updating its tribal consultation policy, which was published in July, 2019. The policy acknowledges the special government-to-government relationship between the Federal agency and the tribes.

So understanding that that process can be complex for tribes as well as States and territories, what training and technical assistance or resources are available to tribes applying for public assistance relief directly from FEMA?

Mr. FENTON. Throughout the year, we provide training to our tribes, even before disasters, and have a number of workshops that we schedule before disasters. With regard to this event specifically, we had discussions with all the tribes across the United States. For example, myself and Region 9 held a call with our State partners in each State to let them know about the options they have as far as being a subgrantee underneath the State and what that meant administratively and effort wise, being a direct recipient of FEMA, or requesting their own declaration.

Then we gave time for the tribes to make that selection. Then what do is reach out to them to officially apply to the Public Assistance program. As part of that process, we have a kind of discussion with them of the application process, which to use as far as documentation, what is eligible. Then we assign them someone to help them with the grant process.

So we are working through that with all the tribes. We do have people dedicated to each State that are working with our different tribes to reimburse them costs from this event, as far as coordinating other types of assistance outside the PA program that may come from the different Federal agencies. So we are coordinating that, things like hoteling for isolation purposes. We have given out tents to some tribes that want to isolate people at home, food, PPE, water, other supplies that are needed as a result of combating COVID.

So we are doing that across the Country, and then there is also coordination calls at the national level, both with the White House and our headquarters, to different tribal members so that we can make sure we are helping and addressing their issues.

The CHAIRMAN. All right. As we have discussed, two of the hardest hit tribes fall within Arizona, the White Mountain Apache and also the Navajo Nation. In your time in Arizona, what preparedness and response has FEMA undertaken to try and control the spread of COVID–19 in these hot spots? And what are your experiences in terms of coordinating with other Federal agencies and also IHS to that?

Mr. FENTON. This event, as I said in my opening comments, is really an all-of-nation or all-of-America event. So it really takes coordination to happen at multiple levels. Not only are we out at those locations and with our State partners coordinating the Federal interagency and all the different departments and agencies that are bringing resources, whether it be IHS and their mission, CDC, ASPR from HHS and others, to include the Corps of Engineers that provided alternate care sites, or VA that is providing nurses out at White Mountain Apache and Navajo Nation.

So our job is to coordinate that overall Federal relief. That includes not only at the Federal level, but to States, local governments, private sector, and non-profits. So by bringing that in to coordinate with tribal entities to address their issues is kind of what has been our focus.

As far as issues, I think that any time you have an event that is a new event like this, that brings complexities and maybe entities that are not used to working together and don't understand each other's authority. So there is a period that we have gone through to understand not only authorities but resources and capa-

bilities to make sure that we are able to address in a timely manner the needs of Native American tribes.

The CHAIRMAN. Admiral Weahkee, same question.

Mr. WEAHKEE. Thank you, Senator. I think that the key is that cross-entity relationship. The VA nurses are a great example. We were able to work with them to bring in critical care nurses, not only to meet the surge capacity but also our nurses that have been seeing patients non-stop working very long hours for the past four months. They need a spell and they need some support.

We now have our contractors asking for hazard pay on top of their contract amounts, so they are asking to increase our rates. But that coordination has been key. And we have, in the same way that have updated our con ops, or concept of operations, we have also updated our guidance for tribes on how to use the FEMA route. So we have asked tribes to go to our area emergency management points of contact. We look within the agency if we can meet that need. If we can't, then we will elevate it to FEMA and the Strategic National Stockpile. We put that into a protocol, it is in writing. It has been shared broadly. It will be there and available to us next time around when we need it, so we don't have to recreate this wheel.

The CHAIRMAN. Thank you. Vice Chairman Udall.

Senator UDALL. Thank you, Mr. Chairman.

Administrator Fenton, I would like to ask you about interagency coordination when it comes to tribes and Urban Indian health programs and accessing Federal channels for testing supplies and PPE. FEMA has led much of the procurement and distribution through the National Response Coordination Center, acquiring testing and PPE supplies for the NRCC from sources like the DOD stockpile, the HHS Strategic National Stockpile, and by other means.

But after several months of calls, briefings, and letters, both from Congress and the tribes, the process for requesting emergency medical supplies remains confusing at best. At one point, I believe the NRCC promised to produce some flow charts on the topic. But I don't believe we have seen anything on that front yet.

This confusion is leading to delays in delivery of these supplies and creates uncertainty related to cost shares for other Federal agencies, for tribes, and for Urban Indian health programs. We need to know that supplies are reaching the ground expeditiously. And we need to know whether any costs will be coming out of IHS, tribal or Urban Indian health program budgets.

Under what circumstances would IHS, a tribe, or an Urban Indian health program have to reimburse FEMA, in full or in part, for supplies it receives during the COVID–19 crisis?

Mr. FENTON. Senator PPE and testing supplies have been a challenge on this event. Any time you have a demand that is 400 percent over what is available through manufacturing, it causes a strain on the whole system. FEMA has done a number of things to improve that process, to expediting movements of resources from private sector medical suppliers, to establishing and working with private sector to established new manufacturing to making sure that there is not price gouging or hoarding of supplies.

Senator UDALL. Mr. Fenton, the question is about reimbursement, will they have to reimburse FEMA in full or in part for this.

Mr. FENTON. With regard to reimbursement, there is a number of ways that a tribe could get supplies. They are getting them directly from either the Strategic National Stockpile, which is not cost shared, that HHS is providing full reimbursement through that. And we have an interagency agreement between us and them to do that. IHS is providing resources to them for their hospitals.

In addition to that, some States are providing resources, for example, California, I know has provided 7 million N95 masks, over which they are not charging them a cost share for that, or any type of EMAC agreement.

When a tribe does not have a resource, it specifically comes to FEMA and puts a request in. That is the only time that something is cost shared. Or if a tribe goes out and procures it on their own, then it would be cost shared, and then they could also use the 75–25, as I said earlier, they could use the CARES Act funding that they received to go ahead and offset that 25 percent cost share.

Senator UDALL. Are there any circumstances where the IHS, tribes or Urban Indian programs are asked to pay a reimbursement when other government or health systems are not?

Mr. FENTON. I am not aware of us charging IHS for masks.

Senator UDALL. Will the NRCC publish any flow charts or guidance on the methods for accessing Federal emergency supplies as promised?

Mr. FENTON. I will circle back with them and make sure that we submit something after this.

Senator UDALL. Thank you very much.

This question is to both Administrator Fenton and Admiral Weahkee. Will you both commit to working together to simplify and clarify how tribes can access medical supplies during disasters and public health emergencies?

Mr. FENTON. Yes, sir.

Mr. WEAHKEE. Yes, sir, absolutely.

Senator UDALL. Thank you. Thank you both. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Vice Chairman Udall. I would like to thank both of our witnesses for being here, and also for the very important work that you are doing.

If there are no more questions for this first panel, members may also submit follow-up questions. We know there are going to be some follow-up questions already, as Senator Murkowski indicated. So other members may submit follow-up questions for the record as well.

So with that, again, thank you to our first panel. We appreciate very much both of you being here. Thank you.

With that, we move right away to our second panel. Today our second panel includes two tribal witnesses. As mentioned earlier, Mr. Scott Davis is a member of the Standing Rock Sioux Tribe and a descendant of the Turtle Mountain Band of Chippewa. He has many years of experience working with tribes and tribal organizations and was appointed to be the Executive Director of the North Dakota Indian Affairs Commission in April of 2009.

In his capacity as Executive Director, Mr. Davis coordinates the State to tribal government relationship, together with addressing issues affecting Native communities in North Dakota. Today's hearing provides a great opportunity to discuss how States and tribes are reducing and preventing Coronavirus at the local level.

Our second witness, Ms. Lisa Elgin, is Secretary of the National Indian Health Board. She will be joining us virtually. Again, we appreciate both of you joining us. With that, I would turn to Mr. Davis and welcome your opening comments.

STATEMENT OF SCOTT J. DAVIS, EXECUTIVE DIRECTOR, NORTH DAKOTA INDIAN AFFAIRS COMMISSION, OFFICE OF THE GOVERNOR, STATE OF NORTH DAKOTA

Mr. DAVIS. Thank you, Chairman Hoeven and respective Vice Chair Udall, thank you.

[Greeting in Native tongue], greetings again on behalf of myself, Scott Davis, a proud member of the Standing Rock Sioux Tribe, and also a descendant of the Turtle Mountain Band of Chippewa. My Lakota name is Oksate' Tawa'. I would definitely bring a good warm handshake if I could. I come here with a good heart. Thank you for the invitation today.

Today I was given permission by both of our tribes, in partnership with our Governor Burgum to provide testimony today regarding the working relationship between the five tribal nations in North Dakota and the State of North Dakota, and also our full partners regarding COVID–19 pandemic. Since the start of the COVID–19 pandemic, I immediately reached out to our five tribal leaders and asked them how they were going to respond to the pandemic in declaring a state of emergency.

As you know, tribes do have the authority to declare on their own through the Sanford Act or to declare with the governor. In this case, the tribes chose to declare with Governor Burgum and by doing so, it opened up a lot of resources to the tribes.

Since then, we have committed to weekly calls from Governor Burgum, my office, and to the five tribal chairs, tribal councils, tribal clinics, and also to the Indian Health Service. The majority of these calls entail discussion about Protective Personal Equipment, PPE, testing kits and supplies, and also discussions that entail guidance on opening businesses, schools, and tribal colleges.

But most importantly, we have partnered with the five tribal nations in conducting mass testing events. Two weeks ago we finished our first round in testing all five tribes. Today, we are continuing those partnered testing events and making sure that all North Dakota tribal communities and members get tested on a regular basis, as requested from tribal leadership. These events at times are led by our National Guard in partnership with the tribal incident command staff, tribal health staff, Indian Health Service, and local county public health offices.

As a result, we have strong working relationships in testing thousands of tribal members. By doing this, we are seeing very low positive testing results from COVID–19 in each of our tribal nations. We attribute this to the resources available that we have developed with the tribes. Examples are the PPE, the testing kits, surge plans, data sharing and consistent communications.

This partnership is a direct result of the commitment Governor Burgum and my office has made with the five tribal nations in North Dakota since he took office. Tribal engagement is one of the five initiatives under the Burgum administration. Prior to the pandemic, Governor Burgum's office and my office have had countless meetings with the tribes, and have held three large conferences entitled Strengthening Tribal, State, and Federal Relations. Each conference has had over 300 attendees from the tribes, States and Federal leaders and their agencies.

Mr. Chairman, this concludes my testimony. I will stand for any questions.

Wopila, Che'Migwetch. Thank you.

[The prepared statement of Mr. Davis follows:]

PREPARED STATEMENT OF SCOTT J. DAVIS, EXECUTIVE DIRECTOR, NORTH DAKOTA INDIAN AFFAIRS COMMISSION, OFFICE OF THE GOVERNOR, STATE OF NORTH DAKOTA

Greetings Chairman Hoeven and members of the U.S. Committee on Indian Affairs. My name is Scott J. Davis, a proud member of the Standing Rock Sioux Tribe and descendent of the Turtle Mt. Band of Chippewa. My Lakota name is Oksate' Tawa'—His Celebration. I greet you all today with a warm handshake and good heart.

I was given to permission from our North Dakota (ND) Tribal Nations to provide testimony today regarding the working relations between our 5 ND Tribal Nations, ND State-Governor's Office and Federal Partners regarding the COVID 19 pandemic.

Since the start of the Covid19 Pandemic, I immediately reached out to the 5 ND Tribal Leaders in asking them how they are going to respond to the pandemic in declaring a State of Emergency. As you now, Tribes have the authority to Declare on their own, through the Sanford Act, or to Declare with the Governor. In this case, the Tribes chose to Declare with Governor Doug Burgum. By doing so, it opened a lot of resources to the Tribes.

Since then, we have committed to weekly calls from Governor Burgum to the 5 Tribal Chairs, Tribal Councils, Tribal Clinics and the Indian Health Service. Majority of the calls entail discussion about Protective Personal Equipment (PPE) and Testing Kits/Supplies. Discussions also entail guidance on opening businesses, schools and Tribal Colleges.

Most importantly, we have partnered with the 5 ND Tribal Nations in conducting Testing Events. Two weeks ago, we finished our first round in testing all 5 ND Tribes. Today, we are continuing those partnered Testing Events in making sure that all ND Tribal communities and members get tested on a regular basis as requested from Tribal leadership. The events, at times, are led by the ND National Guard in partnership with the Tribal Incident Command Staff, Tribal Health Staff, Indian Health Service and local County Public Health offices.

As a result of strong working relations and testing thousands of Tribal members, we have seen low positive COVID 19 cases on each of the 5 ND Tribal Nations. We attribute this to resources available and delivered to the Tribes, e.g. PPE, Testing Kits, surge plans, data sharing and consistent communications.

This partnership is a result of the commitment Governor Burgum has made with the 5 ND Tribal Nations since he took office. Tribal Engagement is one of five initiatives under the Burgum administration. Prior to the pandemic, Governor Burgum's office and my office have held countless meetings with the Tribes and have held 3 conferences entitled, Strengthening Tribal, State and Federal Relations. Each conference has had over 300 attendees from Tribal, State and Federal leaders and agencies.

This concludes my testimony; I will stand for any questions.

Wopila, Che'Migwetch—Thank you.

The CHAIRMAN. Thank you, Mr. Davis. We will turn to Ms. Elgin.

STATEMENT OF LISA ELGIN, SECRETARY, NATIONAL INDIAN HEALTH BOARD

Ms. ELGIN. Good afternoon, Chairman Hoeven, Vice Chairman Udall and members of the Committee . Thank you for inviting me to testify at today's oversight hearing.

My name is Lisa Elgin, and I am the Secretary and California area rep to the National Indian Health Board, or NIHB. I am also tribal administrator for my tribe, which is the Manchester-Point Arena Band of Pomo Indians, and I chair the California Rural Indian Health Board.

I would like to start by thanking the Committee for the work it has done so far to address COVID–19 in Indian Country. This includes over $1 billion for IHS under the CARES Act, and the $750 million tribal set-aside for testing under the Paycheck Protection and Healthcare Enhancement Act. These were necessary investments but not sufficient to stem the tide of the pandemic in tribal communities.

As sovereign governments, many tribal nations have set their own timelines for reopening, which may or may not align with their State. For instance, of the 109 tribal nations in California, 70 percent continue to have tribal emergency and shelter in place orders still in effect, even though the State of California continues to reopen.

What I would first like to focus on in my remarks is how this crisis has devastated Indian Country, the factors that made us more vulnerable, what needs to be done to mitigate the impacts on our people. Just like every public health crisis before it, COVID–19 has disproportionately impacted our people. Here are a few data points I will share to demonstrate this.

According to CDC, our people have the highest COVID–19 hospitalization rate nationwide. Our people are experiencing the second highest COVID–19 death rate nationwide. In New Mexico, our people account for 8 percent of the population, but over 53 percent of all COVID cases. In Montana, our people equal about 6 percent of the population, but over 13 percent of all cases.

None of this is by accident, but the direct result of the United States' ongoing failure to fully honor its treaty obligations for healthcare. Here are a few stats that highlight this truth. Our people suffer more than any population from nearly all the underlying health conditions that CDC noted increase risks of COVID–19, including diabetes, respiratory illness, kidney disease and obesity.

In 2018, per capita health spending was the lowest at IHS $3,779 compared to over $8,000 under Medicaid, over $9,500 under the BIA, and over $13,000 under Medicare. The average age of an IHS hospital is four times the average age of mainstream hospitals. In fact, an IHS hospital built today could not be replaced for 400 years under current spending figures.

Yet in California, we don't have a single tribal or IHS hospital. I repeat, not one hospital. We had an average of 25 percent provider vacancy rate before the pandemic hit, including four physicians, nurses, pharmacists, and nurse practitioners. Nearly 6 percent of our people live in households without running water, compared to less than 1 percent in the Nation.

Roughly 22 percent of our people are uninsured, the highest percentage of any population in the Country. And to clarify, access to IHS is not the same thing as health insurance. In fact, by law, having access only to IHS means you are still uninsured.

Across the 24 federally operated IHS hospitals, there are only a total of 33 ICU beds. Less than half of all IHS and tribal hospitals have operating rooms and only there is only one hospital, a level 3 trauma center in Alaska, that has capacity for more than 40 inpatients per day.

On top of this, our third-party collections from payers like Medicaid and private insurance has plummeted by as much as $5 million per tribe per month. Admiral Weahkee testified before the House earlier this month that, he reported the IHS has seen third-party collections drop 30 to 80 percent below this time last year, that it would take years to recoup those losses.

In short, the challenge are astronomical. Here is what Congress must do moving forward to address COVID–19. We invite you to review our written testimony for additional insight and recommendations on what needs to be done.

We urge you to maintain all tribal provisions in the House-passed Heroes Act. These are tribally vetted and bipartisan measures that are need to alleviate the worst impact of the crisis on our communities.

Ensure timely passage of fiscal year 2021 appropriations for IHS. We cannot afford another continuing resolution or a shutdown during this pandemic.

Pass the bipartisan S. 3937 STIP Reauthorization Act of 2020. We thank Senator McSally and Senator Murkowski on that committee for championing this critical bill that would provide five years of guaranteed funding at an increase of $200 million overall. We are also very pleased that this bill includes language authorizing tribes to receive these funds as 638 contracting and compacting agreements.

Provide at least $1 billion for water and sanitation infrastructure. Thousands of our people from Alaska and Navajo Nation lack running water. Handwashing continues to be the number one way to protect against COVID. To speak plainly, we need running water to do that.

In closing, I would like to leave you with a final thought. During both the 1918 Spanish flu pandemic and the 2009 H1N1 pandemic, our people died at four times the rate of all other races combined. Our treaties were not fully honored back then; the same inexcusable reality is true today.

Once again, I thank you for holding this important hearing, and inviting NIHB to testify. I look forward to your questions.

[Phrase in Native tongue.] Thank you.

[The prepared statement of Ms. Elgin follows:]

PREPARED STATEMENT OF LISA ELGIN, SECRETARY, NATIONAL INDIAN HEALTH BOARD

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, thank you for holding this critical oversight hearing to "Evaluate the Response and Mitigation to the COVID–19 Pandemic in Native Communities." On behalf of the National Indian Health Board and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, I submit this testimony for the record.

Our nation is gripped by the most unprecedented public health crisis in generations. As of June 28, 2020 there are over 2.5 million COVID–19 cases nationwide and over 125,000 COVID–19 deaths, according to the Centers for Disease Control and Prevention (CDC). Public health data continues to demonstrate that not only are new cases not subsiding, they are dangerously increasing in countless jurisdictions nationwide. According to the CDC, on Thursday June 25, the United States recorded 40,588 cases—the highest number of cases reported in a single-day since April 6. In a data analysis from Kaiser Family Foundation, from June 11 to June 25 a total of 26 states reported increased COVID–19 cases including many with large AI/AN populations including Arizona, Oklahoma, Michigan, Nevada, Wisconsin, Washington, Wyoming, Montana, California, and Oregon.[1]

But similar to every prior public health crisis, there are disparate and disproportionate impacts on underserved and marginalized communities, and Indian Country is at the epicenter. According to CDC, people with chronic obstructive pulmonary disease (COPD), type 2 diabetes, and chronic kidney disease are at higher risk for a more serious COVID illness. AI/AN populations are disproportionately impacted by all three of these underlying health conditions. In 2017, CDC reported that age-adjusted percentages of COPD were highest among AI/ANs (11.9 percent vs 6.2 percent across all populations).[2] While rates of End Stage Renal Disease have dropped by 54 percent among AI/ANs as a result of the Special Diabetes Program for Indians (SDPI), AI/ANs continue to experience a significant burden of kidney disease. Similarly, in 2017 it was reported that AI/ANs experienced the highest diabetes prevalence at 15.1 percent, at more than double the percentage for non-Hispanic Whites.[3]

Despite alarming gaps nationwide in population-specific COVID–19 health disparities data, available information clearly demonstrates that Tribal communities are facing the brunt of this public health crisis. The federal government has treaty and trust obligations to fully fund healthcare in perpetuity for all Tribal Nations and AI/AN Peoples, and it is imperative that this obligation be met in the face of the COVID–19 pandemic.

To that end, we are pleased that each previous COVID–19 relief package has included important Tribal health provisions, such as the $64 million in funding for Indian Health Service (IHS) under the Families First Coronavirus Response Act; $1.032 billion in funding for IHS under the CARES Act; and the baseline $750 million Tribal set-aside in testing under the Paycheck Protection and Healthcare Enhancement Act. But despite these meaningful investments, it is clear that they have been insufficient to address the grave impacts of COVID–19 in Indian Country.

Recommendations

On June 2, 2020 NIHB submitted a letter to Senate Majority Leader McConnell and Minority Leader Schumer urging that as the Senate began negotiations on the next relief package, that all of the Tribally-specific funding and legislative provisions outlined in the House-passed HEROES Act be maintained and built upon by addressing critical areas of unmet need. To that end, NIHB has outlined several top priorities—some of which fall squarely under the Committee's jurisdiction, and others that we urge Committee members to work on in lockstep with colleagues serving on Interior Appropriations, Finance, and Health, Education, Labor and Pensions. NIHB also strongly supports the bipartisan S. 3650 and urges the full Committee to pass this important bill.

1.Ensure timely passage and meaningful increases to the overall Indian Health Service (IHS) budget for Fiscal Year 2021 in line with the Tribal Budget Formulation Workgroup Recommendations

- Without an enacted FY 2021 IHS budget that is passed on-time, the Indian health system will be left significantly unprepared to tackle a potentially stronger wave of infections in the fall and winter months ahead.

    —Therefore, it is imperative that IHS not be subject to another continuing resolution or face the threat of another government shutdown.

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[1] Kaiser Family Foundation. 2020. States with Upward of 14–Day Trends in COVID–19 Cases and Positivity Rates. *https://www.kff.org/coronavirus-covid-19/slide/states-with-upward-of-14-day-trends-in-covid-19-cases-and-positivity-rates/*

[2] Wheaton AG, Liu Y, Croft JB, et al. Chronic Obstructive Pulmonary Disease and Smoking Status—United States, 2017. MMWR Morb Mortal Wkly Rep 2019;68:533–538. DOI: *http://dx.doi.org/10.15585/mmwr.mm6824a1external_icon*

[3] Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2018. LTSS Research: Diabetes in Indian Country Annotated Literature Review.*https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS–TA-Center/pdf/Emerging-LTSS-Issues-in-Indian-Country-Diabetes-in-Indian-Country-Annotated-Literature-Review.pdf*

- While we appreciate the $1.032 billion appropriated to IHS under the CARES Act, and the additional $2.1 billion proposed under the House-passed HEROES Act, these investments do not replace the need for strong and meaningful investments in the annual appropriated IHS budget.

  —The IHS Tribal Budget Formulation Workgroup (TBFWG) has outlined the need for $9.1 billion for IHS in FY 2021 to be able to effectively address healthcare needs.

- AI/ANs continue to face significant health disparities, especially for conditions like diabetes and respiratory illnesses, which increase the risk of a COVID–19 infection. Without a bold and substantive FY 2021 IHS budget to equip the Indian health system with the tools to address these disparities, they will continue to go unaddressed, leaving Indian Country more vulnerable to COVID–19 outbreaks.

2. *Pass the bipartisan S. 3937—Special Diabetes Program for Indians Reauthorization Act of 2019—with slight changes to the new "Delivery of Funds" language to ensure Tribes and Tribal organizations are able to receive awards through P.L. 93–638 self-determination and self-governance contracts and compacts*

- According to the CDC, diabetes is one of the strongest risk factors for a more serious COVID–19 infection. AI/AN communities are diagnosed with diabetes at more than double the rate for Whites, and higher than any other population nationwide.
- The Special Diabetes Program for Indians (SDPI) is the only program that has effectively reduced incidence and prevalence of diabetes, and is responsible for a 54 percent reduction in rates of End Stage Renal Disease and a 50 percent reduction in diabetic eye disease. In a 2019 federal report, SDPI was found to be largely responsible for $52 million in savings in Medicare expenditures per year.

  —Despite its documented success, since September 30, 2019, SDPI has gone through four short-term extensions, with the most recent extension occurring under the CARES Act. SDPI is currently set to expire on November 30, 2020.

- The bipartisan S. 3937, introduced by Senator McSally, and supported by Senator Murkowki and Senator Sinema, would provide 5-years of guaranteed funding for SDPI at an increase to $200 million per year overall. This represents the first increase to SDPI in over sixteen years, and the longest reauthorization in over a decade.
- Significantly, S. 3937 would also authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93–638 self-determination and self-governance contracting and compacting agreements, thus allowing for greater local Tribal control over the life-saving program.

  —However, Tribes and NIHB are requesting slight technical tweaks to the new language in S.3937 to further clarify the authority and prevent any potential administrative delays in implementation. We urge the Committee to pass S.3937 with the requested changes below.

  > "(2) DELIVERY OF FUNDS.- On request from an Indian tribe or tribal organization, the Secretary shall award diabetes program funds made available to the requesting tribe or tribal organization under this section as amounts provided under Subsections 106(a)(1) and Subsection 508(c) of the Indian Self-Determination Act, 25 U.S.C. § 5325(a)(1) and § 5388(c), as appropriate."

3. *Provide minimum $1 billion for water and sanitation development across IHS and Tribal facilities*

- In order to stem the tide of the COVID–19 pandemic in Indian Country, it is essential that Congress make meaningful investments in water and sanitation development across IHS and Tribal facilities.
- The HEROES Act only outlined $30 million overall for water and sanitation development in Indian Country ($10 million within IHS, and $20 million within Bureau of Indian Affairs). This is severely below the level of need to protect and preserve health in AI/AN communities.

  —According to the 2018 IHS Sanitation Facilities Infrastructure Report, roughly $2.67 billion is needed to bring all IHS and Tribal sanitation facilities to a Deficiency Level 1 designation.

4. Provide meaningful increases to the IHS budget for telehealth, electronic health records and health information technology (IT) infrastructure development

- Limitations in the availability of AI/AN specific COVID–19 data are contributing to the invisibility of the adverse impacts of the pandemic in Indian Country within the general public. Senior IHS officials, including Chief Medical Officer Dr. Michael Toedt, have stated publicly that existing deficiencies with the IHS health IT system are inhibiting the agency's ability to adequately conduct COVID–19 disease surveillance and reporting efforts.

  —Lack of health IT infrastructure has also seriously hampered the ability of IHS and Tribal sites to transition to a telehealth-based care delivery system. While mainstream hospitals have been able to take advantage of new flexibilities under Medicare for use of telehealth during the COVID–19 pandemic, IHS and Tribal facilities have not because of insufficient broadband deployment and health IT capabilities.
- The TBFWG has previously outlined the need for a roughly $3 billion investment to fully equip the Indian health system with an interoperable and modern health IT system. It is critical that Congress provide meaningful investments in health IT technologies for the Indian health system to ensure accurate assessment of AI/AN COVID–19 health disparities and equip Indian Health Care Providers with the tools to seamlessly provide telehealth-based health services.

5. Eliminate the sunset provisions under Section 30106 of HEROES so that removal of the "four walls" Medicaid billing restriction and extension of 100 percent FMAP to urban Indian organizations are made permanent; Clarify the four walls language to ensure that the fix to the billing restriction is made both for services provided by an Indian Health Care Provider outside the four walls, and those services on the basis of a referral

- Currently, IHS and Tribal providers are largely restricted from billing for medical services outside the four walls of a clinic. This means that home visits, telehealth, and other necessary outpatient COVID response services can't be reimbursed, leading to serious gaps in accessibility of care.
- In March 2020, in an effort to improve access to services during the COVID–19 pandemic, the Centers for Medicare and Medicaid Services (CMS) announced that it would not review claims for compliance with the four walls restriction before January 30, 2021.

  —This means that if Section 30106 of HEROES were to be enacted as is, the fix to the four walls restriction would only be in effect for five months. In addition, the four walls language under Section 30106 only fixes the four walls billing restriction for services on the basis of a referral, not those services provided by Indian Health Care Providers (IHCPs) outside the four walls—such as in patient's homes, schools, jails, or other locations. Not only is it critical that the four walls fix be made permanent, it is equally critical that the fix to the four walls billing restriction be made for both services provided by IHCPs outside the four walls, and those services on the basis of a referral.
- Delaying the four walls issue does not solve it. In addition, there is very little incentive for states to work with Tribes to amend their Medicaid programs for only a five month fix to the four walls issue, especially given the resources that go into that process.

  —However, Tribes and NIHB are vehemently opposed to extending 100 percent FMAP to non-Indian Health Care Providers as part of the legislative fix to the four walls restriction.

6. Authorize Indian Health Care Providers (IHCPs) to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act (IHCIA)—called "Qualified Indian Provider Services"—when delivered to Medicaid-eligible American Indians and Alaska Natives

- Currently, IHCPs only receive reimbursement for health services authorized for all providers in a state. Therefore, although IHCIA authorizes medical services such as long-term care and mental/behavioral services that are crucial for Tribal communities to respond to COVID–19, an IHCP will not be reimbursed for these services if they are not covered by the state Medicaid program.
- Because of chronic underfunding of IHS, many Tribes utilize third party collections from payers like Medicaid to constitute up to 60 percent of their healthcare operating budgets. But without the authority to bill for services al-

ready authorized under federal law, it is further straining Tribal COVID response efforts.

—This provision reinforces the direct relationship between Tribes and the federal government by ensuring that IHCPs are reimbursed at 100 percent FMAP for all services authorized under IHCIA, at no cost to the states.

7. Enact Certain Sections of the Bipartisan CONNECT to Health Act

- The bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (S. 2741) was introduced in October 2019 and has the broad support of over 100 health organizations.

  —Section 3 of the CONNECT to Health Act would provide the U.S. Department of Health and Human Services (HHS) with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on provider types, technology, geographic area, and services. These are critical authorities to ensure flexibility in delivery of mental and behavioral care.

  —Section 8 of the CONNECT to Health Act would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization which make it very difficult to deliver mental and behavioral health care.

- Originating site requirements currently mandate that a patient be in a particular location such as a physician's office, hospital, or other specified clinical setting. These requirements prevent patients from being able to receive mental and behavioral health services from their homes, community centers, or other non-clinical locations.

  —In addition, Sections 4, 5, 7, and 14 of the CONNECT Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expands the list of health professionals who may provide services through telehealth—all of which have immediate and long-term benefits to the Indian health system.

8. Include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to Indian Health Care Providers

- There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country. Because of this shortage, Indian healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists

  —LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, CSWs, and psychologists do. Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including tobacco cessation, and medication-assisted treatment (MAT) for substance use disorders.

- All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead.
- This deprives Indian Health programs of critically needed federal reimbursement for vital healthcare services to AI/ANs, which is critical to an effective COVID–19 response.

9. Permanently Extend Waivers under Medicare for Use of Telehealth

- COVID–19 has dramatically increased the need to connect patients to their providers through telehealth for medical and behavioral health services. In response, CMS has temporarily waived Medicare restrictions on use of telemedicine.
- Yet for many Tribes that lack broadband and/or telehealth capacity and infrastructure, it is not financially feasible to purchase expensive telehealth equipment for a short-term authority.

  —Making permanent the telehealth waivers for both video and audio-based telehealth services would ensure that the telehealth delivery system remains a

viable option for delivery of essential medical, mental and behavioral health services in Indian Country, and helps close the gap in access to care.

The Numbers: COVID–19 in Indian Country

As of June 24, IHS has reported 18,240 positive cases, with roughly 67 percent 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 Tribal health programs, which constitute roughly two-thirds of the Indian health system, are voluntary. According to data analysis by APM Research Lab, AI/Ns are experiencing the second highest aggregated COVID–19 death rate at 36 deaths per 100,000.[4] The CDC reported that from March through June 13, 2020 age-adjusted COVID–19 hospitalization rates among AI/ANs were higher than any other ethnicity, at 221.2 per 100,000.[5] Reporting by state health departments has further highlighted disparities among AI/ANs.

- In New Mexico, AI/ANs represent roughly 8 percent of the population, yet account for over 53 percent percent of all COVID–19 cases.[6]
- As of this writing, the Oyate Health Center in South Dakota has conducted 544 COVID–19 tests, with 114 confirmed positive case results (20.9 percent). Of those 114 cases, 13 were reported between June 10 and June 16.[7]
- In Wyoming, AI/ANs account for over 27 percent of all COVID–19 cases statewide despite representing only 2.9 percent of the state population.[8]
- Similarly in Montana, where AI/ANs constitute about 6.6 percent of the state population, over 13 percent of confirmed COVID–19 cases are among AI/ANs.[9]
- In Arizona where AI/ANs account for roughly 5 percent of the state population, as of June 28, 2020 they represented 15 percent of those hospitalized for COVID and roughly 9 percent of all COVID cases statewide.[10]

Most poignantly, 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.[11]

The COVID–19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID–19, the Indian health system was beset by an average 25 percent clinician vacancy rate,[12] and a hospital system that remains over four times older than the national hospital system.[13] Limited intensive care unit (ICU) capacity to address a surge of COVID cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services. Overall, per capita spending within IHS ($3,779) is at only 40 percent of national health spending ($9,409), making IHS the most chronically underfunded federal health care entity nationwide and thus severely ill-equipped to respond to COVID–19.

For example, while CDC has noted that hand-washing is the number one way of protecting against a COVID–19 infection, water and sanitation infrastructure in In-

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[4] APM Research Lab. The Color of Coronavirus: COVID–19 Deaths by Race and Ethnicity in the U.S. *https://www.apmresearchlab.org/covid/deaths-by-race*

[5] Centers for Disease Control and Prevention. COVID–19 Data Visualization. *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html*

[6] New Mexico Department of Health. COVID–19 in New Mexico. *https://cvprovider.nmhealth.org/public-dashboard.html*

[7] Great Plains Tribal Chairman's Health Board. CEO Update: Oyate Health Center To Host Mass Testing, New Website Launches. *https://gptchb.org/news/ceo-update-oyate-health-center-to-host-mass-testing-new-website-launches/*

[8] Wyoming Department of Health. COVID–19 Map and Statistics. *https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-map-and-statistics/*

[9] Montana Department of Public Health and Human Services. *https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics*

[10] Arizona Department of Health Services. COVID Data Dashboard. *https://www.azdhs.gov/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/covid-19/dashboards/index.php*

[11] University of California Los Angeles. American Indian Studies Center. Coronavirus in Indian Country: Latest Case Counts. Retrieved from *https://www.aisc.ucla.edu/progression__charts.aspx*

[12] Government Accountability Office (GAO–18–580). *https://www.gao.gov/products/GAO-18-580*

[13] Indian Health Service. 2016. IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress. *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display__objects/documents/RepCong__2016/IHSRTC__on__FacilitiesNeedsAssessmentReport.pdf*

dian Country is significantly underdeveloped. Approximately 6 percent of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.[14] 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 percent 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.[15] In fact, in a new peer-reviewed study of 287 Tribal reservations and homelands, COVID–19 cases were found to be 10.83 times more likely in homes without indoor plumbing.[16]

Gaps in COVID–19 AI/AN Public Health Data

These existing capacity and resource shortages meant that the Indian health system was woefully unprepared to prepare, prevent, and respond to the COVID–19 pandemic. Available data on AI/AN COVID–19 health disparities reaffirms this central point. Unfortunately, because of high rates of misclassification and undersampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the scope of the impact in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID–19.

Previous studies have found significantly higher rates of misclassification outside of IHS Contract Health Service Delivery Areas (CHSDA);[17] for all-cause mortality rates in states like Oklahoma;[18] for HIV infections among AI/ANs across five states;[19] and on death certificates reported to CDC.[20] However, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities.

Multiple states with large AI/AN populations including but not limited to Minnesota, Michigan, New York and California are reporting thousands of COVID cases without any information on patient ethnicity, or categorizing cases as "other" on demographic forms. In California for instance, the state has noted that race/ethnicity data is missing for nearly 30 percent of reported cases. Multiple studies have demonstrated that AI/ANs are more likely to be misclassified as "other" or are omitted from surveillance systems entirely.

Thus, these structural challenges in data reporting only serve to render invisible the disparate impact of COVID–19 in Indian Country. Relatedly, Tribal Epidemiology Centers (TEC) continue to face significant barriers in exercising their statutory public health authorities by facing major hurdles in accessing federal and state

[14] US Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from *http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States__DIGITAL.pdf*

[15] Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society, 38(3), 031003.*https://doi.org/10.1116/1.5142283*

[16] Rodriguez-Lonebear, Desi PhD; Barcel¢, Nicol s E. MD; Akee, Randall PhD; Carroll, Stephanie Russo DrPH, MPH American Indian Reservations and COVID–19, Journal of Public Health Management and Practice: July/August 2020—Volume 26—Issue 4—p 371–377 doi: 10.1097/PHH.0000000000001206

[17] Jim, M. A., Arias, E., Seneca, D. S., Hoopes, M. J., Jim, C. C., Johnson, N. J., & Wiggins, C. L. (2014). Racial misclassification of American Indians and Alaska Natives by Indian Health Service Contract Health Service Delivery Area. American journal of public health, 104 Suppl 3(Suppl 3), S295–S302. *https://doi.org/10.2105/AJPH.2014.301933*

[18] Dougherty, Tyler M. MPH, CPH; Janitz, Amanda E. PhD, BSN, RN; Williams, Mary B. PhD; Martinez, Sydney A. PhD; Peercy, Michael T. MPH, MT(ASCP)H; Wharton, David F. MPH, RN; Erb-Alvarez, Julie MPH, CPH; Campbell, Janis E. PhD, GISP Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015, Journal of Public Health Management and Practice: September/October 2019—Volume 25—Issue—p S36–S43 doi: 10.1097/PHH.0000000000001019

[19] Bertolli, J., Lee, L. M., Sullivan, P. S., & AI/AN Race/Ethnicity Data Validation Workgroup (2007). Racial misidentification of American Indians/Alaska Natives in the HIV/AIDS Reporting Systems of five states and one urban health jurisdiction, U.S., 1984–2002. Public health reports (Washington, D.C. : 1974), 122(3), 382–392. *https://doi.org/10.1177/003335490712200312*

[20] Centers for Disease Control and Prevention. 2016. The Validity of Race and Hispanic-Origin Reporting on Death Certificates in the United States: An Update. *https://www.cdc.gov/nchs/data/series/sr__02/sr02__172.pdf*

public health surveillance systems, including for COVID–19 data.[21] These issues continue to have a direct negative effect on health outcomes for AI/AN Peoples, and are exacerbating the impact of COVID–19 in Indian Country.

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 IHS,[22] 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 percent 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 percent 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 percent of their healthcare system and 35 percent 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.[23]

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 percent) lacking access to IHS as well.[24]

Such astronomical losses in Tribal healthcare and business revenue are exacerbating the already disproportionate impact of COVID–19 infections in Indian 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. As such, we urge the Committee to work on the recommendations outlined at the top of this letter, and stand ready to work with you in a bipartisan manner to secure their passage.

Thank you for your consideration of the recommendations outlined in this letter. We look forward to working with you to ensure that Indian Country's health care concerns and priorities are comprehensively addressed, as we respond to the COVID–19 pandemic.

The CHAIRMAN. Thank you, Ms. Elgin.

At this point, we will turn to questions. I am going to start with Mr. Davis. I know Governor Burgum has an excellent working relationship with the tribes in North Dakota, and that you are a very important part of that.

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[21] Centers for Disease Control and Prevention. Issue Brief on Tribal Epidemiology Center Legal Authorities. *https://www.cdc.gov/phlp/docs/tec-issuebrief.pdf*

[22] 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.

[23] Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from *http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming*

[24] 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-19causedincreasesinUninsuredAIANsduetojobloss/EstimatingIncreaseinAIANUninsuredduetoCOVID–19JobLoss*

Can you tell the Committee how testing within the five tribal communities in the state is going? What are lessons learned? Any recommendations you have that could be useful elsewhere?

Mr. DAVIS. Good question, Senator Hoeven, thank you.

That is correct; Governor Burgum has a very good relationship with the tribes. It is not by chance, it has been from hard work, I will just say that. It has been a lot of work go into those relations. I think in times like this, you kind of see the, I hate to use the word, the fruits of it, but in times of this pandemic, in this case, it has shown its fruits, because our tribal members are tested daily, weekly.

We just wrapped up a large testing event up in Turtle Mountain yesterday, the largest tribe in North Dakota. We tested about 250 yesterday in partnership with our county partners, who tested another part of the tribe, and also IHS tested the businesses.

So you will see a unified, partnered strategy here, Senator, and members of the Committee . When I think about this virus, it obviously does not see jurisdiction. So what affects my tribe will affect the county, will certainly affect the State and vice versa. So we are being very, very dedicated to the testing events upon request from the tribes, and exercising the National Guard in partnership with IHS and the health departments and the counties.

So these testing events are very large. I have been to every one of them. I think I missed one. But they are very long, there is a lot of planning involved. But it goes back to the partnerships, the communications we have had. I go back to the weekly calls, Chairman, and the weekly calls that we have with our partners, the feds, obviously the IHS, a part of that, the tribal college presidents, the tribal councils, obviously, and the tribal chairs of where we are.

Also, now we are looking at data. We do have data sharing agreements with the tribes that are a legal document. But now we are trying to home in on the results of these tests, of streamlining where they are by region, also by address. Age and gender is obviously included in that, as well.

So these are the shared data agreements that tribes may have, a data dashboard, if you will. But we do have that, as you know, Governor Burgum is a pretty techie guy, so this data stuff is really important to him.

These are the good things, the tools that we have that we are sharing with the tribe. The PPE stuff, just had two shipments delivered to the tribes today. Those are upon request, whether masks, gloves, you name it, we deliver that, and also testing kits.

So right now, where I am from in Standing Rock, we are trying to work with the State of South Dakota and doing another unified, joint testing event, hopefully down in the South Dakota side this time, and making sure that my tribal members from Standing Rock are all tested as well.

The CHAIRMAN. Recently, there has been an outbreak, I think, on the MHA Nation Reservation. To address community spread, what are you doing in your position with contact tracing and that kind of thing, in order to try to curtail that? Whether in this case it is MHA, or one of the other reservations.

Mr. DAVIS. Chairman Hoeven, another good question there. Yes, that is another big part of the portfolio, if you will, for COVID.

Contact tracing is a big piece of this. Again, I go back to jurisdiction.

So we deploy our contact tracing teams, whether it is through the Department of Health or the university systems, or even sometimes our private hospitals. We make sure that we work in unison with the tribes, in this case, MHA, making sure that that information is shared, but also when the calls are made to the people who are under-investigated, and that is a good word, I guess, in this case, of who that person has been around with a positive test, making sure those folks are tested immediately within one or two days. Then we go from there.

Also, Chairman, at least the homeless shelters. Because as we all know in this room, housing and placing people who have limited water, that was talked about earlier, we are going through one right now back home at Cannonball, we have a family that tested positive there that doesn't have running water. So we deployed our resources, State resources with the tribe, to make sure that there was a hotel room that was available for that family who tested positive.

But that time is running out. We are looking at a deadline of July 11th where that facility will be backing out of that and resuming business. But my call again this morning with FEMA ensures us that that funding will be available for those homeless shelters. It is up to us to find that facility or a private motel of some sort to make sure that tribal members are safe during the quarantine process.

So one thing that I did want to share, Chairman, some of the Federal facilities that the tribes are requesting, I am on these calls with Interior, is that it takes a little bit longer time to get the okay from Interior to get that facility or that building switched over to a homeless shelter or a quarantine area. So you probably see or hear inquiries from tribes, not just from the Great Plains, but I am assuming across Indian Country, on possibly streamlining some of those Federal properties regarding, in this case, Interior, that could be opened for homeless shelters and also the quarantine process.

The CHAIRMAN. Thank you. Vice Chairman Udall.

Senator UDALL. Thank you, Mr. Chairman.

In the House hearing last month, IHS Director Weahkee indicated that IHS facilities have lost 30 to 80 percent of their normal revenue from third-party billing collections due to the COVID–19 pandemic. He also acknowledged that the payments to IHS facilities from the Provider Relief Fund have not fully offset these losses.

Ms. Elgin, is it fair to say that a number of IHS facilities are still feeling the consequences of the revenue shortfalls caused by COVID–19?

Ms. ELGIN. Absolutely. Just two weeks ago, Admiral Weahkee told the House Interior Appropriations Subcommittee that the agency is experiencing third-party revenue shortfalls at 30 to 80 percent, like you said, below collections this time last year, and that it will take years to recoup those losses. The House-passed Heroes Act allocated $1 billion to address revenue shortfalls.

But this was back in mid-May. Since then, COVID cases in Indian Country have only continued to increase, and the need is more

likely higher than $1 billion. We urge the Senate to increase the funding for the tribes as you work on your next COVID relief package.

Senator UDALL. Thank you very much. We are doing that. I am working with a number of colleagues to address these operational funding shortfalls in the next COVID–19 relief package. It is clear that IHS facilities need direct access to supplemental funding. But I believe that there are also policy corrections Congress can enact to further address this issue.

The bill on today's legislative hearing agenda, S. 3650, the Coverage for Urban Indian Health Providers Act, is one such example. It would address a longstanding imbalance within the IHS for Urban Indian health programs, and help reduce their operating costs at a time when many programs would otherwise face furloughs and belt-tightening.

Ms. Elgin, what further policy corrections could Congress enact to alleviate operation funding shortfalls for IHS facilities?

Ms. ELGIN. At the very least, we urge the Senate to maintain the $1 billion outline for revenue shortfalls within IHS tribal and Urban Indian facilities in the House-passed Heroes Act as the adverse impacts of this pandemic carry on, or likely even more relief funding to replenish third-party revenue shortfalls will be needed.

Senator UDALL. Ms. Elgin, I have heard concerns from tribal leaders and Urban Indian health programs about decisions other HHS agencies have made regarding administration of Indian Country's specific COVID–19 health resources, particularly related to administration of funding and grants. Can you provide some examples of grant or resource administration practices within HHS or FEMA that have hamstrung tribal and Urban Indian response and mitigation efforts during the Coronavirus pandemic?

Ms. ELGIN. Yes, there have been significant challenges. Number one, Federal treaty obligations cannot be fulfilled through competitive grants. Even though COVID, like many tribe didn't have dedicated grant writers. When they do, those grant writers are more likely to be wearing multiple hats.

Tribes had limited capacity before COVID. And with the furloughs and reduced hours, capacity is even lower now. Many of HRSA's and CDC's grant application reporting requirements are very onerous, some requiring 20 pages per application and hours upon reporting.

Unfortunately, this has led some tribes to forego applying for some grants to begin with, because they don't have the time to write these long grants. That is a very difficult decision to make, because the tribes absolutely need the money. No tribe should be put in this position. CDC needs to make sure that it is funding every tribe for public health, not just some of them.

To be fair, we are very appreciative of the fact that CDC added an additional $40 million on top of the $40 million Congress set aside for the tribes. And in the Corona Preparedness and Response Act, they also were receptive to the feedback to make the grants non-competitive, which they did with the additional $40 million they allocated to the tribes.

But much more needs to be done and the issues continue. For instance, we still do not know what CDC is doing with the $125 mil-

lion in tribal funding allocated under the CARES Act. We have demanded answers, but have yet to receive them. Tribes need that money to be released as quickly as possible and it must cover every single tribe. If the Federal government can't get away with funding on State and not another, it should not get away with only funding some tribes.

A major issue is lack of technical assistance given tribes on how to spend the COVID money, the timelines for spending it, the restrictions on spending it and eligibility. We need grant administration TA. NIHB is filling in this gap and trying to provide TA to the tribes, but Congress needs to provide HHS with dedicated funding to assist tribes with grant management.

With FEMA, tribes have consistently urged the Administration to waive cost-sharing requirements. We just need a statutory fix to this problem.

Senator UDALL. We really appreciate that.

Mr. Chairman, I have one more question, with your permission.

The CHAIRMAN. Certainly.

Senator UDALL. In 2010, Congress designated tribal epidemiology centers as public health authorities and granted them access to CDC's disease surveillance data bases. But a decade later, when the Coronavirus pandemic struck, the CDC still hadn't worked with Indian Country to implement these important pieces of tribal public health infrastructure. This is a longstanding issue for Indian Country. Access to real-time accurate health data is critical to a successful COVID–19 response.

Ms. Elgin, in NIHB's opinion, can IHS, tribes, and Urban Indian health programs accurately monitor COVID–19 activity using their existing public health surveillance and health IT systems?

Ms. ELGIN. We are trying our best, but there are significant barriers. Chief Medical Officer Michael Toedt has publicly stated that the IHS antiquated health IT system is seriously limiting their ability to engage in COVID surveillance. Many of the tribes have purchased their own commercial, off the shelf, EHR systems. In California, for instance, tribes use NextGen, but one big problem is lack of interoperability, our systems aren't talking to each other as well as they need to be. And that is negatively impacting our patients' health. Through the IHS tribal budget formulation workgroup, the tribes have recommended $3 billion to ensure the full Indian Health system has a well-functioning health IT system. To this end, we absolutely need parity with the VA.

To give one example, under the CARES Act, Congress gave the VA $3.1 billion just for health IT. In comparison, IHS only got $65 million. With IHS relying on the VA system, we need parity in investment. Otherwise, Indian Country will be left behind.

Just a related issue that has received media attention is the fact that the tribes and tribal epicenters have faced serious challenges in accessing public health data from the CDC and from the States. Tribes and tribal epicenters are public health authorities under law.

Yet CDC continues to deny tribes access to CDC's surveillance systems, despite readily giving this to the States. Many States incorrectly cite HIPAA concerns, or flat-out refuse to share data with

the tribes. We are sovereign governments and we have the same authority as States to access public health data.

While tribes have tried working with their States in good faith to access data that rightfully belongs to us, we continue to encounter many barriers. We urge Congress to ensure meaningful funding for health IT for the tribes. One way we can address the problem with access to State data is by having Congress require States to share public health data with tribes and tribal epicenters as a condition of receiving the CDC surveillance funding.

We remain committed to working with all of you in these solutions.

Senator UDALL. Thank you very much, Ms. Elgin. Mr. Chairman, just let me say, I think this has been a very important hearing. We have had two panels. We have looked at oversight in a serious way, and I think it has given us a lot of issues we should be working on.

Congress must do everything in its power to keep every IHS facility up and running during this pandemic. I hope we can work in a bipartisan fashion to expeditiously enact provisions to close some of these policy loopholes and secure more direct funding for the Indian Health Service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Vice Chairman Udall.

We do have Senator Smith who has some questions for the witnesses. Senator Smith?

Senator SMITH. I know it has been a long afternoon and Ms. Elgin has waited to speak with us. So I am grateful just to ask two things I was really anxious to hear your perspective on, Ms. Elgin.

The first has to do with mental health issues and the special mental health issues with tribal youth. This is something I am so concerned about, about all of our youth not being in school, not having access to the nutrition that they are used to, the structure that they are used to, potentially not having a safe place to be during the day, the schools not being open.

I also know that the Bureau of Indian Education, as I understand it, didn't get CARES Act funds out to schools before the end of the year. Many schools in Minnesota haven't received those dollars yet.

My question is, could you give us some advice about how we should think about meeting the mental and behavioral health needs of Native students in the midst of this pandemic?

Ms. ELGIN. Thank you. Yes, I will try. It is a good question highlighting one of the key detriments that have happened around mental health. We heard that from the Administration, that drug overdoses have increased this year, likely as a result of the greater social isolation. Our people and Native youth are definitely being impacted. We have the second highest opioid overdose deaths and experienced the highest increase in drug ODs between 1999 and 2015. Because of that, the tragedy of suicide does continue.

It goes back, many tribal communities struggle with food insecurity. According to USDA, roughly 28 percent of our Native households with children are food insecure. In some areas, rates of food insecurity are higher than 40 percent. Only 25 percent of our peo-

ple living on the reservation are within one mile of the supermarket compared with 60 percent of the general population.

We are all looking at ways to fix this. I just want to say, too, we didn't talk too much about homelessness. But I think this comes into play as well. We know that can happen, even on the reservation, the gentleman talked about homes being overcrowded sometimes, and you have to move away from your family. With that comes this mental anguish and stress, again, that is not just faced by tribal or Native youth, but elders and the whole family in general.

I think tribes are working their best, trying to get measures in place to secure an emergency housing situation that they may need. Speaking for my own tribe, we put things and measures in place that if we have to move a family away, it is going to be somewhere near, and not going to really put them in danger of going to a bigger city. I am two hours away from the biggest town near me, and just trying to get the food stockpiles there, and all the supplies you need, everything, it all comes with this stress and anguish going on now.

So I along with our neighboring tribes here are working together just to come together and a plan that will help and work with the mental health issues surrounding this COVID.

Senator SMITH. I think COVID happens in the context of historic trauma, this is layered on that historic trauma, especially the trauma around an illness and sickness and disease that is brought to Indian Country. I really think this is an area where we have a shortage of mental health services and substance abuse services generally. It is exacerbated in Urban Indian communities and also on tribal land. It is very important for us to think of this now.

I want to just say as I close, Mr. Chair, that the comments you were making, Ms. Elgin, about the challenges that tribes faced dealing with grant-based programs all the time really resonate with me, because that is often our solution. And then it not only puts additional pressure and stress on tribal governments and their leadership and those Urban Indian Organizations, but it also puts tribes in a position of having to compete against one another when that is not at all the spirit of our trust and treaty obligations, when it comes to our relationships with tribal governments.

In exchange for the land, we had promised health care. As a promise, it should not be broken.

I thank you very much, Mr. Chair. I will close, and thank you for the opportunity to be a part of this hearing today.

The CHAIRMAN. Thank you, Senator Smith.

Just a couple of quick questions I have in wrapping up. First, for Mr. Davis, as we work on this, and I know you are involved, you said both from the State side, I think from the Federal side, also from the tribes, as we continue to work on this, what costs do you see as the most in need for reimbursement? As we move forward, what costs are most in need for reimbursement?

Mr. DAVIS. That is a good question, Senator Hoeven.

I know the tribes are counting their costs as we speak, as well as the State. It is very costly. Hopefully, that will be all 100 percent reimbursable from the feds.

As far as the high costs, I think it is the personnel, the time. When I look at the doctors and health care providers and law enforcement, even just leadership, there are a lot of people that I see that I work directly with that are just working day in, day out.

So I think the overtime cost, Admiral Weahkee talked about the hazard pay. I have been in those discussions as well. The testing kits, the PPE, the infrastructure, those are things that I see as well. As we all know, infrastructure is very costly. Some of my tribes back home don't have the infrastructure to handle the cases, so they have to be referred out to Bismarck and Fargo and so forth. So those are the costs I see, Senator, that are coming down the pipeline.

I would also mention, too, with businesses I know, this body has worked diligently on a bipartisan bill for reimbursements for businesses, casinos, all those things. I am so appreciative of that, with Treasury, I have been on those calls as well. But as we all know, it is at times not enough.

I want to go back to what Senator Smith said, when she talked about mental health. For me personally, I have been in recovery for 16 years. What I see back home, we could use treatment centers, every tribe needs one, needs two of them. I think a conduit of that is the workforce in regard to licensing. That is one thing that I see as really, barrier, I kind of hate to say it, the regulation. Maybe it is regulation.

I would rather see innovation in regard to mental health on tribal lands. Because we all know that we have a number of cultural providers, if you will, that can provide services for our members, for our youth, for whoever, who are going through this pandemic, who are going through historical trauma. That could and should be reimbursable through Federal dollars.

So I see that as a barrier, Chairman, as far as mental health services go, those reimbursement costs to those. Most times, when you are working back home in the treatment centers, for mental health, you have to have a license of some sort. I understand that, I agree with that. But also, I think there has to be a way to be innovative of that. Sometimes I look at those licenses as red tape, quite honestly. That red tape leads to poor services, because you are shown to teach mental health a certain way, and when you are trying to teach it culturally to my people, it is different. And it kind of doesn't work.

So I would urge you and your staff, Chairman Hoeven, to look into that, how it can be innovative with similar licensing when it comes to mental health on tribal lands.

The CHAIRMAN. Thank you, Mr. Davis.

Ms. Elgin, does the National Indian Health Board have educational outreach or training that they think has been particularly effective in helping Native communities battle COVID–19?

Ms. ELGIN. Yes. There have been significant challenges, of course, but we have been doing this, they provide the TA that they can. Many of the grant application reporting requirements are always a concern when we try to outreach to tribes that we need to.

Since March, NIHB has had a public health team that has conducted 12 national webinars for tribes to provide education on COVID that connect with tribes regarding resources and unan-

swered technical questions. They have created 35 one-pagers, fact sheets and infographics on everything from how to conduct a sweat lodge during COVID to how to do home-based COVID testing, the vaccines, how to stay safe in multigenerational housing and addressing the mental and behavioral health challenges resulting from this distancing and sheltering in place orders. They are doing everything they can to make sure that tribes have all this information and the resources needed during this pandemic.

The CHAIRMAN. Thank you.

I would like to thank both Mr. Davis and Ms. Elgin for testifying on our second panel. There may be additional questions submitted for the record. We would ask that if there are, you would respond.

With that, again, we want to thank both of you for being here and for the work you are doing.

With that, our hearing is adjourned.

[Whereupon, at 5:11 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF ROBYN SUNDAY-ALLEN, VICE PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH (NCUIH)

My name is Robyn Sunday-Allen and I am the Vice President of the National Council of Urban Indian Health (NCUIH), which represents the 41 Urban Indian Organizations (UIOs) across the nation who provide high-quality, culturally-competent care to Urban Indians, constituting over 70 percent of all American Indians/ Alaska Natives (AI/AN). I also serve as the Chief Executive Officer of the Oklahoma City Indian Clinic, a permanent program within the IHS direct care program and a UIO, which provides culturally sensitive health and wellness services including comprehensive medical care, dental, optometry, behavioral health, fitness, nutrition, and family programs to our patients. I would like to thank both Chairman Hoeven and Vice Chairman Udall for holding this legislative and oversight hearing during this unprecedented pandemic, which has especially impacted Indian Country. My testimony is regarding S. 3650, Coverage for the Urban Indian Health Providers Act, and how it would improve health care outcomes for Oklahoma City's Urban Indian community.

S. 3650, Coverage for the Urban Indian Health Providers Act, was introduced by four Senators of this Committee—Lankford, McSally, Udall, and Smith, who have recognized the essential nature of this technical fix and that it is not a partisan issue. S. 3650 will close a major disparate gap in the Indian Health Service (IHS) system by extending Federal Tort Claims Act (FTCA) coverage to UIOs. FTCA for UIOs was also included in President Trump's FY 2021 budget and the Tribal Budget Formulation Workgroup's FY 2021 and FY 2022 budget recommendations. Both in this esteemed Chamber and in the House of Representatives, the Coverage for Urban Indian Health Providers Act has enjoyed broad support, both geographically and across political parties. This extensive support shows that one thing is clear across the board: FTCA coverage must be extended to UIOs, especially at a time when it is needed most.

At the Oklahoma City Indian Clinic, we spend approximately $200,000 annually on malpractice insurance, money which we would rather invest in our services. If UIOs were covered under the FTCA, we would put every one of these dollars back into services to include preventative care, such as: mammograms, pap smears, immunizations (adult and children), and dental sealants, among other services.

We are not alone in needing these funds even more during the COVID–19 pandemic. Many UIOs fear for our staff and have been forced to institute hiring freezes as we stretch every dollar as far as it will go. In fact, 83 percent of UIOs initially reported they had been forced to reduce their services, and 9 UIOs have reported hiring freezes.

Extending FTCA coverage to UIOs is a simple legislative fix, but the benefits would be significant. A single UIO may pay as much as $250,000 annually in medical malpractice insurance, funds which could instead be used to invest in better health outcomes for their communities or to prepare for public health emergencies like the one we are currently facing. By freeing up federal funding for UIOs, they would be better able to serve their communities with high-quality health care. For instance, some UIOs have reported to NCUIH that they are hesitant to hire additional providers or provide additional services as they cannot cover the costs of additional medical malpractice insurance, even as they are prepared to cover the new salaries and related costs. This directly and substantially limits the services UIOs can provide to their patients as the cost of adding providers or new services to malpractice insurance policies can be the sole prohibition to service expansion.

The federal government maintains a trust obligation to tribes and AI/ANs, which originates in treaties wherein the U.S. promised certain duties to Native populations in exchange for the lands which make up this great Nation; included among these duties is the provision of health care services. The Indian Health Care Improvement Act recognized that the federal trust responsibility to provide health care to AI/AN people does not end at the borders of a reservation and that it extends

to AI/ANs who reside in urban areas. It was also under this Act that Congress formally recognized UIOs as the entities to further the fulfillment of the federal government's responsibilities to Urban Indians. UIOs are an integral component of the IHS system, which facilitates the provision of essential health care services through its three components: Indian Health Service facilities, Tribal Health Programs, and UIOs, commonly referred to as the "I/T/U" system. Each component of the I/T/U system has a significant role to play in providing AI/ANs with high-quality, culturally-competent care. UIOs not only offer a wide range of critical services, which include clinical and behavioral health services, but they are also often the only places in urban settings where Urban Indians can receive traditional care services and function as centers for cultural activities in inter-tribal settings.

Although UIOs are an integral component of the IHS system, UIOs still have to fight to receive parity with the other two components of the I/T/U system. If UIOs are not explicitly included in Indian health care legislation, they are most often implicitly excluded, with the ultimate result that UIOs do not receive the resources they need to provide care to their communities. This is a failure of the trust responsibility.

As it stands, all employees and eligible contractors at IHS and tribal facilities are treated as federal employees for the purpose of medical malpractice liability. This is true for Community Health Center employees and volunteers as well. Unlike these similarly-situated health centers, UIOs must use their limited federal funding to purchase expensive medical malpractice insurance out-of-pocket.

Even absent the current Public Health Emergency, UIOs face disproportionate hardship as they attempt to stretch every dollar to care for a population with higher risks of chronic disease. AI/ANs face significant health disparities, including diabetes, cancer, and heart disease. [1] Many of these disparities place AI/ANs at a higher risk for serious COVID–19 complications. With over 70 percent of AI/ANs living in urban areas, and with the highest rates of COVID–19 taking place in areas of high population density, many UIOs are the central care delivery sites for communities with compounded risks. UIOs receive direct funding from only one line item—and are not eligible for other critical IHS funding, including Health Care Facilities, Sanitation, Purchased/Referred Care, and Equipment, to name a few. Facing a pandemic with decades of underfunding made it clear in the earliest stages of the pandemic that UIOs would need a substantial amount of emergency resources in order to meet the needs of Urban Indians. Congress acted swiftly to support UIOs and the entire IHS system through emergency supplemental appropriations. We are grateful for the support, and cannot emphasize enough how essential these resources have been to positive health outcomes for Urban Indians.

In order to both maximize the value of the money Congress has appropriated to UIOs, and to ensure other critical needs are met, it is imperative that UIOs have access to critical cost-saving measures like FTCA coverage. UIOs have reported that they would use their medical malpractice savings for additional Personal Protective Equipment, infrastructure improvements to ensure proper distancing between patients and staff, hiring additional providers, and expanding available services. All of these are imperative to help UIOs prevent and treat COVID–19 among their patients and communities, while preparing for future Public Health Emergencies.

We thank Congress for your support of UIOs during this Public Health Emergency and we urge you to keep FTCA coverage for UIOs front of mind as your work diligently on the next COVID–19 package. We are grateful for the Committee's continued support of Urban Indians and dedication to improving the health outcomes of Indian Country.

PREPARED STATEMENT OF HON. COLY BROWN, CHAIRMAN, WINNEBAGO TRIBE OF NEBRASKA

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, thank you for the opportunity to offer the Winnebago Tribe of Nebraska's perspectives on the COVID–19 pandemic. I am writing to discuss my tribe's experience with the *Coronavirus Aid, Relief and Economic Security Act* ("CARES Act").

My tribe makes our home on an Indian reservation along the banks of the Missouri River in Northeastern Nebraska and Northwestern Iowa. We have over 5000 tribal members and numerous tribal enterprises that employ thousands of employees in a five-county area, Nebraska, Iowa and around the world. The Tribe formed Ho-Chunk, Inc., the economic development corporation of the Tribe, in 1994. Ho-

[1] National Center for Health Statistics. Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD. 2016.

Chunk, Inc. is now the largest minority-owned company in Nebraska and has received numerous awards for its innovative approaches to tribal economic development. The Tribe also operates two small gaming operations in Nebraska and one relatively modest sized gaming operation in Iowa which provide approximately 40 percent of the Tribal government revenues that are integral to support tribal government operations and programs.

To protect our people, we declared a public health emergency on March 24, 2020. That same day we created the Winnebago Pandemic Task Force to ensure the health, safety and welfare of Tribal members during the public health emergency. The Tribe provides critical health resources and operates social services, law enforcement, education and numerous other important services to our Tribal citizens. Further, we are responsible for protecting our invaluable workforce who provide these services and protections through our Tribal government and Tribal enterprises. We made the difficult decision to close our government and gaming operations on March 17, 2020. We also implemented a curfew on April 15, 2020 and a mandatory face mask policy on April 27, 2020. We have experienced 68 positive cases of COVID–19 of which there have been three tragic losses of life and 63 people have recovered. Currently we have five active cases.

On March 27, 2020, Congress passed the CARES Act which established the Coronavirus Relief Fund (CRF) for state, local and tribal governments to respond to the public health emergency with respect to the Coronavirus Disease 2019. The CARES Act required that amounts to tribal governments ($8 billion) be distributed not later than 30 days of enactment (April 26, 2020). Relief funds are to be used for expenditures incurred March 1—December 30, 2020.

To date, the $8 billion fund has not been fully distributed to Tribal governments. These critical relief funds remain the subject of litigation. Instead of what should have been one payment in full by April 26, my tribe received three partial payments of varying amounts in early May and mid-June. Depending on the outcome(s) of multiple lawsuit(s), there is potential for the remainder of the fund to be paid to tribal governments in yet another payment. We had no insight into the formula that the U.S. Department of the Treasury used despite several tribal leader calls with Treasury on the issue. Even when Treasury made what became the first, second and third payments and described the different formulas used, tribes were unable to determine how such amounts were calculated by Treasury.

As a result, our tribe had no ability to properly plan for an unknown amount of CRF funds that our tribe would receive and therefore, no ability to plan for how to allocate CRF funds among the numerous priorities we have in response to the COVID–19 public health emergency. In addition, since the payment of CRF tribal relief funds was significantly delayed by almost two full months, all tribes, including my own, lost critical time to implement preparedness and response efforts. By the time we received the most recent payment on June 18, positive COVID cases on our reservation totaled 66 and all three of the COVID related deaths we have experienced in our community thus far, had already occurred.

As we continue to respond to the pandemic, there is no end in sight. The Tribe asks Congress to extend the use of CRF funds for necessary expenditures to respond to the public health COVID–19 emergency to September 30, 2021. We further ask that Congress allow Tribes to use relief funds to replace lost revenue and for governmental operations during the pandemic. Unlike state and local governments, Tribes do not have a tax base to draw upon during these trying times to support our governmental functions. Thank you very much for your attention.

PREPARED STATEMENT OF HON. JOSEPH RUPNICK, SR., PRAIRIE BAND POTAWATOMI NATION

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee on Indian Affairs:

The following statement is submitted on behalf of the Prairie Band Potawatomi Nation ("Prairie Band") to be included in the record of the Committee's hearing.

Like all Federally-recognized tribal nations, the Prairie Band has been affected by the COVID–19 pandemic and our Tribal government has declared a disaster, imposed stay-at-home orders on our people, closed our enterprises, and provided direct services and support for our people under quarantine during the last four months. This has resulted in tremendous hardship to our people, our families, and the people we employ in our region in Kansas.

As you know, the CARES Act provided for an $8 billion Coronavirus Relief Fund for Tribal governments ("Tribal CRF"). Payments from the Tribal CRF were to be

paid within 30 days of enactment (March 27, 2020) and that such funds could only be used to cover costs that:

- Were necessary expenditures incurred due to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19);
- were not accounted for in the budget most recently approved as of March 27, 2020 for the affected government; and
- were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020.

The Treasury Department, which was given responsibility for distributing the Tribal CRF monies, has diverged wildly from this Congressional mandate. The Prairie Band and over 200 Tribes were not treated fairly by the Treasury Department in the distribution of Tribal CRF monies.

Background. To implement the CARES Act, the Treasury and Interior Departments held two consultation sessions with Tribal leaders to solicit input on how to distribute the CRF monies. In early April, the Treasury Department (which has the obligation to disburse the funds) requested information from Tribal governments for purposes of developing a distribution formula to allocate 60 percent of the Tribal CRF, or $4.8 billion ("Round 1"). This data request included a request for our Tribal enrollment population, as well as our land base, number of employees, and total expenditures.

Inexplicably, the Treasury Department then proceeded to ignore all of the requested data—including tribal enrollment figures—and instead adopted a formula used to distribute Indian Housing Block Grants ("IHBG"). This was despite its acknowledgment that "Tribal population is expected to correlate reasonably well with the amount of increased expenditures of Tribal governments related directly to the public health emergency." *See* U.S. Department of Treasury, *Coronavirus Relief Fund Allocations to Tribal Governments*, May 5, 2020 (see attached). * And also despite the fact that not one Tribal leader during the consultation process asked for the IHBG formula to be applied. The offered explanation by Treasury officials was that the IHBG "formula area corresponds broadly with the area of a Tribal government's jurisdiction and other areas to which the Tribal government's provision of services and economic influence extend." *Id.*

Based on Treasury's Round 1 formula, the Prairie Band received $2,456,891.27. Our first impression was that this was a low figure, given our tribal population of 4,561 members. However, our suspicions were affirmed when a report analyzing the distributions was issued by the Harvard Project on American Indian Economic Development. See R. Akee, E. Henson, M. Jorgensen, & J. Kalt, *Dissecting the US Treasury Department's Round 1 Allocations of CARES Act COVID–19 Relief Funding for Tribal Governments,* May 18, 2020 ("Harvard Report") (see attached). *

Gross Error by the Treasury Department Revealed. The Harvard Report revealed that, if the Treasury Department had utilized the Tribal enrollment data as originally requested, the Prairie Band would have received $10,327,948, or $7,631,673 more than we actually received! *Id.* at 10. Indeed, the Harvard Report indicated that the Prairie Band was in the "top 25" tribes that were "under-represented" by the Treasury's use of the IHBG formula. We don't consider what Treasury did as "under-representing" the Prairie Band; we consider it as once again an action by the U.S. government to arbitrarily and unfairly treat us as Indian people by disregarding the one verified measure used to identify us to the federal government—our Tribal enrollment figures.

The Harvard Report also revealed even harsher results for many other Tribes, with Treasury recording "zero" Tribal population for some, thus allocating only the minimum $100,000.00 to those Tribes to assist their people.

Why the reason for such unfairness? The Harvard Report explains that the IHBG formula used by Treasury is based on self-identified racial data derived from the U.S. Census. This racebased data includes both individuals who self-identify as American Indian/Alaska Native as "single race" and those who identify as "mixed race". Based on known distributions, it appears that Treasury utilized the "mixed race" data in distributing the CRF monies. Because the foundation of the IHBG formula is race based, HUD rarely incorporates Tribal enrollment data and so its formula generates wildly divergent allocations of housing dollars despite the growth in a particular Tribe's population or its lack of HUD-funded housing. *Id.* at 12–13.

The Prairie Band falls into the latter category. Because of our economic success and our community philosophy regarding housing—we do not rely heavily on federal HUD monies to provide housing to our people. The Prairie Band has only 17 HUD-

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* The information referred to has been retained in the Committee files.

funded housing units! And because of this fact, the Treasury Department underfunded us by 75 percent of the amount of money we would have otherwise received to help our people address the COVID–19 pandemic.

It flies in the face of fundamental principles of federal Indian law and policy that the U.S. Treasury would disregard Tribal enrollment data as a barometer of a Tribal government's service obligation to its people in favor of wildly inaccurate race-based housing data. But that is what happened. And it was arbitrary, capricious, and wrong.

Judicial Relief Not Available. Because of our frustration and anger at Treasury's actions, the Prairie Band filed a lawsuit in Federal District Court to remedy the consequence of Treasury's misconduct and to prevent further arbitrary distributions of remaining Tribal CRF monies. (See U.S. D. Ct. D.C. Civil No. 20-cv1491, Jun. 11, 2020). Ultimately, the District Court denied our request for a temporary restraining order. However, the Treasury Department conceded that there was sufficient litigation risk associated with its position and notified the Court it intended to withhold $679 million for the Prairie Band and the 260 other Tribes that were shorted by Treasury's use of the IHBG data.

Following the litigation, Treasury has since distributed the remaining 40 percent of the Tribal CRF monies and relied upon a formula utilizing employment and expenditure data (see attached). The Prairie Band received an additional $7,355,949 associated with this Round 2 distribution.

Request for Relief. Despite the lack of judicial remedy, I bring to your attention the Prairie Band's experience because Congress should be aware of how poorly the Treasury Department administered the Tribal CRF monies. Hundreds of Tribes received far less than they would have received had Treasury utilized Tribal enrollment data. And that means that hundreds of Tribes received far less support to help their people than Congress intended when it enacted the CARES Act and appropriated the Tribal CRF monies.

We ask for the Committee's assistance in (i) examining why Treasury utilized a funding formula that ignored Tribal enrollment data and seriously underfunded 261 Tribes and (ii) appropriating additional funds to provide restitution to the Tribes adversely affected by Treasury's action to allow us to fully respond to the COVID–19 pandemic.

We are willing to assist you in any way that you may find necessary to address our concerns. Thank you for your consideration.

PREPARED STATEMENT OF PAPA OLA LŌKAHI (POL)

Dear Chairman Hoeven, Vice Chairman Udall, Senator Schatz, Senator Smith, and the Members of the U.S. Senate Committee on Indian Affairs:

Mahalo (thank you) for your leadership during the Novel Coronavirus Disease (COVID–19) pandemic in ensuring that Americans from all walks of life survive these challenging times. Papa Ola Lokahi (POL) is a community-based non-governmental entity that serves as the body with whom federal agencies consult on Native Hawaiian health policy and health care and that coordinates services between the Native Hawaiian Health Care Systems (NHHCS or the Systems). The five Systems provide invaluable direct health care services to the Native Hawaiian community. The Office of Hawaiian Affairs (OHA) is a semi-autonomous state agency tasked with the mission to serve and advance the well-being of Native Hawaiians. On behalf of our organizations and the community we serve, we request parity for POL and the NHHCS with the urban Indian organizations (UIOs) by including POL, the Systems, and their employees as part of the Public Health Service in the expansion of the Federal Tort Claims Act in S. 3650, the Coverage for Urban Indian Health Providers Act, which was introduced by Senator Tina Smith (D–MN).

The federal government, through actions of the U.S. Congress, must honor its trust responsibility to all Native Americans, including American Indians, Alaska Natives, and Native Hawaiians. This trust responsibility extends beyond the trust lands and includes ensuring our native people receive health care and related services wherever they live. Over the past century, the U.S. Congress has repeatedly recognized this responsibility to the Native Hawaiian people in hundreds of legislative actions, including statutes addressing the health challenges faced by the Native Hawaiian community.

Native Hawaiian Health Disparities

Like our native relatives on the continental United States, Native Hawaiians face disproportionate threats to our physical and mental health, including poverty,[1] suicide and depression,[2] infant mortality,[3] alcohol abuse,[4] homelessness,[5] and prejudices against natives. Native Hawaiian infants are twice as likely to die (infant mortality rate of 7.9 per 1,000 live births) than their White peers (infant mortality rate of 3.5 per 1,000 live births) in the State of Hawai'i.[6] Native Hawaiians are more likely to suffer from coronary heart disease, diabetes, and asthma than non-Native Hawaiians in the State.[7] Nearly 16,000 Native Hawaiians suffer from diabetes and more than 36,000 suffer from asthma.[8] These diseases are the result of many factors such as social determinants like housing. Indeed, many Native Hawaiians face homelessness-making up nearly half of the homeless population on the Island of O'ahu,[9] which houses approximately two thirds of the State's total population.

Mental health is also a serious concern for the Native Hawaiian community. More than twenty percent of Native Hawaiian adults reported that they frequently feel their mental health is "not good."[10] Although Native Hawaiians make up only 27 percent of all youth in the State between the ages of ten and fourteen, they constitute 50 percent of the completed suicides.[11] These factors contribute to the fact that Native Hawaiians, despite being the indigenous peoples of the Hawaiian Islands, have the shortest life expectancy of any major population in the State.[12]

The History of the Native Hawaiian Health Care Improvement Act

To respond to the health care needs of the Native Hawaiian people, the U.S. Congress created a Commission and ordered a Needs Study to assist in understanding the status of Native Hawaiian health. The Native Hawaiian Health Care Improvement Act, as it is known today, passed into law in 1988 and created a permanent program to address the health disparities faced by the Native Hawaiian community. As a result of this legislation, POL contracts with the Health Resources and Services Administration at the U.S. Department of Health and Human Services to create, update, and implement a comprehensive health care master plan that promotes health and prevents disease in the Native Hawaiian community.

Papa Ola Lōkahi and the Native Hawaiian Health Care Systems

POL coordinates and assists health care programs and service delivery within the NHHCS. The NHHCS is comprised of five separate Systems with unique service areas. They are Ke Ola Mamo on O'ahu; Ho'ola Lahui Hawai'i on Kaua'i; Hui Malama Ola Na 'Oiwi on Hawai'i Island; Hui No Ke Ola Pono on Maui; and Na Pu'uwai on Moloka'i, which also serves clients on Lana'i. The Systems play a critical role in the delivery of health care services to the Native Hawaiian community. More than 300,000 Native Hawaiians residing in the State, and approximately 615,000 Native Hawaiians across the entire country, are eligible to receive health care services through the Systems. Additionally, as the sole Indian Health Service (IHS)-contracted health care provider in the State, Ke Ola Mamo in partnership with the Sys-

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[1] Anita Hofschneider, Poverty Persists Among Hawaiians Despite Low Unemployment, HONOLULU CIVIL BEAT (Sept. 19, 2018), *https://www.civilbeat.org/2018/09/poverty-persists-among-hawaiians-despite-low-unemployment/*.

[2] NATIVE HAWAIIAN MENTAL HEALTH AND SUICIDE, OFFICE OF HAWAIIAN AFFAIRS (Feb. 2018), *http://www.ohadatabook.com/HTH*_Suicide.pdf.

[3] Ashley H. Hirai et al., Excess Infant Mortality Among Native Hawaiians: Identifying Determinants for Preventive Action, AM. J. OF PUB. HEALTH (Nov. 2013), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3828695/pdf/AJPH.2013.301294.pdf.*

[4] NATIVE HAWAIIAN HEALTH STATUS, OFFICE OF HAWAIIAN AFFAIRS 22 (July 2019), *http://www.ohadatabook.com/NHHS.html.*

[5] ISSUE BRIEF: COVID–19 AND NATIVE HAWAIIAN COMMUNITIES, NATIVE HAWAIIANS OVER–REPRESENTED IN COVID–19 AT–RISK POPULATIONS, OFFICE OF HAWAIIAN AFFAIRS 2 (2020).

[6] Hirai, *supra* note 3.

[7] ISSUE BRIEF: COVID–19 AND NATIVE HAWAIIAN COMMUNITIES, NATIVE HAWAIIANS OVER–REPRESENTED IN COVID–19 AT–RISK POPULATIONS, OFFICE OF HAWAIIAN AFFAIRS 1 (2020).

[8] *Id.* at 1–2.

[9] Id. at 2.

[10] NATIVE HAWAIIAN MENTAL HEALTH AND SUICIDE, OFFICE OF HAWAIIAN AFFAIRS (Feb. 2018), *http://www.ohadatabook.com/HTH_Suicide.pdf.*

[11] David M.K.I. Liu & Christian K. Alameda, Social Determinants of Health for Native Hawaiian Children and Adolescents, HAW. MED. J. (Nov. 2011), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3254224/pdf/hmj7011_suppl2_0009.pdf*

[12] ISSUE BRIEF: COVID–19 AND NATIVE HAWAIIAN COMMUNITIES, NATIVE HAWAIIANS OVER–REPRESENTED IN COVID–19 AT–RISK POPULATIONS, OFFICE OF HAWAIIAN AFFAIRS 2 (2020).

tems and other facilities, also provide health care for the 37,751 American Indians and Alaska Natives who reside in the State and the many thousands more Native American visitors who come to our islands each year.

Each of the five Systems offer unique services to their patients. The Systems as a whole provide primary health care, behavioral health, and dental services as well as health education to manage disease and transportation to attend appointments. The Systems provide preventative care to improve diabetes management and cardiac health, as well as screenings for diseases such as breast and cervical cancer. Further, the Systems provide traditional Native Hawaiian healing through practices such as Lomilomi massage therapy to improve circulation and range of motion and Ho'oponopono, a traditional healing art to promote physical, mental, and emotional health and wellness for individuals, families, and communities. For Native Hawaiians seeking to overcome substance abuse challenges, the Systems offer smoking cessation programs and substance abuse counseling. The Systems also provide their clients with culturally enriching wellness and fitness programs, such as Hula for Health and nutrition classes.

The Systems are working to address the health and well-being of Native Hawaiians at all stages of life. To that end, the Systems provide prenatal support to expectant mothers and offer newborn care. For our older keiki (children), the Systems provide immunizations and school physicals to students and athletes. The Systems also provide health services and nutritional support to teenagers. Finally, Native Hawaiian Kupuna (Elders) are eligible to receive support through adult day care, aging in place programs, and in-home care services.

The Systems ensure access to health care for Native Hawaiians, as well as American Indians and Alaska Natives living in or visiting Hawai?i. They directly serve more than 23,000 clients annually.[13] Each year, the Systems provide more than 4,700 clients with Native Hawaiian traditional healing services; provide more than 8,500 dental services; teach over 2,000 hours of disease and complication prevention classes; transport more than 1,000 clients to health care appointments; and instruct more than 20,000 participants in physical fitness classes.[14] The critical role the Systems play in the Native Hawaiian community is undeniable. Since the COVID–19 pandemic began, the Systems have provided urgent care, telehealth, and telemedicine services that have proven critical during the Stay in Place and quarantine orders in the State. Additionally, POL and some of the Systems performed COVID–19 testing, delivered meals to seniors, and collected information on critical Native Hawaiian community health needs. The Systems have turned to innovation to continue to offer their valuable services during this time.

The Need for Parity for the NHHCS and UIOs in FTCA Coverage

While POL and the Systems are successful in their missions to provide health care services to the Native Hawaiian community, the Systems are forced to spend a significant portion of their budget on malpractice insurance rather than spending those funds on the provision of health care and related services to patients. Including the POL and the Native Hawaiian Health Care Systems' employees under the expansion of the Federal Tort Claims Act (FTCA) found in S. 3650, Coverage for Urban Indian Health Providers Act, will provide parity for the Systems alongside the UIOs, which play a parallel role in the urban Indian communities. FTCA coverage will free an estimated $220,000 annually to provide quality health care services in response to the effects of the COVID–19 pandemic, not only for those infected by the disease but also for individuals who no longer receive employer-based insurance due to loss of employment or reduced hours. This would help the Systems to continue providing services to patients who are most at risk of contracting COVID–19 and who may not have any other means to receive health care in the aftermath of this pandemic.

The high costs of malpractice insurance during the pandemic imposes limitations on the types of services the Systems can provide and creates barriers to retention and recruitment. Further straining the Systems, the provision of health care to American Indians and Alaska Natives in Hawai?i adds roughly twice as much in health costs compared to the level of funding the Systems receive from IHS to provide these services, including serving as the payor of last resort for patients in need, each year. With FTCA coverage, the Systems would be able to provide an estimated 25,000 additional encounters for up to 2,000 more patients and to provide expanded services, including primary care and behavioral health services, additional transportation to appointments, and increased traditional healing practices to cope with the

[13] Native Hawaiian Health, Papa Ola Lōkahi (2020).
[14] Id.

stress placed on families facing increased hardships during the pandemic, among other things.

Significantly, this expansion of coverage would also mean that the NHHCS can more effectively recruit and retain high-caliber medical professionals with specializations. For example, although some of the Systems already provide pediatric care, an expansion would allow the remaining Systems who do not offer such services to recruit a pediatrician to provide our keiki health services at the same place that their parent receives care. Additionally, the Systems could increase their collaboration between Systems by recruiting different types of specialists to provide care across the Systems and decrease patient travel. The Systems also project the ability to offer 25 percent more events addressing the social determinants of health while integrating relevant traditional practices and culture.

The COVID–19 pandemic has exacerbated and will widen the health disparities Native Hawaiians face. Unemployment in Hawai'i has skyrocketed, with many organizations reporting Hawai'i as the second worst state in terms of unemployment levels.[15] We do not expect unemployment to lower significantly in the foreseeable future because one of our biggest industries, tourism, is almost completely shut down and many small business have permanently closed as a result. Our economy will likely not begin to see growth again until the last stages of the COVID–19 pandemic recovery. Native Hawaiians will continue to be disproportionately affected by this fact because nearly one in four Native Hawaiians are employed in the service industry closely tied to tourism in Hawai'i.[16] This pandemic threatens the continued success and survival of the NHHCS. The inclusion of the NHHCS in the extension of the FTCA protections will address some of the most urgent needs facing the NHHCS and help provide parity in carrying out the federal government's trust responsibility to Native Hawaiians.

Mahalo again for your leadership during this difficult time in our nation. We understand that the pandemic has negatively affected the health and economic wellbeing of all native communities across the nation, and the Native Hawaiian community is no different. During this public health crisis, we are confident you will support providing all native health care providers with equal treatment and the necessary protections to continue caring for the health of our people despite the many hardships resulting from this pandemic.

PREPARED STATEMENT OF KEVIN J. ALLIS, CEO, NATIONAL CONGRESS OF AMERICAN INDIANS

Dear Chairman Hoeven and Vice-Chairman Udall:

On behalf of the National Congress of American Indians (NCAI), thank you for holding this hearing on "Evaluating the Response and Mitigation to the COVID–19 Pandemic in Native Communities" and on S. 3650, Coverage for Urban Indian Health Providers Act. Founded in 1944, NCAI is the oldest and largest representative organization serving the broad interests of tribal nations and communities.

As the infection rate and death toll of the COVID–19 pandemic intensifies, it is clear that American Indian and Alaska Native (AI/AN) communities are disproportionately impacted due to a chronic underfunding of the federal trust and treaty responsibilities. While we are grateful for Congress' support of Indian Country in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, greater aid is needed in addition to addressing the numerous issues, barriers, and delays that tribal nations encountered in accessing congressional COVID–19 relief. On July 14, 2020, we submitted extensive testimony to the United States Commission on Civil Rights on this topic and made short-term and long-term recommendations. To aid this Committee's work, we enclose that testimony for your consideration and record.*

Additionally, with regard to S. 3650, Urban Indian Organizations (UIOs) are an essential part of the Indian healthcare delivery system alongside the Indian Health Service (IHS) and tribal health programs (I/T/U). Currently, both IHS and tribal health programs receive Federal Tort Claims Act (FTCA) coverage but UIOs do not. As a result, UIOs are forced to spend their limited resources on tort claim coverage,

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[15] Dave Segal, Hawaii's Unemployment Rate Remains High at 22.6 percent, STAR ADVERTISER (June 19, 2020), *https://www.staradvertiser.com/2020/06/19/hawaii-news/hawaiis-unemployment-rate-remains-high-at-22-6/*.

[16] ISSUE BRIEF: COVID–19 AND NATIVE HAWAIIAN COMMUNITIES, NATIVE HAWAIIANS OVER–REPRESENTED IN COVID–19 AT–RISK POPULATIONS, OFFICE OF HAWAIIAN AFFAIRS 3 (2020).

* The information referred to has been retained in the Committee files and can be found at *http://www.ncai.org/resources/testimony/written-testimony-of-president-fawn-sharp-at-the-hearing-on-covid-19-in-indian-country-the-impact-of-federal-broken-promises-on-native-americans.*

which has negatively impacted the scope of services that they can provide. S. 3650, addresses this gap by expanding FTCA coverage to UIOs. NCAI supports extension of FTCA parity which will enable UIOs to increase the delivery of services to urban AI/ANs at a time when those services are most needed.

PREPARED STATEMENT OF ESTHER LUCERO, CEO, SEATTLE INDIAN HEALTH BOARD

Dear Chairman Hoeven and Vice Chairman Udall:

The Seattle Indian Health Board (SIHB) would like to thank you and the Senate Committee on Indian Affairs for holding the Oversight Hearing on "Evaluating the Response and Mitigation to the COVID–19 Pandemic in Native Communities and Legislative Hearing to Receive Testimony on S. 3650". We appreciate the opportunity to provide written comments on our experiences mitigating the COVID–19 pandemic at SIHB, and our research division, the Urban Indian Health Institute (UIHI) and express our support of S. 3650.

SIHB is one of 41 Urban Indian Health Programs (UIHP) that assist the federal government in fulfilling their trust responsibility to provide healthcare for the American Indian and Alaska Native citizens living in urban areas. UIHPs are a critical component of the Indian Health Service (IHS) Direct/Tribal 628/UIHP (I/T/U) system of care and offer culturally attuned health services to the 1.5 million American Indians and Alaska Natives who live in 117 counties across 24 states.

UIHI is an IHS designated Tribal Epidemiology Center (TEC) and public health authority which conducts data, research, and evaluation services for over 62 urban Indian organizations nationwide. These health, social, and cultural service agencies provide culturally attuned health services to urban Indian communities. Of the twelve TECs, UIHI is the only one with a national purview, the other eleven operate regionally, serving tribal nations.

Indigenous Resilience in Confronting COVID–19

SIHB is one of the thousands of frontline health care organizations that is actively working to limit the spread of COVID–19 our communities. As a UIHP and Federally Qualified Health Center, we have remained open for business throughout the COVID–19 pandemic. We are adapting our service delivery models to ensure continued access to care for of our clients, for example:

- Within weeks, our clinic operationalized a COVID–19 testing site at our main clinic and within two months were operating a low-barrier community-based testing site at our satellite site—Chief Seattle Club. Over the course of three months, our staff reconfigured physical spaces and adjusted clinical workflows to increase social distancing and implement safety measures for patients, staff, community members, and vendors. Notably, due to internal adjustments and supplemental funding, SIHB did not experience mass furloughs or layoffs like many of our healthcare partners.
- Over the course of several months, we have operationalized expanded telehealth options for medical, dental, behavioral health, and traditional Indian medicine. Today, the majority of our appointments are telehealth visits. To orient our patients to this new service delivery model, we developed the "Call Our Relatives Home" initiative to outreach past and present patients and encourage reconnecting to care.
- To offer telehealth services to our patients experiencing homelessness, we were able to create "telehealth kiosks"—private rooms on site that maintain social distance and are set up for telehealth appointments.
- Through flexible supplemental HRSA funding, we were given the ability to finance modest infrastructure changes that improved telehealth, facility security, and sanitation measures. For example, new features like keyless entry, automatic doors, and plexiglass protections will work to limit the spread of the virus.
- Through supplemental SAMHSA funding, we are in the process of standing up an intensive outpatient program where we can offer a higher level of care for our behavioral health patients. This program will begin to address a longstanding community need. These funds combined with new federal and state telehealth waivers that allowed for increased flexibilities and payment parity have proven to be successful policy changes.
- To meet the preventative health care needs of our pediatric and prenatal patients, we created a Saturday clinic—open exclusively to pediatrics and prenatal patients and staffed with integrated care teams for wrap around health and social services.

Each of these efforts demonstrate the adaptive and innovate approaches UIHPs take to support the health and well-being of urban American Indian and Alaska Native people.

As a TEC, UIHI immediately began producing newsletters, fact sheets, and webinars focused COVID–19 impacts for tribes, UIHPs, and urban Indian communities. To date, UIHI has disseminated 20 factsheets and resources for clinics, workplaces, and community members. Topics range from best practices for American Indian and Alaska Native data collection, to COVID–19 information tailored for urban Native homelessness service providers. UIHI has partnered with the National Council on Urban Indian Health (NCUIH) to create an urban Indian organizations national surveillance system. As of June 28, 2020:

- 75 percent of UIHPs submitted data to the surveillance system;
- 19 of the participating UIHPs report screening a total of 37,476 patients for COVID–19;
- A total of 5,636 patients were tested for COVID–19 with 6 percent testing positive;
  - —Among the positive COVID–19 patients where age was submitted, 87 percent are age 18–64 in comparison to 74 percent in national surveillance data; [1]
  - —Among the positive COVID–19 patients where race/ethnicity was submitted, 49 percent are American Indian or Alaska Native;
  - —Among the positive COVID–19 patients where gender was submitted, 64 percent are female, in comparison to 51 percent in national surveillance data; [2] and
  - —Among the positive COVID–19 patients where home status was submitted, 94 percent live in multigenerational homes.

This national UIO surveillance data is the only data that specifically looks at the experience of UIHPs in detail and is therefore critical to understanding the prevalence of COVID–19 and supporting data-driven decisionmaking among urban American Indian and Alaska Native communities.

These are just a few examples of the work that UIHPs and TECs are undertaking to ensure the health and well-being of American Indian and Alaska Native people. Despite the remarkable successes of Indian healthcare providers in response to COVID–19, there continues to be notable challenges with monumental implications for American Indian and Alaska Native people. The following sections outline three areas of concern on the federal response to COVID–19 in urban Native communities. We share these continued challenges with the intent of working in partnership with Congress and federal agencies to overcome these barriers and support the health and well-being of urban American Indian and Alaska Native people.

Health Disparities Increase COVID–19 Risk Among American Indians and Alaska Natives

The IHS continues to be the most chronically underfunded healthcare system in the United States, despite federal promises to tribes dating back to the 1800s. As a result of this chronic underfunding of trust and treaty obligations, American Indian and Alaska Native communities around the country suffer from disproportionate rates of diabetes, heart disease, asthma and cancer, as compared to other racial or ethnic groups [3]—all of which are COVID–19 risk factors. Very recent studies seem to show that some of the most common comorbidities in fatal COVID–19 cases were diabetes or heart disease.

In a factsheet entitled: *Special Diabetes Program for Indians (SDPI): Mitigating COVID–19 Risk,* UIHI outlines that individuals with diabetes are at a higher risk for severe complications of COVID–19 and potentially at a higher risk for fatality. Given that American Indian and Alaska Native people currently have the highest rates of diabetes compared to other racial or ethnic groups, there is an increased concern that American Indian and Alaska Native people are at a disproportionately higher risk for severe complications and possibly fatal outcomes related to COVID–

[1] "Cases in the U.S." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 23 June 2020. Retrieved from: *www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.*

[2] Stokes EK, Zambrano LD, Anderson KN, et al. Coronavirus Disease 2019 Case Surveillance—United States, January 22–May 30, 2020. MMWR Morb Mortal Wkly Rep. ePub: 15 June 2020.DOI: *http://dx.doi.org/10.15585/mmwr.mm6924e2external icon*

[3] Urban Indian Health Institute. (2018). Urban Indian Health Data Dashboard. Retrieved from: *https://www.uihi.org/urban-indian-health/data-dashboard/*

19. Currently, SDPI is the only national public health intervention that has been shown to improve diabetes related outcomes including treatment and prevention and has the potential to help mitigate the high risk of COVID–19 for American Indian and Alaska Native people with diabetes.

Incomplete Data on COVID–19 Impacts Among American Indians and Alaska Natives

Recent CDC data show that ". . .age-adjusted hospitalization rates [for COVID–19] are highest among non-Hispanic American Indian or Alaska Native and non-Hispanic black persons, followed by Hispanic or Latino persons."[4] Even with the release of this data, our understanding of the impacts of COVID–19 on American Indian and Alaska Native people is limited. As we have seen throughout the COVID–19 response, incomplete demographic data complicates our understanding of health disparities and impacts in tribal and urban Indian communities.

Data collected on tribal and urban Indian communities by local, state, and federal governments has historically misrepresented, misclassified, and omitted American Indian and Alaska Native populations in their analysis and reports. The incorrect and inaccurate data ultimately affects the overall health and well-being of the American Indian and Alaska Native population. Since the COVID–19 outbreak, we are seeing that American Indian and Alaska Native data is often not being reported or has been included in the "other" data category by non-Indigenous entities.

Efforts led the twelve Tribal Epidemiology Centers, have shed light on the data gaps for American Indian and Alaska Native people. In May 2020, *UIHI released a set of best practices for American and Alaska Native data collection* to ensure state and local public health agencies work collaboratively with tribal and urban Indian communities, including Tribal Epidemiology Centers, who are adept and proficient with data collection and analysis of the American Indian and Alaska Native population.

Continued Administrative Barriers for Urban Indian Organizations

The federal trust responsibility is a legal obligation and cornerstone of relations between the U.S. federal government and tribes; it was created by hundreds of treaties and centuries of court decisions. The IHS fulfills the federal trust responsibility to deliver healthcare to American Indian and Alaska Native citizens through the I/T/U system of care. Nationwide, over 70 percent of the American Indian and Alaska Native population live in urban areas, yet UIHPs receive less than one percent of the IHS budget, and TECs have been chronically underfunded since their inception in 1996. On average, an IHS contract or grant is $281,128 for a UIHP and $338,675 for a TEC, but the need is much greater. As a result, many UIHPs rely on third-party reimbursements from Medicaid, Medicare, and private health insurance and grants to provide basic services, while TECs seek out additional public and private funding through grants and contracts.

Recent federal investments are contributing to an increasingly integrated health care system. Yet, there is much to be done to address decades of chronic under-funding. As a result of legislative education and outreach and congressional champions, urban Indian organizations are increasingly included in federal legislation as a part of the I/T/U system of care. All four federal COVID–19 bills (Pub.L. 116–123, Pub.L. 116–127, Pub.L. 116–136, and Pub.L. 116–139) included urban Indian organizations as defined by title V of the Indian Health Care Improvement Act.

While the congressional intent was to fund urban Indian organizations, administrative challenges persist. The following bullet points summarize common barriers for urban Indian organizations:

- *Exclusionary grant eligibility*—Public policies and federal grant eligibility requirements are often restricted to tribes and tribal organizations, thereby excluding urban Indian organizations. While federal legislation is increasingly inclusive of urban Indian organizations as part of the I/T/U system of care, there can be a disconnect when funding is allocated through certain federal agencies. For example, CDC's COVID–19 funding strategy included a grant opportunity open to only 11 of the 12 IHS TECs because grant eligibility criteria were limited to tribes and tribal organizations. This effectively eliminated UIHI from epidemiology and surveillance funds. This is a significant gap given that not only is UIHI the sole TEC that operates on a national level, but 70 percent of the American Indian and Alaska Native population live in urban areas.

[4] Centers for Disease Control and Prevention. (2020). COVID–19 in Racial and Ethnic Minority Groups. Retrieved from: *https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html*

- *Limited contracting with urban Indian organizations*—Level of experience and engagement working with the I/T/U system of care varies across HHS. Some agencies have limited contracts or grants with urban Indian organizations thereby complicated expeditious funding. For example, when the CDC announced a $80 million investment in tribes, tribal organizations, and urban Indian organizations in March 2020, dissemination of funds across the I/T/U system of care was delayed.[5] Due to CDC's limited existing contracts with urban Indian organizations, NCUIH was awarded funds to establish grants to UIHPs. As an unintended consequence, it took three months for SIHB to access $190,000. To date, this is the only CDC funding SIHB has received of at least $205,000,000 set aside by CDC for the I/T/U system of care.
- *Lack of Urban Confer policies across HHS agencies*—IHS is the only HHS agency with an Urban Confer policy. Urban Confer policies allow federal agencies and urban Indian organizations to engage in an open and free exchange of information and opinions that leads to mutual understanding and comprehension, and emphasizes trust, respect, and shared responsibility.[6] These policies do not substitute for, nor do they invoke, the rights of a tribal nation, rather they allow urban Indian organizations to represent the needs of urban American Indian and Alaska Native citizens as an Indian Health Care Provider. Without an Urban Confer policy, HHS agencies have no formal mechanism for gathering feedback from urban Indian organizations and vice versa. As a result, submitting feedback to HRSA, SAMHSA, and CDC was a significant barrier for urban Indian organizations.
- *Limited understanding of the public health authority status of Tribal Epidemiology Centers*—SIHB and UIHI are committed to understanding the impacts of COVID–19 in urban American Indian and Alaska Native communities. As a TEC and public health authority, UIHI supports the epidemiological needs of 62 urban Indian communities nationwide. Thanks to recent Congressional oversight, TECs now have access to CDC COVID–19 Case Surveillance. Yet, barriers persist for other HHS data access. UIHI continues to be denied access to the National Notifiable Disease Surveillance System (NNDSS) by CDC. A failure to grant data access perpetuates systemic health inequities in American Indian and Alaska Native communities. Timely analysis of NNDSS data is critical to supporting tribal and urban Indian organizations as they prevent, prepare, and respond to a second surge of COVID–19. To fully operate as public health authorities alongside local, state, and federal entities, the roles and authorities of TECs must be upheld.

Recommendations

We applaud the committee on your efforts to support the I/T/U system of care to address longstanding and emergent racial and ethnic health disparities in American Indian and Alaska Native Communities. As a result of your advocacy, tribal and urban Indian communities continue to innovate and demonstrate the resilience of Indigenous communities in the face of a global pandemic. As we work together to address historical and current disparities and promote the well-being of American Indian and Alaska Native communities, we ask that the committee:

- Continue to include tribes, tribal organizations, and urban Indian organizations in legislative language when intending to support the I/T/U system of care.
- Extend 100 percent Federal Medical Assistance Percentage (FMAP) to urban Indian organizations to ensure *payment parity for Indian Health Care Providers* and reduce the burden on states responding to COVID–19.
- Extend the IHS Urban Confer policy to all HHS agencies to encourage mutual understanding and strengthen relationships between HHS agencies and urban Indian organizations.
- Support investments in Tribal Epidemiology Centers to provide culturally competent support and services to tribes and urban Indian communities responding to COVID–19 including resources for emergency response planning, training and technical support, communications, outreach and education, and other public health surveillance activities.

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[5] Health and Human Services. (2020). HHS announces upcoming action to provide funding to tribes for COVID–19 response. Retrieved from: *https://www.hhs.gov/about/news/2020/03/20/hhs-announces-upcoming-action-to-provide-funding-to-tribes-for-covid-19-response.html*

[6] Indian Health Service. Indian Health Manual: Ch. 26—Conferring with Urban Indian Organizations. Retrieved from: *https://www.ihs.gov/ihm/pc/part-5/p5c26/*. Accessed (2020).

- Leverage Congressional oversight authority to ensure HHS agency compliance with data sharing requirements.
- Support a $1.7 billion Emergency Third-Party Reimbursement Relief Fund for the I/T/U system of care to submit claims for relief funding based on health care service needs or losses related to COVID–19.
- Permanently Reauthorize the Special Diabetes Program for Indians (SDPI) to ensure continued access to culturally attuned and tribally-driven diabetes prevention and treatment.
- Permanently extend telehealth waivers under Medicare to ensure expanded telehealth services across the I/T/U system of care.
- Support S. 3650—Coverage for the Urban Indian Health Providers Act to extend Federal Tort Claims Act coverage to Urban Indian Health Program Employees.

Thank you for your continued advocacy to address the health and wellness of our American Indian and Alaska Native communities. If we can provide any additional information in support of this request, please contact us by phone or email.

PREPARED STATEMENT OF HON. BILLY FRIEND, CHIEF, WYANDOTTE NATION

Thank you Chairman Hoeven, Vice Chairman Udall, and Members of the Committee for the oppo1iunity to submit testimony on S. 2165, the Safeguard Tribal Objects of Patrimony (STOP) Act of2019. The Wyandotte Nation strongly supports swift passage of the STOP Act.

My name is Billy Friend and I am the Chief of the Wyandotte Nation. The struggle to protect tribal cultural heritage from illegal trafficking is a tragically common challenge for communities across Indian Country. The Wyandotte Nation is no exception. International markets have become a safe harbor for trafficking federally protected tribal cultural heritage items, and they will remain this way until Congress enacts federal law to address this issue. We firmly believe the STOP Act will make tremendous strides in preventing international trafficking of federally protected tribal cultural heritage items and securing their return home to their tribal communities.

I. The Wyandotte Nation Has Fought to Protect Our Tribal Cultural Heritage

Items of tribal cultural heritage are as unique as the tribal nations to whom they belong. These items share the common characteristics of being of deep intangible and tangible significance to a tribal nation. Many people view our cultural heritage as beautiful works of art, as talismans of a past culture they would like to own, or as items to trade for profit. Whatever intrinsic beauty these items possess, that is not their intended purpose.

Our items of cultural heritage have significant roles to play within our cultures, our traditional calendars. our families, and our ways of life. Our cultural heritage also helps us honor and uphold our values and teach those values to our community members, particularly our young people. So important are these items of cultural heritage that they belong to the community as a whole- as our shared inheritance and as our shared responsibility to honor and protect for present and future generations.

The Wyandotte Nation has first-hand experience in fighting to prevent the loss of our cultural heritage due to theft, trafficking, and illegal sales. Many of our tribal artifacts are now in museums abroad or in private collections outside the jurisdiction of the United States, due to fact that we for many years did not have the financial means or the ability to track down and acquire the items that were historically ours.

II. Support for the STOP Act to Close Gaps in Existing Federal Law

The Wyandotte Nation fully supports the passage of the Safeguard Tribal Objects of Patrimony (STOP) Act of 2019, S. 2165. Gaps in existing federal law have enabled dealers and collectors to operate in the shadows when it comes to items of tribal cultural heritageespecially once exported abroad. The STOP Act illuminates these dark corners.

There is an already-existing international mechanism through which countries can request the return of cultural property from other countries. The Convention on the Means of Prohibiting and Preventing the Illicit Import, Export and Transfer of Ownership of Cultural Property is a 1970 international treaty that the United States signed. France, now a safe harbor for those seeking to sell federally protected

tribal cultural heritage items, is also a signatory. When a signatory prohibits export of particular cultural patrimony items and introduces an accompanying export certificate, that signatory can call on other signatories to control imports of those items and help with repatriation. The United States has not explicitly prohibited export of tribal cultural heritage items otherwise protected under federal laws like the Native American Graves Protection and Repatriation Act (NAGPRA) and the Archaeological Resources Protection Act (ARP A). Instead, when we try to regain our sacred items from an auction block abroad, we are told these gaps in United States law prevent government action to facilitate return.

The STOP Act places an emphasis on facilitating the return of protected cultural heritage items trafficked internationally. The STOP Act sets out to accomplish the two main goals of: (1) stopping the export and facilitating the international repatriation of tribal cultural heritage items already prohibited from being trafficked under federal law; and (2) facilitating coordination among federal agencies in protecting and repatriating such items and in aiding the voluntary return of tribal tangible cultural heritage more broadly.

The STOP Act is designed to meet these very narrow goals. But NAGRA and ARPA have other serious limitations that make even their domestic implementation difficult, including restrictive provenance requirements. While the STOP Act works to prevent the export of items already protected under NAGPRA and ARPA and to secure their return, we hope to see larger changes to NAGPRA and ARP A in the future meant to resolve these other limitations.

We understand the STOP Act has been developed with significant expert feedback, including from seasoned agency officials. We welcome this expert feedback to strengthen the STOP Act so that it best meets its goals.

We need the STOP Act now. Without it, we will continue to see our tribal cultural heritage trafficked just out of our reach and in front of our very eyes. The Wyandotte Nation urges you to act swiftly to enact the STOP Act into law.

PREPARED STATEMENT OF HON. RODNEY CAWSTON, CHAIRMAN, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION

On behalf of the Confederated Tribes of the Colville Reservation (the "Colville Tribes" or the "Tribes"), I thank you for this opportunity to provide written testimony for the record on the Committee's oversight hearing on the federal government's response and mitigation to the COVID–19 pandemic in Native communities.

After more than three decades of trying to construct a new clinic in Omak, Washington, the Colville Tribes was fortunate for the Omak clinic to have been one of the five projects that the Indian Health Service (IHS) selected earlier this year for the Joint Venture (JV) Facility Construction Program. COVID–19, however, has affected the ability of the Colville Tribes and other JV awardees to build their facilities due to the precipitous decline in third party revenue.

The Colville Tribes joins the National Indian Health Board, the National Congress of American Indians, and the Northwest Portland Area Indian Health Board in requesting that the Senate include funding to cover the construction costs of the eligible JV projects as part of any infrastructure bill that it may consider this year.

By way of background, the Confederated Tribes of the Colville Reservation is, as the name states, a confederation of twelve aboriginal tribes and bands from across eastern Washington state as well as parts of Oregon, Idaho, and British Columbia. The Colville Reservation encompasses approximately 1.4 million acres and is in north central Washington state. The CCT has nearly 9,600 enrolled members, making it one of the largest Indian tribes in the Pacific Northwest. About half of our tribal members live on or near the Colville Reservation.

I. The Colville Tribes' Health Facility Needs and Joint Venture Application

In 2019, for the second time in the past decade, the Colville Tribes applied to replace its temporary modular building in Omak, Washington, with a new clinic through the IHS's JV program. The IHS solicits applications for the JV program very infrequently—every six or seven years—and the program is extraordinarily competitive. When the IHS selects a tribal project for the JV program, the tribe agrees to construct and, in most cases, equip the facility, and the IHS agrees to pay for 80 percent of the recurring staffing costs for at least 20 years.

For decades, the Colville Tribes and its citizens have lacked a tribal health care facility in Omak, the largest population center on the Colville Reservation. In September 2007, the CCT, out of desperation, used tribal funds to modify a small modular office building for use as a temporary clinic in Omak and redeployed resources

from its already understaffed operations in Nespelem, Washington, in an effort to provide at least some health care to Omak residents.

The temporary Omak modular building is so cramped that it barely allows for wheelchair access in its main hallway. The lack of square footage has inhibited the Colville Tribes' ability to add and retain health care providers in Omak, which has resulted in long wait times for patients and fewer billable patient encounters. The Colville Service Unit has been operating under historically low staffing ratios since its inception in the late 1930s, so the Colville Tribes were already facing a critical shortage of providers in its health delivery system. The reduction in patient encounters caused by the lack of providers has had the domino effect of eroding the Colville Tribes' user population count and negatively impacting the Colville Service Unit's base funding.

When the IHS solicited applications in 2009, the Colville Tribes intended to apply, but was unable to do so because of a lack of available tribal funds due to the downturn in the timber market associated with the housing market crash. At that time, the CCT heavily relied on income from the sale of on-reservation timber. In recent years, as its economy has diversified, the Colville Tribes have been able to utilize tribal resources to develop plans for a new Omak clinic and secure financing for that facility.

The Colville Tribes applied in 2014, but its application did not progress beyond the pre-application phase. Since then, the Colville Tribes also engaged with the IHS on ways to improve its application when the IHS once again solicited applications. The Colville Tribes appreciates the cooperation and assistance that IHS officials and staff provided as it prepared its 2019 application.

Early last month, the IHS finally announced the five projects it selected for the JV program out of the 10 nationwide finalists and 34 total applicants, and the CCT was extremely grateful to be one of those selected. A bipartisan group of the northwest congressional delegation weighed in with the IHS with letters of support. The selection of the Omak clinic by the IHS represents just the second JV project ever awarded to an Indian tribe in the IHS's Portland Area, the geographic region of the IHS that includes more than 60 Indian tribes in Washington, Oregon, and Idaho.

II. Impact of COVID–19 on the Colville Tribes and Its JV Project

The COVID–19 outbreak has impacted Indian country in a multitude of ways and the Colville Tribes is no exception. Since the outbreak, our health care system has struggled to obtain personal protective equipment, to treat tribal member patients with COVID–19 and others with chronic conditions, and with decreased budgets due to an abrupt decline in third party revenue.

A significant portion of the Colville Tribes' business plan to repay the funds needed to build the Omak clinic hinges on collection of third-party revenue, most notably Medicaid. As of this writing, the Governor of Washington has instructed state agencies to incorporate 15 percent cuts for the remainder of the current budget biennium. While Washington state has a comparatively generous Medicaid program, it also has many options to cut its Medicaid costs, including implementing provider cuts, freezing inflation increases, or not allowing rebasing of payments. Washington's Medicaid program also provides eligibility for individuals whose income exceeds the federal poverty level and could easily reduce eligibility thresholds down to just the minimum required levels, thereby reducing the number of Medicaid eligible beneficiaries.

For the Colville Tribes' Omak JV project, any reduction in the number of Medicaid eligible patients or services will affect the Tribes' revenue forecasts and its ability to service debt for the construction of the clinic. This is coupled with the COVID–19 related decreases in third party revenue in the Indian health system generally, which Director Weahkee testified at the June 11, 2020, House Subcommittee on Interior and Related Agencies oversight hearing to be a 30–80 percent reduction for IHS-operated facilities. We understand that other JV project awardees, specifically those in Alaska, are facing similar challenges to the viability of their construction plans.

III. Include Funding for the Eligible JV Project Finalists as Part of any Infrastructure Bill the Senate may Consider

The Colville Tribes requests that the Committee support including funding for the eligible JV projects in any infrastructure legislation that it may consider on its own or negotiate with the House. Because the JV program has a highly competitive and rigorous application process, the most recent awardees represent the best evidence of true health facility needs in all of Indian country.

Also, unlike some projects on the legacy IHS Priority Construction list, the JV projects are truly "shovel ready" in that the IHS weighed construction planning

heavily in the final selection process and successful applicants were required to provide comprehensive construction details in their applications. The Colville Tribes will be able to break ground as soon as the IHS approves our construction plans.

Most significantly, there is no more important investment in infrastructure for Indian country than health care facilities when considering the myriad of health problems that affect Native Americans on a disproportionate basis. To the extent the Committee can recommend investments in Indian country in any infrastructure package that the Senate assembles or negotiates, we encourage you to include funding to construct the JV program awardees.

PREPARED STATEMENT OF THE ROBERT WOOD JOHNSON FOUNDATION (RWJF)

The Robert Wood Johnson Foundation (RWJF) is the nation's largest philanthropy dedicated to improving health and health care in the United States. Since 1972, we have worked with public and private-sector partners to advance the science of disease prevention and health promotion; train the next generation of health leaders; and support the development and implementation of policies and programs to foster better health across the country, including high-quality health care coverage for all. RWJF is working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity to live the healthiest life possible.

On May 28, 2020, RWJF issued these Health Equity Principles for State and Local Leaders in *Responding to, Reopening, and Recovering from COVID–19:*

COVID–19 has unleashed a dual threat to health equity in the United States: a pandemic that has sickened millions and killed tens of thousands and counting, and an economic downturn that has resulted in tens of millions of people losing jobs-the highest numbers since the Great Depression. The COVID pandemic underscores that:

- Our health is inextricably linked to that of our neighbors, family members, child- and adult-care providers, co-workers, school teachers, delivery service people, grocery store clerks, factory workers, and first responders, among others;
- Our current health care, public health, and economic systems do not adequately or equitably protect our well-being as a nation; and
- Every community is experiencing harm, though certain groups are suffering disproportionately, including people of color, workers with low incomes, and people living in places that were already struggling financially before the economic downturn.

For communities and their residents to recover fully and fairly, state and local leaders should consider the following health equity principles in designing and implementing their responses. These principles are not a detailed public health guide for responding to the pandemic or reopening the economy, but rather a compass that continually points leaders toward an equitable and lasting recovery.

1. Collect, analyze, and report data disaggregated by age, race, ethnicity, gender, disability, neighborhood, and other sociodemographic characteristics.

- Pandemics and economic recessions exacerbate disparities that ultimately hurt us all. Therefore, state and local leaders cannot design equitable response and recovery strategies without monitoring COVID's impacts among socially and economically marginalized groups.1 Data disaggregation should follow best practices and extend not only to public health data on COVID cases, hospitalizations, and fatalities, but also to: measures of access to testing, treatment, personal protective equipment (PPE), and safe places to isolate when sick; receipt of social and economic supports; and the downstream consequences of COVID on well-being, ranging from housing instability to food insecurity. Geographic identifiers would allow leaders and the public to understand the interplay between place and social factors, as counties with large black populations account for more than half of all COVID deaths, and rural communities and post-industrial cities generally fare worse in economic downturns. Legal mandates for data disaggregation are proliferating, but 11 states are still not reporting COVID deaths by race; 16 are not reporting by gender; and 26 are not reporting based on congregate living status (e.g., nursing homes, jails). Only three are reporting testing data by race and ethnicity. While states and cities can do more, the federal government should also support data disaggregation through funding and national standards.

2. Include in decisionmaking the people most affected by health and economic challenges, and benchmark progress based on their outcomes.

- Our communities are stronger, more stable, and more prosperous when every person, including the most disadvantaged residents, is healthy and financially secure. Throughout the response and recovery, state and local leaders should ask: Are we making sure that people facing the greatest risks have access to PPE, testing and treatment, stable housing, and a way to support their families? And, are we creating ways for residents-particularly those hardest hit-to meaningfully participate in and shape the government's recovery strategy?

  Accordingly, policymakers should create space for leaders from these communities to be at decisionmaking tables and should regularly consult with community-based organizations that can identify barriers to accessing health and social services, lift up grassroots solutions, and disseminate public health guidance in culturally and linguistically appropriate ways.

  People of color (African-Americans, Latinos, Asian Americans, American Indians, Alaska Natives, and Native Hawaiians and other Pacific Islanders), women, people living in congregate settings such as nursing homes and jails, people with physical and intellectual disabilities, LGBTQ people, immigrants, and people with limited English proficiency.

  For example, they could recommend trusted, accessible locations for new testing sites and advise on how to diversify the pool of contact tracers, who will be crucial to tamping down the spread of infection in reopened communities. They could also collaborate with government leaders to ensure that all people who are infected with coronavirus (or exposed to someone infected) have a safe, secure, and acceptable place to isolate or quarantine for 14 days. Key partners could include community health centers, small business associations, community organizing groups, and workers' rights organizations, among others. Ultimately, state and local leaders should measure the success of their response based not only on total death counts and aggregate economic impacts but also on the health and social outcomes of the most marginalized.

3. Establish and empower teams dedicated to promoting racial equity in response and recovery efforts.

- Race or ethnicity should not determine anyone's opportunity for good health or social well-being, but, as COVID has shown, we are far from this goal. People of color are more likely to be front-line workers, to live in dense or overcrowded housing, to lack health insurance, and to experience chronic diseases linked to unhealthy environments and structural racism. Therefore, state and local leaders should empower dedicated teams to address COVID-related racial disparities, as several leaders, Republican and Democrat, have already done. To be effective, these entities should: include leaders of color from community, corporate, academic, and philanthropic sectors; be integrated as key members of the broader public health and economic recovery efforts; and be accountable to the public. These teams should foster collaboration between state, local, and tribal governments to assist Native communities; anticipate and mitigate negative consequences of current response strategies, such as bias in enforcement of public health guidelines; address racial discrimination within the health care system; and ensure access to tailored mental health services for people of color and immigrants who are experiencing added trauma, stigma, and fear. Ultimately, resources matter. State and local leaders must ensure that critical health and social supports are distributed fairly, proportionate to need, and free of undue restrictions to meet the needs of all groups, including black, Latino, Asian, and Indigenous communities.

4. Proactively identify and address existing policy gaps while advocating for further federal support.

- The Congressional response to COVID has been historic in its scope and speed, but significant gaps remain. Additional federal resources are needed for a broad range of health and social services, along with fiscal relief for states and communities facing historically large budget deficits due to COVID. Despite these challenges, state and local leaders must still find ways to take targeted policy actions. The following questions can help guide their response.

  Who is left out? Inclusion of all populations will strengthen the public health response and lessen the pandemic's economic fallout for all of society, but federal actions to date have not included all who have been severely harmed by the pandemic. As a result, many states and communities have sought to fill

gaps in eviction protections and paid sick and caregiving leave. Others are extending support to undocumented immigrants and mixed-status families through public-private partnerships, faith-based charities, and community-led mutual aid systems. Vital health care providers, including safety net hospitals and Indian Health Service facilities, have also been disadvantaged and need targeted support.

Will protections last long enough? Many programs, such as expanded Medicaid funding, are tied to the federal declaration of a public health emergency, which will likely end before the economic crisis does. Other policies, like enhanced unemployment insurance and mortgage relief, are set to expire on arbitrary dates. And still others, such as stimulus checks, were one-time payments. Instead, policy extensions should be tied to the extent of COVID infection in a state or community (or its anticipated spread) and/or to broader economic measures such as unemployment. This is particularly important as communities will likely experience re-openings and closings over the next six to 12 months as COVID re-emerges.

Have programs that meet urgent needs been fully and fairly implemented? All existing federal resources should be used in a time of great need. For example, additional states should adopt provisions that would allow families with school-age children to receive added Supplemental Nutrition Assistance Program (SNAP) benefits, and more communities need innovative solutions to provide meals to young children who relied on schools or child care providers for breakfast and lunch. States should also revise eligibility, enrollment, and recertification processes that deter Medicaid use by children, pregnant women, and lawfully residing immigrants.

5. Invest in strengthening public health, health care, and social infrastructure to foster resilience.

- Health, public health, and social infrastructure are critical for recovery and for our survival of the next pandemic, severe weather event, or economic downturn. A comprehensive public health system is the first line of defense for rural, tribal, and urban communities. While a sizable federal reinvestment in public health is needed, states and communities must also reverse steady cuts to the public health workforce and laboratory and data systems. Everyone in this country should have paid sick and family leave to care for themselves and loved ones; comprehensive health insurance to ensure access to care when sick and to protect against medical debt; and jobs and social supports that enable families to meet their basic needs and invest in the future. As millions are projected to lose employer-sponsored health insurance, Medicaid expansion becomes increasingly vital for its proven ability to boost health, reduce disparities, and provide a strong return on investment. In the longer term, policies such as earned income tax credits and wage increases for low-wage workers can help secure economic opportunity and health for all. Finally, states and communities should invest in affordable, accessible high-speed Internet, which is crucial to ensuring that everyone-not just the most privileged among us-is informed, connected to schools and jobs, and engaged civically.

Conclusion

These principles can guide our nation toward an equitable response and recovery and help sow the seeds of long-term, transformative change. States and cities have begun imagining and, in some cases, advancing toward this vision, putting a down payment on a fair and just future in which health equity is a reality. Returning to the ways things were is not an option.

NATIONAL COUNCIL OF URBAN INDIAN HEALTH

July 17, 2020

The Honorable Mitch McConnell,
Majority Leader;
The Honorable Charles Schumer,
Minority Leader,
United States Senate,
Washington, DC.

Dear Leader McConnell and Leader Schumer:

On behalf of the National Council of Urban Indian Health (NCUIH), which represents 41 urban Indian organizations (UIOs) and the American Indian and Alaska Native (AI/AN) populations they serve, we write to express our gratitude for your

tireless efforts in protecting our Nation during this pandemic. We appreciate your commitment to ensuring urban Indians have access to the critical health care they need by including UIOs in the COVID–19 emergency response packages.

In continuation of this commitment, NCUIH is asking you to include necessary supplemental funding as well as critical legislative fixes for UIOs in the next Coronavirus legislative package to ensure UIOs can protect their urban Indian communities.

- IHS—Urban Indian Health—$64 million (in HEROES Act)
- Medicaid—Extension of the Full (100 percent) Federal Medical Assistance Percentage (FMAP) to UIOs Permanently (H.R. 2316/S. 1180) (in HEROES Act)
- Health Care Access for Urban Native Veterans Act (H.R. 4153/S. 2365) (in HEROES Act)
- Parity in Medical Malpractice Liability for UIOs (H.R. 6535/S. 3650)
- IHS—Urban Facilities Line Item—$80 million and Amend Facilities Renovation to Remove Unnecessary Limitations on Accreditations so UIOs can make COVID–19 Renovations (25 U.S.C. 1659)
- IHS—UIO Behavioral Health—$7.3 million for 3 years
- IHS—UIO Health Information Technology—$20 million
- Confer Policy for HHS with UIOs
- Inclusion of UIOs in Advisory Committees with Focus on Indian Health

These requests are essential to ensuring urban Indians are properly cared for, both during this crisis and in the critical times following. Thank you for your continued partnership. Communications on this matter may be directed to Meredith Raimondi, Director of Congressional Relations for NCUIH.

Sincerely,

FRANCYS CREVIER, *Executive Director* *

May 21, 2020

Hon. Charles E. Schumer,
Senate Democratic Leader,
U.S. Senate,
Washington, DC;

Hon. Frank Pallone,
Chairman,
House Committee on Energy & Commerce,
U.S. House of Representatives,
Washington, DC;

Hon. Tom Udall,
Vice Chairman,
Senate Committee on Indian Affairs,
Washington, DC.

RE: INCLUDING NATIVE HAWAIIAN HEALTH CARE SYSTEMS IN PARALLEL URBAN INDIAN HEALTH ORGANIZATION MEASURES

Dear Leader Schumer, Chairman Udall, and Chairman Pallone:

Mahalo (thank you) for your leadership during the Novel Coronavirus Disease (COVID–19) pandemic to ensure that Americans from all walks of life survive these challenging times. We are a group of Native Hawaiian organizations that provide health, educational, cultural, community development, and other services to the Native Hawaiian community. On behalf of our organizations and the community we serve, we request parity for Papa Ola Lokahi (POL) and the Native Hawaiian Health Care Systems (NHHCS) with the urban Indian health organizations in the upcoming COVID–19 response package(s).

In the interest of parity, we request that you include POL and the NHHCS in any relief provision that benefits urban Indian health organizations. Specifically, we support including these five provisions—similarly requested by a consortium of tribal organizations—in the next package:

1. Extend full Federal Medical Assistance Percentage coverage for Native Hawaiians receiving care at the NHHCS;

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*Francys Crevier's Interior Appropriations Subcommittee Testimony on June 11, 2020 has been retained in the Committee files.

2. Classify NHHCS and its employees as part of the Public Health Service under the Federal Tort Claims Act;
3. Provide reimbursements for primary health care services to Native Hawaiians during this and any future health crisis;
4. Reimburse the NHHCS for health services provided to Native Hawaiian veterans otherwise eligible for treatment at a Veterans Health Administration facility and exempt Native Hawaiian veterans from any cost sharing requirements; and
5. Clarify that the NHHCS could receive reimbursement for services provided outside a physical clinic.

This pandemic threatens the continued success and survival of the NHHCS, and these provisions will address the most urgent needs facing the NHHCS. The above five Native Hawaiian Health Care Improvement Act amendments would most efficiently address these needs and provide parity in carrying out the federal government's trust responsibility to Native Hawaiians. If parallel urban Indian health organization measures are not yet included in this response package, we also request your consideration to include those provisions as well.

Mahalo again for your leadership during this difficult time in our nation. We understand that the pandemic has negatively affected the health and economic well-being of native communities across the nation, and the Native Hawaiian community is no different. We are confident that you will ensure the Native Hawaiian community does not face greater health disparities as a result of this pandemic by providing parity for the Native Hawaiian Health Care Systems with the urban Indian health organizations.

Attachments:

(1) Native Hawaiian Health Care Improvement Act amendment language to address the five provisions mentioned above;

(2) Senator Schatz's Native Hawaiian Health Care Improvement Act language summary and background information; and

(3) April 15, 2020 Letter from American Indian and Alaska Native organizations. *

U.S Senate,

1,070 people have signed a petition on Action Network telling you to Petition to Provide Adequate Support for Indian Country in Phase IV Stimulus Package: a Citizen-Led Initiative.

Here is the petition they signed:

MAY 21, 2020

Dear U.S. Senators,

Petition to Provide Adequate Support for Indian Country in Phase IV Stimulus Package: a Citizen-Led Initiative The COVID–19 pandemic is highlighting the disparities this country has endured for centuries. Indian Country has always endured the greatest burden after disastrous events, but we always emerge stronger. As of May 18, there have been 5,626 confirmed cases of COVID–19 in the Indian Health System and 174 total deaths. Right now, tribal citizens from across the continent are disproportionately feeling the pandemic's impacts: they have lost jobs and health care, resources are stretched thin, youth cannot attend school, broadband Internet access is disproportionately lacking, and so many elders are in need of food and financial support.

We will not accept being an afterthought in federal relief efforts made in this country-the country where Native people have been for centuries.

And yet, an afterthought is exactly how we have been treated throughout this crisis. Indian Country has been undersupported by federal relief efforts. Tribes and tribal entities received $8 billion in the Phase III stimulus package, but this support fell far short of the $20 billion for which the National Congress of American Indians initially advocated to cover the true needs of Indian Country. Moreover, the current administration was extremely slow getting the funds out the door, delaying the resources meant for Native communities. Now the HEROES Act recently passed by the U.S. House of Representatives includes $20 billion more for Tribal governments—urgently needed forward progress. We ask the Senate to maintain this level of funding in any Phase IV stimulus package. These funds will be used to feed tribal citizens, aid health care work, and jump start our economic recovery plan. Tribal nations and communities contribute not just to their enrolled members, but to peo-

* The attachments have been retained in the Committee files.

ple from other tribes and to non-Native people, too. Our contributions should be recognized, and our people should be acknowledged and adequately supported!

We must ensure Indian Country is accounted for in the Phase IV stimulus package. Specifically the Senate must do the following:

Maintain the appropriations for tribal governments and entities in the HEROES Act of $20 billion, consistent with the needs of Indian Country. In addition, require that the administration get the funds out the door in a timely manner, so they are not held up in the same way that the CARES Act funding was.

Provide tribal set-asides from the Federal Reserve, the U.S. Treasury, and other department lending, guarantees, and forbearance programs to ensure that Tribal governments and entities can access these programs without burdensome restrictions.

As citizens of our respective Tribal Nations and the United States, we will continue to hold our representatives accountable for including us in the ongoing efforts to fight and survive this pandemic. The lives of millions of our people are on the line. We look forward to the day this has passed and to the new lessons that emerge from it.

Sincerely,

ISABEL CORONADO, TRIBAL AFFILIATION: MUSCOGEE (CREEK) NATION
OWEN L. OLIVER, TRIBAL AFFILIATION: QUINAULT/ISLETA PUEBLO
CHRISTIE J. WILDCAT, TRIBAL AFFILIATION: NORTHERN ARAPAHO/EUCHEE/NAVAJO/CHEROKEE
JAZMINE B. WILDCAT, TRIBAL AFFILIATION: NORTHERN ARAPAHO/EUCHEE/NAVAJO/CHEROKEE
MIKAH CARLOS, TRIBAL AFFILIATION: SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY
ADAM J. SOULOR, TRIBAL AFFILIATION: MOHEGAN TRIBE
SAM SCHIMMEL, TRIBAL AFFILIATION: ST. LAWRENCE ISLAND SIBERIAN YUPIK/KENAITZE INDIAN

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO ROBERT J. FENTON, JR.

Question 1. You testified that FEMA's role in the pandemic response changed on March 19, 2020 when the agency moved from playing a supporting role in assisting the U.S. Department of Health and Human Services (HHS), which was designated as the initial lead agency for COVID–19 pandemic response, to leading the "Whole-of-Government response" to the COVID–19 pandemic. This new role includes managing shortages and distributing medical supplies across agencies like the Indian Health Service (IHS) and to Tribal governments directly. But FEMA's "Whole-of-Government response" has led to confusion on payment of cost-shares associated with the medical supplies being provided to other federal agencies and Tribal governments. For instance, Tribal governments report that it is unclear whether the 25 percent non-federal cost-share under Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) emergency disaster assistance grants applies to medical supplies. Please answer for the record the following questions on FEMA's "Whole-of-government" response. Does the 25 percent non-federal cost-share under the Stafford Act apply to the procurement and distribution of medical supplies to Tribal governments?

Answer. Eligible emergency protective measures taken at the direction or guidance of public health officials, and not provided or funded by the authorities of another federal agency, may be reimbursed under the Federal Emergency Management Agency (FEMA) Public Assistance (PA) program. Reimbursable activities for the COVID–19 pandemic fall under Category B of the FEMA PA program-Emergency Protective Measures.

Summary of COVID–19 Emergency Protective Measures

Medical Care

- Emergency and inpatient clinical care
- Purchase, lease and delivery of specialized medical equipment
- Purchase and delivery of Personal Protective Equipment (PPE), durable medical equipment and consumable medical supplies
- Medical waste disposal
- Certain labor costs associated with medical staff

Temporary Medical Facilities

- Leasing, purchasing, constructing, mobilizing, operating, and maintaining temporary and expanded medical facilities

Non-Congregate Sheltering to Isolate or Quarantine Populations Such as:

- Those who test positive for or have been exposed to COVID–19 and do not require hospitalization but need isolation (including those exiting from hospitals)
- Healthcare workers and first responders who require isolation

Provision and Distribution of Food

- Purchasing, packaging, and/or preparing food
- Delivering food to distribution points and/or individuals
- Leasing distribution and storage space, vehicles, and necessary equipment

Other Measures to Reduce Immediate Threats to Life, Property, and Public Health and Safety

- Operating state or tribal Emergency Operations Centers related to COVID–19 responses
- Disseminating public health and safety information
- Technical assistance and training to state and local governments on disaster management and control

The amount of non-federal cost share applied to Stafford Act assistance for COVID–19 declarations depends on the type and timing of the request. Tribal recipients may request reimbursement for emergency protective measures. Additionally, tribes that do not have the resources to procure their own equipment, supplies, or services may request Direct Federal Assistance (DFA). DFA is applicable when FEMA purchases goods and services directly and provides them to state, territories or tribes, or directs another federal agency through a mission assignment to directly provide these goods or services directly to a state, territory, or tribe. Both of these request types—reimbursement and DFA—are subject to a 25 percent non-federal cost share.

However, for COVID–19 related declarations, FEMA and the U.S. Department of Health and Human Services (HHS) signed a reimbursable agreement for certain medical supplies. DFA requests for these supplies made within the April 14—June 13, 2020 time period will be paid in full by HHS (i.e., without a non-federal cost share) when the $1.383 billion national cap has not been reached. Eligible requests under this agreement include, but are not limited to, PPE, hygiene and infection control products, portable mechanical ventilators and testing supplies, including the transport, storage and tracking of these items.

For requests that fall outside the FEMA/HHS reimbursable agreement, a tribal recipient would be subject to the 25 percent non-federal cost share. Tribal subrecipients would be subject to the portion of the 25 percent non-federal cost share that state recipient chooses to pass on to its subrecipients. Some State recipients choose to cover some or all of the non-federal cost share for their subrecipients.

During COVID–19-related declarations, tribes may use federal funding from the U.S. Department of the Treasury's CARES Act Coronavirus Relief Fund or the U.S. Department of Housing and Urban Development's Community Disaster Block Grant and Indian Community Development Block Grant programs to meet the non-federal cost share required for Public Assistance.

Question 2. Are there any circumstances in which a Tribal government must reimburse FEMA for medical supplies?

Answer. Tribal recipients are required to reimburse FEMA for the non-federal cost share of DFA requests. When DFA requests meet the eligibility requirements as described above under the FEMA/HHS reimbursable agreement, tribes will not be asked to reimburse FEMA or HHS.

Additionally, tribes could be required to reimburse FEMA if benefits have been duplicated by another federal agency. Section 312 of the Stafford Act prohibits all federal agencies from duplicating benefits for disaster relief. Multiple agencies having authority to expend funds for the same purpose is not, by itself, a duplication of benefits under Section 312. However, all federal agencies are prohibited by Section 312 from paying state, local, tribal and territorial governments for the same work twice. FEMA is coordinating closely with other federal agencies to provide information about the eligible use of various COVID–19 funding resources. Recipients and subrecipients are ultimately responsible for ensuring that they do not accept

payment for the same item of work twice. FEMA applicants will certify in the PA application process that assistance is not being duplicated.

If a tribal government received duplicative assistance for medical supplies—e.g., it requested reimbursement for medical supplies it received from another source and/or it accepted funding from two sources for the same medical supplies, FEMA may deobligate funding to avoid a duplication of benefits.

Question 3. How is the procurement and distribution of medical supplies to agencies like IHS budgeted and accounted for, e.g., are these expenses FEMA or IHS budget line-items?

Answer. Procurement and Distribution of PPE to agencies like Indian Health Service (IHS) is through an Inter-Agency Agreement (Form 7600 A&B). These expenses are not FEMA budget line-items.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO ROBERT J. FENTON, JR.

Question 1. In Alaska, so many Native people have grown up hearing stories of devastation from the 1918 flu. This traumatic event looms over the current response efforts at a generational scale. Some communities have still not recovered from the 1918 epidemic. The memory of this almost unfathomable loss, where 82 percent of all deaths in the state were Alaska Natives—this motivates a lot of our tribal health system's response in Alaska.

Alaska Natives face a combination of chronic health conditions, delayed access to care, inadequate housing, and limited water and sanitation services, which all contribute to the alarmingly disproportionate impact epidemics have on Alaska Native communities.

FEMA's role in addressing the public health crisis is critical.

We have heard from Tribal Health Organizations that there is a need for FEMA to preauthorize Category B expenditures (which include all COVID–19 disaster declaration expenses). Currently Tribal Health Organizations have to spend funds and have to wait months for a determination of what might be allowable to be reimbursed. Would FEMA support preauthorizing these expenditures?

Answer. As with most federal grants, FEMA's PA Program already allows the award of subgrants, including for Category B expenditures, prior to the work being started. FEMA refers to these as "Standard" projects. Additionally, unlike many other federal grants, FEMA also allows the award of subgrants for work that was already completed prior to requesting assistance, as long as it is directly related to the response or recovery from the disaster event and would be otherwise eligible under the program, and refers to these as 'work completed' projects. Once awarded, for both types, funds are generally made available within 1–3 days to the Recipient (typically the state, tribal, or territorial emergency management agency), which can then provide the funds to their subrecipients in accordance with their own procedures and the general guidelines of 2 CFR Subpart D (which does allow for the advancement of funds prior to the work being completed). As a result, FEMA already routinely approves funds prior to the work being completed, however it is not uncommon for the Recipient to hold the funds under their own procedures.

In addition to the standard request for assistance, FEMA also allows recipients and subrecipients to make an expedited funding request, referred to as an 'Expedited' project based on limited information. These projects are awarded at half of the expected costs to provide immediate funding, with the remainder of funds being made available during a later reconciliation. These projects can be processed in as little as a few days and are provided as an option specifically for applicants that have an immediate need for funding.

Question 2. We heard that tribes in Region 9 were not able to get access to the FEMA grants portal (and that it took months) but other Regions took only 2–3 days to get tribes access to the grants portal—can you tell me why this process isn't consistent across all FEMA Regions?

Answer. Each FEMA Region has unique geographical differences that can affect the timing of assistance. One such difference is the number of federally-recognized tribes within a Region. During this unprecedented public health emergency, every Region had to work with each tribe and with FEMA headquarters to determine the best path for providing tribes assistance in accordance with the options available to tribes under the Tribal Declarations Pilot Guidance, as well as under the President's March 13, 2020 nationwide emergency declaration for COVID–19.

The backdrop for these discussions was one of record setting disaster declaration and operations activity across every corner of the nation.

Receiving access to FEMA's Grant Portal platform is just one step in a series of administrative and programmatic requirements that tribes must take to receive Public Assistance (PA). Each step in the process may take more or less time depending on the nature of the event, the capacity of the tribe, the activity in the FEMA region and across the Nation, and the choices the tribe makes on how to request assistance.

Tribal governments typically have three options for FEMA's PA program under a major disaster or emergency declaration; as a subrecipient under a state, as a recipient under a state, or as a direct recipient. Under the President's March 13, 2020 nationwide emergency declaration for COVID–19, a tribal government could choose to receive FEMA PA under the nationwide emergency declaration without submitting a declaration request.

In Region IX, all 48 tribal governments elected to be recipients under a state. When a tribal government requests to be a recipient under a state, each request must be processed manually and for new recipients this can take 2–3 days to process. Once the FEMA-Tribe Agreement has been signed, the regional office submits a request to the Grants Portal administrator at FEMA HQ to create a new recipient profile under the state's declaration number. The Grants Portal administrator must then create a change request with the Grants Portal developer to duplicate the state declaration number for the tribal government.

Question 3. We heard there was confusion on processing resource requests from tribal clinics and IHS facilities and that some of requests were delayed due to this confusion—what is IHS and FEMA doing to avoid this issue in the future?

Answer. Resource requests from IHS or tribal clinics were screened by an IHS representative to ensure sourcing and distribution were aligned properly. FEMA has added IHS in its customer profiles as a drop-down section (instead of a manual write-in) in the Web Emergency Operation Center software. (screen shot has been retained in the Committee files).

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO HON. REAR ADMIRAL MICHAEL D. WEAHKEE

Question 1. On May 27, 2020, I sent you a letter requesting additional information concerning reports that private company had provided IHS with substandard personal protective equipment (PPE) under a $3 million federal procurement contract. [1] On June 30, 2020, you sent a letter in response to my May 27 letter that did not answer the questions I posed. [2] You committed to answering these questions at the hearing. Please answer for the record, under what circumstances did IHS become aware of and enter into the contract referenced in my May 27 letter? What safeguards did IHS deploy to ensure that this new contractor was qualified and able to meet the terms of the contract?

Answer. In early April, IHS was conducting market research into a variety of sources of PPE. An IHS contract physician was contacted by a third party regarding a possible source of N95 or KN95 masks. The contract physician forwarded the information to several individuals in IHS, who then forwarded the information to the IHS contracting team. This market research was conducted in accordance with Part 10 of the Federal Acquisition Regulation. Notwithstanding, this matter has been reported to the Department of Health and Human Services (HHS), Office of Inspector General (OIG). No payment has been made to Zach Fuentes LLC, and depending on the outcome of the OIG investigation, additional administrative actions may be warranted

Question 1a. Did IHS verify the KN95 masks supplied by this contractor met all Food and Drug Administration standards?

Answer. The question of whether the KN95 masks supplied by the contractor met all Food and Drug Administration standards has been raised and referred to the HHS, OIG for an investigation.

The IHS supply centers utilize quality assurance coordinators to: work with subject matter experts to determine requirements; verify that products involved in procurement meet technical and/or clinical specifications; approve products moving forward for procurement; inspect products upon receipt for worthiness and effective-

[1] Letter from Sen. Tom Udall, Vice Chairman, S. Comm. on Indian Affairs, to Michael Weahkee, Director, Indian Health Service, Dep't of Health and Human Services (May 27, 2020) (letter on file with S. Comm. on Indian Affairs).

[2] Letter from Michael Weahkee, Director, Indian Health Service, Dep't of Health and Human Services, to Sen. Tom Udall, Vice Chairman, S. Comm. on Indian Affairs (June. 30, 2020) (letter on file with S. Comm. on Indian Affairs).

ness; and develop processes for routine evaluation and quality control. Each IHS supply center is responsible for ensuring quality assurance processes are in place as intended to ensure patient safety.

IHS contracting personnel ensure technical reviews are conducted for each proposed product, as presented by the contractor, prior to award. After IHS technical evaluations and the contracting personnel documents determination of fair and reasonableness, the contract/order is issued. Upon IHS receiving the products, inspections occur and if a discrepancy or defect is found then the subject matter experts will conduct a quality review and present findings to the contracting personnel. The contracting personnel will then notify the contractor of discrepancy or defect and will request the contractor to correct. If the contractor cannot correct, then the entire order will be cancelled in its entirety.

Question 1b. What measures did IHS take to ensure PPE provided under this contract was not faulty before distribution and use?

Answer. The personal protective equipment (PPE) (KN95 masks) provided under this contract were not distributed or used.

Question 1c. What portion of the masks sent to IHS under this contract has the IHS distributed to date? Has IHS recalled those masks or determined if any masks resulted in the potential exposure of IHS or Tribal medical personnel?

Answer. None of the masks delivered under the contract have been distributed or used, therefore no recall was necessary.

Question 1d. What protocols are in place to guard against IHS procuring substandard PPE? How does IHS generally prevent against substandard PPE from entering the field?

Answer. The IHS supply centers utilize quality assurance coordinators to: work with subject matter experts to determine requirements; verify that products involved in procurement meet technical and/or clinical specifications; approve products moving forward for procurement; inspect products upon receipt for worthiness and effectiveness; and develop processes for routine evaluation and quality control. Each IHS supply center is responsible for ensuring quality assurance processes are in place as intended to ensure patient safety.

IHS contracting personnel ensure technical reviews are conducted for each proposed product, as presented by the contractor, prior to award. After IHS technical evaluations and the contracting personnel documents determination of fair and reasonableness, the contract/order is issued. Upon IHS receiving the products, inspections occur and if a discrepancy or defect is found then the subject matter experts will conduct a quality review and present findings to the contracting personnel. The contracting personnel will then notify the contractor of discrepancy or defect and will request the contractor to correct. If the contractor cannot correct, then the entire order will be cancelled in its entirety.

Question 1e. How will IHS ensure that the Navajo Service Area has sufficient PPE to replace the unsuitable masks? What is IHS headquarters doing more generally to meet current PPE demand with sufficient and quality supplies?

Answer. The IHS is actively engaged in finalizing an Interagency Agreement (IAA) with the Assistant Secretary for Preparedness and Response (ASPR) to provide assisted acquisition support for the acquisition of supplies, including but not limited to, PPE, hygiene and infection control products, portable mechanical ventilators, testing supplies, nasopharyngeal Swabs/UTM and pharmaceutical drugs. IHS is also part of the HHS Testing At Scale Workgroup which includes representatives from multiple HHS agencies and programs. HHS Office of the Assistant Secretary for Health currently provides IHS with Abbott ID Now Analyzers, test kits, QC kits, nasal swabs, nasopharyngeal swabs, and transport media.

Question 2. In your June 30 letter regarding the substandard PPE procurement issue referenced in question one, you stated, "the contractor refused [to enter into a no-cost termination of the contract] and submitted a certified claim for payment." What steps will the Service take in response to the contractor's request for payment? Please specifically confirm whether or not IHS will issue payment to the contractor.

Answer. Due to questions concerning the contractor's misrepresentation of fact in contract formation, a referral was made to the HHS Office of Inspector General. In the meantime, the contractor has not and will not be paid for items that did not meet the contract requirements. Depending on the outcome of the OIG investigation, additional administrative actions may be warranted.

Question 3. During a briefing with my Committee staff on March 18, 2020, IHS personnel indicated that the Service was not certain how many intensive care unit (ICU) beds, negative pressure rooms, or ventilators exist within the network of IHS

federally-operated, Tribally-operated, and urban Indian organization operated facilities (i.e., ITU system). This uncertainty raises questions about IHS's preparedness to respond to public health emergencies, especially outbreaks of infectious respiratory diseases. How many ICU beds, negative pressure rooms, and ventilators did the ITU system have prior to the President's declaration of a national emergency concerning COVID–19 on March 13, 2020?

Answer. The IHS has the ability to report on various metrics within the IHS, Tribal, and UIO (I/T/U) community including the number of intensive care unit (ICU) beds, negative pressure rooms, and ventilators that exist within the network of the IHS system. IHS can currently only report on the sites that send data to the centralized data store, so data may be incomplete.

IHS began collecting daily data from IHS direct facilities, manually, on March 11, 2020, prior to the President's declaration of a national emergency concerning COVID–19 on March 13, 2020. The table below reflects additional data collected from Tribal and Urban facilities on March 18, 2020. IHS can provide the information collected by I/T/U operated facilities that submit data to our centralized data store on the number of ICU beds, negative pressure rooms, and ventilators. IHS did not experience ICU/Negative pressure room capacity issues early on in the pandemic. As most hospitals have limited capabilities for severely ill patients, many were referred to outside facilities which could provide higher levels of care for critically ill patients.

I/T/U Hospital Data for March 18, 2020

I/T/U	ICU Beds	Negative Pressure rooms	# of Ventilators/Available Ventilators	Hospital Beds
Federal (I)	27	102	70/58	482
Tribal (T)	6	15	9/9	772
Urban (U)	0	0	0	0

Question 3a. How many ICU beds, negative pressure rooms, ventilators, and temporary hospital beds did IHS facilities (federally-operated, Tribally-operated, and urban Indian organization operated) have as of the date of this hearing?

Answer. IHS is able to track and report on various metrics around ICU beds, negative pressure rooms, ventilators and hospital beds at I/T/U operated facilities. IHS began collecting data, manually, on March 11, 2020 and enabled data collection via a web based application on or about April 14, 2020. Although tools were developed to streamline data collection, the reporting, data accuracy, completeness, and integrity is contingent upon each I/T/U site. Although IHS, to date, has over 789 I/T/U sites/facilities reporting, only a subset provide data on the aforementioned metrics and the accuracy of the data is contingent upon the site entering the data into the IHS web portal.

I/T/U Hospital Data for July 1, 2020

I/T/U	ICU Beds	Negative Pressure rooms	# of Ventilators/Available Ventilators	Hospital Beds
Federal (I)	27	123	123/122	603
Tribal (T)	28	48	123/112	533
Urban (U)	0	0	0	0

Note: this data reflects the manual information reported pending validation at the individual site level. Most of the change in the tribal ICU bed data and ventilator counts reported over time in this period reflects the vast improvement over time in reporting from tribal sites. The change in federal data between March 18 and July 1 is due to the increased number of negative pressure rooms, ventilators, and hospital beds at individual facilities. Individual facilities increased the available hospital beds by staffing previously unstaffed beds and creating temporary beds.

Question 3b. Prior to the declaration of the COVID–19 national emergency on March 13, 2020, what steps did IHS take to prepare for potential public health emergencies, including pandemics?

Answer. In January and February 2020, the IHS Chief Medical Officer sent reports and information regarding the novel Coronavirus infection (2019-nCoV) to IHS Areas, facilities, and providers. This information was provided to advise and prepare health care facilities for the potential impact to patients and the delivery of care in Indian Country.

On March 6, 2020, RADM Weahkee activated the IHS Incident Command Structure (ICS). The ICS was activated to mitigate negative impacts of COVID–19 outbreak responses on IHS operations. The IHS senior leadership used resources available from the Federal Emergency Management Agency for development of the IHS ICS. Shortly after activating the ICS, the IHS finalized the COVID–19 Concept of Operations that guides clinical and administrative actions from headquarters.

Prior to the COVID–19 national emergency, IHS had previously developed a Provider Influenza Resources webpage that included several documents developed for 2009 H1N1 and included a Resource Guide for American Indian and Alaska Native Governments. See the following websites: *https://www.ihs.gov/flu/resources/providerinfluenza/* and *https://www.cdc.gov/h1n1flu/statelocal/DTLL__H1N1__Guide__10-7-09.pdf.* IHS also utilized the Office of the Assistant Secretary for Preparedness and Response 2017 Update to the HHS Pandemic Influenza Plan, available at *https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf.* In addition, IHS created the IHS Headquarters Continuity of Operations Special General Memorandum (SGM No. 16–01) for the implementation and sustainment of responsibilities, as well as the headquarters' office building Occupant Emergency Plan: Evacuation and Shelter-in-Place Procedures.

Question 4. During a recent hearing before the House Subcommittee on the Interior, Environment, and Related Agencies, [3] you indicated the ITU system has experienced an estimated third-party revenue loss of 30 to 80 percent due to the COVID–19 pandemic. You stated:

"It will likely take several years to make up for the loss of third-party revenue collected previously . The initial allocation that we received [from the CARES Act Provider Relief Funds]—the $500 million that went out from HHS to all of our federal, Tribal, and urban sites—did help to offset some of those costs. But, we still have many sites concerned about needing to furlough or even close their doors."

Is IHS aware of any ITU facilities that have closed, reduced operations, furloughed staff, reduced staff, or reduced services as a result of third-party revenue losses caused by the COVID–19 pandemic? If so please provide the number and service area location of the facilities that have experienced these impacts.

Answer. IHS is aware of tribal and urban programs that have had to reduce operations, furlough staff, and reduce staff and services due to the impact of the COVID–19 pandemic. In addition to a nation-wide reduction in non-essential surgeries, and in inpatient and outpatient visits, almost all I/T/U facilities have reduced services for Dental and Optometry to emergency only. However, a variety of factors have gone into the decisions to implement short-term and long-term workforce and operation reductions and other cost saving strategies due to the economic and operational impacts of the COVID–19 emergency. For example, a temporary furlough may be required due to a temporary lack of revenue, risk reduction, an increase in costs for PPE, telehealth, and staff pay, or reduction in work due to reduced patient visits during the COVID–19 emergency.

Question 4a. What steps has IHS taken to ensure the ITU system can participate equitably within the CARES Act Provider Relief Fund allocation structures set up by HHS?

Answer. The IHS provided technical assistance, data, and other support to HHS and operating divisions such as the Health Resources and Services Administration in determining the allocation of $500 million for I/T/U programs from the Provider Relief Fund. Full details of the allocation are available here.

Question 4b. How much money would Congress need to provide for IHS to fully address the third-party revenue shortfalls experienced by the ITU system as a result of the COVID–19 pandemic?

Answer. It is difficult to say exactly how much funding would be needed to address shortfalls as a result of COVID–19 given Tribes and UIOs' third party revenue reporting requirements. I/T/U programs have anecdotally reported losses ranging

[3] Indian Health Service COVID–19 Response: Hearing before the H. Subcomm. on the Interior, Environment, & Related Agencies, 116th Cong. (2019) (statement of Michael Weahkee, Director, Indian Health Service, Dep't of Health and Human Services).

from 30—80 percent.[4] Like health care facilities across the country, revenues declined as health facilities restricted the provision of routine care to prevent the spread of Coronavirus. For example, some IHS facilities depend on third-party revenue for up to 60 percent of their operating budget to expand health services and pay staff.

Question 5. The CARES Act provided $1.032 billion in additional IHS funding. Of that amount, Congress directed the Service to reserve up to $65 million for electronic health record stabilization and support. Please describe all activities related to electronic health record stabilization and support IHS has undertaken with these funds.

Answer. The IHS will establish a project management office for Electronic Health Record (EHR) modernization, support acquisition planning, and stabilize the current technology environment and IHS electronic health record system, the Resource and Patient Management System (RPMS), in FY 2020. The project management office will focus on governance, acquisition, program planning, Health IT design, and organization change management. The funding is being used for some federal positions and tribal stakeholder and engagement. Additionally, the IHS is also piloting an eHealth Exchange connection to support interoperability with the VA, DOD, Tribes, and other certified health systems in the current and future Health IT infrastructure.

Question 5a. Using its current electronic health record systems, is IHS able to track and report data on hospitalizations or adverse health outcomes for COVID–19 patients in federally-operated IHS facilities or within the ITU system as a whole?

Answer. The EHR provides for applications and utilities for tracking of Hospital Adverse Events (Emergency Department and Hospital Admissions) and population health data at each site. These results are reported to the agency Incident Response team, aggregated and presented in an agency dashboard for continuous monitoring.

The IHS is able to track and report data on hospitalizations or adverse health outcomes for COVID–19 patients in federally operated IHS facilities or within IHS, Tribal, Urban health care systems as a whole. IHS leverages its Business Intelligence framework, which consists of a centralized data store, or National Data Warehouse, that enables the ability to collect, integrate and posture data for data reporting and analytics. To date, IHS has over 789 I/T/U sites/facilities, within 198 service units, across 12 geographical areas are participating in daily data collection and reporting of COVID–19 related metrics.

Question 5b. How do the ITU system's electronic health record systems impact the ability to accurately monitor COVID–19 activity?

Answer. While every effort was made to adapt the IHS EHR to provide adequate direct care capabilities to address COVID–19 for hospitals and clinics, its decentralized design is not well suited for nationwide surveillance and reporting to monitor COVID–19 activity. A standardized EHR graphical user interface template and note titles were created to electronically document COVID–19 patient visits. Training was provided to the critical care teams for this COVID–19 template and the note titles. Specific Document and Note Titles can be searched as part of the EHR Community Alerts due to this standardized approach. Each clinical site must make this update to their local EHR to utilize the COVID–19 template.

Question 6. According to a recent Politico article,[5] the Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) are limiting or denying Tribal epidemiology centers (TECs) access to federal public health databases, including infectious disease surveillance databases. This limitation appears to be in violation of the Indian Health Care Improvement Act (IHCIA), which designates TECs as public health authorities under the *Health Insurance Portability and Accountability Act* Privacy Rule, and specifies that HHS must grant TECs access to "data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary[6]."[7]

How is IHS working with other agencies within HHS to ensure Tribes and Native public health entities have equitable access to federal public health data resources,

[4] For more information specific to UIOs, see the National Council of Urban Indian Health's report "Recent Trends in Third-Party Billing at Urban Indian Organizations" available at *https://www.ncuih.org/reimbursement.*

[5] Darius Tahir & Adam Cancryn, American Indian Tribes Thwarted in Efforts to Get Coronavirus Data, Politico (Jun. 11, 2020), *www.politico.com/news/2020/06/11/native-american-coronavirus-data-314527.*

[6] 25 U.S.C. § 1621m(e)(1).

[7] 25 U.S.C. § 1621m(e)(2).

including disease surveillance data, to combat coronavirus spread within Native communities?

Answer. The IHS has longstanding cooperative agreements used to fund the Tribal Epidemiology Centers (TECs). Since the beginning of the COVID–19 response, the IHS has actively engaged on weekly calls with TECs along with colleagues from the Centers for Disease Control and Prevention (CDC). These calls are coordinated and led by the TECs and include sharing best practices and group problem solving related to national and regional COVID–19 response.

IHS is working with federal agencies, Tribes, and tribal programs to ensure that tribal public health authorities receive the information they need for public health planning and contact tracing. The IHS remains committed to advocacy for such access to data as permitted by law.

IHS has several ongoing coordinating efforts with CDC, including a number of weekly operational coordination calls with CDC at various organizational levels. The CDC is working with TECs to provide access to needed data. CDC participated on an All TECs conference call on June 30, 2020 to discuss the process of transferring and receiving COVID–19 case data for all TECs. Data were transferred to the TECs on July 15, 2020 and will be updated every 2 weeks.

CDC met with the Urban Indian Health Institute (UIHI) on June 18, 2020 to discuss how to transfer and receive the COVID–19 data and followed up on June 23, 2020 to provide technical assistance on connecting via a secure server. CDC sent COVID–19 data to UIHI on June 24, 2020. As with the other TECs, CDC will continue to send the most up-to-date COVID–19 data set to UIHI every two weeks.

Additionally, CDC worked with UIHI on a recent Morbidity and Mortality Weekly Report (MMWR) on COVID–19 among AI/AN in selected states: COVID–19 Among American Indian and Alaska Native Persons—23 States, January 31–July 3, 2020 (available at *https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm?s_cid=mm6934e1_w*). CDC invited all TECs to participate in drafting this MMWR. CDC is engaged with UIHI in other ways as well. For example, they are discussing a second MMWR about COVID–19 among urban Indians with UIHI.

CDC is working to address access to other data and will continue to work with tribal and other involved stakeholders to do so. The IHS will continue to support such data access through partnership with CDC.

Question 7. The IHS and Department of Veterans Affairs (VA) have informed the Committee that they are drafting an inter-agency agreement (IAA) to allow VA to treat non-Veteran IHS patients during public health emergencies. The agencies involved have committed to keeping Congress updated on the negotiations related to this IAA, including how the IAA would address repayment for VA's costs to provide care for uninsured non-veteran IHS patients. What is the current status of the IAA?

Answer. The IHS continues to work with VA to execute an interagency agreement for bed space, healthcare, resources, and staff.

Question 7a. What information about this agreement has IHS provided to Indian Tribes and urban Indian organizations? And, has IHS sought feedback from Indian Tribes or urban Indian organizations regarding the structure of the IAA?

Answer. The IAA is between IHS and VA as Federal agencies. The IHS has notified Indian Tribes and UIOs about the goals and intent of the IAA, but has not actively sought feedback regarding the structure. For example, the IHS has shared the lifesaving benefit of an IAA as demonstrated through the coordination that occurred, when the Gallup Indian Medical Center experienced a critical clinical issue. The facility had four critical COVID–19 patients, all requiring mechanical ventilation for life support. GIMC was unable to find any accepting transfer beds. Without hospital decompression for these critical patients, GIMC would not have been able to accept any subsequent critical patients. The VA came through in this crisis, accepting the patients at the Albuquerque VA Medical Center, allowing for decompression of GIMC, and allowing GIMC to remain available for additional critical patients.

Question 7b. Will the IAA be fully compliant with federal law governing IHS patient balance billing prohibitions and IHS payer-of-last resort provisions?

Answer. Yes, the IHS and VA must comply with Federal law. The IHS is the payer of last resort by statute, 25 U.S.C. § 1623(b). This authority prohibits IHS from paying for care when there are alternate resources. The IHS would not consider VA to be an alternate resource for IHS beneficiaries who are non-Veterans, unless those non-Veterans are eligible for care through VA. Based upon our conversations with VA, we understand that VA has certain authority to provide care to non-Veterans. However, those non-Veterans would not be eligible for services from VA and VA would be required to charge. This includes care provided to non-Veteran IHS beneficiaries at the request of IHS. The IHS would defer to VA for a further explanation of VA's authorities and requirements.

Question 7c. How many patients has the ITU system sent to VA facilities for COVID–19 related care?

Answer. The information below is reported by the IHS Area offices. Tribes and UIOs are not required to report this data to IHS, and the data below may not be representative of all patients transferred to the VA by Tribes or UIOs.

IHS Area	Facility	Number of patients
Albuquerque	Zuni Service Unit	1
Navajo	Gallup Service Unit	14
Phoenix	Colorado River Service Unit	1

Question 7d. To the best of IHS's knowledge, has VA attempted to bill IHS or any uninsured COVID–19 IHS patients sent to VA facilities for treatment for the cost of providing this care?

Answer. IHS has currently received three bills from the VA for patients referred to the VA in Albuquerque from the IHS Navajo Area.

Question 8. Congress directed CDC, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Administration for Community Living to reserve over $200 million in COVID–19 resources for Indian Tribes, tribal organizations, and urban Indian health organizations in the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act, and the CARES Act. However, I've heard concerns from Tribal leaders and urban Indian health program directors relating to the administration and allocation of these funds. As IHS Director, you are co-chair of the HHS Intradepartmental Council on Native American Affairs (ICNAA) and a member of the White House's Indian Country COVID–19 response team—roles that should allow to monitor and advocate for changes to Tribal-specific COVID–19 programs within HHS agencies. What kind of technical assistance or guidance is IHS providing to these other agencies about best practices when administering Tribal and urban Indian organization specific funding during the coronavirus pandemic?

Answer. The IHS provides support to our sister agencies in distributing COVID–19 funds for tribes and UIOs as needed. For example, the IHS provided technical assistance to the CDC on the funding methodology for the $40 million for Component A of CDC's new non-competitive grant for tribal nations, consortia, and organizations.

Question 8a. How can Congress, the Administration, Tribes, and urban Indian organizations work together to make sure future COVID–19 legislation addresses any administrative barriers or challenges uncovered through implementation of previous COVID–19 related legislation?

Answer. The IHS has unique funding authorities and mechanisms, including the Indian Self-Determination and Education Assistance Act (ISDEAA), which allow for streamlined distribution of funds. Our sister agencies, which are not authorized to transfer funds under the ISDEAA, often rely on grant mechanisms to award funds, which generally take longer to award because they require the agency to post a solicitation and review applications. Our sister agencies, like CDC, worked hard to alleviate potential administrative burdens associated with grant mechanisms and shorten the timeline as much as possible. However, when bill language appropriates the funds to these agencies, or directs funds to be awarded by grant or cooperative agreement, the agencies must abide by that requirement and their other authorities. Tribal leaders have long voiced opposition to the use of grant mechanisms due to the administrative burden that comes along with this award type.

Question 9. The Committee has received reports from Direct Service Tribes (DST) that the service units in their communities are not coordinating appropriately with the Tribes' COVID–19 responses efforts. In particular, several DSTs have noted that their IHS facilities developed CARES Act spend plans in isolation without soliciting input from the Tribes' and without regard for the resource needs identified by each community. Please describe the policies and practices IHS has implemented to ensure robust COVID–19 response coordination between IHS service units and the Tribes they serve, including DSTs.

Answer. It is the policy of the IHS that consultation with Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Tribes. Such actions refer to policies that have Tribal implications and substantial direct effects on one or more Tribe(s) regarding the relationship between the Federal Government and the Tribe or Tribes, or on the distribution of power

and responsibilities between the Federal Government and the Tribe or Tribes. The IHS tribal consultation policy can be found here: *https://www.ihs.gov/ihm/circulars/2006/tribal-consultation-policy/*.

Question 9a. Did IHS require service units to consult with DSTs regarding development of CARES Act spend plans? Please also describe how federally-operated IHS facilities developed their CARES Act funding spend plans.

Answer. The IHS tribal consultation policy addresses consultation at the Service Unit level. All IHS Service Units have a process to ensure that full consultation with all Tribes within the service unit is coordinated, and that process may vary depending on the unique needs and preferences of the Tribal communities served.

Question 10. On April 24, 2020, and again on May 11, 2020, Committee staff requested information from IHS regarding its use of volunteers in IHS facilities during the COVID–19 pandemic. Does IHS have a way to track the total number of volunteers working within the ITU system? If so, please provide an estimate of the number and service area location of volunteers currently working within the IHS.

Answer. The information below is reported by the IHS Area offices. Tribes and UIOs are not required to report this data to IHS, and the data below does not include all volunteers that may be currently working for Tribes or UIOs.

IHS Area	Facility	Volunteers
Great Plains	Pine Ridge Service Unit	9
Navajo	Chinle Service Unit	8
Navajo	Gallup Service Unit	12
Navajo	Kayenta Service Unit	10
Navajo	Shiprock Service Unit	5
Navajo	Winslow Service Unit (Tribal)	11
Phoenix	Whiteriver Indian Hospital	1
Phoenix	Urban Indian Center of Salt Lake	10*
Portland	Yakama Service Unit	3

*Volunteers per month.

Question 10a. How does IHS ensure that all medical volunteers seeking to work in an IHS facility are appropriately credentialed and privileged?

Answer.It is the IHS policy to credential and privilege all providers, whether they are employees, contractors, or volunteers. Providers are credentialed and privileged according to the facility's bylaws, policies, and accreditation standards. Each facility also performs regular provider performance reviews and continuous credential verification through the IHS Centralized Credentialing System.

Question 10b. Have provider vacancies within each IHS service area grown or decreased during the course of the COVID–19 pandemic?

Answer. IHS's overall vacancy rate in February was 21 percent, and the vacancy rate in May was 21 percent. At this point it does not appear that COVID–19 has impacted vacancy rates.

Question 11. On April 23, 2020, IHS announced its allocation plan for CARES Act funding—including reserving $10 million to support sanitation and potable water needs.[8] Please provide the Committee with details of the recipients, including award amounts, of the $10 million included in the CARES Act to support sanitation and potable water needs.

Answer. See attachment, CARES Act Project PDS List.[*]

Question 12. In responses to a question for the record I posed last year to ICNAA Co-Chair and Administration for Native American Commissioner Jeannie Hovland regarding ICNAA's plans to discuss the findings for the National Climate Assessment, she stated the Council would address the assessment during the Council's

[8] Press Release, Indian Health Service, Dep't of Health & Human Services, IHS Statement on Allocation of Fiscal $367 million from CARES Act (Apr. 23, 2020), available online at *https://www.ihs.gov/newsroom/pressreleases/2020-press-releases/ihs-statement-on-allocation-of-final-367-million-from-cares-act/*.

[*] The information referred to has been retained in the Committee files.

next meeting in late May 2019.[9] Please provide an update on the status of discussions within HHS, IHS, or the ICNAA regarding the findings in the National Climate Assessment.

Answer. At the May 22, 2019 meeting of the Secretary's Intradepartmental Council on Native American Affairs (ICNAA) Director Patrick Breysse of the CDC National Center for Environmental Health/Agency for Toxic Substances and Disease Registry (NCEH/ATSDR) outlined the wide variety of environmental issues affecting Indian Country. These issues include uranium mining in the Southwest, indoor air pollution from dirty fuel types, and the contamination of water due to mining. Funding to address environmental concerns was also discussed as the Administration for Children and Families Administration for Native Americans offers funding to American Indians, Alaska Natives, Native Hawaiians, Pacific Islanders, and Native nonprofits. Environmental Regulatory Enhancement grants can be used to address environmental concerns within Native communities.

The ICNAA also identified environmental issues as one of its priority areas for collaboration across HHS operating divisions. The ICNAA Chair and Vice Chair were able to raise this issue as a priority area when addressing the Secretary's Tribal Advisory Committee (STAC) in September of 2019. At the November 2019 ICNAA liaison meeting a representative of the CDC NCEH/ATSDR office provided an update on the upcoming Chlorinated Substances Conference that included coverage of a national study on water and sanitation for Native communities. A potential collaboration between CDC NCEH/ATSDR and the National Institutes of Health (NIH) National Institute of Environmental Health Sciences (NIEHS) on a 2020 conference was also discussed.

The question of addressing environmental issues collaboratively was discussed among the ICNAA liaisons and the CDC outlined their plan to host regional summits with tribes. The Tribal Environmental Health Summit was one of these events, coordinated by the CDC National Center for Environmental Health, to be held in March of 2020. However, due to the COVID–19 outbreak, this event had to be cancelled. The CDC NCEH/ATSDR's also had a presentation on addressing environmental health concerns in Indian country planned for the National Indian Health Board Tribal Public Health Summit in late March. This event was also cancelled due to the COVID–19 pandemic.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HON. REAR ADMIRAL MICHAEL D. WEAHKEE

Rear Admiral Weahkee, the impact that the pandemic has had on the Alaska tribal health system is unprecedented. With tribal providers forced to shut down elective procedures and clinics, the negative financial impact cannot be overstated. It is estimated that third party collections have dropped by 80 percent in some cases. More resources are needed to sustain the Alaska Tribal health system, which is the only provider in the vast majority of rural Alaska. Adequately resourcing and removing unnecessary regulatory barriers are essential for the Alaska Tribal health system to effectively limit the outbreak of COVID–19 in Native communities and to properly treat Native individuals that become infected. Water and sewer service in Alaska Native communities have long been lacking, but the pandemic has highlighted how essential adequate sanitation is for communities.

The importance of adequate water and sewer to prevent 'water wash' disease is very clear. CDC studies document skin and respiratory infections in rural Alaska communities without water service to homes that are 5 to 11 times higher than the national average. This is especially critical now, since COVID–19 is a respiratory disease whose spread can be prevented by hand washing, avoiding close contact with others, and cleaning/disinfecting surfaces. Lack of water service in these rural Alaska villages creates extreme challenges in practicing two of these three basic prevention techniques.

Of the 190 Alaska Native communities, 32 are still not served with in-home water/sewer. These communities typically have a washeteria building (that is a combination water treatment plant, laundromat, toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a 5-gallon bucket, and haul their sewage from their home in a different 5-gallon bucket.

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[9] 45th Anniversary of the Native American Programs Act and the Establishment of the Administration for Native Americans: Hearing Before the S. Comm. on Indian Affairs, 116th Cong. 46 (2019) (statement of Jeannie Hovland, Commissioner, Admin. for Native Americans, Admin. for Children & Families, Dep't of Health & Human Services).

Question 1. Many rural communities do not have access to adequate water due to the high construction costs of projects in those communities, particularly in Alaska. The IHS has established cost caps per home that when approached both decrease the priority of the project in the scoring system and limits the amount of funding available.

Would IHS be willing to eliminate, or at least raise, the cost caps for projects that provide piped water and sewer into these unserved communities?

Answer. The process for developing and updating allowable unit costs is being reviewed with IHS Area staff. A proposal was developed to move the program toward the use of more local, actual cost data collected by IHS, Tribes, and tribal organizations. Until such time that we have the data necessary to adjust the methodology, the current approach will continue to be used.

When a project exceeds the allowable unit costs it is flagged as economically infeasible. If other funding partners are willing to fund portions of a project that is deemed economically infeasible, the IHS is willing to provide funding for that project up to the allowable unit costs amount.

The allowable unit costs are developed for each State, with the exception of Alaska, which has three regional allowable unit costs to account for geographical differences that impact costs of construction within Alaska. The three regions are separated as follows: Northern Region: $235,500; Southern Region: $169,000; and Central and Western Regions: $197,500. IHS developed the total allowable unit costs (also known as threshold costs) to provide a basis for developing overall project economic feasibility. The allowable unit cost represents the cost to construct all water, sewer, and solid waste facilities for a typical home. The methodology used to develop these costs is based on cost indices used by the IHS facilities program and the Department of Housing and Urban Development.

Question 2. This pandemic has highlighted the need for community public health measures, the most basic and important being access to running water and sanitation. You've expressed willingness in past hearings to work with tribal organizations in Alaska on overcoming the issues of community contributions in "Indian communities" for sanitation projects. With the current emergency situation, is IHS willing to waive the non-Indian contribution requirement in "Indian communities?"

Answer. Since the inception of the IHS Sanitation Facilities Construction (SFC) program nearly 61 years ago, the IHS has consulted with and encouraged the participation of Tribes, States, other federal agencies, local governments, non-profits and other potential stakeholders in all phases of SFC projects. Collaborative sanitation projects among IHS, Tribes, project participants, contributors and other stakeholders is the original tenet for the SFC program. All SFC projects are collaborative projects initiated by tribal request and requiring participation by, contributions from, and coordination among, the stakeholders. This approach helps ensure that communities are jointly engaged in the development of projects and that the limited funds appropriated for the program expressly benefit Tribal homes in need of sanitation improvements. Advance planning prior to the appropriation of federal resources is essential to ensure prorated contributions for all ineligible units are received/confirmed prior to the allocation of federal funds.

The SFC program works with a variety of funding partners and assists communities with identifying potential sources of contributions. The contribution requirement is premised on and consistent with 42 U.S.C. § 2004a(3). SFC CARES Act funds will be administered as part of the IHS Facilities Appropriation and as such are bound by P.L. 86–121, IHCIA, and the IHS policy/guidelines developed through these two pieces of legislation.

Question 3. Testing Needs: Tribal health needs access to Cepheid GenXpert testing kits. The Cepheid GenXpert analyzers are available at regional hospitals, but the ATHS does not have adequate access to the testing kits needed. These kits have been supplied to commercial enterprises in Alaska, such as fishing. Will you work to provide equal access for proper testing for COVID–19 to prevent its spread to rural Alaska?

Answer. IHS Division of Acquisition Policy (DAP) established an indefinite delivery, indefinite quantity (IDIQ) (ordering) contract with Cepheid. This contract has numerous line items for various molecular laboratory analyzer types, associated warranty and maintenance agreements as well as the needed COVID–19 testing kits. IHS Area Offices now have the ability to issue funded orders against this contract once IHS senior leadership approves the order. The delivery dates for orders will be dependent on availability due to global demand. On August 12, 2020, DAP hosted an IHS-wide call to answer questions about the contract and ordering process.

On August 20, 2020, IHS met with Cepheid representatives to discuss COVID–19 testing kit supply allocations for IHS facilities, production capacity for additional molecular laboratory analyzers, and the need to continue a steady supply of testing kits for facilities with active analyzers. A follow-up meeting was held on August 25, 2020, with IHS Leadership and Cepheid representatives. This meeting covered IHS expectations and Cepheid supply chain realities in regard to supporting active analyzers with a steady supply of testing kits. Commitments were made from Cepheid regarding the ongoing support of all active I/T/U analyzers in the field, including those in rural Alaska through their direct contract with the Alaska Native Medical Center. DAP intends to have another IHS-wide call during the week of August 31, 2020 to address any remaining questions or issues. Additionally, weekly recurring meetings have been set up with Cepheid representatives to discuss testing kit supply volumes, any increased capacities, and outstanding logistics or administrative action items.

IHS has been successful in receiving the Abbott ID NOW COVID–19 point of care analyzers from HHS, which has an active contract with Abbott. This contract has allowed IHS to receive analyzers and an ongoing supply of test kits which are distributed through the IHS National Services Supply Center to I/T/U Indian Health programs. To date, the Alaska Area has received and distributed 31 Abbott ID analyzers and tests kits in support of those 31 analyzers. Both Cepheid and Abbott have confirmed they will work to increase production capacity so as to allow further allocations to IHS of both analyzers and test kits to be made available to I/T/U programs including those in rural Alaska.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO HON. REAR ADMIRAL MICHAEL D. WEAHKEE

Question 1. IHS acted swiftly to include funding for the newly recognized Little Shell Chippewa Tribe in the FY 2021 Budget Justification. However, the placeholder request of $2.6 million is inadequate. Based on the Tribe's projected user population and the IHS average per capita expenditure, the Tribe should receive an allocation of roughly $8–10 million. Can you commit to updating IHS's initial request in order to adequately reflect the true costs of providing services to Little Shell?

Little Shell is also in the process of purchasing and renovation a facility in hopes that its IHS allocation will be used to staff the facility with IHS personnel. Can you ensure that the Tribe's allocation is placed under the appropriate IHS account?

Answer. The IHS requested $2.6 million in the FY 2021 Budget Justification for New Tribes funding for the Little Shell Band of Chippewa Tribe. This funding level is an estimate, and the IHS has been working with the tribe to finalize the necessary data to update the amount. These funds are requested as New Tribes funding, consistent with the IHS policy for newly federally-recognized tribes, outlined in the Indian Health Manual.

We understand that the tribe plans on opening its own health care facility in the near future. If that is the case, the tribe could ultimately seek to operate its own program under the ISDEAA, and use the New Tribes funding in support of that facility.

Question 2. The Rocky Mountain Tribal Epidemiology Center provides support and information to Tribes in Montana and Wyoming yet they have experienced significant roadblocks to accessing critical COVID data from the IHS. How does IHS partner with TECs to make sure they can access the IHS public health surveillance data they need to be resources to Tribes?

Answer. Rocky Mountain Tribal Epidemiology Center (RMTEC) has an active Epidemiology Data Mart (EDM) sharing agreement with the Indian Health Service. Supported by this agreement, RMTEC receives routine access to fresh, limited data sets several times a year. On July 30, 2020, the IHS technical managers of the EDM hosted a conference call including RMTEC to review the elements of the EDM that are relevant for COVID response.

Since the coronavirus pandemic began, the IHS has also worked to expand data access for Tribal Epidemiology Centers (TECs) to aid their response efforts. The IHS began sharing influenza-like illness syndromic surveillance reporting with TECs, and is currently working to develop standalone reporting to TECs for daily COVID–19 testing data reported nationally to IHS Headquarters. In addition, the Oklahoma City Area Office of IHS recently developed an agreement with the Southern Plains Tribal Epidemiology Center to disclose certain IHS data (including Protected Health Information in accordance with law) to carry out specific activities directly related to the novel COVID–19, including contact tracing efforts. On July 27, 2020, IHS Headquarters sent notice of the finalized agreement to the remaining IHS Area Of-

fices to inform and support them in considering similar agreements and partnership with TECs.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARTHA MCSALLY TO HON. REAR ADMIRAL MICHAEL D. WEAHKEE

Question 1. While early outbreaks were clustered in the northeast part of the state, unfortunately we are now seeing more and more hotspots in other tribes. For example, the White Mountain Apache Tribe now has the highest infection rate per capita in Arizona. Rural tribes in Arizona like White Mountain are in need of mobile test sites.

What is IHS doing to deploy mobile testing in rural areas? Does IHS have enough employees and healthcare workers to conduct the necessary amount of testing and provide treatment to these hard hit communities? What steps could be taken to increase resources in these areas?

Answer. IHS continues to work with HHS and testing analyzer/kit/swab/media suppliers to acquire testing materials for IHS and tribal health programs. The IHS is not always able to immediately supply all testing analyzer/kit/swab/media orders requested due to the lack of supplies. Testing strategies vary by location and state. Several Tribes are working with federal and state partners to conduct mass testing events for their communities. From the onset of the pandemic, and continuing into the future, the IHS will work with federal and Tribal programs to support the availability of as many tests as possible. This work will continue as determined by epidemiological factors (e.g., decreased number of cases), transmission, population immunity, and/or through the availability of safe and effective vaccines which could eliminate the need for broad scale testing. As of June 29, the IHS had performed 272,935 tests, equating to 16 percent of the IHS User Population, and exceeding the U.S. all races testing rate of 10.8 percent. As of August 29, the IHS had performed 650,223 tests, equating to 39.1 percent of the IHS User Population, compared to the U.S. all races testing rate of 25.4 percent. Also as of August 29, 36.8 percent of reported tests completed have been done with the Abbott ID NOW COVID–19 analyzer.

Question 2. As states begin to reopen, many are providing free testing to any individual who requests it. This allows businesses to open with confidence and have employees tested on a regular basis to ensure safe operation. Are tribal members able to utilize IHS or 638 contract facilities to get free testing on demand?

Answer. Yes. Tribal members should contact their IHS or 638 contract health care facilities for specific information pertaining to the testing programs available.

Question 3. Tribal communities in Arizona are among the least digitally connected communities in the country. How has the lack of access to broadband hindered the IHS in moving forward with telemedicine opportunities throughout IHS facilities across the country?

Answer. IHS significantly expanded telehealth capabilities across the U.S. during the COVID–19 pandemic. The most successful telehealth programs are those that provide video conferencing services within IHS facilities. These types of telehealth visits are primarily physician-to-physician or remote specialists to patients within an IHS facility. IHS is able to expand telehealth between our facilities despite the lack of broadband access to many tribal communities. Our primary challenge is conducting patient-to-provider telehealth visits while the patient is at home. The IHS has recognized the challenges with lack of access to patient due to broadband connectivity. Some rural patients do not have the necessary equipment such as a smart phone or laptop with adequate signal or broadband connectivity in their home or community.

The IHS has supported telephonic telehealth visits to mitigate these issues. Also, IHS plans on using the $95 million CARES Act funds for central program management and services to provide a solid foundation which supports long-term sustainability of telehealth infrastructure and services. The literature has shown that system-level planning and support for telehealth, as opposed to a fragmented approach, improves continuity of primary care, access management, economies of scale, and platform standardization.

Question 4. In my conversations with tribal leaders and healthcare administrators, they have expressed concern about the loss in revenue as “elective procedures” are put on hold to focus on coronavirus response. Are IHS facilities or Urban Indian Health Organizations being told to cancel elective procedures to address the pandemic? If so, has the effect of the loss of revenue from the procedures been accounted for when calculating the overall needs for IHS facilities?

Answer. The IHS has not advised tribal or urban Indian health programs to cancel any procedures or patient appointments. However, some tribal and urban Indian health programs have done so. I/T/U programs have anecdotally reported third party revenue losses ranging from 30—80 percent.[10]

In some IHS Areas, due to the need to preserve patient bed capacity for COVID–19 patients and to prevent the spread of the COVID–19 virus, elective surgeries were place on hold or rescheduled. The effect of the loss of revenue from elective procedures has been accounted for when calculating the overall needs at IHS. For example, in one Area due to delaying elective surgery procedures, there has been a decline in third party revenues and the Provider Relief Funds have been applied to the hospitals' budgets to cover portions of revenue gaps in FY 2020. In addition, other areas of the hospitals' budgets have been adjusted to decrease expenses such as travel, training, equipment replacement, and medical supplies used for elective surgeries.

Question 5. Among the factors that have contributed to higher transmission rates on the Navajo Nation is lack of access to running water in as many as 30 percent of homes on the Nation. This is unacceptable. It has been reported that the Indian Health Service Navajo Area has $620,000 to deploy water and sanitation facilities projects on the Navajo Nation. It is my understanding that a survey of all 110 chapters are complete and there are crews on the ground working on a few identified projects.

Can you tell me how IHS is prioritizing which water projects to pursue? Can you provide a list of the identified water projects, their cost, and the status of each project?

Answer. The SFC Program developed guidance to ensure that priority is given to homes without access to piped water. The priorities were established to identify the immediate need as it relates to COVID–19 response activities:

Priority 1: Intent is to increase access to temporary water points at no charge to homeowners with failed individual water systems, cistern systems, and other tribal homes without access to piped water. Priority 1 also provided public outreach information to increase community knowledge about the availability of temporary water access points, safe water hauling practices, and avoidance of septic tank effluent.

Priority 2: Intent is to provide PPE for solid waste and wastewater utility operators to ensure reduced work related virus exposures.

Priority 3: Intent is to provide emergency project funding to address failed or non-operational individual water or sewer systems to ensure that all tribal homes have access and subsequently to reduce risk of coronavirus spread and basic needs such as hygiene. Also, intent is to provide emergency project funding to address failed treatment/distribution equipment and ensure that treatment chemicals are available for continued operation of water supply and waste disposal systems during the COVID–19 outbreak.

Based on these three priorities, Area SFC Programs were directed to reach out to their tribal contacts to identify potential projects. Projects were submitted to HQ Division of Sanitation Facilities Construction for review and if they fit into these priorities the Area received funding for the project.

The IHS has provided $5.15 million in CARES Act funding to the Navajo Nation to fund a single project. This project will install transitional water point in approximately 58 Chapters, support the water fees from all Chapter operated water points for the duration of the Navajo Nation COVID–19 Public Health Emergency (budgeted for two years), offer Chapters up to 37,000 five gallon water storage containers, and up to 3.5 million in water disinfection tablets for distribution to residents of homes with no piped water. The project will include development of public communication platform that will contain information about the location, Chapter contact information, operational hours, and public health messages about the benefits of safe water collection at the water points and in-home safe water storage. The map below shows the locations of the existing permeant water points and transitional water points and their construction status as of August 24, 2020. A summary of these status is also provided in the table below.*

Question 6. It has been reported that the Tséhootsooí Medical Center, or TMC, in Fort Defiance, Arizona still doesn't not have enough testing capabilities to test everyone that requires a COVID–19 test. In fact, Tséhootsooí Medical Center has reported to directing people to Gallup Indian Medical Center for testing. This is due

[10] For more information specific to UIOs, see the National Council of Urban Indian Health's report "Recent Trends in Third-Party Billing at Urban Indian Organizations" available at *https://www.ncuih.org/reimbursement.*

* The information referred to has been retained in the Committee files.

to TMC having a limited number of testing cartridges for the Abbott ID NOW COVID–19. Though TMC also has the Cepheid GeneXpert analyzer, which is more reliable than Abbott ID NOW COVID–19, TMC has a limited number of testing cartridges and swabs to be able to test at the rate needed for the community and surrounding areas. Additionally, the Abbott ID NOW COVID–19is notorious for providing false negatives, which results in providers needing to double-check the Abbott ID NOW COVID–19by either using the GeneXpert or sending the specimen to a commercial laboratory, overusing the limited supply of swabs and cartridges.

Does IHS have a plan to improve testing capacity at the P.L. 93–638 health care facilities? If so, please share this plan with the Committee. If not, when can IHS provide a plan to the Committee?

Answer. IHS continues to work with Tribes, Tribal organizations, HHS, and testing analyzer/kit/swab/media suppliers to acquire testing materials for I/T/Us. The IHS is not always able to immediately supply all testing analyzer/kit/swab/media orders requested due to the lack of supplies. Testing strategies vary by location and state. Several Tribes are working with Federal and state partners to conduct mass testing events for their communities. From the onset of the pandemic, and continuing into the future, the IHS will work with Federal, Tribal, and UIO programs to support the availability of as many tests as possible. This work will continue as determined by epidemiological factors (e.g., decreased number of cases), transmission, population immunity, and/or through the availability of safe and effective vaccines which could eliminate the need for broad scale testing. As of June 29, the IHS had performed 272,935 tests, equating to 16 percent of the IHS User Population, and exceeding the US all races testing rate of 10.8 percent. As of August 29, the IHS had performed 650,223 tests, equating to 39.1 percent of the IHS User Population, compared to the U.S. all races testing rate of 25.4 percent. Also as of August 29, 36.8 percent of reported tests completed have been done with the Abbott ID NOW COVID–19 analyzer.

With regards to testing analyzers, the Gallup Indian Medical Center performed a correlation study comparing the accuracy of the Abbott ID NOW COVID–19 analyzer with that of the Cepheid GENEXPERT analyzer. The Abbott COVID instrument has been found by IHS to be acceptable for patient testing. The ABBOTT instrument tested at 98.9 percent accuracy to that of the Cepheid instrument. Independent correlation testing done by the Oklahoma City Area IHS also found the Abbott to be acceptable for use.

On May 14, 2020, the Food and Drug Administration (FDA) released notice to the public of possible concerns with the accuracy of test results obtained on the Abbott ID NOW analyzers for COVID–19. Early data had suggested the potential inaccuracies of results, specifically false negatives. IHS provided awareness and guidance for interpretation of data per FDA recommendations on May 15, 2020. IHS also shared among its users, technical documents that were provided by Abbott following the FDA news release of validity of test results on the Abbott ID NOW analyzers. On June 11, 2020, Abbott released updated technical documents supporting these changes; IHS also shared this information with its Abbott users. Current product data and manufacturers updates can be found here: *https://www.abbott.com/IDNOW.html.*

We agree that a negative test should be treated as presumptive and, if inconsistent with clinical signs and symptoms or necessary for patient management, should be tested with an alternative molecular assay. Negative results do not preclude SARS-CoV–2 infection and should not be used as the sole basis for patient management decisions. Negative results should be considered in the context of a patient's recent exposures, history, presence of clinical signs and symptoms consistent with COVID–19.

However, many IHS federal and tribal sites still find the test highly useful, as a positive test result is returned in under 15 minutes, and can allow for definitive management in that case. Negative results should be treated as presumptive and tested with an alternative FDA authorized molecular assay, if necessary for clinical management, including infection control.

Cepheid testing supplies are in very short supply globally, and it is expected that the situation for the scarce availability of those supplies will likely persist.

Question 7. It is my understanding that the Navajo Area IHS is operating isolation units at Shiprock, Chinle, and Gallup for individuals to safely self-isolate. How is IHS communicating to individuals who wish to self-isolate at the IHS controlled Isolation Units and what is the process for a patient to access those services? What is the occupancy rate of the Alternative Care Sites and Isolation Units in Shiprock, Chinle, and Gallup? Could you share with the Committee the occupancy rate of the care Sites and Isolation Units from the date of initial operation?

Answer. In the Navajo Area, IHS patients can be referred to non-congregate isolation sites by health care providers or public health nurses after receiving confirmation of COVID–19 positive testing. A Patient Mobilization Center at the Navajo Area Office refers patients to non-congregate isolation sites and assists with patient transfers. Isolation site Operational Managers have been assigned on the west and east sides of the Navajo Nation. The managers oversee admissions to the non-congregate isolation sites. In addition, a patient can also choose to use an isolation kit to stay on their own property to effectively isolate. The kits include water, food, cleaning supplies, and a tent. Currently, patients are not being referred to congregate alternative care sites (ACS).

As of July 7, 2020, the occupancy rate at the congregate ACS sites and non-congregate isolation sites are as follows:

- Congregate ACS
  - — Chine, AZ: 12 patients, opened on May 14, 2020 and now converted to a congregate isolation site in standby status. This site will need support services (e.g., food service, waste removal, security, cleaning, and laundering services) in place before the site reopens for isolation services. The Navajo Nation Unified Coordination Group (UCG) is presently pursuing a contract for the support services.
  - — Gallup, NM: 35 patients, opened on April 25, 2020 and closed on June 17, 2020.
  - — Shiprock, AZ: no patients, opened on May 15, 2020 and now demobilizing.
- Non-congregate Isolation Site
  - — Aztec, NM hotel: 45 patients, received first patient on May 9, 2020.
  - — Chinle, AZ hotel: 102 patients, received first patient on May 20, 2020.
  - — Farmington, NM hotels: 6 patients, received first patient on June 7, 2020.
  - — Gallup, NM hotels: 800 patients, received first patient on March 24, 2020. These hotels were leased by the State of New Mexico for COVID–19 isolation purposes. The Gallup Indian Medical Center and the Navajo Area Patient Mobilization Center were approved by the State of New Mexico to place isolation patients in an isolation hotel room as needed.
  - — Kayenta, AZ hotel: Navajo Nation UCG is presently pursuing a contract for this site.

Question 8. The Navajo Nation views the Navajo Area Indian Health Service (NAIHS) as a valuable partner in the delivery of health services to the Navajo people. The IHS has a federal responsibility to support the Navajo Nation and our P.L. 93–638 health facilities and tribal health programs during this pandemic.

On March 13, 2020, shortly after the first reported case on the Navajo Nation, the Navajo Health Command Operations Center was activated to coordinate and oversee the directions, instructions, and policies coming from the Navajo Department of Health related to COVID–19. Nearly two (2) months after the detection of the initial positive COVID–19 cases on the Navajo Nation, on May 14, 2020, the Navajo Nation created a Unified Command Group (UCG) to coordinate COVID–19 response activities and efforts.

The purpose of the UCG is to provide a unified, interactive approach to delivering services to individuals and families impacted by COVID–19. The UCG medical and public health branches are co-led by the Navajo Nation, NAIHS, and P.L. 93–638 representatives.

Why did it take Navajo Area IHS two months to establish coordinated approaches to the Navajo Nation?

Answer. The Navajo Area IHS stood up its Emergency Operations Center on February 25, 2020 in preparation for COVID–19 activities. Additionally, the Navajo Area IHS Leadership was in immediate contact with the Navajo Nation President and Vice President and joined the Navajo Nation's COVID–19 Task Force on February 28, 2020. The purpose of the Task Force was to begin interagency communication, coordination and planning in preparation for the possibility of COVID–19 cases on the Navajo Nation. The Navajo Area IHS Leadership participated in multiple Task Force meetings beginning in March and attended Navajo Nation-sponsored Logistics Section meetings three days per week beginning on March 27, 2020 and continues to participate in these coordination meetings to date.

On April 6, 2020, at the request of the Navajo Nation, the Navajo Area IHS began serving as a member of the Nation's incident command structure. On May 7, 2020, the Navajo Nation, in coordination with FEMA representatives and the Navajo Area IHS representatives, established a Unified Coordination Group (UCG) structure to incorporate the various Tribal, state, federal, volunteer, and other organizations into

the command structure. The draft UCG structure underwent reviews by several Tribal and federal programs and the final structure was officially released on May 14, 2020. Since that time, the Navajo Area IHS continues to support the Navajo Nation and participates as an active member of the UCG.

Question 9. The Hopi Tribe is landlocked directly in the middle of the Navajo Reservation so when the pandemic flared at the Navajo Nation it completely surrounded Hopi. During those early days I heard from the Hopi Tribe that they could not obtain real time test and infection information from the IHS. This information was crucial for Hopi leadership to make appropriate decisions including quarantining individuals, closing villages, and similar actions. Even more disturbing is that without this information Hopi first responders were placed in unnecessary danger. What has the IHS done to aid in the flow of information from its facilities to the communities they serve, including the Hopi?

The Hopi clinic continues to struggle with maintaining an adequate supply of PPE and testing kits. Governor Ducey has helped the Hopi Chairman secure supplies recently but it is an ongoing problem. How is IHS working with Hopi to ensure the clinic has the supplies that it needs?

Answer. The IHS is the primary provider of public health services for the Hopi Tribe. Prior to the COVID–19 response, the Hopi Tribe did not have formal recognition as the Public Health Authority and therefore was not receiving direct data communication from IHS. Hopi Tribe requested formal recognition by the IHS as the Public Health Authority for the COVID–19 response on April 15, 2020. Since that time, the tribe has received the necessary information needed to serve the public health purpose. The IHS Phoenix Area has established a Public Health Authority process to streamline additional requests from Tribes throughout the region, thereby ensuring timely communication of information needed to streamline decisionmaking processes.

The IHS has been given priority access to rapid point-of-care COVID–19 test systems as part of White House efforts to expand access to testing in rural communities. The IHS received 250 ID NOW COVID–19 rapid point-of-care test systems which were distributed to federal and tribal health care facilities throughout Indian Country in 31 states. This test allows for medical diagnostic testing at the time and place of patient care, can provide COVID–19 results in under 13 minutes, and expands the capacity for coronavirus testing for individuals exhibiting symptoms, as well as for healthcare professionals and the first responder community. Additionally, this will save personal protective equipment and ensure our critical workforce is safe and able to support the response, as only gloves and a facemask are necessary to administer this rapid point-of-care test.

IHS facilities generally have access to testing for individuals who may have COVID–19; however, there are nationwide shortages of supplies that may temporarily affect the availability of COVID–19 testing at a particular location. In addition to using rapid point-of-care testing systems, clinicians, including those at IHS, collect samples with standard synthetic fiber specimen collections swabs and access laboratory testing through public health laboratories in their jurisdictions. The IHS also utilizes commercial and other approved laboratories to test specimens as those services are available.

Regarding the supply of resources, there are nationwide shortages of PPE. The Phoenix Area coordinates with the IHS NSSC center for PPE orders and allocations for the Hopi Health Care Center, as well as coordinating approvals of PPE donations from outside sources. When PPE is not readily available through regular direct purchase mechanisms, the Phoenix Area procures PPE internally through the Strategic National Stockpile in coordination with the ADHS/FEMA.

The Phoenix Area works closely with facility supply chain managers to monitor PPE inventory and mobilize procurement strategies when burn rates indicate less than a 4-week PPE for gowns, face masks, gloves, N95 respirators, and face shields. As of July 24, 2020, the Hopi Health Care Center was >28 days for all monitored PPE elements.

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