

**S. 3126, S. 3264, S. 3937, S. 4079, AND S.
4556**

HEARING
BEFORE THE
COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE
ONE HUNDRED SIXTEENTH CONGRESS
SECOND SESSION

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SEPTEMBER 23, 2020
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WEDNESDAY, SEPTEMBER 23, 2020

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

The Committee met, pursuant to notice, at 2:49 p.m. in room 628, 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. I call this legislative hearing to order.

Before we begin, I want to remind members who are connecting with us remotely to mute your microphone, if you would when you are not testifying.

With that, thank you, and today the Committee will receive testimony on five bills, S. 3126, a bill to amend the Public Health Service Act to Authorize a Special Behavior Health Program for Indians; S. 3264, a Bill to Expedite and Streamline the Deployment of Affordable Broadband Service in Tribal Land, and for Other Purposes; S. 3937, a bill to amend Section 330C of the Public Health Service Act to Reauthorize Special Programs for Which Provide Services for the Prevention and Treatment of Diabetes, and for Other Purposes; S. 4079, a bill to authorize the Seminole Tribe of Florida to Lease or Transfer Certain Land, and for Other Purposes; and S. 4556, a bill to authorize the Secretary of Health and Human Services, Acting through the Director of the Indian Health Service, to Acquire Private Land to Facilitate Access to the Desert Sage Youth Wellness Center in Hemet, California.

First, S. 3126. On December 19th, 2019, Senator Smith introduced S. 3126, the Native Behavioral Health Access Improvement Act of 2019. Senators Udall, Tester, Cortez Masto, and Warren are cosponsors. American Indians and Alaska Natives have the second highest overdose rates from opioids than any other racial or ethnic group. Substance abuse further increases the need for behavioral health treatment among Native people.

With the opioid abuse epidemic and now the COVID-19 pandemic, tribal communities continue to need access to services to properly address substance abuse and mental health disorders. S. 3126 will establish a special program designed for Indian tribes to access Federal grant funding of \$150 million per year for five years to address mental health needs and substance use disorders among Native people.

S. 3264. On February 11, 2020, Senator Udall introduced S. 3264, which was referred to the Committee. Senators Heinrich, Cantwell, Warren, Smith, and Schatz are cosponsors of the bill. No House companion bill has been introduced at this time.

This bill contains a number of initiatives designed to ensure that the residents of tribal lands enjoy the levels of highspeed broadband access equivalent to those of other well connected communities across the Country. For instance, the bill establishes a tribal broadband interagency working group to coordinate broadband programs among key Federal agencies like the Federal Communications Commission, the Department of Agriculture, and the Department of Interior. The bill contains a tribal set-aside of 20 percent from the Department of Ag's Rural Utility Service, and 5 percent of the Federal Communication Commission's Universal Service Fund for Broadband Deployment on tribal lands.

Access to broadband is a vital tool for economic development, educational and job opportunities, and public health and safety throughout the Nation. Tribal communities continue to lag behind the rest of the Country in access to affordable and reliable broadband service. The Committee is committed to taking steps necessary to identify and eliminate any barriers to the deployment of broadband services and infrastructure in Indian Country.

S. 3937. On June 10, 2020, Senator McSally introduced S. 3937, the Special Diabetes Programs for Indians Reauthorization Act of 2020. Senators Sinema and Murkowski are the cosponsors. In 1997, Congress established the Special Diabetes Program for Indians, SDPI, to decrease the growing rate of diabetes among American Indians and Alaska Natives. Since then, the SDPI program has received \$150 million per year to provide grants to eligible entities that offer diabetes treatment and prevention services.

A recent report found that diabetes has significantly decreased since 2013, which is attributable to the success of the SDPI program. S. 3937 reauthorizes the SDPI program for fiscal years 2021, 2022, 2025, and increases funding from \$150 million to \$200 million per year. Additionally, the bill gives eligible grantees the option to receive funds through self-governance contracts, cooperative agreements or compacts under the Indian Self-Determination and Education Assistance Act.

S. 4079. June 25, 2020, Senators Rubio and Scott introduced S. 4079, a bill to authorize the Seminole Tribe of Florida to lease or transfer certain lands and for other purposes. This legislation authorizes the Seminole Tribe of Florida to convey or otherwise transfer interest in land. This authorization does not include lands held in trust.

The bill rectifies the limitations placed on the tribe by the Non-Intercourse Act. Originally enacted in 1970, the Non-Intercourse Act requires the tribe to first get Federal approval before conveying any land interest. S. 4079 would allow of the tribe to operate without this unnecessary delay and exercise greater control over their own affairs.

S. 4556. On September 10, 2020, Senator Feinstein introduced S. 4556, a bill to authorize the Secretary of Health and Human Services, acting through the Director of the Indian Health Service, to acquire private land to facilitate access to the Desert Sage Youth

Wellness Center in Hamet, California, and for other purposes. Desert Sage Youth Wellness Center is an IHS youth regional treatment center located in Hamet, California. This center provides culturally sensitive substance abuse treatment in a co-ed residential facility for Native youth.

Currently, the only access to the center is on a dirt and gravel road. During extreme weather conditions, access to the center becomes dangerous and limited. In order to provide better access to the center, HHS must purchase land from local owners to construct a paved road. S. 4556 authorizes HHS to acquire land from willing sellers to construct and maintain a paved road to the Desert Sage Youth Wellness Center.

With that, I will turn to Vice Chairman Udall for his opening statement.

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

Senator UDALL. Thank you, Mr. Chairman, for scheduling this hearing.

Before I begin, I would like to congratulate the Chairman on successful passage of our Bipartisan Progress for Indian Tribes Act this week, along with four other bills we shepherded through this Committee. My Native American Business Incubators program, Senator Murkowski's Savanna's Act, Senator Cortez Masto's Not Invisible Act, and Senator Merkley's Middle Oregon Bill, are all now on their way to the President's desk. Once again, this Committee's tradition of bipartisanship and advancing Indian Country's priorities is something we should all be proud of.

I would also like to extend a special welcome to Chairman Chavarria, the All Pueblo Council of Governors, who is also Governor of the Santa Clara Pueblo in my home State of New Mexico. Thank you, Governor, for testifying today.

Turning to today's bills, we will hear testimony on a diversity of subjects, including creation of a special behavioral health program for Indians, the need for improvements to broadband deployment and availability in Indian Country, and reauthorizing the Special Diabetes Program for Indians, and expanding it to include self-determination contracting.

In the interest of time, I will focus my remarks on three of these bills. My bill, the Bridging To The Tribal Digital Divide Act, would improve the deployment of broadband in Indian Country by shoring up broadband programs at the FCC and the USDA through funding set-asides from the FDA's Rural Utilities Service, and FCC's Universal Service Fund, to direct address tribal needs. Notably, it also establishes a pilot program for tribes to permit rights of way for broadband deployment on tribal lands, and a tribal advisory committee so that Congress can tailor legislation to truly meet Indian Country's broadband needs.

Senator Smith's Native Behavioral Health Access Improvement Act, which I am proud to support as a co-sponsor, would create a special behavioral health program for Indians, to help tribes access flexible resources to address their community's mental health needs. The severe lack of access to comprehensive, culturally competent behavioral and mental health services in Native commu-

nities is one of the many disparities that the current COVID-19 pandemic has laid bare. And this bill, which builds on the successful SDPI model, is an important tool we should work to provide tribes as quickly as possible.

Finally, a short note on the Special Diabetes Program for Indians Reauthorization Act. I have worked with Senator Murray to lead the charge on reauthorization of SDPI as far back as 2013, when I introduced a bill that would permanently reauthorize this important program. The bill before us today puts forward a new SDPI proposal related to self-determination authority.

As a long-time support of self-determination and self-governance, I look forward to working with the bill's sponsors to ensure Congress achieves tribal self-government. Thank you, Mr. Chairman.

The CHAIRMAN. With that, I would ask our other members for opening statements. My understanding is that Senator McSally, who is joining us virtually, has an opening statement.

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

Senator MCSALLY. Thanks, Chairman Hoeven and Vice Chairman Udall, for holding this legislation to review, including my bill, S. 3937, the Special Diabetes Program for Indians Reauthorization Act.

I am honored to have Chairman Timothy Nuvangyaoma, from the Hopi Tribe in Arizona, participating remotely to offer testimony in support of this bill, and to provide important background and context to the way Hopi has utilized SDPI to improve the health of tribal community members. Diabetes affects millions of Americans, but its impact on tribal communities is especially severe. In fact, according to the CDC, American Indians and Alaska Natives have a greater chance of having Type II diabetes than any other population. For nearly two out of three Native Americans who have kidney failure, diabetes is a primary factor.

This makes diabetes the fourth leading cause of death for Native Americans, while it is seventh in the general population. With 22 federally recognized tribes and more than 300,000 Native constituents in Arizona, this makes addressing this disparate impact of diabetes on indigenous populations a priority that hits close to home for Arizonans.

Since it was created in 1997, the Special Diabetes Program for Indians has shown great success in reducing the rate of Type II diabetes in Native populations, while improving overall health. SDPI currently awards \$150 million in grants each year to more than 300 entities to expand access to diabetes treatment services, as well as administer innovative prevention and wellness programs.

While demonstrably effective, the SDPI has suffered in recent years from a series of short-term reauthorizations and stagnant funding that has hindered the program's full potential. This uncertainty has constrained the long-term planning capabilities of the Indian Health Service and individual tribes and grant recipients when long-term strategies are key to successfully getting Type II diabetes rates in check.

The bill I introduced along with Senators Sinema and Murkowski will provide a long-term five-year reauthorization of the Special Di-

abetes Program for Indians. It will also increase SDPI's authorization from \$150 million per year to \$200 million a year, and allow tribes to administer the program through self-governance contracts, cooperative agreements, or compacts under the Indian Self-Improvement and Education Assistance Act. The COVID-19 pandemic has underscored the critical need to address underlying health conditions, such as diabetes. The changes and updates included in my bill will provide long-term stability to a successful program and will allow SDPI to better meet today's tribal needs in a culturally competent manner.

I want to again thank my Hopi Chairman, Chairman Nuvangyaoma, for his support and participation in today's hearing and the Committee's consideration of my bill. I yield back.

The CHAIRMAN. Thank you, Senator McSally.

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

Senator CANTWELL. Thank you, Mr. Chairman, and thank you, Vice Chair Udall, for holding this hearing and including the Vice Chairman's bill, S. 3264, the Bridging the Digital Divide Act, which we have worked with on and sponsored with him. Far too long, our tribal communities have been left on the wrong side of the digital divide, and obviously, the COVID crisis shows us how important this issue really is.

Less than half of rural households in tribal lands have access to fixed broadband services, according to an FCC report of 2019. The same report revealed that tribal lands have fallen behind in access to wireless broadband as well. According to a separate 2020 FCC report on nationwide broadband deployment, well over 1 million people in Indian Country lack access to adequate broadband and the critical health care and education services, jobs, and other economic opportunities that broadband affords.

So we all know the FCC numbers underestimate the problem. The COVID pandemic has exacerbated the harms caused by the lack of broadband, leaving many communities without the ability to participate in online learning or telehealth. These tribes in our States are very concerned about this. Members of the Hoh Tribe, located in the Pacific Coast, essentially have had to ration their internet use. In the past, different members of the tribe would wait until the children went to school to even send things as basic as email because of the extraordinary low speeds.

This has become worse with the COVID pandemic. For the Colville Tribe in North Central Washington, many of the households don't have access to the internet. This means many of the households don't have access to emergency service notifications. Connectivity is critically important during fire season, especially this year, as fires have forced evacuations from homes and businesses. It is absolutely unacceptable for these tribes and many others living on tribal lands throughout the State of Washington to not have access to basic, reliable broadband.

We need to address this and the connectivity needs in tribes, now, which is why closing the tribal digital divide remains one of my top priorities, and I know for this Committee is also a big priority. It is why I have joined with the Vice Chairman, Senator

Udall, and others in writing the FCC Chairman Ajit Pai two weeks ago to use all of the FCC's current authority and resources to take immediate steps to address the broadband shortcomings in Indian Country. It is why Senator Udall's bill and Senator Heinrich earlier this year introduced S. 3264, the Bridging the Digital Divide Act.

As the Vice Chairman has worked on this issue, he knows that it improves coordination across Federal broadband programs, several tribal communities make it easier for tribes to navigate application processes and for them, the technical assistance that often comes with deploying broadband. Importantly, the bill sets aside 5 percent of the broadband deployment funds at the FCC and the USDA for tribes to build out broadband infrastructure in Indian Country.

Additionally, the bill for the first time will place tribal lands on the same footing as other countries when it comes to the FCC's statutory mandate to provide universal service. The FCC has not taken the obligation seriously, so this bill will stress that agencies can no longer downplay the needs of tribal citizenry and will have to deal with this issue.

So prior to helping the Makah build out a network which we worked on in my State, tribal students had to travel to another school, 40 minutes away, to basically do just basic internet broadband testing. So if they wanted to do the test, they had to go 40 miles just to take a test.

We all know what Indian Country looks like in our States. We need to do better by them. So I thank the Chair, and thank you for giving me that moment.

If I could just say a special thank you to Senator Murkowski for her leadership on Savanna's Act. So glad that Savanna's Act is on its way to the President's desk. Hopefully, indigenous women will be better protected in the future.

The CHAIRMAN. Thank you, Senator Cantwell.

Senator Murkowski, and I would like to echo Senator Cantwell's comments regarding your leadership on Savanna's Act, and of course also acknowledge former Senator Heitkamp from my State as well on that legislation.

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

Senator MURKOWSKI. Thank you, Mr. Chairman, for that, and Senator Cantwell. Thank you for allowing good bills to come out of this Committee. We have a good slate here today. But I appreciate the recognition and the acknowledgement of where we are, not only with Savanna's Act, but also the Not Invisible Act, which is the measure that Senator Cortez Masto and I have been working on that deals with not only murdered and missing indigenous women, but those who are trafficked as well, and recognizing that we need to be doing more in that area.

So to the Chairman and to the Vice Chairman, thank you for helping us advance those through Committee and to so many of our colleagues who have really worked to shine a spotlight on this issue.

I was up in Alaska just last month. We gathered to recognize the opening of a cold case office in Anchorage, one of six around the

Nation that is being established to focus in on these very significant issues as they relate to our indigenous women. You recognized the work of Senator Heitkamp, who began this all with Savanna's Act. I had an opportunity to send her my congratulations the other day, very important. So we thank you all for that help with that.

I mentioned that there is a good slate of bills on the calendar today. So many of them have impact on where we are with the impacts of COVID-19 on our Native peoples, and how the pandemic is exacerbating the disparities that we know exist. In Alaska, we have started to see some really concerning statistics, heard some difficult calls. I have heard that police calls have risen 150 percent in some of our villages. Sexual assaults probably will be as high as last year by the end of this summer. Homeless is still a major issue. Food insecurity, loss of income, lack of transportation, and the public health measures are taking their toll not only physically but also on mental health as well.

We had a village in southwest Alaska that lost its only store to a fire. They couldn't get things like groceries and other supplies because the fear of the Coronavirus kept the villagers from moving from one village to another, so literally cut off. Another Native village off the road system, Newtok, made the news last week because they were three weeks without power. And we can get by in the summertime without lights, and without heat. But you need to be able to keep your subsistence meats and fish frozen. So they lost almost all of their subsistence harvest that they had gathered.

In one region, tribes reported that their suicide rate has doubled. As I have raised so often in this Committee, we still have far too many communities for whom washing your hands and basic hygiene in a time of COVID or any time is simply not possible. You can't sing the ABCs because you just don't have the water in order to wash.

We have, as you know, a very difficult history with pandemics prior, 1918 was pretty severe in Alaska. One Native village, Wales, lost three quarters of their population in a week. And those memories don't leave people. So when you are faced with the likes of what we are seeing with COVID-19, the efforts to be as cautious as we possibly can is an imperative. Native leaders in our State believe very, very strongly that overcrowding and lack of sanitation is still the key.

So all of this reinforces why so many of these measures on the docket today are so important. The need for improving Native behavioral health access, for improving infrastructure, most notably bridging the digital divide, supporting the tribal health system, these are all imperatives.

The last point that I want to make is to acknowledge the work of Senator McSally on her legislation that will reauthorize the Special Diabetes Program. We have seen the benefit there. We have seen how this program empowers our tribal leaders to make these local decisions, choose the best practices, adapt the programs and it is culturally appropriate. It has been vital to its success. As she pointed out, these short-term extensions have not been helpful. We need to reauthorize SDPI on a long-term basis, and to provide this predictability as well as, predictability for the funding, but also to allow for self-determination of this critical program.

I know that the House Resolution that we are looking at offers a mere 11-day extension of the SDPI program, the fifth such extension in a year, shortest extension of the program on record. And as has been pointed out, these programs are tribal programs and the lack of funding does nothing to increase any level of certainty.

So as we are talking about the impacts of COVID-19, I think it is important to recognize that diabetes is a leading risk factor in the severe effects of COVID-19. So the importance, the priority that we can place on this very, very important program is greatly appreciated.

With that, I thank the Chairman for an extended period of time to comment. Thank you.

The CHAIRMAN. Thank you, Senator Murkowski.

I remember being up there with you, when you talk about the subsistence living in terms of food and the need to be able to refrigerate it. I remember being up in one of those villages and they had just gotten a seal. They were very excited about it. Such a big animal, that to try to save that through the summer, of course, that keeps the polar bear aided, which was pretty exciting. But it makes you realize, they do have to have power for that refrigeration. It is a remarkable place.

We will turn to Senator Cortez Masto, virtually. Senator, are you there?

All right, while we are checking on that, we will go to Senator Tester.

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

Senator TESTER. I am good, Mr. Chairman, I am just here to listen to the folks give their testimony. I have some questions about mental health care in Indian Country and the pandemic and PPE and testing supplies going forward and how that is working out in Indian Country right now. I think we all understand that Indian Country has been hit very, very hard by this pandemic. I just want to hear how IHS has potentially done things a little differently because of this pandemic.

So I am looking forward to the testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Tester. Now we will check again with Senator Cortez Masto. All right, there are some issues with muting of her microphone. We will move forward with our witnesses and come back to Senator Cortez Masto.

First, we are going to hear from the Honorable Rear Admiral Michael Weahkee, Director of the Indian Health Service. He is here in person. We will also hear from the Honorable Marcellus Osceola, Jr., who is Chairman of the Seminole Nation of Florida, in Hollywood, Florida. We will hear from the chairman virtually. Then we will hear from the Honorable Timothy Nuvangyaoma, who is the Chairman of the Hopi Nation, in Kykotsmovi, Arizona, virtually. I know I probably didn't get all that right, but fortunately, our Vice Chairman is going to nail all those names perfectly. He will make sure that is covered for me, including any mistakes I make on the next one; the Honorable Michael Chavarria, Chairman, All Pueblo

Council of Governors, Albuquerque, New Mexico. We will also hear from him virtually.

So with that, Rear Admiral Weahkee, if you would 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, Chairman Hoeven, Vice Chairman Udall, and members of the Committee. Thank you for this opportunity to testify on three bills today, S. 3937, the Special Diabetes Reauthorization Act of 2020; S. 3126, the Native Behavioral Health Access Improvement Act of 2019; S. 4556, a bill authorizing the Department of Health and Human Services to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California.

I will go straight to the bills, noting the five-minute allowance for my oral statement. S. 3937, the Special Diabetes Programs for Indians Reauthorization Act of 2020, would amend the Public Health Service Act to reauthorize SDPI for five years at an increased annual funding level of \$200 million, which would significantly bolster IHS' diabetes prevention and treatment efforts, and enable us to reach tribal programs that currently do not have access to resources.

In addition, while S. 3937 provides for the SDPI to continue as a grant program overall, for the first time, this bill includes language stating that the grant may be awarded pursuant to an Indian tribe or tribal organization's Indian Self-Determination and Education Assistance Act, contract or compact.

My written testimony states many positives of the SDPI that I won't mention here due to time. But I do want to mention the bill's new language regarding the issue of how these grant funds would be transferred to tribes or tribal organizations. Currently, under Title V of the ISDEAA, a statutorily mandated grant such as SDPI may be added to a Title V funding agreement after award. However, the ISDEAA authority is not currently applicable to Title I contracts. One of the major benefits of the SDPI program's structure is that it supports community driven interventions and local decision making, which aligns well with the ideals of the ISDEAA.

S. 3126, the Native Behavioral Health Access Improvement Act of 2019, will create a special behavioral health program for Indians by awarding grants to prevent and treat mental health and substance use disorders. This bill requires the IHS to coordinate with the Office of the Assistant Secretary for Mental Health and Substance Use to support the behavioral health needs of American Indian and Alaska Native communities, establish a technical assistance center and develop specific metrics in consultation with tribes to monitor and evaluate outcomes and impact of the Special Behavioral Health Programs for Indians.

IHS has managed behavioral health grant programs that support community-based, culturally appropriate prevention and treatment services and supports to tribal and urban communities. Behavioral health disparities experienced among the American Indian and Alaska Native population, both prior to and during the pandemic, continue to impact the overall health and well-being of individuals,

families, and their communities. In response to the pandemic, and to support tribal communities experiencing new demands and stay-at-home orders, IHS has provided administrative flexibilities to our grantees to the greatest extent possible.

IHS acknowledges the mental and behavioral health impact of the pandemic and that the associated consequences will likely be felt for a long time to come. The backdrop of COVID-19 and its impact will play a role in the future of mental health and how those services are delivered across the ITU system.

Like other agencies, IHS is adapting to meet the needs of the new normal for providing health care and beginning to see an influx of new patients seeking care for grief, anxiety, and depression due to the effects of the pandemic. We anticipate this need to continue as long as the pandemic is impacting daily life.

Our staff are equally impacted, as front line providers are working hard and stretching their limits to support the mission of the Indian Health Service. S. 3126 will provide additional tools to address mental health disorders across the ITU system, which are noted in my written testimony. Such a program would expand existing IHS efforts by increasing availability, access, and quality of evidence-based treatment and recovery services for alcohol and substance use disorders.

In addition, the program would support tribes as they develop priority activities aligned with the Administration's national treatment plan, addressing unmet need by expanding access to medication for opioid use disorder and specialty addiction treatment programs, expanded clinical settings such as emergency departments and medical mobile units, and efforts to create a robust peer recovery training program.

To wrap up, S. 4556 would authorize the IHS Director through the HHS Secretary to acquire private land that contains a dirt road in order to facilitate better access to the IHS Desert Sage Youth Wellness Center in Hemet, California. Once the land is acquired, the IHS Director could construct and maintain a paved road on that land and improve the road to provide safe access to the Desert Sage facility for both staff and emergency vehicles.

Thank you again for this opportunity to meet with you today. I look forward to answering your questions.

[The prepared statement of 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, Ranking Member Udall, and members of the Committee on Indian Affairs. Thank you for the opportunity to testify on S. 3937, Special Diabetes Reauthorization Act of 2020; S. 3126, Native Behavioral Health Access Improvement Act of 2019; and legislation to authorize the Department of Health and Human Services (HHS) to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California.

As an agency within HHS, the Indian Health Service (IHS) mission is to raise the physical, mental, social, and spiritual health of American Indian and Alaska Native people to the highest level. This mission is carried out in partnership with American Indian and Alaska Native Tribal communities through a network of over 605 Federal and tribal health facilities and 41 Urban Indian

Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.6 million American Indian and Alaska Native people annually.

S. 3937

S. 3937, Special Diabetes Programs for Indians (SDPI) Reauthorization Act of 2020, would amend section 330C of the Public Health Service Act to reauthorize the SDPI for five (5) years at an increased annual funding level of \$200 million, which would significantly bolster SDPI's diabetes prevention and treatment efforts. In addition, while S. 3937 provides for the SDPI to continue as a grant program overall, for the first time, this bill includes language stating that the grant may be awarded pursuant to an Indian tribe or tribal organization's Indian Self-Determination and Education Assistance Act (ISDEAA) contract or compact.

Congress established the SDPI in the Balanced Budget Act of 1997 (P.L. 105–33) to address the burgeoning diabetes epidemic in American Indian/Alaska Native (AI/AN) people. The initial annual funding amount of \$30 million was increased to \$100 million in Fiscal Year (FY) 2001 and again in FY 2004 to its current level of \$150 million. There are currently 301 SDPI program sites in 35 states operated by Tribes, Tribal Organizations, UIOs, and the IHS.

FY 2020 is the twenty-third (23rd) year of the SDPI and recent data show that, since the beginning of the SDPI, tremendous improvements have been made in many important diabetes outcomes in AI/AN people. New cases of diabetes-related kidney failure decreased by 54 percent between 1996 and 2013¹ and a just published study² shows that those decreases have been sustained. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) has estimated that this decrease in kidney failure will save Medicare as much as half a billion dollars over 10 years.³

Diabetic eye disease incidence has also decreased by more than half⁴ and hospitalizations for uncontrolled diabetes have decreased by 84 percent.⁵ We are also happy to report that, after years of increasing, the prevalence of diabetes in AI/AN people decreased each year from 2013 to 2017,⁶ while it has plateaued in U.S. adults overall as well as for other racial/ethnic groups.⁷ As Congress envisioned, tremendous improvements are occurring in diabetes outcomes for AI/AN people—and the SDPI plays a key role in making them happen.

Regarding the issue of how these grant funds would be transferred to tribes or tribal organizations, currently, under Title V of the ISDEAA, a statutorily mandated grant such as SDPI may be added to a Title V funding agreement after award. This ISDEAA authority is not applicable to Title I Contracts. A statutorily mandated grant program added to a funding agreement is subject to the terms and conditions of the grant award (e.g., reporting requirements of the grant award program remain in place).

S. 3126

S. 3126, the Native Behavioral Health Access Improvement Act of 2019, would authorize the creation of a Special Behavioral Health Program for Indians by awarding grants to prevent and treat mental health and substance use disorders. This bill requires the IHS to coordinate with the Office of the Assistant Secretary for Mental Health and Substance Use to support the behavioral health needs of AI/AN communities, establish a technical assistance center and develop specific metrics, in consultation with Tribes, to monitor and evaluate outcomes and impact of the Special Behavioral Health Program for Indians.

¹ Bullock A, Burrows NR, Narva AS, Sheff K, et al. Vital Signs: Decrease in incidence of diabetes-related end-stage renal disease among American Indians/Alaska Natives—United States, 1996–2013. *MMWR* 2017;66(1):26–32

² Burrows NR, Zhang Y, Hora I, Pavkov ME, et al. Sustained lower incidence of diabetes-related end-stage kidney disease among American Indians and Alaska Natives, Blacks, and Hispanics in the U.S., 2000–2016. *Diabetes Care* 2020;43:2090–2097

³ Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Special Diabetes Program for Indians: estimates of Medicare savings. ASPE Issue Brief. Department of Health and Human Services, May 10, 2019. <https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings>

⁴ Bursell SE, Fonda SJ, Lewis DG, Horton MB. Prevalence of diabetic retinopathy and diabetic macular edema in a primary care-based teleophthalmology program for American Indians and Alaska Natives. *PLoS ONE* 2018;13(6):e0198551

⁵ Agency for Healthcare Research and Quality. Data Spotlight: Hospital admissions for uncontrolled diabetes improving among American Indians and Alaska Natives. AHRQ Publication No. 18(19)-0033–7-EF. December 2018. <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/dataspotlight-ai-an-diabetes.pdf>

⁶ Bullock A, Sheff K, Hora I, Burrows NR, et al. Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006–2017. *BMJ Open Diab Res Care* 2020;8:e001218. doi:10.1136/bmjdr-2020-001218

⁷ Benoit SR, Hora I, Albright AL, et al. New directions in incidence and prevalence of diagnosed diabetes in the USA. *BMJ Open Diab Res Care* 2019;7:e000657.

I appreciate the opportunity to share our efforts within IHS that address the behavioral health disparities impacting the AI/AN population. The Division of Behavioral Health manages and administers national behavioral health initiatives and policy development for mental health, alcohol and substance abuse, and family violence prevention programs for AI/AN people. IHS works in partnership with our IHS Facilities, Tribes, Tribal organizations, and Urban Indian health organizations (I/T/Us) to implement evidence-based, practice-based and culturally-based activities, to share knowledge and build capacity in Indian Country.

IHS has managed behavioral health grant programs that support community-based, culturally appropriate prevention and treatment services and supports to tribal and urban communities. These programs include the Substance Abuse and Suicide Prevention Program, the Domestic Violence Prevention Program, and the Youth Regional Treatment Center Aftercare Pilot Projects. IHS also supports initiatives focused on improving behavioral health services within clinical settings, including the Zero Suicide Initiative and the Behavioral Health Integration Initiative. We anticipate publication of the funding announcement for a new grant program designed to combat the opioid crisis, the Community Opioid Intervention Pilot Projects, will occur before the end of September.

The behavioral health disparities experienced among the AI/AN population prior to, and during, the pandemic continue to impact the overall health and wellbeing of individuals, families and communities.⁸ In response to the pandemic and to support tribal communities experiencing new demands and stay-at-home orders, IHS provided administrative flexibilities to our grantees to the greatest extent possible. For example, for current grants and initiatives scheduled to end in FY 2020, we authorized a one-year extension on the project period to provide additional time to implement services and complete objectives of the grant.

IHS acknowledges the mental and behavioral health impact of the pandemic and that the associated consequences will likely be felt for a long time to come. These priorities will shape our approach to behavioral health in ways that we could not have imagined a few years ago. The backdrop of COVID-19, and its impact will play a role in the future of mental health and how those services are delivered across the I/T/U system. Like other agencies, IHS is adapting to meet the needs of the “new normal” for providing healthcare, and mental health care in particular. We are beginning to see an influx of new patients seeking care for grief, anxiety, and depression due to the effects of the pandemic and we anticipate this need to continue as long as the pandemic is impacting daily life. Our staff is equally impacted as front-line providers working hard and stretching their limits to follow the mission of the IHS.

S. 3126, the Native Behavioral Health Access Improvement Act of 2019, would expand tools to address mental health, alcohol and substance abuse disparities, and increase access to treatment across the I/T/U system. The IHS currently provides access to outpatient clinical and preventive mental health services through a system of IHS, tribally operated and urban Indian health programs. While IHS is a direct service provider for behavioral health, the majority of behavioral health services are provided by tribes under Indian Self-Determination Act contracts and compacts. The AI/AN population continues to experience persistently higher rates of serious behavioral health issues than the general population, and the impact on the overall health and wellbeing of individuals, families and communities demands a comprehensive approach.

The suicide rate in AI/AN communities has previously been discussed before this Committee, and remains a priority IHS continues to address in partnership with the tribes. According to the CDC, the suicide rate for AI/AN adolescents and young adults ages 15–34 was 1.3 times higher than the national average for that age group in the general population. Suicide is the eighth leading cause of death among all AI/AN across all ages.⁹ According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health, AI/AN adolescents had a prevalence rate of 16.3 percent for major depressive episode with or without severe impairment, which was the highest rate compared to other ethnicities. In addition, the AI/AN adult prevalence rate of 8.0 percent for a major depressive episode with or without severe impairment was the highest when com-

⁸ MMWR—Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons—23 States, January 31–July 3, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1166–1169. DOI: <http://dx.doi.org/10.15585/mmwr.mm6934e1>

⁹ Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from

pared to other ethnicities, and their prevalence rate of 18.9 percent was the third highest for serious mental illness compared to other ethnicities.¹⁰

Under S. 3126, the creation of a Special Behavioral Health Program for Indians grant program would provide additional tools to address mental health disorders across the I/T/U system. The grant would increase the number of behavioral health providers and expand access to services such as: acute inpatient crisis stabilization to focus on first episode psychosis and suicidal ideation, mobile crisis teams, first episode psychosis peer support, behavioral health services within primary care and emergency rooms, assessment and treatment of early childhood mental health disorders and developmental disabilities, and assessment and treatment of post-traumatic stress disorder. With the expansion of services at local systems of care through these new grants, individuals would receive interventions aimed at preventing the development of severe and possibly life threatening symptoms.

The Committee, as evidenced by past oversight and legislative hearings on the opioid crisis in Indian Country, is well aware of the significant impact the opioid crisis has had on the AI/AN population. The rate of drug overdose deaths among AI/ANs is above the national average. From 2015–2017, the overall rate of overdose deaths for AI/ANs increased by 13 percent. The IHS Alcohol and Substance Abuse Program's mission is to reduce the incidence and prevalence of alcohol and substance abuse among AI/ANs to a level at or below the general U.S. population. The Alcohol and Substance Abuse Program provides funding, policy, training, and technical assistance to local IHS, tribal, and urban Indian programs to ensure a variety of treatment options exist. IHS actively solicits feedback and works with tribes to develop and implement models of care that are effective and sustainable. Our primary focus is to support treatments that are evidence-based and culturally effective and that will have a significant impact on the prevention, treatment and recovery efforts to combating alcohol and substance abuse.

Under S. 3126, a Special Behavioral Health Program for Indians would expand existing IHS efforts by increasing availability, access, and quality of evidence-based treatment and recovery services for alcohol and substance use disorders, particularly in rural, urban, and other underserved tribal communities. In addition, the program would support tribes as they develop priority activities aligned with the Administration's National Treatment Plan addressing unmet need by expanding access to medication for opioid use disorder in specialty addiction treatment programs, expanded clinical settings such as emergency departments and medical mobile units and efforts to create a robust peer recovery training program. The expansion of the IHS Community Health Aide Program (CHAP) could play a significant role in the training and development of a cadre of peer recovery specialists whose services are grounded in traditional and cultural-based practices and could be sustainable through reimbursement of treatment services. The ability to collect data and evaluate these interventions of this new program could help facilitate IHS taking a more unified approach in working with tribal communities to evaluate the overall impact of these interventions and build on lessons learned.

Despite our best efforts, access to behavioral health care services has been a long-standing issue in many Native communities. Though true for all behavioral health needs, this is especially true for pediatric and other specialty care. One effective and efficient means of increasing access to care is telebehavioral health. To date, the IHS Telebehavioral Health Center of Excellence provides clinical services and technical assistance to 26 facilities with an established waitlist for an additional 31 sites. To better determine need, in December of 2019, IHS polled the waitlisted sites. We found a significant and growing demand for services include a request for 268 hours of behavioral health services (roughly 450 to 500 patients) per week. When asked about the types of services needed, 93 percent wanted services for youth and 74 percent requested behavioral health prescribing services.

While many of our IHS and tribal behavioral health clinics adapted swiftly to offer limited continuity of care through telebehavioral health services following the outbreak of the COVID–19 pandemic, we expect an influx of new patients seeking care for grief, anxiety and depression due to the effects of the pandemic. To address these concerns, and to provide timely support to Tribal communities, IHS has prioritized the expansion of telebehavioral health. Given the efficacy and efficiencies of telebehavioral health and the clearly documented need, the expansion of telebehavioral health would have a significant and positive impact on access to behavioral health services. S. 3126 would greatly expand the IHS efforts to provide effec-

¹⁰U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from <https://nsduhweb.rti.org/respweb/homepage.cfm>

tive telebehavioral health services across the entire I/T/U system, especially those communities that are the most rural and remote.

Finally, I would like to discuss the establishment of the Technical Assistance Center described in S. 3126. Both the Indian Health Service and SAMHSA currently provide technical assistance to grantees funded by the different behavioral health grant programs within a limited scope based on the grant objectives. We are also aware SAMHSA has other tribal technical assistance centers focused on AI/AN communities funded through contracts and cooperative agreements. A technical assistance center for the Special Behavioral Health Program for Indians could help support tribes as they implement behavioral health programming within their communities, and could help improve behavioral health services. For instance, our grantees have shared challenges that range from administrative challenges such as insufficient staffing or staff turnover to crisis response resources and coordination. In addition, a technical assistance center could assist in the coordination of data collection between IHS and all facilities that serve the AI/AN population to improve evaluation efforts demonstrating lessons learned, progress, and outcomes.

S. 4556

S. 4556, legislation introduced by Senator Feinstein would authorize HHS to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California. This legislation authorizes the IHS Director, through the HHS Secretary, to acquire land that contains a dirt road known as “Best Road” and other land or interests in lands in order to facilitate access to the IHS Desert Sage Youth Wellness Note to Center (Desert Sage), in Hemet, California. Once the land is acquired, the Feinstein legislation provides for the IHS Director to construct and maintain a paved road on that land.

The IHS Desert Sage is a co-ed residential treatment facility for youth (ages 12–17) with substance abuse and co-occurring disorders. Approximately 8,000 American Indian and Alaska Native youth per year in California require substance abuse treatment based on Census 2000 data. The facility concurrently provides care for maximum of 32 youth. Services offered include mental health, chemical dependency counseling, individual and group counseling, family therapy, traditional healing services, traditional arts and crafts, cultural activities, field/recreation trips, educational opportunities, academic and life-skills education, fitness program, and access to medical specialties and dental care. Desert Sage began operations in 2017 and received The Joint Commission accreditation on February 11, 2019. Desert Sage’s activities are authorized under Section 704 of amended P.L. 94–437, Indian Health Care Improvement Act.

The Desert Sage facility is located on the “Taylor Ranch” property in Riverside County (County) near Hemet, California. The property was purchased in October 2012 for the facility. At that time, IHS had an agreement with the landowners to use the unpaved easement, Best Road, to cross two properties (Genus and Moon Valley Nurseries) to access the facility.

Best Road is an unimproved road, privately owned, and approximately 0.5 mile long located in the County that runs from Sage Road to the driveway entrance of the Desert Sage facility. The road conditions on Best Road deteriorate during storm events and become nearly impassible due to flooding in low-lying areas, poor surface drainage, and the lack of all-weather driving surface. Since October 2017, the IHS California Area Office continues to perform regularly scheduled maintenance every other month including grading and backfilling low areas with gravel. Emergency work is also done on an as-needed basis after major storm events. Currently, IHS does not have the authority to acquire and/or improve Best Road. The Feinstein legislation would authorize the Director of IHS to acquire and improve Best Road to provide safe access to the Desert Sage facility for staff and emergency vehicles.

We appreciate all of your efforts in helping us provide the best possible care to the people we serve. Thank you again for the opportunity to meet with you today.

The CHAIRMAN. Thank you, Admiral Weahkee.

Next, we will turn to the Honorable Marcellus Osceola, Chairman of the Seminole Nation of Florida.

**STATEMENT OF HON. MARCELLUS OSCEOLA, JR., CHAIRMAN,
SEMINOLE NATION**

Mr. OSCEOLA. Thank you, Chairman. I appreciate the time today. Chairman Hoeven, Ranking Member Udall and members of the Committee, my name is Marcellus Osceola, Jr. I am Chairman of

the Seminole Tribe of Florida, Tribal Council. I am here today to urge Congress to move quickly to enact legislation that will clear that the Seminole Tribe of Florida has the authority to lease or transfer fee lands without requiring prior Congressional approval.

I especially want to thank Florida Senators Marco Rubio and Rick Scott for introducing the bill and working with us through this process.

Seminoles have lived in Florida for thousands of years. In 1830, when the United States enacted a law requiring that all Native people east of the Mississippi be removed west, we resisted and remained free and unconquered in the swamps of Florida. We kept our ways and our traditions, as well as our home, and we continue to do so to this day.

We have grown and prospered over the time and number more than 4,000 tribal members today. We are a sovereign government with our own schools, police, and courts. We run one of the largest cattle operations in the United States. We own Hard Rock Hotel and Casinos, an international business with locations in 74 countries. And yet we still continue our traditions of sewing, patchwork, chickee building, and alligator wrestling. The world has changed, and we have adapted, while at the same time keeping our traditional ways, our culture, and our lives.

A key strategy we have chosen to pursue in adapting to a changing world is diversification of our investments and revenue sources. I am here to ask for your help in addressing an outdated and paternalistic law that is hampering our efforts to diversify.

The Seminole Tribe has established an investment fund to invest in commercial real estate properties in order to create generational wealth for the Seminole Tribe of Florida and its members. The tribe plans to establish a State chartered subsidiary to hold the title to invest property while acquiring and entering into financing transactions and grant to lender and mortgage interest in the property.

However, we have been unable to move forward with the first project due to concerns raised by a lender and title insurance company about the Indian Non-Intercourse Act. The NIA in effect requires Congressional authorization before an Indian tribe can sell or mortgage any land that it owns. This is relevant to our investment fund because the lender requires that they be granted a mortgage on the investment property they finance, and that the mortgage be insured by the title insurance policy.

Title insurance companies have interpreted the NIA to apply to real estate owned by the investment fund, which is a State chartered subsidiary of the tribe. Title companies will not insure the mortgage without an exception for the NIA. This effectively kills the ability to finance an acquisition.

The Act dates back to the 1800s and was designed to prevent Indian tribes from being defrauded. Today, it is hampering efforts to diversify for tribes that are imminently capable of making their own business decisions.

In order to address this issue, Senators Rubio and Scott introduced S. 4079 to make clear that the NIA does not apply to fee land owned by the Seminole Tribe. Florida Representative Darren Soto has introduced the House counterpart with six bipartisan

members of the Florida delegation as cosponsors. This legislation is necessary for the investment fund to acquire properties, and there is a precedent for doing so. Congress has routinely approved similar legislation for other tribes.

On behalf of the Seminole Tribe of Florida, I ask this Committee and the full Senate to act quickly to approve S. 4079 in order to allow the Seminole Tribe to reach our goal of economic diversity and help secure the future of our tribal members.

Thank you for the opportunity to appear before you today. I am happy to answer any questions that you may have. Sho-Na-Bish. [The prepared statement of Mr. Osceola follows:]

PREPARED STATEMENT OF HON. MARCELLUS OSCEOLA, JR., CHAIRMAN, SEMINOLE NATION

Chairman Hoeven, Ranking Member Udall and Members of the Committee, my name is Marcellus Osceola, Jr. and I am chairman of the Tribal Council of the Seminole Tribe of Florida. I am here today to urge Congress to move quickly to enact S. 4079, legislation that will make clear that the Seminole Tribe of Florida has the authority to lease or transfer certain fee lands without requiring prior congressional approval. I especially want to thank Florida Senators Marco Rubio and Rick Scott for introducing the bill and working with us throughout this process.

Seminole have lived in Florida for thousands of years. Our ancestors were the first people to come to Florida. In 1830, when the United States enacted a law requiring that all Native People east of the Mississippi River be "removed" west, we resisted and remained free and unconquered in the swamps of Florida. We kept our ways and our traditions as well as our home, and we continue to do so to this day.

We have grown and prospered over time and number more than four thousand Tribal members today. We are a sovereign government with our own schools, police, and courts. We run one of the largest cattle operations in the United States. We own Hard Rock Hotel & Casinos, an international business with locations in 74 countries. We still continue our traditions of sewing, patchwork, chickee building, and alligator wrestling. The world has changed, as it always has, and we have adapted, as we always have; while keeping our ways, our culture, and our lives, to remain the Unconquered Seminole Tribe of Florida.

A key strategy we have chosen to pursue in adapting to a changing world is diversification of our investments and revenue sources. I am here today to ask for your help in addressing an outdated and paternalistic law that is hampering our efforts to diversify.

The Seminole Tribe has established an investment fund to invest in commercial real estate properties in order to create generational wealth for the Seminole Tribe. The Tribe will seek properties with a targeted rate of return of 4 percent per year on unlevered investments and 7 percent on levered investments, based upon invested equity. The proposed structure for the acquisition is for the Seminole Tribe to establish a state chartered subsidiary entity to act as a holding company. The holding company then creates a subsidiary entity to hold title to the property, enter into financing transactions and grant any lender a mortgage interest in the property.

However, we have been unable to move forward with our first project due to concerns raised by the lender and proposed title insurance company about the Indian Non-Intercourse Act (NIA). The NIA states in part:

"No purchase, grant, lease, or other conveyance of lands, or of any title or claim thereto, from any Indian nation or tribe of Indians, shall be of any validity in law or equity, unless the same be made by treaty or convention entered into pursuant to the Constitution."

Lenders require that they be granted a mortgage on the property financed and that the mortgage be insured with a mortgagee title insurance policy. At least two title insurance companies approached for first transaction we considered have interpreted the NIA to apply to real estate owned by a state chartered subsidiary entity of the Tribe. While we believe this is a wrong reading of the NIA, the title companies approached have not changed their view and will not insure the mortgage without an exception for the NIA. This effectively kills any ability to finance an acquisition.

The Act dates back to the 1800's and in part was designed to prevent Indian tribes from being defrauded. Today, it is hampering efforts to diversify for tribes that are imminently capable of making our own business decisions.

In order to address this issue and provide certainty to lenders and title insurers, Senators Rubio and Scott introduced S. 4079 to make clear that the NIA does not apply to fee land owned by the Seminole Tribe. Florida Representative Darren Soto has introduced the House counterpart, H.R. 7565, with six bipartisan Members of the Florida delegation as cosponsors. This legislation is necessary for the investment fund to acquire properties.

Congress has routinely approved similar legislation for other tribes. For example, "The Oregon Tribal Economic Development Act", Public Law 115-79, and Public Law 114-127 allowed certain tribes in Oregon and the Miami Tribe of Oklahoma to alienate non-trust property without further federal approval.

On behalf of Seminole Tribe of Florida, I ask that this Committee and the full Senate act quickly to approve S. 4079 in order to allow the Seminole Tribe to reach our goal of economic diversity and help secure the future of our tribal members. In fact, I urge Congress to consider taking up broader legislation going forward in order to assure that this outdated and paternalistic NIA language will no longer hinder economic opportunities for any federally recognized Indian tribe.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions you may have. Sho-Na-Bish.

The CHAIRMAN. Thank you, Chairman.

Now we will turn to the Honorable Timothy Nuvangyaoma, who is Chairman of the Hopi Nation. Chairman?

**STATEMENT OF HON. TIMOTHY NUVANGYAOMA, CHAIRMAN,
HOPI NATION**

Mr. NUVANGYAOMA. Good afternoon, Chairman Hoeven, Vice Chairman Udall, and honorable members of the Senate Committee on Indian Affairs.

My name is Timothy Nuvangyaoma, and I have the honor of serving as chairman of the Hopi Tribe. Located in the northeast corner of Arizona, the Hopi Reservation is approximately 2.5 million square miles. Roughly half of the tribe's population resides on the reservation's 12 villages.

I do want to thank you for the opportunity to testify and express our strong support for S. 3937, the Special Diabetes Program for Indians Reauthorization Act of 2020. I would like to begin by thanking Senator McSally for introducing this important legislation and Senator Sinema for being an original cosponsor.

We also appreciate our representative, Tom O'Halloran, introducing similar legislation in the House of Representatives. Our Congressional delegation clearly understands the importance of the life-changing Special Diabetes Programs for Indians, the SDPI.

The Hopi Special Diabetes Program, or HSDP, was awarded its first SDPI grant in 1998. The HSDP mission is to provide quality preventive services to the Hopi community in order to reduce the incidence rate of Type II diabetes. The program operates the Hopi Wellness Center, the HWC, and the Hopi Veterans Memorial Center, the HVMC. The HWC provides a free public use fitness center, childcare services for fitness center users, and diabetes prevention education. The HVMC is a multipurpose facility used for community and recreational events.

The HSDP utilizes effective, evidence-based intervention strategies to provide the Hopi community with a broad, community-centered public health approach to diabetes prevention. Since the program's inception, we have implemented programs focused on reduc-

ing obesity, improving nutrition, addressing food insecurity, physical fitness, and weight management.

I am particularly proud of our efforts to incorporate Hopi culture into our programs. In 2019, the HSDP served over 17,000 people through these various programs.

In spite of the ongoing health pandemic, the HSDP has been able to continue fulfilling its mission. In March, 2020, the Hopi tribe issued executive order 01-2020, declaring a public health state of emergency across the Hopi reservation due to the Coronavirus pandemic. Due to the health risks posed, we had to make a tough decision to close the Hopi Wellness Center and our Hopi Veterans Memorial Center. As a result, several HSDP events were canceled or postponed.

Knowing the importance of maintaining a healthy body and mind during these trying times, the HSDP quickly adapted and began offering virtual health and wellness services. We are currently offering a wide array of online fitness classes from Monday through Friday, including Native fitness which incorporates traditional Hopi song and dance. In addition, HSDP is hosting a fitness bucks challenge, where participants earn fitness bucks by completing a virtual fitness class, classes that are held on the Hopi wellness center's Facebook page.

HSDP also modified two programs that celebrate the Hopi's long-standing tradition of running. The 28th annual 100-Mile Club event just wrapped up, and despite it being virtual, there were nearly 800 participants ages 5 and up. Participants had to log 100 miles within 14 weeks. As we speak, 750 tribal members are gearing up for the 14th annual Taawaki Trail Run, which will take place on October 2nd and October 4th. Participants in this event will be completing an 8K, 10K, or half marathon in one session.

The SDPI funding has been critical in allowing the HSDP to develop diabetes prevention and management programs. There is no doubt that our program has changed the course of diabetes in the Hopi community. Reauthorizing SDPI and providing an increase in its funding level is critical as we continue our efforts to combat the high rates of diabetes in our community.

Therefore, the Hopi Tribe strongly supports S. 3937, the Special Diabetes Program for Indians Reauthorization Act of 2020.

Considering many of the issues we are dealing with are inter-related, I would like to take a brief moment to express the tribe's support for two other bills included in today's hearing: S. 3126, the Native Behavioral Health Access Improvement Act, and S. 3264, the Bridging the Tribal Digital Divide Act. Modeled after SDPI, Senator Smith's bill would provide tribes with critical resources to battle mental and behavioral health challenges in our communities. Further, Senator Udall's bill is needed now more than ever as we are relying heavily on broadband service during the ongoing pandemic.

Once again, thank you for the opportunity to testify. The Hopi Tribe encourages the Committee to approve S. 3937, the Special Diabetes Program for Indians Reauthorization Act of 2020; S. 3126, the Native Behavioral Health Access Improvement Act; and S. 3264, the Bridging the Tribal Digital Divide Act.

I am happy to answer any questions that you may have. Thank you.

[The prepared statement of Mr. Nuvangyaoma follows:]

PREPARED STATEMENT OF HON. TIMOTHY NUVANGYAOMA, CHAIRMAN, HOPI NATION

Good afternoon Chairman Hoeven, Vice Chairman Udall, and Honorable Members of the Senate Committee on Indian Affairs. My name is Timothy Nuvangyaoma and I have the honor of serving as Chairman of the Hopi Tribe. Located in the northeast corner of Arizona, the Hopi Reservation is approximately 2.5 million square miles. Roughly half of the Tribe's population resides on the Reservation's 12 villages.

Thank you for the opportunity to testify and express our strong support for S. 3937, the Special Diabetes Program for Indians Reauthorization Act of 2020. I would like to begin by thanking Senator McSally for introducing this important legislation and Senator Sinema for being an original cosponsor. We also appreciate our Representative, Tom O'Halleran, introducing similar legislation in the House of Representatives. Our Congressional delegation clearly understands the importance of the life-changing, Special Diabetes Program for Indians (SDPI).

The Hopi Special Diabetes Program ("Program or HSDP") was awarded its first SDPI grant in 1998. The HSDP mission is to provide quality preventative services to the Hopi community in order to reduce the incidence rate of type 2 diabetes. The Program operates the Hopi Wellness Center (HWC) and the Hopi Veteran's Memorial Center (HVMC). The HWS provides a free, public use fitness center; childcare services for fitness center users; and diabetes prevention education. The HVMC is a multi-purpose facility used for community and recreational events.

The HSDP utilizes effective, evidence-based intervention strategies to provide the Hopi community with a broad, community-centered public health approach to diabetes prevention. Since the Program's inception, we have implemented programs focused on reducing obesity, improving nutrition, addressing food insecurity, physical fitness, and weight management. I'm particularly proud of our efforts to incorporate Hopi culture into our programs. In 2019, the HSDP served over 17,000 people through these various programs.

Despite the ongoing health pandemic, the HSDP has been able to continue fulfilling its mission. In March 2020, the Hopi Tribe issued Executive Order #01-2020, declaring a public health state of emergency across the Hopi Reservation due to the Coronavirus pandemic. Due to the health risks posed, we made the tough decision to close the Hopi Wellness Center and the Hopi Veteran's Memorial Center. As a result, several HSDP events were cancelled or postponed.

Knowing the importance of maintaining a healthy body and mind during these trying times, the HSDP quickly adapted and began offering "virtual" health and wellness services. We are currently offering a wide array of online fitness classes from Monday through Friday, including "Native Fitness," which incorporates traditional Hopi song and dance. In addition, HSDP is hosting the "Fitness Bucks Challenge," where participants earn "fitness buck" by completing virtual fitness classes that are held on the Hopi Wellness Center's Facebook page.

The HSDP also modified two programs that celebrate the Hopi's longstanding tradition of running. The 28th annual "100 Mile Club" event just wrapped up and despite it being "virtual" there were nearly 800 participants (ages 5 and up). Participants had to log 100 miles within 14 weeks. As we speak, 750 tribal members are gearing up for the 14th annual Taawaki Trail Run, which will take place on October 2nd and October 4th. Participants in this event will be completing an 8K, 10K, or half marathon in one session.

The SDPI funding has been critical in allowing the HSDP to develop, sustain, and implement quality diabetes prevention and management programs. There is no doubt that our Program has changed the course of diabetes in the Hopi community. Reauthorizing SDPI and providing an increase in its funding level is critical as we continue our efforts to combat the high rates of diabetes in our community. Therefore, the Hopi Tribe strongly supports S. 3937, the Special Diabetes Program for Indians Reauthorization Act of 2020.

Considering many of the issues we are dealing with are interrelated, I would like to take a brief moment to express the Tribe's support for two other bills included in today's hearing: S. 3126, the Native Behavioral Health Access Improvement Act (Smith), and S. 3264, the Bridging the Tribal Digital Divide Act (Udall). Modeled after SDPI, Senator Smith's bill would provide tribes with critical resources to battle mental and behavioral health challenges in our communities. Further, Senator Udall's bill is needed now more than ever as we are relying heavily on broadband service during the ongoing pandemic.

Once again, thank you for the opportunity to testify. The Hopi Tribe encourages the Committee to approve S. 3937, the Special Diabetes Program for Indians Reauthorization Act of 2020; S. 3126, the Native Behavioral Health Access Improvement Act; and S. 3264, the Bridging the Tribal Digital Divide Act. I would be happy to answer any questions.

The CHAIRMAN. Thank you.

Next, we will turn to the Honorable Michael Chavarria, Chairman of the All Pueblo Council of Governors, in Albuquerque, New Mexico.

STATEMENT OF HON. MICHAEL CHAVARRIA, GOVERNOR, SANTA CLARA PUEBLO; CHAIRMAN, ALL PUEBLO COUNCIL OF GOVERNORS

Mr. CHAVARRIA. [Greeting in Native tongue.] I send respect and good afternoon.

Thank you, Chairman Hoeven, and Ranking Member Udall, and members of the Committee. Today I have been requested to provide testimony on two bills, S. 3126, and S. 3264. I appreciate the invitation to provide testimony this afternoon. My name is Michael Chavarria, I serve as Governor for Santa Clara Pueblo, and the Chairman of the All Pueblo Council of Governors here in New Mexico.

First, I will provide oral testimony on S. 3126, the Native Behavioral Health Access Improvement Act of 2019. Santa Clara Pueblo has been plagued by substance abuse disorder for a number of decades. Northern New Mexico and the Espanola Valley where the Pueblo is located has among the highest rates of opioid abuse and overdose in the Nation. Unfortunately, in 2000, the New York Times labeled Chimayo as the heroin capital of Rio Arriba County. This is a recognition no one wants, particularly when it refers to our own back yard.

Of course, the opioid epidemic is not just a local problem, but a regional and national problem. Other forms of substance abuse, like alcohol abuse, still exist, too. For this testimony, however, I will focus on our experience with opioids.

Since 2014, Santa Clara Pueblo has seen at least 30 cases involving opioids come to our tribal court system and the number continues to rise. Unfortunately, we have experienced serious crime in connection with drugs in the form of assaults, batteries, domestic violence, child and elder abuse, and babies born to addiction. Many of these cases involved individuals suffering from opioid addiction and a mental and behavioral health disorder.

Tragically, we do not have the resources to access the unmet needs for services. Decades of underfunding, coupled by the effects of COVID-19, the pandemic, have made it very difficult for people to get help that they need. Critical medication assistance treatment and residential treatment programs are unreachable due to the facility closures. Counseling therapies are taking place on virtual platforms that our members cannot even access, and service assessment and evaluations are disrupted.

This disparate impact has been exacerbated by longstanding issues of access to quality and timely health care caused by the chronic underfunding of the Indian Health Service. Tribal self-gov-

ernance and tribal 638 clinics meet less than 60 percent of that need.

With that said, it is very important that legislation targeting behavioral health access and improvements take into account these complex factors, as well as the effects of historical trauma, to address the holistic health of our members. S. 3126 has the potential to do this, with the creation of a Special Behavioral Health Program for Indians. We believe such a program could be a vehicle for improving the behavioral and mental health resources available in tribal communities if implemented comprehensively and in consultation with tribes.

It cannot be a one size fits all approach. The program must be designed with tribal flexibility in mind. For example, we would want to use a program to support the training and retention of home-grown health care providers and to provide all levels of treatment at the local level in a culturally relevant manner.

In closing, Chairman, members of the Committee, I appreciate the time to provide testimony this afternoon, and I fully support S. 3126, to amend the Public Health Service Act to authorize a Special Behavioral Health Program for Indians. Our team has worked very hard to create written testimony which is submitted for the record.

At this time, Mr. Chairman, out of respect, and members of the Committee, I ask for your authorization to continue to provide testimony on S. 3264, Bridging the Tribal Digital Divide Act of 2020. So Mr. Chairman, I am asking for your permission to carry on at this time.

The CHAIRMAN. Without objection.

Mr. CHAVARRIA. Thank you, Chairman and members of the Committee. Thank you, Ranking Member Udall, and cosponsors of the Committee for proposing this critical piece of legislation.

Broadband infrastructure development, maintenance and access is an underlying and persistent need not only in Pueblo Country, but all of Indian Country. During this difficult time of the COVID-19 pandemic, we have seen and experienced how severely limited and nonexistent broadband infrastructure on tribal lands has had a direct and harmful impact on Native health and welfare, leaving us vulnerable to health and safety risks.

Broadband is vital for public safety. It enables communities to shelter in place while remaining connected to tribal government updates, to engage in tele-health, work, and education, to stay entertained, connected with family and friends. Quite frankly, it allows them to connect with hope. Yet in 2020, many of our Pueblo communities and families are cut off from these benefits, and live in isolation due to the lack of internet services. This puts our people at tremendous risk, as they must either venture off our lands for services, or go without, which is unacceptable.

An all hands investment in addressing this situation is urgently needed. Federal legislation must facilitate leveraging opportunities and support broadband procurement, training, maintenance, spectrum rights and access, and the last-mile connectivity services. This will provide our Pueblo communities with the internal capacities and capabilities to deploy and maintain critical wireless services on all of our lands.

While S. 3264 does not address all these matters at once, it comes close. It provides an avenue for tribal nations to help their communities connect to the essential broadband services through long-term infrastructure investments, tribal set-aside funding within key USDA and FCC telecommunication programs, a tribal broadband right-of-way pilot program, and the provision for technical assistance to underserved tribal nations to develop appropriately tailored plans to meet deployment benchmarks, including spectrum purchases and internal capacity building.

The creation of a tribal broadband interagency working group and a tribal broadband deployment advisory committee would be very positive. Both of these types of bodies are key to active tribal inclusion in Federal decision making processes, in raising our Pueblo and others out of electronic isolation.

The Pueblos and other tribal nations are sophisticated partners in helping to develop and shape Federal policies and procedures impacting our communities. I fully support the proactive measures included in S. 3264 to advance the sustainable deployment of affordable broadband on tribal lands.

So in closing, Chairman, members of the Committee, I appreciate the time to provide testimony on both these critical bills, and I fully support, and our team has worked very hard to create written testimony which has been submitted for the record.

At this time, Chairman, members of the Committee, kuunda, thank you very much, and now it is time for questions.

[The prepared statement of Mr. Chavarria follows:]

PREPARED STATEMENT OF HON. MICHAEL CHAVARRIA, GOVERNOR, SANTA CLARA PUEBLO; CHAIRMAN, ALL PUEBLO COUNCIL OF GOVERNORS

Introduction

Thank you Chairman Hoeven, Ranking Member Udall, and Members of the Committee for inviting to testify on S. 3126, the “Native Behavioral Health Access Improvement Act of 2019” and S. 3264, the “Bridging the Tribal Digital Divide Act of 2020.” Behavioral health and broadband access represent two areas of increasingly dire need in Pueblo Country. S. 3126 and S. 3264 would make critical strides in addressing these two areas of unmet need.

My name is J. Michael Chavarria and I am the Governor of Santa Clara Pueblo, also serving in the capacity of the Chairman of the All Pueblo Council of Governors (APCG), which is comprised of the leaders of the nineteen Pueblos of New Mexico and Ysleta del Sur Pueblo in Texas. Together and individually, our communities are dedicated to improving the health and welfare of our Pueblo citizens. I testify today on behalf of the Pueblo of Santa Clara to share our experience in the hope that it will assist you and your staff in considering these vitally important bills.

Santa Clara Pueblo and the Ubiquitous Need for Behavioral Health Services

Our Pueblo has felt and continues to feel the direct impacts of inadequate access to behavioral health services. It affects our students at the Kha’p’o Community School, our adults in social support programs, and our teenagers and youth throughout the community. Because the needs in this area are so great and diverse, it would be possible to spend the entirety of my testimony on this topic alone. However, for the purposes of manageability, I will focus on the connection between substance abuse disorders (SUDs) and behavioral health.

Northern New Mexico and the Española Valley, where Santa Clara Pueblo is located, have the lamentable distinction of having among the highest national rates opioid abuse and overdose. Our home county of Rio Arriba reported an annual average of 89 drug-related fatalities per 100,000 residents between 2012 and 2016. For comparison, New Mexico as a whole averaged 24 drug-related fatalities annually for the same period. Our Pueblo has not been spared. Tribal Court cases involving opioid use are on the rise with at least 30 such cases coming before our Tribal Judge

since 2014. Many of these cases involved individuals subject to a dual diagnosis of an opioid SUD and a mental health disorder that must be treated together. Unfortunately most facilities and programs treat addiction and mental health separately and that is one of the reasons for high rates of recidivism.

In the last six years, our Tribal Court has played an essential role in reducing crime by over 50 percent and reducing the incarceration budget by 66 percent. To continue this success, there must be more beds and facilities for those needing integrated dual diagnosis treatment. In general, the most effective treatment for a dual diagnosis individual is treatment at a long-term or residential care facility followed by targeted support upon discharge.

Tragically, we do not have the behavioral and mental health resources to assist our Pueblo members in breaking cycles of addiction and staying on the path of sobriety. The effects of decades of understaffing, insufficient resourcing (including funding), and inadequate facilities are now painfully evident. The IHS, for example, has only twelve behavioral health specialists to serve the entire Albuquerque Area, an area that covers three states and twenty-seven tribal nations. Our members must often wait extended periods for an appointment with a behavioral health specialist. In the interim, our people must suffer through behavioral or mental health crises without formal support—placing both themselves and the greater community at risk.

Extenuating Circumstances Caused by the COVID-19 Pandemic

As Ranking Member Udall is well aware, the current public health emergency has disproportionately impacted Pueblo and tribal communities in New Mexico. At one point, AI/ANs accounted for nearly 60 percent of all COVID-19 positive cases in the State. Today, the AI/AN positivity rate stands at 30 percent, meaning that 1 in 3 cases in New Mexico is an AI/AN individual—a terrible feat given that we make up only 11 percent of the State's overall population.

The disparate impacts are attributable, in significant and substantial part, to the direct connection between a chronically underfunded Indian Health Service and our members' physical welfare. Pueblo people suffer from high rates of chronic and acute health conditions like diabetes and heart disease that contribute to severe COVID-19 cases and increased rates of patient mortality. The Special Diabetes Program for Indians and other federally-funded health programs are key to managing contributing health factors and symptoms.

Like other tribal nations, the Pueblo of Santa Clara has closed tribal businesses, offices, and borders in an attempt to stem the incursion of COVID-19 onto our lands. Our members have been instructed to shelter in place and to only leave home for essential services and emergencies. The prolonged social isolation is a deep hardship for many members. Our Pueblos are communal in nature with life taking place through community interactions and the gatherings of our extended, intergenerational families. The pandemic has prevented us from expressing these essential aspects of our Pueblo identities—unmooring us from our communal, ceremonial, and traditional lifestyle. The result is an across-the-board increase in depression, anxiety, and loneliness, along with a dangerous increase in SUDs and suicide risk among our vulnerable members.

Broadband and Telehealth Limitations at this Time

Pueblo members struggle to manage the many economic, social, familial, personal, emotional, and physical stressors being placed upon them with limited to no formal support. Members who struggled with SUDs before the pandemic also have to deal with the unfortunate additional stressor of being abruptly cut off from individual and group therapies, treatment services (including Medication Assisted Therapy or MAT), and immersive SUD programs like residential and long-term treatment centers.

Our members have been directed to use telehealth services to meet their behavioral health support and case management needs during the pandemic. The direction, however, assumes that (a) individuals have access to Internet at home through a smartphone or other device; and (b) communities have the requisite infrastructure to support high-speed connections across tribal lands. Both of these assumptions are false when talking about Pueblo Country. Individuals and families lack sufficient data plans to access services via cell phone and many homes are not connected to any kind of wireless or broadband service. Where connections are possible, the bandwidth is often overstretched due to the high demand for services as everyone in the household is logged on simultaneously for work, school, grocery shopping, family calls, and appointments. Further, overcrowding and potential unsafe housing conditions may make it difficult, if not impossible, for individuals to access services with any privacy.

We are establishing hot spots across Pueblo lands to facilitate community access to the Internet. Students, families, workers, behavioral health patients, and others endure scorching temperatures and discomfort to use these hot spots for everything from classroom instruction to bill payments to medical and therapy appointments. How can we expect community members to continue this type of behavior as the pandemic stretches into the winter months? Telehealth and tele-service programs are only as effective as the systems that support them. We simply must find a way to provide high-speed Internet at reduced or no cost to our Pueblo members. Without it, it is as if our most vulnerable Pueblo members have been given a boat filled with holes and told to make it to shore with just a single plug . and no oars. Is it any wonder that the behavioral and mental health needs of our members are at an unprecedented high?

Opportunities for Positive Change Presented by S. 3126

The Native Behavioral Health Access Improvement Act would provide Pueblo members with the tools they need to plug into urgently needed behavioral and mental services and stay afloat. The central tool for this effort is the creation of a Special Behavioral Health Program for Indians (SBHPI) modeled after the Special Diabetes Program for Indians (SDPI). SDPI has been broadly successful in reducing incidences of diabetes and diabetes-related conditions in Indian Country through the successful integration of cultural derived and evidence-based health prevention, management and treatment practices. SDPI also provides tribal nations with funding flexibility to tailor their programs to meet local needs. We think that taking the best practices learned from SDPI to create a targeted SBHPI could be effective in addressing unmet behavioral and mental health needs.

It is vital that covered services for a SBHPI grant include workforce development. As mentioned earlier, there is a severe shortage of behavioral and mental specialists in the IHS Albuquerque Area. We firmly believe that a greater investment in home-grown healthcare providers is needed to help address this workforce deficit and connect our people to culturally competent care. Flexible SBHPI grants could go a long way in facilitating targeted workforce development and training programs to increase access to behavioral health and mental health services in Pueblo Country.

We fully support the requirement in S. 3126 that grant reporting requirements for the SBHPI be developed in consultation with tribal nations. Our Pueblo and other tribal nations have expressed frustration with grant reporting requirements that are overly burdensome, rigid, and unresponsive to the diverse governing structures and internal capacities of our country's 574 federally recognized tribal governments. Incorporating tribal voices into the development process of this new program would help to preemptively address these concerns.

It has been the general experience of Santa Clara Pueblo and Pueblo Country overall that where there are behavioral health programs available through the IHS or tribal health programs, those programs are severely underfunded and cannot meet the existing and growing need for specialized services in our communities. Additional information on how Congress intends to fund the \$150 million annual appropriation for the SBHPI. We would not want to see the establishment of the new program come at the direct cost of a line item that is serving Indian Country in the IHS, Substance Abuse and Mental Health Services Administration, or other federal agency budget.

Opportunity to Connect Pueblo and Indian Country to Essential Broadband under S. 3264

The Bridging the Tribal Digital Divide Act contains numerous provisions that would help facilitate advancements in high-speed broadband deployment and access in tribal communities like ours. We appreciate the multi-faceted approach of the bill. As you well know, the limited access to broadband and healthcare services that we experience daily in Indian Country cannot be fixed in isolation. They require a holistic response. One that looks at the challenge of rural geography in running fiber optic cables; the density of adobe walls in impairing signal strength; the need for AI/AN workforce development in sustainable programming; and the reality of low-income households that must too often choose between groceries and car payments or Internet bills and SUD treatments.

S. 3264 does not address all of these matters at once, but it provides avenues for tribal nations to help their communities connect to essential broadband services through long-term infrastructure investments, tribal aside funding within key USDA and FCC telecommunications programs, a Tribal Broadband Right-of-Way Pilot Program, and the provision of technical assistance to underserved tribal nations to develop appropriately tailored plan for meeting deployment benchmarks, including spectrum purchases and internal tribal capacity building. We support these

proactive measures to advance the sustainable deployment of affordable broadband on tribal lands.

We are also very pleased by how S. 3264 would create both a Tribal Broadband Interagency Working Group and a Tribal Broadband Deployment Advisory Committee. The former would improve coordination across federal broadband programs that are available to tribal nations by breaking down the communication silos that exist across the federal government. The latter would ensure that tribal leaders have an active voice in assessing telecommunications regulations and identifying innovative means of meeting the broadband needs of tribal communities. Both of these types of bodies are key to raising our Pueblo and others out of electronic isolation.

Conclusion

Kuunda, thank you, for the opportunity to testify on behalf of these two compelling legislative proposals. We turn to Congress and our federal partners to ask for your sustained assistance in addressing the healthcare and broadband access needs of our Pueblo and of other tribal communities across the United States. Passage of S. 3126 and S. 3264 would mark two critical steps in the right direction.

Attachment

The information below was prepared by the Direct Service Pueblo Governors of the Santa Fe Service Unit in New Mexico for their virtual roundtable discussions with Department of Health and Human Services Deputy Secretary Eric Hargan and Indian Health Service Director RADM Michael Weahkee. Governor Chavarria submits this document for the legislative hearing record on S. 3126 and S. 3264 as it contains information that he believes may be value to the Committee Members and their staff in considering the benefits that these two bills may bring in addressing healthcare disparities, technological gaps, and needs in Pueblo Country.

VIRTUAL ROUNDTABLE BRIEFING DOCUMENT OF THE DIRECT SERVICE PUEBLOS OF THE SANTA FE SERVICE UNIT FOR HHS DEPUTY SECRETARY HARGAN AND RADM WEAHKEE—AUGUST 24, 2020

Thank You and Invitation to Speak with the APCG. On behalf of the Direct Service Pueblo Governors, I would like to thank Deputy Secretary Hargan and RADM Weahkee for the opportunity to speak with you during the Roundtable Discussion of August 19, 2020, and for taking the time to personally visit the Santa Fe Service Unit (SFSU). My name is J. Michael Chavarria and I serve as the Governor for Santa Clara Pueblo and as the Chairman for the All Pueblo Council of Governors (APCG), a consortium of the 19 Pueblos located in New Mexico and the Pueblo of Ysleta Del Sur in Texas.

The Direct Service Pueblo Governors appreciated your engagement on the call, as well as your clear understanding of Indian health care issues. While the Pueblos share commonalities, we also differ in many ways, and it is important to hear our diverse voices. As extended on the call, we warmly invite you both, along with your staff, to speak with the full membership of the APCG in the near future to learn more about Pueblo Country concerns and healthcare matters, including best practices. We would be glad to work with your offices on logistics.

Overview of Briefing Document. This briefing document summarizes our top priorities related to the Santa Fe Service Unit at this time. These include: reestablishing SFSU's ambulatory and specialty care capabilities; remedying the PRC billing system; and addressing pandemic-related needs. Attached to this briefing document is an addendum that sets forth a series of our broader healthcare priorities, along with specific questions for a federal response and our recommendations/requests related to healthcare services in Pueblo Country.

Reinstitute Full Ambulatory and Specialty Care Services at SFSU. A number of Pueblos receive Direct Services through SFSU and the Santa Clara Health Clinic. Others have pulled their Tribal Shares and now operate Title I or Title V facilities. It is important to stress the critical need to continue to provide adequate healthcare to our Pueblo people through all of these facilities.

SFSU once operated as an ambulatory care facility and full-fledged hospital, providing specialty healthcare services such as inpatient services, surgical procedures, and prenatal services. However, as we learned on the call, SFSU will only serve as a day clinic and possible ambulatory care facility going forward. Consequently, if our members require specialty services, they must leave the area pursuant to referrals for services paid through the Purchase Referred Care (PRC) line item. We urge you to reinvest in SFSU's facility capabilities so that it can once again provide critically needed ambulatory and specialty care services in our home community.

PRC Billing Improvements. One major challenge that our Pueblo has encountered relates to the shortcomings in the PRC billing system—on a number of occasions elderly members have called my office asking for assistance because they have re-

ceived notice from collection agencies seeking payment, which is problematic. Our CHR Director has reported that these bills are being hand delivered to the SFSU PRC office. We urge you to engage in supplemental outreach to educate providers on the PRC billing system and to invest in internal improvements to mitigate instances of patient billing and avoid potentially negative impacts on Pueblo members.

SFSU and the COVID-19 Response. In the beginning, it was a challenge for the SFSU and the Santa Clara Health Clinic to address this public health emergency. There were very little to no test kits available, and when tests were administered, they were sent off-site for analysis with lengthy turnaround times that placed our already endangered communities at further risk. There were also challenges related to contact tracing, investigations, and data-sharing.

We understand that this virus has placed all of us in an unfortunate and difficult situation—not just the leadership of the Indian Health Service but also Tribal Leaders. None of us have been through such an all-encompassing experience before. I have been fortunate to talk with RADM Weahkee and Dr. Toedt on the weekly White House calls and have regularly expressed my concerns to them. We also remain engaged with Administration officials and Members of Congress to ensure our needs are accounted for in the various phases of relief legislation. I continue to push on health-related matters the best I can on behalf of all of our Pueblo members.

As Governor, I know that we face substantial challenges in meeting COVID-19 care needs in Pueblo Country. Because of the lack of sufficient isolation units in our healthcare facilities, the Buffalo Thunder Resort and College of Santa Fe were designated as isolation sites in cooperation with the New Mexico Department of Health. Greater communication between the State, SFSU CEO, and other officials is needed to provide clarity on each party's respective roles and responsibilities in patient care at those facilities.

We were pleased to learn during the Roundtable Discussion that AI/ANs are being included in the NIH's internal discussions on stratifying priority groups for an eventual vaccine distribution. We urge you to continue to support the inclusion of AI/ANs as a high risk priority group for the early distribution of any COVID-19 vaccination. Thank you for your work in educating NIH on the unique healthcare factors that place AI/ANs at high risk for severe symptoms and mortality from the virus. We appreciate your personal efforts, as our trustees, in advocating on our behalf in discussions with NIH and other decision-makers on vaccine distributions.

Tribal Data Protection. We are deeply concerned by the release of sensitive tribal data by the New Mexico in response to an Inspection of Public Record Request (IPRA). We are in discussions with the State on Data Sharing Agreements; however, we firmly believe that the IHS should serve as the gate keeper of IHS patient information as our trustee. The State is not subject to the same trust and legal obligations. The State and SFSU leadership must engage in regular and transparent communications on data protection. We ask for your assistance in protecting tribal data sovereignty through the HIT Modernization Project and in discussions with state health agencies.

Conclusion. Thank you for visiting our facilities and for the opportunity to discuss critical matters related to the Santa Fe Service Unit directly with you as leaders within the HHS and IHS. We appreciate the continuing and robust dialogue that HHS and the IHS in particular have engaged in with tribal leaders. Direct communication between federal and tribal leadership is vital to a healthy government-to-government relationship. We reiterate our open invitation to continue this exchange with the full membership of the APCG on a follow-up call in the near future.

We look forward to addressing the matters raised in this briefing document and the attached addendum with you and your staff. Kuunda; thank you.

Addendum

Pueblo Healthcare Priorities and Concerns

I. Partnerships with HHS Programs

a. *Background.* The pandemic has made indisputable clear the importance of inter- and intra-governmental cooperation in addressing unmet needs. Coordinating supply chain distributions and targeting response actions are essential to protecting community welfare. It is the mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services for Pueblo people—a mission that is based on the trust responsibilities flowing from the political government-to-government relationship between federal and tribal sovereigns.

b. *Issue.* Non-IHS agencies designated as the administering entities for tribal funds too often lack the institutional knowledge and funding distribution networks for working effectively with Indian Country. This has contributed, among other challenges, to significant delays in delivering funds to tribes. This is unacceptable at a time when every day counts in meeting the needs of our people.

c. *Question.* What internal processes are non-IHS agencies preparing now to ensure that future tribal relief funds provided by Congress are administered efficiently? It is our understanding that the White House Council on Native American Affairs is leading discussions on ways to coordinate funding opportunities across agencies.

d. *Request:* The IHS is the HHS agency with the greatest familiarity in working with tribes and with the most efficient network for quickly and effectively processing tribal funds. We recommend healthcare funds intended for Indian Country be processed directly through the IHS or, in the alternative, that administering agencies be directed to work closely with IHS on the development of funding distribution methodologies and implementation.

e. *Request:* We also urge the HHS to streamline, to the maximum extent possible, reporting requirements across funding opportunities targeting tribes. These funds should be provided with the greatest flexibility to ensure that tribes can target the use of funds to best meet their peoples' needs. This would alleviate burdensome and duplicative administrative requirements and maximize the use of federal dollars.

II. Planning for the Fall and Winter

a. *Background.* The CDC and other federal health officials have repeatedly warned that this fall and winter will be a treacherous time for national health. With the confluence of COVID-19 and a new flu season, our hospitals and clinics will need a replenishment of medical supplies and personnel to make it through. As of today, they are still running at threadbare levels in both of these areas while also trying to meet the increasing healthcare needs of chronic care patients and others.

b. *Issue.* The Pueblos do not have the resources to sustain a high-level response to the virus, let alone the virus and the flu. Supply chain disruptions and shortages have made it almost impossible to meet demand, which is only expected to grow with the devastating numbers predicted for the fall. We have established the APCG Pueblo Relief Fund as a stopgap measure to purchase disinfecting supplies, PPE, and food services for impacted communities. We cannot rely on this Fund alone.

c. *Question.* How is the HHS preparing for the fall and winter season? What targeted measures are being put in place to address the PPE and other medical supply needs of the Indian health system? How will resources be distributed to tribal facilities?

d. *Question.* It is our understanding that some of SFSU mortuary equipment has started failing and it is unclear if replacements are being planned. Ohkay Owingeh is working with a local funeral home to provide storage services in the interim. What is the status of the SFSU mortuary equipment?

e. *Request:* We seek a targeted investment in PPE and other medical equipment stockpiles in Pueblo Country both to address existing resource needs and to prepare for future waves of the virus and other illnesses, like the flu. We also request that our Pueblo people be considered as priority for vaccines—our people suffer from many health disparities and are considered as high risk and vulnerable to COVID-19.

f. *Request:* In addition, preparing for the future will require us to continue to maximize the use of telehealth and telemedicine services. The flexibilities provided in Medicaid and Medicare telehealth billing and in expanding access to telehealth services across the Indian health system have been critical in meeting patient needs, particularly the elimination of the originating site limitations. We strongly urge the HHS Secretary to exercise his authority, to the extent permissible, to make these telehealth and telemedicine flexibilities permanent after the public health emergency.

III. Provider Relief Fund

a. *Background.* The Provider Relief Fund was established under the CARES Act for to distribute financial support to healthcare providers impacted by the pandemic. The Fund included a targeted distribution of \$500 million to the Indian health system, along with General Distributions to qualifying Medicaid and Medicare providers—the deadlines and eligibility criteria for the General Distributions was recently expanded in response to requests made by tribal advisory committees. We were pleased by and appreciate this responsive and positive development.

b. *Issue.* HRSA, in a recent consultation call with tribal leaders, reported that for the purposes of the Uninsured pot of funding, IHS eligible beneficiaries are being treated as insured and, therefore, no claims can be made on their behalf. This is concern. The HHS has official materials stating that “the IHS is not insurance.” Further, beneficiaries are eligible for IHS services due to their affiliation with a federally recognized tribe. This is automatic and does not require an enrollment like private insurance.

c. *Question.* What reasoning guided HRSA’s decisionmaking process in regards to IHS eligible beneficiaries and the Uninsured tranche of the Provider Relief Fund?

d. *Request:* Additional support is needed within the Indian health system to respond to COVID–19 and its impacts. We recommend that another \$500 million be provided to the Indian health tranche of Provider Relief Funds.

IV. Third-Party Revenue Reimbursements

a. *Background.* Under Section 206 of the Indian Health Care Improvement Act, tribal health programs receive third-party reimbursements for services provided to IHS eligible patients. These funds provide a vital source of revenue for the Indian health system—at times comprising the majority of a tribal health facility’s budget—that support service expansion, facility improvements, and other healthcare purposes.

b. *Issue.* With the severe contraction of patients seeking routine and emergency care aside from COVID–19, the Indian health system has seen this revenue stream all but dry up. As direct result, some programs have been forced to furlough staff and restrict service availability. Without government intervention, the accumulating impacts of these lost resources will devastate our healthcare system. While we appreciate the relief funding that has been provided to assist with testing, PPE, and other needs, the issue of lost third-party reimbursements remains pressing.

c. *Question.* What actions and/or policy changes is HHS taking or considering to help address financial pressures on the Indian health system resulting from the loss of third-party reimbursements?

d. *Request:* We urge HHS to support the establishment of a \$1.7 billion Emergency Reimbursement Relief Fund for the Indian health system as part of its technical assistance on any future COVID–19 relief. We will continue to advocate with Congress on including third-party reimbursement relief in the next phase of COVID–19 legislation.

V. FY 2021 Budget

a. *Background.* COVID–19 has underscored how the persistent gaps in funding for the Indian health system have contributed to negative health outcomes for Native peoples and the under-resourcing of IHS, tribal, and urban Indian healthcare facilities. Planning for future fiscal years must address not only the immediate needs of the Indian health system, but also its long-term preparedness and financial sustainability.

b. *Issue.* The end of the current fiscal year is rapidly approaching with no final appropriations legislation in sight. We are deeply concerned that we will enter FY 2021 with either no appropriations legislation in place or under a short-term continuing resolution. Such a situation would cause further stress to our programs and contribute to even greater uncertainty in the Indian health system.

c. *Question.* What is the HHS doing to prepare in the event that Congress enacts a continuing resolution or resolutions for FY 2021? Specifically, what is being done to ensure that no interruptions or diminishment of services/personnel impact the Indian health system?

d. *Question.* What is the status of discussions on advance appropriations for the IHS?

The CHAIRMAN. Thank you, Chairman Chavarria. We appreciate it, and with that we will proceed with five-minute rounds of questioning for the witnesses.

I am going to begin with Rear Admiral Weahkee. According to your written testimony, the Indian Self-Determination and Education Assistance Act authority is not applicable to Title I contracts. However, an Indian tribal organization that is under Title V of the Indian Self-Determination and Education Assistance Act

may add their Special Diabetes Program for Indians grants to a funding agreement after being awarded.

The question is, since statutorily mandated grant programs like the Special Diabetes Programs for Indians are subject to parts of Indian Self-Determination and Education Assistance Act, are there any negative consequences the Committee should be aware of by providing the full authorities found in S. 3937?

Mr. WEAHKEE. Thank you, Chairman Hoeven, for the question. I think an initial response, I wouldn't necessarily characterize it as a negative, but as a concern that we see in really being clear about Congress' intent, which is how those funds should be treated. If they are to be treated as grant funds, there are special considerations that have to be taken into account. Whereas, if they are treated as program awards, they would be treated differently.

So we definitely look forward to working with the Committee and are willing to provide any TA necessary to help to clarify that language for everybody. As we read it currently, we would identify that tribes would not be eligible for contract support costs, and those funds would be treated as grant funds. Also, there would be reporting requirements that would come into play with those funds as well.

The CHAIRMAN. IHS currently provides grants that address a multitude of health disparities, including substance abuse, mental health issues, and so forth. While it is noted in the testimony that IHS and the Substance Abuse and Mental Health Services Administration provide technical services to grantees, I am interested to know how this bill is different than what is currently being provided by your agency.

Does S. 3126 expand or create any new authorities that the IHS can't implement already on its own?

Mr. WEAHKEE. Thank you, Chairman. I feel that the most important aspect to point out is what was brought up in tribal testimony by Governor Chavarria, which is the ability to utilize the funds at the community level based on community needs. So similar to the Special Diabetes Program for Indians, where funding is allocated out and tribal communities are able to utilize the funds as best meets their local needs. That local level decision making is key and very important. Most of the funding that we have currently through our Substance Abuse, Suicide Prevention, Zero Suicide Initiative, they are somewhat prescriptive in the use of the funds. This Behavioral Health Initiative would enable that local level decision making.

It also would help us to implement some programs that have been authorized under the Indian Health Care Improvement Act. One good example is the CHAP program, the Communication Health Aide Program. It includes a component which is the behavioral health aides, and getting those community members trained up and able to provide behavioral health related services would be very beneficial across the entire agency.

The CHAIRMAN. S. 4556 authorizes the IHS to purchase private land to construct and maintain a paved road to access the Desert Sage Youth Wellness Center in Hamet. How much land is the IHS going to purchase, and does the agency have the funds to purchase

the land? And to clarify, what status will the land be? Is it going to be in trust, or what will be the status?

Mr. WEAHKEE. Thank you, Chairman Hoeven. I have had the opportunity to see this land firsthand. It is approximately .5 or a half mile long dirt road. I think they have measured it out to be approximately 200,000 square feet total. It is across two different parcels of land in Hamet, California.

The road conditions are definitely treacherous. It is almost like a river runs through the road when rains get high. So it definitely is in need of repair.

So about 200,000 square feet. The funding, we believe that we have. And we do not believe that there will be any requirement to put that land into trust.

The CHAIRMAN. One final question for you, Admiral. Can you elaborate on the idea of creating a charitable foundation within the Indian Health Service and what kind of work you might be able to do with the idea that, given the pandemic, there has been obviously contributions and interest in further contributions to help? So there has been discussion of this idea of setting up a charitable foundation to receive that.

Mr. WEAHKEE. Thank you, Chairman Hoeven. Through this pandemic, there have been many different philanthropic entities and private citizens who have come to the agency and come to Indian Health sites across the Country, exhibiting interest in providing funding to support the efforts. I signed off on the acceptance of a few checks, but having a separate foundation to be able to handle that type of business will be very beneficial.

In addition, many of our tribal leaders have seen the direct benefit of the CDC Foundation, and how they have been able to obtain services and support. So there have been requests to look at an Indian Health Service Foundation, similar to what exists at the CDC and the Food and Drug Administration and the National Institutes of Health, to further expand and support the matters that would help Indian health care in general, that may not be easily reached through annual appropriations.

The CHAIRMAN. Right. CDC has received over \$87 million in donations in the fiscal year. Do you need legislative authority to do this?

Mr. WEAHKEE. I do believe so, yes, sir, I think we would need that legislative authority.

The CHAIRMAN. That is something we need to look at.

Thank you, Admiral. I will turn to the Vice Chairman.

Senator UDALL. Thank you, Admiral. Director Weahkee, your testimony on 638 provisions in the SDPI reauthorization bill suggests that current bill language would only authorize the IHS to deliver SDPI funds through the ISDEAA contracts and compacts. Do I understand that correctly? Would the language as written allow tribes to receive contract support costs if they opt to use this new provision?

Mr. WEAHKEE. Thank you, Vice Chairman Udall. That is exactly the language that we would like to work with the Committee to clarify what Congress' intent is. There is some ambiguity there whether we put a grant into a ISDEAA mechanism. The way that we currently read it, those grants requirements would still carry

over. So we just want to clarify how we should address those funds, and whether Congress' intent is to provide CSE, and to streamline reporting, or if we want to keep the provisions in as we have done historically for Title V.

Senator UDALL. My understanding is that Senator McSally disagrees with what you are saying. Her intent is to do it differently. So we will work with you to see that the language reflects the intent of the Senator who introduced it.

Let me shift over here, and I may come back to you, Admiral, on this broadband rights-of-way pilot program. The need to deploy broadband services throughout, and this is for our tribal witnesses here today, our tribal leaders. The need to deploy broadband services throughout Indian Country is important now more than ever. During the Coronavirus pandemic, access to the internet is critical for health care, education, public safety needs. But there are unique challenges to deploying broadband services on tribal lands that predate the pandemic. Remoteness, rough terrain, complex permitting processes, and a lack of necessary infrastructure make it difficult, even sometimes impossible, to ensure uninterrupted internet service.

While we can't easily change landscapes, we can provide authority for tribes to control permitting rights-of-way for broadband deployment on their own lands. My bill establishes a pilot program that allows the Interior Secretary to delegate authority to participating tribes to approve rights-of-way for broadband deployment. Such authority now rests solely with the Secretary, creating a potential logjam for broadband maintenance and construction projects that are needed to, for example, respond to COVID-19 crises.

Chairman Chavarria, would this pilot program benefit New Mexico's Pueblo communities, especially during a national health crisis, when access to the internet is absolutely necessary?

Mr. CHAVARRIA. Chairman, members of the Committee, Vice Chairman Ranking Member Udall, thank you for that question. Yes, I believe the proposed legislation benefit not just my Pueblo, but all tribal nations during the time of this pandemic, and after. This COVID-19 has brought a light on all the existing technological infrastructure disparities affecting Indian Country. Our families lack home broadband, students lack individual computers or iPads, hospitals have insufficient networks, and entire communities lack fiber optic cable and wireless capabilities.

The Right-of-Way pilot program proposed in your bill, S. 3264, will assist us all in addressing each of these barriers by helping us lay the foundation we need for community-wide broadband access. I also feel this critical piece of legislation will aid in leveraging other technological opportunities, such as a short-term 90 day special temporary authority due to FCC that allows us to use the spectrum over Santa Clara lands until a tribal priority window is closed, and final authorization is granted by November 2nd.

Leveraging is key to closing the gaps to delivering services on our lands. The pilot program will help all of us achieve this goal. So thank you, Chairman, members of the Committee.

Senator UDALL. Thank you, Mr. Chairman.

The CHAIRMAN. Next, we will turn to Senator Smith, virtually.

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

Senator SMITH. Thank you, Mr. Chair, and thank you, Vice Chair Udall, for holding this hearing today. I want to thank Rear Admiral Weahkee and our tribal leaders joining us today.

I would like to just first say a word about the Native Behavioral Health Access Improvement Act which is being considered today. Thank you so much for the consideration, and I want to also thank Senators Udall and Tester and Cortez Masto on this Committee for joining me on this bill.

This bill addresses the issues that we have meeting culturally appropriate, connected care for mental health and behavioral health services in tribal communities, and the importance of being able to address needs around mental health in ways that really work for tribes. So we know, especially right now in the midst of COVID, that so many people are struggling with this need.

So what my goal would do is to create a special behavioral health program based on the model of the Special Diabetes Program for Indians, something that we have also discussed today. Programs like these see broad support in Indian Country, certainly in Minnesota, because they give tribes the flexibility to develop solutions that work in your communities, using traditional practices and culturally competent care.

So thank you for this hearing today. I want to turn first to Rear Admiral Weahkee. I thank you for your testimony on this today. I just want to make sure you are there, because I don't see you on my screen.

Mr. WEAHKEE. Yes, ma'am, I am here.

Senator SMITH. There you are, thank you.

So for a few years now, some of my colleagues and I have supported these behavioral health pilot programs, so that tribes can start having access to these resources as soon as possible. Unfortunately, despite our success in funding these pilots programs in annual appropriations bills, there are still no current grant recipients who have benefited yet.

So as you recognized in your testimony, access to mental and behavioral health care can save lives. It has life or death consequences. So let me just start by asking, can you explain why the Indian Health Service has not yet awarded any grants as part of the behavioral health pilot program?

Mr. WEAHKEE. Thank you, Senator Smith. And I do think that the delay in the funding for that particular program is a sign of the times. There are several different factors that contributed, noting that the funds were first appropriated to the Indian Health Service in 2019 a \$10 million per year. We now have \$20 million available to us.

Reminding everybody that we started last year with a government shutdown, which didn't enable us to move forward with necessary next steps, to include tribal consultation, review of the consultation comments. When we did eventually get the consultation initiated, tribal leaders asked for an extension in the time frame to provide their comments, which we granted. And then as we got close to the end of the year, we started to run up against end of year deadlines, and then the pandemic hit.

So really, a perfect storm of a variety of different issues hat have come into play. We do have the Federal Register notice developed, and do plan to access all \$20 million of those funds and make those available for program awards just as quickly as we can.

Senator SMITH. Do you have a sense of when that might be, what we could expect? Or could you let me know when you know? Because I think this is important.

Mr. WEAHKEE. Yes, ma'am, we will definitely let you know. My understanding is that it is in the final clearance process, and we are hoping to have it on the street just any time now.

Senator SMITH. Okay. Thank you, and I appreciate your attention to getting those dollars out as quickly as possible.

I just have a couple of seconds, but I want to turn to the tribal leaders who have joined us today. I am wondering if you could take a stab at telling us a little bit about how the mental and behavioral health needs in your community have changed during the COVID pandemic, and whether you have the support that you need. Anybody want to take a stab at that?

Mr. CHAVARRIA. Thank you, Senator Smith. This is Governor Chavarria from Santa Clara.

Senator SMITH. Good to see you, Governor.

Mr. CHAVARRIA. Good to see you again. Yes, Mr. Chairman, and members of the Committee, yes, the pandemic has significantly increased the need for mental and behavioral health services in our community. I have firsthand seen the unfortunate increases in the emotional, mental, physical, and social stress on many of my community members.

Facility closures, service and shipment disruptions, and prolonged isolation to stress, leaders like family and traditional ceremonies are taking a toll across the country. In response to COVID-19, our public government exerted our sovereign right to close down our business, our offices, our schools in an effort to protect our most vulnerable. We also instituted stay-at-home orders, limited travel, restricted access to tribal lands, and ceased all traditional communal gatherings, including our feast day, which is unfortunate. This isolation has created hardship for many of our members. I have had conversations with grandparents, parents, children, that all have expressed the toll the virus has caused upon them. not knowing the end, when safety will be restored or what the future will hold has increased instances of depression, anxiety, loneliness, substance abuse, and suicide risk is on the rise.

So I feel the pain of my members, I hurt for them. Because as governor, along with my administration, tribal council staff, it is our responsibility to provide comfort, provide guidance, provide the necessary resources our Pueblo need to cope with this issue. COVID-19 has stolen that ability of our people to see behavior and mental health specialists. Limited appointments are available, access to [indiscernible] check into residential long-term treatment programs, and to engage in the traditional healing process within our community.

So it exacerbates the problem, through no technological capacities within Pueblo country. Not every household has a broadband connection, let alone a computer or a smart phone to access to allow services. Many of our people are caught in a dangerous limbo

with no in person and no tele-health options available to them to confront the confidence, the trauma being experienced.

So lastly, the Pueblos do not have the required resources to handle the increased demand we are experiencing for behavioral and mental health services. While tribal 638 programs are often most robust for behavioral health provider staffing than IHS, these programs too have been impacted by COVID-19 closures and restrictions, and often lack updated tele-health equipment and technology, further decreasing patient access during this critical time.

Senator, and members of the Committee, I hope this is a response to your question, Senator.

Senator SMITH. Thank you so much, Governor. I appreciate it. You have painted the picture very well, and the need. Thank you so much.

The CHAIRMAN. Thank you, Senator Smith.
Senator Cortez Masto.

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

Senator CORTEZ MASTO. Thank you, Mr. Chair and Ranking Member. And thanks to all of you for this important conversation.

Let me just start off by saying thank you so much to my colleagues for the introduction of these important bills.

Let me start with S. 3264, Senator Udall, thank you. This is an issue that I have been dealing with in the State of Nevada. That is why I introduced the Access Broadband Act, along with my colleague in the House. The House passed their version. We are still looking to get the Access Broadband Act passed.

Your bill sets us on a course to move even further in that direction. Let me briefly just say, the Access Broadband Act actually requires the Department of Commerce to establish the Office of Internet Connectivity and Growth within the National Telecommunications and Information Administration. The focus there is to include and streamline all of the broadband processes for all of our underserved communities. That is why I like your bill. The tribal communities need that support and connectivity. There are so many others that are underserved as well.

I am hopeful that we can work together, there is a way we can work together so that both of our bills may be compatible, or look at language that I might be able to work with you on. Because I think you are on the right track here, and I so appreciate your bringing it forward.

The other bill that I am a cosponsor of and absolutely support is S. 3126, behavioral health services in general. Thank you to the Chairman for having this conversation. It is so needed, even before the pandemic. Now with COVID-19, as we have all seen, it is a highlighted area, lacking in so many of our tribal communities when it comes to access for services for behavioral health.

For that reason, and this is an area that was important for me, I introduced the Virtual Peer Support Act. It is a bill that would create a grant program to enable eligible local tribal and national organizations who currently offer peer behavioral health services to transition from in-person services to online platforms to meet the increased need because of the COVID-19 pandemic.

I throw that out there because, Admiral Weahkee, I would love to talk to you about the bill, see if there are any concerns or issues or thoughts that you have about it, and get your input and support for it as well. I am hopeful that you would be willing to do that.

Mr. WEAHKEE. Thank you, Senator Cortez Masto. Definitely look forward to working with you on that. Some of the work that we have done under the Tribal Behavioral Center of Excellence in our ECHO program has been exactly in that area, of peer support, resiliency, and depression and crisis intervention. So I look forward to working with you on that.

Senator CORTEZ MASTO. Thank you. And thank you all for being here. I can't stress enough what we have heard today, I hear it in my State of Nevada with our tribal communities. So much work needs to be done. We need the connectivity of our services, and so many more services, particularly now during COVID-19.

So thank you for the hearing today.

The CHAIRMAN. Thank you, Senator Cortez Masto.

We will turn to Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I will continue on this same vein of behavioral health. Admiral Weahkee, I appreciate the work that you have done. As you well know, in Indian Country, they are often on the wrong side of the digital divide. If you are on the wrong side of the digital divide, you also know that tele-health doesn't work so very, very good. I think it is essential when it comes to behavioral health services.

Can you tell me what the IHS is doing to help those folk who don't have broadband access?

Mr. WEAHKEE. Thank you, Senator Tester. I appreciate your questions.

As we have noted, many of our services during the pandemic have turned to alternate means of service provision. One of those which we have accessed heavily has been tele-health. But as you note, there are many tribal, rural communities that don't have the necessary broadband access. So for many of those communities, they are going without services currently, if they are not able to access the clinic and don't have that tele-health opportunity.

I noted the Tele-Behavioral Health Center of Excellence, which the Indian Health Service has stood up and has been running for a few years now has provided a number of different opportunities for that tele-health expansion. I think the statistic is that they have increased their visits by 63-fold from the beginning of the pandemic, providing direct patient care and also the training for our behavioral health providers.

We have also leveraged our academic partnerships with entities like the University of New Mexico, their ECHO program. They have provided a number of trainings and supports to the agency. We are working with the Casey Family on a variety of different supportive mental health trainings as well.

But as you note, when it comes to circumstance like a global pandemic, getting services in a rural reservation community is very difficult when they don't have their go-tos like tele-health to rely upon.

Senator TESTER. Amen, brother. We just have to figure out a way to get these folks connected up. I know the Chairman and Ranking Member understand that very, very well.

Admiral Weahkee, in Indian Country, we continue to see a rise in cases, at least in Montana, we are, in Northern Cheyenne, and in Crow, I think there has been about 20 community members that have passed because of COVID-19, which is not good. Those aren't good statistics. Unfortunately, I continue to hear from tribes about the need for personal protective equipment and testing supplies. Can you tell me how IHS is making sure that tribes in Montana and actually across the Country, they are getting PPE and testing supplies that they need here on the 23rd of September of 2020?

Mr. WEAHKEE. Thank you, Senator Tester. I appreciate this opportunity to update the Committee on our COVID-19 activities. Really, I feel strongly that the Indian Health Service and Indian Country in general has fared pretty well when you look at us in comparison to other health systems, and in comparison to other rural communities. With the support of Congress and special White House initiatives and HHS leadership, we have been the benefactors of direct allocations of special technologies like the Abbott ID Now Test Analyzers. We were the recipients of 470 of those machines which we allocated out across the Indian Health System.

As we speak here on September 23rd, I think that we are looking at 787,000 tests that have been conducted throughout Indian Country. Our National Supply and Service Center, or NSSC, which is located in Oklahoma City, has done a fabulous job. They are basically our logistics arm. They have supplied more than 65 million units of PPE, more than 400,000 tests have flowed through that center. They have also just recently completed an intra-agency agreement with the Assistant Secretary for Preparedness and Response, which manages the Strategic National Stockpile, so that we can leverage their special purchasing power to build our core levels and to be able to obtain hard-to-find PPE when the rest of the Country is competing for a limited supply.

Dr. Toedt is the lead for our testing. Our testing, our rates are higher than the U.S. general population testing rates. We have tested at a higher percentage. We are currently at a testing rate of 6.5 percent positives. Our seven-day positivity rates are 5.7 percent. Both of those compare favorably with the U.S. general population testing rate.

As of this point, we have tested 47.3 percent of our user population in comparison to the U.S. all races rate of 31.9 percent. So we are testing more, which is important, and we do, because as has been noted in this hearing, there is disproportionate impact on our American Indian communities. This has been identified now in several CDC studies. Higher hospitalization rates at 5.2 percent more than the general population. Our infection rate is three and a half times higher than the general population.

And recent data that has come out around deaths has identified that we have about a 1.4 percent higher death rate, using the National Center for Health Statistics data, early in the pandemic.

So thank you for the opportunity, Senator Tester. I do feel that tribal leaders for the most part across the Country have been very supportive of our efforts. We do hear from time to time issues with

certain components of PPE or certain testing companies. One item that has been hard to find is the Cepheid test supplies. That is one specific test analyzer.

And we will hear from time to time concerns about identifying N-95 masks or a certain size of a glove. But our team works very hard to shore up those needs just as quickly as they hear about them.

Senator TESTER. I appreciate that. I will tell you that the picture you paint I hope is the right one. Because I hear of challenges in Indian Country quite regularly. And we will continue to be communicating with you and the tribes back home to make sure that they get what they need.

Very quickly, Mr. Chairman, I just want to say that Little Shell appreciates IHS acting so quickly on Little Shell. They are going to be recognized, as the Committee knows, in the fiscal year 2021 budget justification. However, I would just say the placeholder doesn't reflect the tribe's actual user population. It is much higher than IHS estimates.

I would just say that the virus isn't going away any time soon, you all know that. We have to make sure Little Shell gets their funds. I would just ask you to commit to updating IHS' request to make sure that it actually reflects the need of the trust costs to Little Shell members. That is all. And I would just like a head nod from Admiral Weahkee on that one.

Okay, thank you.

The CHAIRMAN. Thank you, Senator Tester.

I just have one question, and then I will turn to Vice Chairman Udall before we wrap up. I do want to ask Chairman Osceola, tribes have routinely had to come to Congress when their land development plans are derailed by the Non-Intercourse Act. So how did the need for this bill come about and what can Congress do to ensure that other tribes aren't faced with some of the same obstacles?

Mr. OSCEOLA. Thank you, Chairman. I appreciate the opportunity to explain a little further. The reason for this bill, as I stated earlier, was a single tribe has created a real estate fund to diversify its money for the tribe and its future. We already lost one investment chance because a title company refused to insure the title. Their interpretation of the NIA requires Congressional authorization before a tribe can sell or mortgage fee land.

It is likely that other tribe will face us in the future as well, and as I said, other exceptions have been made in the past. I think that it is important for us today to get this bill passed for the Seminole Tribe, cause of our diversification prior to COVID. I think that in the future, I encourage Congress to take up legislation that is more broad and hits all the points, so that all tribes can benefit from the Non-Intercourse Act and its hurdles, so to speak. Thank you.

The CHAIRMAN. Thank you, Chairman.

With that, I will turn to Vice Chairman Udall.

Senator UDALL. Thank you, Mr. Chairman, and thank you to all of the witnesses today.

We have votes already going off, we actually have three votes, so that is why we are trying to wrap things up. Director Weahkee, after our hearing in July, I submitted some questions to you about

how the IHS and the Department were coordinating with direct service tribes during the COVID-19 pandemic.

One of our witnesses today, Chairman Chavarria, is just one of the tribal leaders I have heard from with concerns that the coordination with direct service tribes have been lacking. I have also heard from Picuris Pueblo about its IHS direct service facility's failure to coordinate on the development of a CARES Act spend plan, leaving the pueblo without a means to safely transport patients for COVID-19 related testing and care. Most recently, I have heard from Acoma Pueblo with concerns about the potential closure of their direct service emergency room during the pandemic.

Chairman Chavarria, do you believe that there are still COVID-19 relief barriers for direct service tribes that IHS and HHS need to tackle? That is kind of a yes or no question, I think, but if you want to elaborate just a little bit.

Mr. CHAVARRIA. Okay, Chairman, and members of the Committee, Vice Chairman Udall, yes, it is. I do have a list of comments, I can be short as well. We did have a meeting on August 19th with Deputy Secretary Hargan and Admiral Weahkee, as they visited the service unit here at Santa FE. We discussed a number of challenges our communities continue to face. So I can submit that document for the record, with the permission of the Chairman and members of the Committee. Chief among this is lack of adequate PPE, medical supplies, needing to replenish, to make it through the treacherous fall and winter that CDC and others have repeatedly earned.

So IHS is running at threadbare levels in terms of being prepared to handle the COVID-19 and the flu related illnesses. Supply chain disruptions have made it almost impossible to meet that demand. So the demand, which is only expected to grow, will be devastating, is our prediction for the fall.

So we do recommend that Congress invest in a targeted PPE and medical equipment stockpile for Pueblo Country as well as dictate dedicated stockpiles to serve all of Indian Country. Those stockpiles must be able to meet current levels of resource need to include at least a three-month supply that has been recommended by some of the Federal health care officials. AND HHS Secretary and FEMA administrators need to exercise their delegated authority to the maximum extend permissible to streamline tribal access to the National Health Supply Reserves.

So, Mr. Chairman, members of the Committee, I do have some additional statements, but due to time, I can go ahead and submit those for the record. Thank you.

Senator UDALL. With the permission of the Chair.

The CHAIRMAN. Yes.

Senator UDALL. Thank you very much. We will also share those with Director Weahkee, or you can do that directly.

Admiral Weahkee, can I get your commitment that the IHS will reach out to direct service tribes in the Albuquerque area and find out ways to improve coordination in New Mexico?

Mr. WEAHKEE. Thank you, Senator Udall. You have my commitment.

Senator UDALL. And Admiral Weahkee, I also want to add on the issue flagged by the Acoma Pueblo that I view the closure of any

IHS emergency service during the COVID-19 pandemic as a threat to the health and safety of Indian Country. For Acoma and the surrounding area, the ACL hospital is not only a lifeline, it is part of the region's COVID-19 response structure.

I appreciate that you have been in contact with Governor Vallo, and that your team is working to minimize disruption of services at the ACL hospital. But I am interested in hearing what more IHS can do to help the emergency room doors stay open there.

Has IHS looked into the use of the director's emergency fund as a way to prevent closures of the ACL emergency room, or could IHS use some of its reserve CARES Act funds for that purpose?

Mr. WEAHKEE. Thank you, Senator Udall. And the situation at the Acoma-Canoncito-Laguna Hospital is definitely one that we are watching closely here at the national level. Dr. Leonard Thomas, the area director, and his team, are in active negotiations with the Laguna Tribe. I believe that their targeted contract date or negotiation completion date is the end of this month, September 29th. We will have a much better picture of the funding and operating costs that will be available for the rest of that facility at that time.

In my conversations with Dr. Thomas and with Governor Vallo, we have committed to robust consultation and engaging the tribe in what that scope of service will look like at the facility post-Laguna contract. One of the important factors that we need to really focus on is the conditions of participation for managing and operating the emergency department. That is a high bar and CMS takes it very seriously.

There are some other models available to us currently with a critical access hospital. There are others that have been pushed by the National Rural Health Association to include a community outpatient hospital, which enables a streamlined emergency department to be maintained.

So we are watching those proposals closely. That might be something that would be helpful for a site like Acoma. But at this point, we will be looking at all available resources. The Director's Emergency Fund has about \$3 million in it each year. We have had a number of tribes already request funds for wildfires, hurricanes, and other emergencies. But we will look at that as a potential resource.

And of course, any CARES Act, if we can justify use of funds for pandemic purposes, and get my CFOs right off on that, that we won't get ourselves into any trouble, we will look at all available funding sources to help alleviate that and make it a smooth transition.

Senator UDALL. Great, thank you. And you will commit to continuing your work with Acoma to address their concerns?

Mr. WEAHKEE. Absolutely, yes, sir.

Senator UDALL. Thank you, Mr. Chairman. Thank you very much, and thank you for your courtesies.

The CHAIRMAN. Thank you, Vice Chairman Udall.

At this point, we will conclude the hearing. The hearing record will be open for two more weeks. Again, I want to thank all the witnesses for being here. We appreciate it very much.

With that, this legislative hearing is adjourned.

[Whereupon, at 4:23 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THE BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR

Thank you for the opportunity to provide the Department of the Interior's (Department's) views on S. 3264, Bridging the Tribal Digital Divide Act of 2020, a bill to expedite and streamline the deployment of affordable broadband services on tribal land.

S. 3264

Title I—Interagency Coordination Program

Title I of S. 3264 directs the Assistant Secretary of Commerce for Communications and Information and the Secretary of Agriculture to establish an Interagency Working Group to be known as the Tribal Broadband Interagency Working Group (Working Group). S. 3264 identifies the Administrator of the Department of Agriculture's (USDA) Rural Utilities Service and the Assistant Secretary of Commerce for Communications and Information as the co-chairs of the Working Group, which is tasked with improving Federal coordination, including activities of the USDA, Department of Commerce, Department of Education, Department of Health and Human Services, Department of Housing and Urban Development, Department of Labor, Federal Communications Commission (FCC), Institute of Museum and Library Services, any other appropriate Federal agency, and the Department.

Connecting Indian Country to broadband and energy transmission is a priority for the Department. In 2020, the FCC Broadband Deployment Report stated that 28 percent of Native Americans who live on tribal lands lacked access to sufficient broadband capabilities. The Department has been implementing broadband initiatives since 2017, bringing necessary utilities and communications facilities to rural communities. These initiatives align with all aspects of the Department's trust relationship with tribes and individuals.

The Department and its bureaus, including the Bureau of Indian Affairs, currently participate as members of the Administration's American Broadband Initiative (ABI), an interagency effort co-chaired by the National Telecommunications and Information Administration and USDA to remove regulatory barriers to broadband deployment, leverage public resources for broadband expansion, and maximize the impact of federal broadband funding. Incorporating a Tribal Broadband Interagency Working Group is consistent with the ABI's mission to coordinate federal broadband activities. The Department supports the continued coordination of federal stakeholders and recommends that a representative of the Department chair a new Tribal Working Group within ABI.

Title V—Broadband Rights-of-Way

Title V of S. 3264 directs the Secretary to establish a Tribal Broadband Right-of-Way Pilot Program (Program), which would delegate certain authorities to eligible tribes to grant ROWs over and across tribal land. Under S. 3264, no fewer than 10 tribes would be selected for the Program, with no fewer than 5 of those tribes from Arizona and New Mexico. The Secretary's authority for the Program would expire 10 years from enactment. Except for individual allotted lands, tribes could obtain the delegated authority to grant a ROW over and across tribal land without further approval of the Secretary. The ROW must be granted in accordance with approved tribal regulations and for a term not to exceed 25 years, except that the ROW may include an option to renew for two additional terms, each of which may not exceed 25 years.

The Bureau of Indian Affairs (BIA) has the authority to approve ROWs and leases for broadband development on Indian trust land and individual restricted lands. The BIA protects and maintains the integrity of trust lands and trust resources, as part of the overall bureau mission to enhance the quality of life, to promote economic opportunity, and to carry out the responsibility to protect and improve the trust assets of American Indians, Indian tribes and Alaska Natives.

The Program would connect the selected Tribes' communities with broadband projects, which furthers the BIA's mission to support tribal self-determination and self-governance. The Department is supportive of efforts to streamline approvals needed to support broadband projects, but the Department sees no reason to limit the Program to a few selected tribes. The Department recommends an eligibility structure similar to leasing authorities available to tribes under the Helping Expedite and Advance Responsible Tribal Home Ownership (HEARTH) Act of 2012, 25 U.S.C. 415(h). Under the HEARTH Act, once tribal leasing regulations have been approved by the Secretary, tribes are authorized to negotiate and enter into leases without further approvals by the Secretary. In support of tribal self-determination, the HEARTH Act requires the Secretary to approve tribal leasing regulations, if the regulations are consistent with the Department's leasing regulations at 25 CFR Part 162 and they provide for an environmental review process that meets HEARTH Act requirements. Opening up opportunities for all tribes who are interested in developing their own ROW tribal codes and removing bureaucratic obstacles and bottlenecks would more effectively address the need in Indian Country for broadband development.

Under Title V of S. 3264, participating tribes would be given an opportunity to compact and amend their Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. 5304, funding agreements to include technical assistance in developing their own tribal broadband regulations. The Department recommends that all federally recognized tribes have the opportunity to receive funding for technical assistance to develop regulations. In addition, the Department recommends that the bill clearly indicate that Secretarial approval of tribal codes is required, that the codes would be consistent with existing regulations under 25 CFR Part 169, and that environmental reviews be addressed through a tribal process similar to the HEARTH Act requirements.

The Department strongly supports efforts to expand broadband capacity in Indian Country. If the legislation is addressed as noted above, it would be an important step toward allowing tribes greater control in developing broadband projects on their lands for their communities. Tribal control of the broadband ROW regulatory process over tribal lands would reduce the time and expense currently required in seeking ROW approval from BIA.

The Department appreciates the opportunity to present its views on S. 3264. We welcome the opportunity to work with the Committee to provide technical assistance that will improve this legislation, and thereby expand broadband capacity in Indian Country.

Thank you for the opportunity to provide the Department of the Interior's (Department) views on S. 4079, a bill to authorize the Seminole Tribe of Florida to lease or transfer certain land, and for other purposes.

S. 4079

S. 4079 would expressly allow the Seminole Tribe of Florida (Tribe) to lease, sell, convey, warrant, or otherwise transfer all or part of the Tribe's real property that is not held in trust by the United States without further approval, ratification, or authorization by the United States. Under S. 4079, action by the United States is not required to validate the Tribe's land transactions for Tribally owned fee land. The legislation clearly states that S. 4079 does not authorize the Tribe to lease, sell, convey, warrant, or otherwise transfer lands held in trust or affect the operation of any law governing such transactions. The Department defers to Congress on this specific matter.

Further, the Department believes that this legislation would be unnecessary, at least as applied to off-reservation lands, if Congress clarified that all Tribes had authority to lease, sell, convey, warrant or otherwise transfer all or part of their off-reservation fee property. Congress should enact more general legislation that extends this authority to all Tribes. Over the years, individual tribes have expressed that they have encountered difficulties when attempting to lease, sell, convey, warrant, or otherwise transfer all or any part of their interests in any off-reservation real property not held in trust by the United States unless authorized by Congress. Tribes are presumably referring to federal law, 25 U.S.C. § 177, which prohibits any "purchase, grant, lease, or other conveyance of lands, or of any title or claim thereto, from any Indian nation or tribe of Indians." We urge Congress to clarify the issue of whether fee land owned by a tribe would fall under this prohibition, and to do so by expressly providing that tribes may transfer off reservation fee lands that they own. Such a clarification will remove obstacles to economic development opportunities and enhance tribal sovereignty.

Conclusion

The Department appreciates the opportunity to present its views on S. 4079. This bill would enable the Tribe to more effectively manage its fee property by clarifying its legal authority to do so. Moreover, the Department notes that Congress should enact more general legislation that extends authority to lease, sell, convey, warrant or otherwise transfer all or part of their off-reservation fee property to all Tribes.

JOINT PREPARED STATEMENT OF THE OFFICE OF HAWAIIAN AFFAIRS AND PAPA OLA LÖKAHI

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

Mahalo for your leadership during the Novel Coronavirus Disease (COVID-19) pandemic to protect the rights and honor the trust responsibility owed to all Native Americans, including American Indians, Alaska Natives, and Native Hawaiians. Papa Ola Lōkahi (POL) is a community-driven, non-governmental entity that serves as the body with whom federal agencies consult on Native Hawaiian health policy and health care and that oversees the activities of the five Native Hawaiian Health Care Systems (NHHCS or the Systems). The Systems provide invaluable direct health care services to the Native Hawaiian community in alignment with the overarching health system, with an added layer of focus on meeting the nuanced health needs of Native Hawaiians similar to how urban Indian organizations strive to meet the specific needs of American Indians and Alaska Natives. The Office of Hawaiian Affairs (OHA) is a semiautonomous 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 urge the Committee to include all Native American communities, including American Indian, Alaska Native, and Native Hawaiian communities, in legislative actions to uphold the federal trust responsibility owed to all Natives. With that in mind, we seek to inform the Committee about how the issues discussed in S. 3126, the Native Behavioral Health Access Improvement Act of 2019 and S. 3937, the Special Diabetes Programs for Indians Reauthorization Act of 2020 affect the Native Hawaiian community. Additionally, we would like to express our support for broadband initiatives that aim to close the digital divide.

In tandem with our Native cousins on the continental United States and in Alaska, Native Hawaiians face disproportionate threats to physical and mental health.¹ As a result, Native Hawaiians have the shortest life expectancy of any major population within the State of Hawai'i.² Behavioral health and diabetes are contributing factors to these health outcomes in the Native Hawaiian community.

Behavioral Health in the Native Hawaiian Community

Similar to American Indian and Alaska Native communities, the Native Hawaiian community faces a high burden of behavioral health challenges. Native Hawaiians face disproportionate rates of suicide and depression.³ More than twenty percent of Native Hawaiian adults reported that they frequently feel their mental health is “not good.”⁴ 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 completed suicides.⁵ Additionally, Native Hawaiian youth have among the highest rates of youth drug use in the State of Hawai'i.⁶ For our Native Hawaiian kupuna (elders), depressive disorder is 9.3 percent, which is higher than that of non-Hawaiians of the same age.⁷ Despite the evidence of overrepresentation in mental health challenges, Native Hawaiians frequently underutilize existing mental health services or seek therapy only after illness becomes severe.⁸ Those who choose to seek services may not find it due to limited resources.⁹

To address these mental health issues and substance use disorders, the Native Hawaiian Health Care Systems each offer a unique set of direct behavioral health services and enabling services to the Native Hawaiian communities that they serve. See the figure below for a breakdown of services provided.

Clinic	Islands Served	Services Provided
Hui Malama Ola Na'Oiwi	Hawai'i Island	Offers a variety of behavioral health services through the support of a licensed clinical social worker

Clinic	Islands Served	Services Provided
Hui No Ke Ola Pono	Maui	Offers patients access to behavioral health therapists to improve sleep patterns; improve diet; cope with stressors from grief and relationships; reflect on harmful habits like alcohol, tobacco, and drug use; and practice self-care
Na Pu'uwai	Moloka'i and Lana'i	Offers services in partnership with the Native Hawaiian Health Scholarship program and others to ensure patients receive culturally sensitive behavioral services and also provides smoking cessation and drug recovery programming
Ke Ola Mamo	O'ahu	Offers individual, group, couples, and family counseling, as well as tobacco cessation, substance abuse, and stress management workshops hosted by licensed clinical social workers and other trained professionals
Ho'ola Lahui Hawai'i	Kaua'i	Provides substance abuse, case management, and other behavioral health services Beyond POL and the NHHCS, a handful of other service providers tailor behavioral health services to the Native Hawaiian community. Among the most well-known providers is I Ola Lahui, ¹⁰ a 501(c)(3) nonprofit corporation in Hawai'i that was created to respond to the urgent behavioral health needs of Native Hawaiian and rural communities. This nonprofit provides culturally-minded psychological services for chronic diseases and traditional mental health needs. While these providers help to address the behavioral health needs of the Native Hawaiian community, more resources are necessary to fill the gaps in services facing many Native Hawaiians.

Diabetes in the Native Hawaiian Community

Recent studies show that one in three Native Hawaiian adults have or are at risk for diabetes or pre-diabetes.¹¹ As a result, Native Hawaiians have been hospitalized at higher rates for short-term and long-term diabetes complications; uncontrolled diabetes; and lower extremity amputations than the State of Hawai'i's overall rate.¹² Native Hawaiians report increased participation in diabetes self-management activities, which may be due in part to increased diabetes management education through the NHHCS and other clinics.¹³

The POL and the NHHCS offer a variety of support for those who are pre-diabetic or diabetic. Hui Malama Ola Na Oihi offers diabetes management classes to teach participants about diabetes, nutrition, exercise, medication, and the tools for continued management of diabetes. They also host bimonthly diabetes support groups. Hui No Ke Ola Pono hosts a Diabetes Self-Management Program, which includes classes on the signs, symptoms, and treatment for hypoglycemia and hyperglycemia; lifestyle adjustment; and reducing complications caused by diabetes. Additionally, they operate a Simply Healthy Café which serves meals for the Ho'ola Pu'uwai program, an Ornish Lifestyle Medicine program that assists in safely managing diabetes. Na Pu'uwai offers screenings to prevent diabetes and programs in wellness like diabetes prevention and self-management, as well as promoting lifestyle changes like improved nutrition. Ke Ola Mamo provides education and screening to assist in controlling and preventing diabetes. Ho'ola Lahui Hawai'i provides diabetes screening and prevention, education, and disease management support. The reaches of these services are capped by limited resources to dedicate to this important health challenge, but they provide culturally relevant and tailored support to Native Hawaiians who may not have other places to turn, or who have not found success in other diabetes programs.

The Digital Divide

Reliable Internet and broadband service is not available in rural and remote areas in the State of Hawai'i, which coincides with where many Native Hawaiians live. Approximately 10 percent of Native Hawaiian households do not own a computer, and just under 20 percent lack Internet access.¹⁴ During the pandemic, the lack of reliable Internet service has highlighted the effects of the digital divide on Native Hawaiian families, who cannot access telehealth services, online distance learning,

and other critical services without this basic resource. With this in mind, we support efforts to close this divide so that Native communities can take advantage of the powerful technologies delivering innovative programming into Native homes.

Because pervasive diseases like behavioral health challenges and diabetes disproportionately affect the Native Hawaiian community, legislation addressing these issues is critical to the long-term health of the Native Hawaiian people. Mahalo for the opportunity to share information about the status of behavioral health and diabetes in the Native Hawaiian community, and how our organizations move to meet the specific needs of our people. Again, we urge the Committee to include all Native Americans, including American Indians, Alaska Natives, and Native Hawaiians, in its efforts to meet the obligations of the federal trust responsibility owed to all Native communities.

‘O māua iho nei,

Papa Ola Lōkahi

ENDNOTES

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

³ NATIVE HAWAIIAN MENTAL HEALTH AND SUICIDE, OFFICE OF HAWAIIAN AFFAIRS (Feb. 2018), http://www.ohadatabook.com/HTH_Suicide.pdf.

⁴ NATIVE HAWAIIAN MENTAL HEALTH AND SUICIDE, OFFICE OF HAWAIIAN AFFAIRS (Feb. 2018), http://www.ohadatabook.com/HTH_Suicide.pdf.

⁵ 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

⁶ HAW. STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP, 2018 STATE EPIDEMIOLOGIC PROFILE: SELECTED YOUTH AND ADULT DRUG INDICATORS 7, (2018), https://health.hawaii.gov/substanceabuse/files/2019/06/Drug_2018_Hawaii_State_Epidemiologic_Profile.pdf.

⁷ Hawai‘i Health Data Warehouse. (2011–2015), Hawai‘i Department of Health Behavior Risk Factor Surveillance System (BRFSS).

⁸ Addressing Native Hawaiian Mental Health Needs Through Culturally Informed Programs and Services, OFFICE OF HAWAIIAN AFFAIRS 1, 1 (2019), <https://19of32x2yl33s8o4xza0gf14-wpengine.netdna-ssl.com/wpcontent/uploads/OHA-4-Mental-Health-Council-External-White-Paper-Final.pdf>.

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¹⁰ I OLA LAHUI, <http://iolalahui.org/> (last visited Sept. 21, 2020).

¹¹ M.A. Look et al., Assessment and Priorities for Health & Well-Being in Native Hawaiians & Other Pacific Peoples, UNIV. OF HAW. JOHN A. BURNS SCHOOL OF MEDICINE 1, 12 (2013), http://www.hicore.org/media/assets/JABSOMStudyreNHHealth_20131.pdf.

¹² Native Hawaiian Health Fact Sheet 2015, OFFICE OF HAWAIIAN AFFAIRS (2015), <https://www.oha.org/wpcontent/uploads/Volume-I-Chronic-Diseases-FINAL.pdf>.

¹³ M.A. Look et al., Assessment and Priorities for Health & Well-Being in Native Hawaiians & Other Pacific Peoples, UNIV. OF HAW. JOHN A. BURNS SCHOOL OF MEDICINE 1, 9 (2013), http://www.hicore.org/media/assets/JABSOMStudyreNHHealth_20131.pdf.

¹⁴ ISSUE BRIEF: COVID-19 AND NATIVE HAWAIIAN COMMUNITIES, NATIVE HAWAIIANS OVER-REPRESENTED IN COVID-19 AT-RISK POPULATIONS, OFFICE OF HAWAIIAN AFFAIRS 1, 4 (2020).

PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS (NCAI)

On behalf of the National Congress of American Indians (NCAI), thank you for holding this hearing on tribal health and broadband legislation. Founded in 1944, NCAI is the oldest and largest representative organization serving the broad interests of tribal nations and communities. Tribal leaders created NCAI in 1944 in response to termination and assimilation policies that threatened the existence of American Indian and Alaska Native (AI/AN) tribal nations. Since then, NCAI has fought to preserve the treaty and sovereign rights of tribal nations, advance the government-to-government relationship, and remove historic structural impediments to tribal self-determination.

To facilitate the Senate Committee on Indian Affairs' (SCIA) work, NCAI submits this written testimony in support of the following bills.

S. 3937—Special Diabetes Programs for Indians Reauthorization Act of 2020

The Special Diabetes Program for Indians (SDPI), enacted in 1997, provides assistance for developing local initiatives to treat and prevent diabetes and has served as a comprehensive funding source to address diabetes issues in tribal communities. Because of SDPI, rates of End-Stage Renal Disease and diabetic eye disease have dropped by more than half.¹ A report from the U.S. Department of Health and Human Services (HHS), Assistant Secretary for Preparedness and Response, found that SDPI is responsible for saving Medicare \$52 million per year.² Despite its great success, SDPI has been flat funded at \$150 million since 2004 and has lost much of its buying power due to medical inflation.

In addition, since September 2019, Congress has renewed SDPI five times in short increments of just several weeks or several months. Right now, SDPI is set to expire on December 11, 2020. These short-term extensions have caused significant distress for SDPI programs and have created undue challenges for our patients and community members. They have also led to the loss of providers, curtailing of health services, and delays in purchasing necessary medical equipment due to uncertainty of funding—all while tribal nations are also battling the COVID-19 pandemic. S. 3927 provides a five-year reauthorization to SDPI with added flexibility for tribal nations to receive funds through contracts and compacts would ensure Indian Health Service (IHS), tribal health facilities, and urban Indian health programs (collectively known as the "I/T/U" system) have the necessary funds to address diabetes and the increased risk it poses for a more severe COVID-19 illness. NCAI has long supported increased appropriations and permanent reauthorization for SDPI. Additionally, in 2019 our membership passed Resolution ABQ-19-042, supporting SDPI funding through Title I and Title V Indian Self-Determination and Education Assistance Act contracts or compacts. Accordingly, NCAI strongly supports the immediate passage of S. 3927.

S. 3126—Native Behavioral Health Access Improvement Act of 2019

AI/ANs are disproportionately impacted by mental and behavioral health issues, which adversely impact the well-being of individuals, families, and communities. These behavioral health issues are not isolated and have created an urgency for tribally driven solutions. Unfortunately, the lack of tribal resources for education, treatment, preventative services, and public safety in tribal communities impact Indian Country's ability to create lasting positive change in this arena. Increased funding for mental and behavioral health is critically needed, and in 2016 NCAI passed Resolution PHX-16-027, supporting increased federal resources to combat opioid abuse and addiction in Indian Country. S. 3126 addresses this gap by requiring the Director of the IHS, in coordination with the HHS Assistant Secretary for Mental Health and Substance Use, to create grants for the I/T/U system in the amount of \$150 million per year for five years to address important mental health and substance abuse issues. Further, the bill models this behavioral health program after the successful SDPI program which allows tribal leaders to make local level decisions, choose best practices, and adapt programs to be culturally appropriate. This framework of program implementation, alongside the funding that S. 3126 proposes is critically needed in Indian Country. Accordingly, NCAI supports the immediate passage of S. 3126.

S. 3264—Bridging the Tribal Digital Divide Act of 2020

Tribal nations experience lower rates of fixed broadband service than their non-tribal rural counterparts, with less than half of households on rural tribal lands having access to fixed broadband service.³ This disparity is exacerbated as tribal nations without reliable Internet access struggle to respond to and mitigate the challenges brought forth by the COVID-19 pandemic.

¹ Bursell SE, Fonda SJ, Lewis DG, Horton MB. Prevalence of diabetic retinopathy and diabetic macular edema in a primary care-based teleophthalmology program for American Indians and Alaska Natives.

² Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Special Diabetes Program for Indians: estimates of Medicare savings. ASPE Issue Brief. Department of Health and Human Services, May 10, 2019. <https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings>

³ Report on *Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018*, Federal Communications Commission, p. 1, (2019), <https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf>

Tribal nations face many barriers related to program procedure, funding, and build out when trying to access broadband networks on their lands. There are various federal agencies that offer programs that aid in the development, deployment, and maintenance of broadband networks. Unfortunately, none of these programs are tailored specifically to assist tribal nations with their needs. Each of these federal broadband programs has its own provisions, regulations, policies, and procedures that do not always consider the unique and varying circumstances of tribal nations. Navigating each of these programs and deciding between them can be a complicated process. Once a tribal nation chooses to pursue a program, they encounter barriers to deployment. These barriers include lack of investment and funding, restrictive definitions for service areas, and complex right-of-way statutes that limit tribal nations' ability to permit projects on their own land.

S. 3264 addresses these barriers and attempts to remove or lessen their impact to increase broadband access rates on tribal lands. S. 3264 establishes a Tribal Broadband Interagency Working Group to improve coordination between federal broadband programs and helps streamline the application and planning process for tribal nations. This legislation also creates set asides through the Federal Communications Commission (FCC) and the United States Department of Agriculture (USDA) to better fund tribal broadband initiatives and broadens restrictive definitions to increase eligible broadband service areas for tribal nations. Finally, S. 3264 further establishes the Tribal Broadband Right-of-Way Pilot Program. This program, at the discretion of the Secretary of the Interior, would enable select tribal nations to grant a broadband right-of-way across their tribal lands.

The pandemic has shown that broadband is critical infrastructure for tribal communities and the digital divide must be closed to address the health, safety, and welfare needs of tribal peoples. S. 3264 aids this goal by addressing structural issues that have decreased tribal access to broadband deployment and, accordingly, NCAI supports its immediate passage.

Conclusion

Thank you for the opportunity to provide testimony on this legislation. We greatly appreciate SCIA's work to address the many challenges and barriers faced by AI/AN communities and look forward to working together to support the passage of S. 3937, S. 3126, and S. 3264 and advance other federal policies supporting our tribal communities.

PREPARED STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, thank you for holding a legislative hearing on September 23, 2020 to receive testimony on S. 3126, S. 3264, S. 3937, S. 4079, and S. 4556. 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, we submit this testimony for the record.

S. 3937

NIHB strongly supports S. 3937, the Special Diabetes Program for Indians (SDPI) Reauthorization Act of 2020, introduced by Senator McSally and supported by Senator(s) Murkowski and Sinema.

The bipartisan S. 3937 would provide five years of guaranteed funding for SDPI at an increased funding authorization level of \$200 million annually. This represents the first increase to SDPI's funding level in sixteen years, and the longest reauthorization of the program in more than 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. In short, self-determination and self-governance reinforce inherent Tribal sovereignty, and impart greater local Tribal control over programming to ensure maximize effectiveness.

As NIHB has shared with the Committee in prior testimony, Tribes are requesting technical changes to the introduced text in S. 3937 to clarify the intent of the "Delivery of Funds" language in order to ensure proper implementation of the new 638 authority. Specifically, we urge the Committee to pass S. 3937 with the requested changes to the Delivery of Funds section outlined 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."

During the Committee’s legislative hearing in September, Rear Admiral (RADM) Weahkee stated that Title V self-governance Tribes already have the authority to add their SDPI awards to their annual funding agreements (AFAs) while Title I self-determination Tribes do not. We believe this statement requires further context and explanation. While Title V self-governance Tribes may currently “add” their SDPI awards to their AFAs, they are restricted from accessing the full scope of authorities established under Title V of the Indian Self-Determination and Education Assistance

Act (ISDEAA) to support their SDPI operations. For example, Title V Tribes who have elected to add their SDPI funds to their AFAs are not currently entitled to Contract Support Costs (CSCs) for their SDPI programs, nor are they able to streamline diabetes data reporting. Authority for Tribes to receive CSCs and other ISDEAA related provisions specifically for SDPI would require a statutory change. Tribes drafted the legislative language shared earlier in this section precisely to achieve that goal.

Moreover, the intent of the Tribes in pushing for this structural 638 change to SDPI’s governing statute is not simply to ensure both Title I and Title V Tribes can simply “add” SDPI funds to their AFAs—it is to ensure Tribes who choose to receive their SDPI funds through the 638 mechanism are entitled the corresponding statutory provisions, such as CSCs and streamlined data reporting.

Not only would S. 3937 further reinforce Tribal self-determination and self-governance, but it would also finally insulate the program from its recent string of destabilizing short-term extensions. SDPI is currently slated to expire on December 11, 2020. Its most recent extension, under H.R. 8337, Continuing Appropriations Act, 2021 and Other Extensions Act, lasts for only eleven days—SDPI’s shortest extension on record and its fifth short-term extension since September 2019 alone. In her opening remarks during the legislative hearing in September, Senator McSally stated that “SDPI has suffered from a series of short-term reauthorizations, and stagnant funding, that’s hindered the program’s full potential.” Similarly, Senator Murkowski brought attention to the mere eleven day extension of SDPI in her opening comments, and discussed how short-term extensions hurt the programs and “do nothing to increase any level of certainty” for Tribal SDPI grantees. The Senator also acknowledged that diabetes is a leading risk factor for a more serious COVID-19 illness according to the Centers for Disease Control and Prevention (CDC), as Tribes and NIHB have repeatedly referenced as clear evidence of the need for long-term reauthorization of this life-saving program.

As NIHB reported in prior testimony, a national survey of SDPI grantees conducted by NIHB found that nearly 1 in 5 Tribal SDPI grantees reported employee furloughs, including for healthcare providers, with 81 percent of SDPI furloughs directly linked to the economic impacts of COVID-19 in Tribal communities. Roughly 1 in 4 programs have reported delaying essential purchases of medical equipment to treat and monitor diabetes due to funding uncertainty, and nearly half of all programs are experiencing or anticipating cutbacks in the availability of diabetes program services—all under the backdrop of a pandemic that continues to overwhelm the Indian health system.

We appreciate this Committee’s bipartisan commitment to SDPI, but Tribes need Congress to collectively act on long-term reauthorization to ensure Tribes and Tribal citizens can continue to benefit from this indispensable public health program.

S. 3126

AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before this public health emergency began, and many of these challenges have only worsened under the pandemic. This is especially true for Native youth. A 2018 study found that AIAN youth in 8th, 10th, and 12th grades were significantly more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days.¹ According to the Centers for Disease Control and Prevention, suicide rates for AIANs across 18 states were reported at 21.5 per 100,000—3.5 times higher than demographics with the lowest rates.²

To that end, NIHB supports S. 3126, the Native Behavioral Health Access Improvement Act of 2019. The concept of a special behavioral health program modeled on SDPI to address chronic and pervasive behavioral health challenges in Indian

¹Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open*. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

²Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives—National Violent Death Reporting System, 18 States, 2003–2014. *MMWR Morb Mortal Wkly Rep* 2018;67:237–242. DOI: <http://dx.doi.org/10.15585/mmwr.mm6708a1>

Country was first presented by a cohort of NIHB's Native Youth fellows. In May 2017, the NIHB Board of Directors passed a resolution formally requesting funds be allocated toward substance abuse prevention and intervention programs for AI/AN Youth that promotes high self-esteem and resilience through cultural enrichment. We greatly appreciate Senator Smith's leadership in introducing S. 3126, and thank Vice Chair Udall, Senator Tester, Senator Cortez Masto, and Senator Warren for supporting this critical legislation.

S. 4556

We support the passage of S. 4556 for the Director of IHS to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California. Currently, IHS does not have the authority to acquire and/or improve Best Road. The legislation would authorize the Director of IHS to acquire and improve Best Road to provide safe access to the Desert Sage facility for staff and emergency vehicles. Desert Sage is the first Youth Regional Treatment Center in CA to provide culturally-sensitive substance use treatment for AIAN youth. Previously, AIAN youth attended out-of-state treatment facilities that inconveniently removed them from their critical support systems during recovery. AI/AN youth are disproportionately impacted by substance use, addiction, overdose, and suicide. A 2018 study found that AIAN youth in 8th, 10th, and 12th grades were significantly more likely than non-Native youth to have used alcohol or illicit drugs in the past 30-days.³ For California Native youth, access to Desert Sage is critical to address these disparities.

Conclusion

We thank the Senate Committee on Indian Affairs for holding this hearing on important legislation, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for all AI/ANs, and raises health outcomes.

PREPARED STATEMENT OF ESTHER LUCERO, (DINÉ), MPP, 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 Legislative Hearing to receive testimony on S. 3937: Special Diabetes Programs for Indians Reauthorization Act of 2020 and the S. 3126: Native Behavioral Health Access Improvement Act of 2019 on September 23, 2020.

Background on Seattle Indian Health Board

SIHB is one of 41 Indian Health Service (IHS)-designated Urban Indian Health Programs (UIHP), as defined by Section 4 of the Indian Health Care Improvement Act, and a HRSA 330 Federally Qualified Health Center, which serves nearly 5,000 American Indian and Alaska Native people living in Seattle-King County, WA. As a culturally attuned service provider, we offer direct medical, dental, traditional health, behavioral health services, and a variety of social support services on issues of gender-based violence, youth development, and homelessness.

We also house the Urban Indian Health Institute (UIHI), an IHS-designated Tribal Epidemiology Center and public health authority, which conducts data, research, and evaluation services for 62 urban Indian communities nationwide. We are part of the IHS continuum of care, which is comprised of IHS Direct, Tribal 638, UIHP (I/T/U system of care). We honor our responsibilities to work with our tribal partners and to serve all tribal people. Our role is to address the community and health needs of the over 70 percent of American Indian and Alaska Native people that live in urban areas.

A Proven Culturally Attuned Model of Care: Special Diabetes Program for Indians

Research has shed light on the health and psychological vulnerabilities of American Indian and Alaska Native people that have resulted from a legacy of historical trauma shaped by colonization and forced removal of American Indian and Alaska Native people from traditional homelands. This has resulted in diminished natural resources, persistent malnutrition and nutritional deficiencies, and eliminated access to traditional foods.^{1 2 3} As a result, type 2 diabetes is more prevalent in Amer-

³Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. *JAMA Netw Open*. 2018;1(1):e180382. doi:10.1001/jamanetworkopen.2018.0382

ican Indian and Alaska Native people than in any other race and is two times higher than that of non-Hispanic Whites.⁴ Additionally, American Indian and Alaska Native people have higher proportions of diabetes precursors such as poor nutrition, high blood pressure, insufficient physical activity, heart disease, and obesity.⁵

Since 1998, Special Diabetes Program for Indians (SDPI) has offered thousands of American Indian and Alaska Native people access to culturally attuned diabetes prevention and management services across Indian Country. SDPI has proven to be an inexpensive and highly cost-saving measure of diabetes care and prevention by establishing diabetes-focused clinical teams, diabetes patient registries, culturally tailored diabetes education tools, nutrition services for children and youth, and weight management programs for adults. The SDPI program has saved millions of Medicaid dollars through prevention and management of diabetes and associated health problems such as hypertension, cardiovascular disease, retinopathy, neuropathy, and end-stage renal disease. The SDPI program has increased diabetes programs and services resulting in several improvements in health outcomes, including:

- A decrease in mean A1c, decrease in mean LDL cholesterol, and well-controlled blood pressure measurements which can reduce the rate of diabetes complications.^{6,7}
- The rate of increase in diabetes prevalence among American Indian and Alaska Native adults has slowed from 2006 to 2012 and narrowed the gap between American Indian and Alaska Native adults and all adults in the general United States population; and the prevalence has not increased since 2011.⁸
- Obesity and diabetes rates in American Indian and Alaska Native youth remained nearly constant in more than 10 years.⁹
- Diabetes eye diseases rates decreased 50 percent, reducing vision loss and blindness.¹⁰
- Kidney failure from diabetes dropped by 54 percent in 1996 to 2013 in American Indian and Alaska Native adults and was steeper than any other racial/ethnic group and was the same as the incidence in Non-Hispanic Whites.¹¹

In the past five years, SDPI services at Urban Indian Health Programs has demonstrated successful implementation and service delivery resulting in the following outcomes:

- Maintained healthy eGFR levels in patients (eGFR > 60 ml/min/1.7m2).
- Maintained good blood pressure control in patients with diabetes (SBP and DBP below 140/90 mmHg).
- In 2018, there was a high proportion (79.8 percent) of patients with diabetes and hypertension prescribed ACE inhibitors or ARBs.
- In 2018, there was a high proportion (78.0 percent) of patients with diabetes who use tobacco referred to cessation counseling.
- Over the five period (2014 to 2018), there was a statistically significant increase in the proportion of patients with diabetes receiving an annual dental exam.
- Over the five period (2014 to 2018), there was a statistically significant increase in the proportion of patients with diabetes receiving the hepatitis B vaccine series.¹²

In addition to clinical markers of success, many SDPI services at Urban Indian Health Programs offer integrated models of care that incorporate services and activities from traditional Indian medicine, community gardening and traditional foods, cooking classes, and youth fitness programming. Integrated services create a more holistic wellness experience for patients and families confronting diabetes. Many Urban Indian Health Programs tailor integrated services specifically to support patients with multiple health conditions, social barriers, and trauma-related stressors.

In April 2020, UIHI released a factsheet entitled: Special Diabetes Program for Indians (SDPI): Mitigating COVID-19 Risk. This factsheet highlights that American Indians and Alaska Native people have the highest diabetes rates compared to the general public and diabetes increases the chance of severe illness from COVID-19. Therefore, the continuation of SDPI is crucial to mitigating COVID-19 in tribal and urban Indian communities through sustained diabetes prevention, treatment, and management efforts. The SDPI program is the only national public health intervention program that has improved diabetes related outcomes for American Indian and Alaska Native people.

Unaddressed Behavioral Health Access Needs in Native Communities

Historically, American Indian and Alaska Native people have been subjected to utilizing westernized systems of care for behavioral health. The American Indian and Alaska Native community experiences higher rates of behavioral health challenges due to exposure from violence, trauma, and historical trauma. A continuing barrier to accessing behavioral health services within Indian Country is the lack of funding to develop both an adequate and culturally appropriate program. As COVID-19 persists, Indian Country is experiencing a rise in behavioral health issues that needs to be addressed.

Data show that American Indian and Alaska Native people are disproportionately represented in poor behavioral health outcomes. American Indian and Alaska Native people often suffer from higher rates of behavioral health conditions such as mental health, substance use disorders, or suicide. For example, analysis of SIHB's 2017 patient data shows that 7 percent of clientele were diagnosed with Opioid Use Disorder (OUD) compared with national rates of less than 1 percent.¹³ According to the National Institute of Mental Health, youth and middle-aged American Indian and Alaska Native have the highest suicide rate in the country.¹⁴ Furthermore, a 2017 report from the CDC's National Violent Death Reporting System shows that American Indian and Alaska Native people are over two times as likely to commit suicide than other minority groups.¹⁵

Older American Indian and Alaska Native populations, who have a higher rate of depression than their non-Native counterparts, also have a low rate of seeking out mental health services. This is often attributed to a lack of culturally attuned healthcare systems that are reflective of Indigenous values.¹⁶ Not only is there a demonstrated need behavioral health services in Native communities, there is also a national behavioral health provider shortage documented by federal agencies. A 2016 HRSA report found significant shortages of psychiatrists, psychologists, social workers, school counselors, and marriage and family therapists.¹⁷ As of 2019, HRSA has identified Washington State as a Mental Health Professional Shortage Area, estimating that 12.23 percent of the need for mental health providers is being met.¹⁸

As healthcare systems move towards integration of behavioral health and medical care, it is a critical time to make targeted investments in building up the behavioral health workforce and programming across the Indian healthcare system. Our workforce development incentives and programs must reflect priorities of health integration, consumer demand, and identified community needs.

Recommendations

As we work together to address historical and current health disparities and promote the well-being of American Indian and Alaska Native communities, we ask the committee to support:

- The Special Diabetes Programs for Indians Reauthorization Act of 2020 or S. 3937 to reauthorize SDPI for five years to protect the health of American Indians and Alaska Native people with diabetes during the COVID-19 pandemic and beyond; and
- The Native Behavioral Health Access Improvement Act of 2019 or S. 3126 to allow tribes and urban Indian organizations the opportunity to develop behavioral health solutions that incorporate traditional and cultural practices into evidence-based prevention, treatment and recovery programs.

Thank you for your continued advocacy to support Indian healthcare systems during the COVID-19 pandemic. We urge you to continue working for the health and wellness of American Indian and Alaska Native communities.

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PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is pleased to provide the Senate Committee on Indian Affairs (SCIA) with testimony for the record of the legislative hearing to receive testimony on S. 3126, S. 3264, S. 3937, S. 4079, and S. 4556. Our testimony will address four of the bills, as we defer to those who are more directly affected by S. 4556 for a discussion on its merits. USET SPF appreciates SCIA's efforts to continue Committee business, given the multiple competing priorities posed by the COVID–19 pandemic and other current events. Though many of these bills are related to COVID–19 in some way, the problems they seek to remedy existed long before the public health emergency, caused by decades of federal under-investment, neglect, and harmful policies. It is our expectation that SCIA will make every effort mark-up these bills, and other pending legislation, prior to the end of the 116th Congress.

USET SPF is a non-profit, inter-Tribal organization advocating on behalf of thirty (30) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.¹ USET SPF is dedicated to promoting,

¹ USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Arosotook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe-Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock

protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations, and assisting our membership in dealing effectively with public policy issues.

S. 3126, The Native Behavioral Health Access Improvement Act

USET SPF strongly supports the intent of S. 3126, the Native Behavioral Health Access Improvement Act, which would provide critical behavioral health resources to Tribal communities by creating a Special Behavioral Health Program for Indians (SBHPI). The SBHPI is modeled after the Special Diabetes Program for Indians (SDPI), a successful Tribal health program that has had a significant impact on diabetes within Tribal communities. Like SDPI, SBHPI responds to a public health crisis by providing dedicated funding to Tribal Nations to address behavioral health and substance use disorders, including opioid abuse and addiction. In addition, it would support cultural competency by promoting the incorporation of both modern and traditional practices into Tribal behavioral health programs. In order to ensure that SBHPI funding is distributed equitably, USET SPF recommends that the bill clarify the program will use a formula-based distribution methodology developed in consultation with Tribal Nations. This will provide the opportunity for Tribal Nations without grant-writing infrastructure to benefit from these funds. USET SPF notes that this hearing also addressed extending self-governance authority to SDPI. Given the structural design of the SBHPI, as well as our principle that all federal funding should be contractable and compactable, we urge that self-governance authority be a part of the conversation as S. 3126 continues to move through the legislative process.

S. 3264, Bridging the Tribal Digital Divide Act of 2020

According to a 2018 Federal Communications Commission (FCC) report on broadband deployment in Indian Country, just 46.6 percent of housing units on rural Tribal lands have access to high speed broadband, a nearly 27-point gap when compared with non-Tribal rural households. As our nation becomes ever more dependent upon these tools, including to combat COVID-19 and to maintain our way of life amid lockdowns, the digital divide between Indian Country and other communities throughout America becomes even more stark. For example, lack of connectivity is impeding the COVID-19 response by acting as a barrier to public health announcements and other urgent communications from Tribal leadership and officials, as well as access to information from other reliable sources regarding COVID-19 prevention measures. It also creates extreme difficulty as Tribal Nations work to trace the contacts of those who have been infected.

Connectivity issues also impact Indian Country's ability to adapt to the 'new normal' of conducting our daily business in the virtual realm. In the absence of adequate broadband and 4G, many of the adaptive measures that other communities have taken are unavailable to some Tribal communities. This leaves our citizens without access to preventative care and check-ups, the ability to telework, and the opportunity to continue their studies during school closures-compounding the disparities we already face in these areas.

It is with this in mind that USET SPF extends its support to S. 3264. The Bridging the Tribal Digital Divide Act would spur the deployment of broadband on Tribal homelands by providing for improved federal coordination and focusing federal dollars in Indian Country. It also ensures that Tribal Nations have access to technical assistance, a streamlined application process, and control over broadband rights-of-way within our territories. Passage of this bill would be a significant step forward in bringing Tribal connectivity into the 21st century.

S. 3937, The Special Diabetes Programs for Indians Reauthorization Act of 2020

As this body well knows, the Special Diabetes Program for Indians (SDPI) is a lifesaving initiative for the treatment and prevention of type-2 diabetes in Indian Country. In order to continue to make progress on the devastating effects of diabetes in Tribal communities and provide certainty to SDPI programs, Congress must provide a multi-year reauthorization of SDPI. With the short-term reauthorizations provided over the last several Congresses (including five short-term extensions just this year), Indian Country has been forced to focus on advocating for SDPI's continued funding rather than patient care and programmatic expansion. Tribal Nations

Tribes (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

and Congress have made significant investments in preventing and managing the disease. Now is the time to provide certainty to this critical program.

USET SPF continues to be frustrated by short-term reauthorizations, as well as the persistent flat funding of the program, in spite of a wealth of reliable data showing both its efficacy and continued necessity, as well as rising medical inflation. We have joined others in Indian Country in consistently advocating for an increase in funding that will account for newly recognized Tribal Nations, IHS/Tribal/Urban Indian Health Programs that haven't had the opportunity to access SDPI, and increases in medical costs.

Further, in accordance with our effort to modernize the nation-to-nation relationship between the United States and Tribal Nations, USET SPF has consistently urged that all federal funding be eligible for inclusion in self-governance contracts and compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA), rather than grants, in recognition of the retained sovereign authority of Tribal Nations and reflective of 21st century self-determination. In addition, SDPI's grant application and reporting requirements are burdensome, not reflective of our sovereign status, and undermine service delivery, as staff time is dedicated to these grant-related tasks.

USET SPF strongly supports the goals of S. 3937 and extends its appreciation to Sen. McSally for its introduction. The bill would provide a long-overdue increase in funding for SDPI, as well as a 5-year reauthorization, both of which are necessary for program continuity in Indian Country. Importantly, it also seeks to extend self-governance authority to the program for the very first time. In an effort to clarify the Tribal position on this provision, USET SPF asserts that our objective is to extend the full benefit of ISDEAA to SDPI, including reducing burdensome and unnecessary reporting requirements, while ensuring that any programs that do not operate under this authority remain unchanged. With our partners, including National Indian Health Board and Tribal Self-Governance Communication and Education, we are working to offer legislative language that reflects these aims. We refute previous technical assistance provided by the Indian Health Service to the U.S. House of Representatives as being inappropriate, incorrect, and fearmongering, and are encouraged that Rear Admiral Weahkee took a more constructive tone during the SCIA hearing. A critical part of IHS' trust obligation includes promoting and supporting Tribal sovereignty and self-determination. Extending ISDEAA authority to SDPI will serve only to strengthen Tribal programs and our Nation-to-Nation relationship with the United States. USET SPF looks forward to working with Sen. McSally, SCIA members, our partners, and IHS to achieve this next step forward in Tribal self-governance.

S. 4079, A Bill To Authorize the Seminole Tribe of Florida to Lease or Transfer Certain Land, and for Other Purposes

Despite the many advances made in federal Indian law over the last several decades, there remain numerous examples of anachronistic and paternalistic laws that have yet to be repealed or rescinded. These policies are remnants of an era and mindset that has no place in current Nation-to-Nation relations, as it is based on two deeply flawed and paternalistic assumptions: (1) that Tribal Nations are incompetent to handle our own affairs, and (2) that Tribal Nations would eventually disappear. Indian Country has proven both of these assumptions wrong over and over again. The time is now to revisit and remove existing barriers that interfere with our ability to implement our inherent sovereign authority to its fullest extent. S. 4079 would confirm that as a sovereign government, the Seminole Nation, a USET SPF member Tribal Nation, has the authority to lease or transfer certain fee lands without Congressional approval. USET SPF strongly supports this legislation, as it more fully recognizes the sovereignty of the Seminole Nation and promotes its economic development. We encourage SCIA and this Congress to explore opportunities to fully repeal any provisions of law that do not fully recognize the sovereignty of Tribal Nations.

PREPARED STATEMENT OF THE RIVERSIDE COUNTY BOARD OF SUPERVISORS

On behalf of the Riverside County Board of Supervisors we write to express our support for H.R. 4495—Access Road for Desert Sage Youth Wellness Center.

It is our understanding that the Desert Sage Youth Treatment Center provides culturally sensitive treatment for American Indian and Alaska Native (AI/AN) youths between ages 12 and 17 suffering from Substance Use Disorders (SUD). Previously, AI/AN youth used out-of-state facilities which took away their support systems at this crucial time of recovery from SUD. Desert Sage was constructed in

2016 and can serve up to 32 patients at a time. It is the only IHS Youth Regional Treatment Center in California.

When the facility was constructed, the Indian Health Service-IHS was unable to reach agreement with landowners on adjacent properties in order to pave and maintain an access road. Dr. Ruiz's legislation would give IHS the authority to purchase the land from willing sellers and construct a road to the facility. H.R. 4495 would permit the IHS to acquire the land and construct an access road. After construction the road would be transferred to the county for permanent operation and maintenance.

For these reasons, we support S. 4556, A bill to authorize the Secretary of Health and Human Services, acting through the Director of the Indian Health Service, to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California, and for other purposes.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
HON. REAR ADMIRAL MICHAEL D. WEAHKEE

Question 1. In response to questions for the record concerning IHS's public health emergency preparedness that I submitted to IHS following the Committee's July 1st hearing, you described, among other actions, creating a "continuity of operations special general memorandum" and utilizing the Office of the Assistant Secretary for Preparedness and Response's 2017 Update to the Department of Health and Human Services (HHS) Pandemic Influenza Plan. How did these pre-pandemic actions inform IHS's response to COVID-19?

Answer. As part of preparedness, IHS participated in a Pandemic Influenza Exercise: Operation Crimson Contagion, between January 2019 and August 2019, in collaboration with the HHS. Operation Crimson Contagion moved through a severe influenza pandemic scenario from activation of the disaster simulation through devolution. In addition, IHS Areas and Service Units participate in disaster preparedness exercises to test their disaster response plans based on local and tribal all hazard vulnerability analysis results. The IHS was able to leverage the planning exercises, including the pandemic influenza planning, to begin to address the COVID-19 pandemic. The IHS used lessons learned from exercises to direct continuity of operations, start planning for Alternative Care Sites (ACS), coordinate alternative screening areas, create a linkage to the Secretary's Operation Center, and make the early decision to follow all CDC guidelines. Communication lessons learned allowed for quick sharing of clinical and administrative guidelines and expansion of existing relationships with key partners such as ASPR, which strengthened our emergency operations capability.

Question 1a. What difficulties did IHS encounter mobilizing its response in the early days of the pandemic?

Answer. At the onset of the COVID-19 pandemic, the IHS encountered work environment and efficient surveillance system difficulties. In early March 2020, IHS senior leadership activated the Headquarters Incident Command Structure (ICS) to respond to COVID-19 using the IHS pandemic response plan and disaster plans in IHS healthcare facilities. Subsequently, IHS drafted the IHS COVID-19 Response Concept of Operations (CONOPs) aligning with the US COVID-19 Response plan. The IHS ICS team is comprised of incident command leadership, Facilities/Area Coordination Group, Liaison Section, Public Information Officer, Systems Support Section, Operations Section, Planning Section, and Safety Officer. With the evolution of the COVID-19, stay at home/shelter in place orders, and the maximum utilization of telework for staff at the IHS HQ 5600 Fisher Lane building in Rockville, MD, the ICS moved to virtual operations in late March 2020. The IHS stood up a data surveillance system to track the detection of new COVID-19 cases and assist in planning IHS response. The surveillance system collects facility level data on COVID-19 related outcomes, such as ventilator use and hospital bed capacity, along with aggregated testing data from all federal sites and participating tribal and UIO facilities. The surveillance system has helped the IHS coordinate critical data that assists in addressing planning and COVID-19 surveillance challenges initially encountered.

Question 1b. Is IHS evaluating the effectiveness of its COVID-19 response actions? What are the lessons learned looking forward?

Answer. Yes, the IHS has engaged and continues to evaluate COVID-19 response actions. The ICS has continued regular communication with Areas to assess local needs and response, and at 100 days into the formal response, the IHS conducted an assessment of activities. The assessment examined actions by the IHS COVID-

19 Action Plan to prevent, detect, treat, and recover. The IHS is also compiling a review of lessons learned, early analysis indicates that:

- Regular communications from and across leadership, through the daily (then tri-weekly) IHS COVID-19 ICS Daily Check-In, proved to be one of the most important tools for ensuring that I/T/U leaders and staff received consistent and standard updates, and that issues and/or risks could be highlighted and resolved in a timely manner.
- Essential to the success of IHS efforts was the daily coordination and integration with federal agencies (e.g., Centers for Disease Control and Prevention (CDC), Federal Emergency Management Agency (FEMA), and Veterans Health Administration (VHA)), state, Tribal, and local governments, as well as health systems, hospitals, providers and other stakeholders.
- Leaders focused early on important data resources, metrics and measures, and informed decisions through daily analysis leveraging the data surveillance system and improved National Healthcare Safety Network (NHSN) reporting from all direct service hospitals.
- IHS' National Supply Service Center (NSSC) provided essential coordination and management support for the distribution of pharmaceuticals, medical, and other health care related supply items including personal protective equipment to IHS, Tribal, and Urban Indian Organization health care facilities and programs nationwide.

Question 2. In response to questions for the record concerning the impacts of COVID-19 related lost third-party revenue on the ITU system that I submitted to IHS following the Committee's July 1st hearing, you stated, "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." Given that the majority of IHS third-party revenue comes from increased coverage options authorized by the Patient Protection and Affordable Care Act—If the ACA were repealed before the end of the year, would IHS be able to ensure that all federally-operated IHS facilities, Tribally-operated IHS facilities, and Urban Indian health programs could remain open and retain sufficient staff to continue serving their communities and meet all accreditation standards?

Answer. The Indian health system, as a whole, relies heavily on third party resources to maintain accreditation and certification, sustain health care services and operations, address facilities maintenance and operations, and procure medical equipment. The third party revenue stems from all Third Party Resources: Medicaid (including Medicaid Expansion), Medicare, Private Insurance (including Marketplace Coverage), Department of Veterans Affairs and Other.

In some instances, third party collections may constitute 50 percent or more of a facility's operating budget. Declining collections due to the COVID-19 pandemic caused as a result of a decrease in routine and non-emergency health services has led to significant resource challenges across the system. Any changes to Patient Third Party Coverage could have an impact on Tribes and Federal facilities.

Between April and September 2020, IHS (Federal) collections were 16-17 percent lower when compared to the same time period in the previous year. Continued reductions of this magnitude compound the challenges of operating during a pandemic. The IHS continues to monitor the status of collections and adjust plans for mitigating impacts of reduced revenue levels.

Question 2a. How would repeal of the ACA impact IHS's current COVID-19 response efforts and initiatives?

Answer. If any losses in revenue occur as a result of changes to third party reimbursement, priorities may have to be shifted.

Question 2b. What contingency planning, if any, has IHS undertaken to determine what authorities would disappear if the entire ACA (including the Indian Health Care Improvement Act (IHCA) amendments and reauthorization) were repealed?

Answer. The IHS is committed to providing quality health care, consistent with its statutory authorities and its government-to-government relationship with each Indian tribe. In accordance with the IHS Tribal Consultation policy (IHS Indian Health Manual—IHS Circular 2006-01), a change in law would constitute a critical event that has or may have substantial impact on Indian Tribes or Indian communities. To address any such critical event, the IHS would initiate formal Tribal consultation to seek input on implementation of changes in IHS programs or policies.

Question 2c. What current authorities or programs would be lost for IHS, Tribes, and Urban Indian health programs if changes made by to the IHCA by the ACA were repealed?

Answer. The IHS has a duty to carry out its statutory responsibilities. The IHS administers discretionary appropriations and operates under broad, general authorities that give IHS significant discretion in how to provide health care to Indian Tribes.

The Indian Health Care Improvement Act (IHCIA), the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, was made permanent as part of the Patient Protection and Affordable Care Act (PPACA). If the PPACA was repealed, then Congress would need to reauthorize the IHCIA in order for those programs to continue. In 2013 and 2019, the Government Accountability Office (GAO) reported on effects of the PPACA on the American Indian and Alaska Native population, see reports GAO-13-553 and GAO-19-612.

Question 3. Your testimony for this hearing discusses the mental and behavioral health impacts of the COVID-19 pandemic on Native communities and mentions that IHS has seen an influx of new patients seeking care for these types of issues. It further states that Senator Smith's Native Behavioral Health Access Improvement Act would provide additional tools to address some of the longstanding mental and behavioral health access barriers for Native communities. Does IHS have any data that indicates a level of increased demand for mental and behavioral health services observed since the onset of the COVID-19 pandemic?

Answer. Due to COVID-19, many of the referral systems of care have temporarily halted services, discharged patients, and limited onboarding of new patients. This is additionally complicated by increased medically managed detoxification needs for patients experiencing precipitated withdrawal due to changes in illicit opioid supply chains and changes in access to alcohol resulting from shelter in place orders. As a result, alcohol withdrawal patient visits declined from 5,802 to a projected 5,115 between FY19 and FY20. Between FY14 and FY19, IHS reported an increase in opioid related outpatient visits by 69 percent, representing an upward trend of increasing access to treatment prior to COVID-19. However, in FY20, the average number of visits to receive care per year declined for both alcohol and opioid related categories. Consequently, IHS estimates a decline in medication assisted treatment (MAT) related encounters based on FY20 Naloxone and Buprenorphine prescription data.

Overall, IHS has documented an increase for all service categories of ambulatory, telehealth, and telephone contacts from March to June 2020 of the COVID-19 Public Health Emergency. From March to April 2020, the number of such encounters increased 1,555 percent and from April to May 205 percent. Finally, the telehealth related behavioral health and alcohol/substance use encounters (based on facility type and/or taxonomy developed for Alcohol SA encounter identification) is expected to increase 93.5 percent from FY19 to FY20 based on the first 8 months of data.

Question 3a. If Tribes had additional mental and behavioral health tools, like those proposed by Senator Smith's bill, what kind of impacts on Native communities' overall health and wellbeing would IHS expect to see?

Answer. It appears the intention of S. 3126 is to create a behavioral health program modeled after the successful Special Diabetes Program for Indians (SDPI) program. Many of the elements of the SDPI and lessons learned over the years can be adapted for a Behavioral Health Program (BHP), such as flexibility to allow for local priorities and approaches to programs and activities, standardized collection of program data to evaluate progress and outcomes, and the creation of a technical assistance center to provide guidance and resources to Tribes receiving grant funding.

Question 4. HHS recently held Tribal consultation and urban confer sessions on COVID-19 vaccination plans and indicated that Tribes will have the option to receive COVID-19 vaccines through either the IHS or the state in which they are located. How will IHS ensure that all Tribes and Urban Indian health facilities, including those that offer only outreach and referral services, receive adequate COVID-19 vaccine allocations?

Answer. In preparation for vaccine allocation and distribution, IHS requested vaccination estimates from all Tribal and Urban Indian health programs that choose to receive their vaccine from IHS. These estimates will be included in the overall vaccine allocation estimates across the health care system.

Those programs that do not have vaccine clinic services or capability will be advised to utilize their existing network for receiving vaccine services to ensure access to COVID-19 vaccine allocations. IHS does not anticipate allocating COVID-19 vaccine to facilities where clinical services to store and administer the vaccine do not exist.

Question 4a. What safe guards will HHS and IHS deploy to ensure Tribes and Urban Indian health facilities that opt to receive vaccine distributions by working through relevant state agencies are treated equitably by states?

Answer. On September 24, 2020, HHS, through IHS and CDC, initiated Tribal Consultation to seek input from Tribal Leaders on COVID-19 vaccination planning for Indian Country. This Tribal Consultation complements the state planning process that began with the September 16, 2020 publication of the CDC's COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations. This playbook guides Immunization Program Awardees (e.g., state and local jurisdictions with routine immunization programs) in planning and operationalizing their COVID-19 vaccination response. HHS hosted six Tribal consultation sessions to seek input from Tribal leaders on COVID-19 Vaccination Planning for Indian Country. The Centers for Disease Control and Prevention (CDC), Food and Drug Administration, Indian Health Service (IHS), and National Institutes of Health participated in the consultation sessions. Additional information on the strategy for vaccine distribution can be found in the Operation Warp Speed Strategy for Distributing a COVID-19 Vaccine.

In parallel with CDC's efforts encouraging states to reach out and work with the tribes and urban programs, IHS continues to encourage programs to work through their existing vaccine infrastructure and distribution networks and with their respective state, county, and local jurisdictions. IHS continues to offer technical assistance to Tribal and Urban Indian health programs working with their respective states, and the Agency is preparing to monitor vaccine distribution and allocation on an ongoing basis.

Question 4b. How will IHS ensure that Tribes and Urban Indian health facilities have the necessary infrastructure to safely transport, store, and administer an approved vaccine?

Answer. The IHS National Supply Service Center is actively monitoring vaccine development, the supply chain, and working to meet the transport, storage, and administration requirements associated with any potential vaccine received by IHS. For tribal and urban sites that receive their vaccine through the IHS, IHS is working to ensure any necessary requirements will be met for all sites. The IHS Vaccine Task Force has teams dedicated to developing necessary infrastructure and training requirements to meet transportation, storage and administration of the COVID-19 vaccine.

Question 4c. Will IHS's COVID-19 vaccine allocations to Tribes include doses for non-Tribal members who serve essential community roles (e.g., public safety officers)?

Answer. Yes, IHS expects dosage estimates and allocation to include non-tribal members who serve essential community roles, including health care workers, tribal employees, public safety officers, and others.

Question 4d. How does IHS plan to provide education and outreach to Tribal citizens, Tribal health facilities, and Urban Indian Organizations on a COVID-19 vaccine once developed and approved for use?

Answer. The IHS vaccine task force includes a communications team which is developing a strategic communication plan for vaccine allocation and distribution, including culturally appropriate key messages. IHS understands that education and outreach is critical, and collaboration with our federal partners and tribal communities will be key in reaching our American Indian and Alaska Native population. Throughout the COVID-19 response, IHS has worked with tribal communities and federal partners to issue several communications including: issuing public service announcements, social media messages, and developing COVID-19 community prevention materials.

Question 5. Last week, the National Academies of Sciences, Engineering, and Medicine released their final report outlining a four-phased equitable COVID-19 vaccine distribution framework. Phase I b of the framework proposes covering "approximately 10 percent of the population and includes people of all ages with comorbid and underlying conditions... that put them at significantly higher risk of severe COVID-19 disease or death." The report also suggests the Department make special efforts to counter the impacts of systemic racism that have contributed to higher comorbidities and increase risk for a more serious COVID-19 illness among certain populations, including American Indians, Alaska Natives, and Native Hawaiians. How are IHS, HHS, and Operation Warp Speed incorporating the findings and recommendations of this report into its COVID-19 vaccine allocation plan for Tribes, Urban Indian health facilities, and Native Hawaiian health systems?

Answer. Beginning in March 2020, the IHS joined the White House, HHS, Department of Interior and several other Federal agencies in scheduled calls with tribal leaders to provide updates on COVID-19. This all-of-government approach to provide updates and hear input from tribal stakeholders related to the COVID-19 pandemic strengthened communications across HHS to expeditiously sharing information to help inform planning and decisions. For example, IHS has staff assigned to

both the HHS Secretary's Operation Center and to Operation Warp Speed to support communications through appropriate channels, such as HHS Office of Intergovernmental and External Affairs or the White House Office of Intergovernmental Affairs. In addition, IHS is working on several activities related to the National Academies of Sciences, Engineering, and Medicine (NASEM) recommendations including, developing appropriate population vaccination estimates (recommendation 1), conducting tribal consultation and urban confer on the IHS COVID-19 Pandemic Vaccine Draft Plan (recommendations 1-2), and developing a strategic communications plan to develop key messages that are culturally appropriate (recommendation 4). IHS will continue to review report recommendations on an ongoing basis and will incorporate recommendations as appropriate and consistent with CDC recommendations.

The NASEM Phase I b focuses attention on two groups that are particularly vulnerable to severe morbidity and mortality from COVID-19 disease. The first group includes people of all ages with comorbid and underlying conditions that put them at "significantly higher risk", defining this as having two or more comorbid conditions. The second group includes older adults living in congregate or overcrowded settings.

The IHS is working to provide robust national estimates of the populations it serves, specifically attempting to identify the number of individuals in the Phase I a and I b Tiers. The IHS COVID-19 Vaccine Task Force is in the process of collecting estimates from each IHS, Tribal and Urban (I/T/U) site within the agency to identify priority groups. Each I/T/U is using internal reporting methods to identify the number of elders and those with underlying medical conditions as defined by the CDC/Elixhauser ICD-10 codes. All estimates will be shared with the CDC and Operation Warp Speed for allocation purposes to ensure that these entities are fully aware of the IHS needs.

Question 5a. Would IHS, HHS, or Operation Warp Speed require additional resources to fully implement the National Academies' recommendations?

Answer. As previously stated, IHS is already working on several activities related to NASEM recommendations, consistent with CDC recommendations, and does not anticipate additional resources will be required for implementation. IHS anticipates that a critical aspect of vaccine distribution will be adapting or adjusting electronic health records, including the Resource and Patient Management System, in anticipation of new reporting requirements. Through feedback received during the HHS tribal consultation process, tribes and urban programs asked if funding sources have been identified for vaccine administration, storage, reporting, infrastructure, and communications.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
HON. MICHAEL CHAVARRIA

Question 1. Do you believe that there are still COVID-19 relief barriers for direct service tribes that IHS and HHS need to tackle?

Answer. Chairman and Members of the Committee—thank you for this question. Yes, I do see barriers remaining for Direct Service Pueblos in accessing critical COVID-19 relief and supplies. These Pueblos receive their primary care from the IHS through the Santa Fe Service Unit. My Pueblo, the Pueblo of Santa Clara, is a direct service tribe.

Last month, on August 19th, the Direct Service Pueblos met with HHS Deputy Secretary Hargan and RADM Weahkee. During that virtual session, I discussed the challenges our communities continue to face during the pandemic.

Chief among these is the lack of adequate PPE and medical supplies. The Santa Fe Service Unit needs to replenish its supplies to make it through the treacherous fall and winter that the CDC and other federal health officials have repeatedly warned is coming—and may, in fact, have already started with the upward trends we are seeing across at least 27 states and rising.

As of today, the IHS is still running at threadbare levels in terms of being prepared to handle COVID-19 cases and flu related illness—all while also trying to meet the increasing healthcare needs of chronic care patients and routine healthcare.

Supply chain disruptions and shortages have made it almost impossible to meet demand, a demand which is only expected to grow with the devastating numbers predicted for the fall.

Barriers to accessing the necessary PPE and medical equipment include limited supply available generally, regulatory and administrative restrictions and burden-

some reporting requirements, and disparate levels of need across the Indian health system that make the equitable distribution of limited supplies difficult to achieve.

We are starkly unprepared.

So what can be done?

We recommend that Congress invest in a targeted PPE and medical equipment stockpile for Pueblo Country, as well as other dedicated stockpiles to serve Indian Country. These stockpiles must be able to meet current levels of resource need and include at least a three months' supply of necessary materials for future healthcare needs. A three month stockpile is the minimum level of supplies recommended by the federal healthcare officials.

We also recommend that Congress direct the HHS Secretary and FEMA Administrators to exercise their delegated authority to the maximum extent permissible to streamline tribal access to national supply reserves.

Further, it is critical that we plan now for the post-pandemic world. We should take best practices learned during the crisis to help improve the Indian health care system in the long-term. For instance, Congress should invest in broadband development and deployment in Indian Country—as advanced under the Bridging the Tribal Digital Divide Act—and direct the HHS Secretary to make permanent the telehealth and telemedicine flexibilities adopted in the pandemic.

Broadband and healthcare are inseparable now and should remain in strong partnership after the public health emergency is lifted.

Finally, the HHS could remove a significant barrier to COVID relief for Direct Service and other tribes simply by streamlining reporting requirements across tribal funding opportunities and providing those dollars with maximum flexibility. All of our tribal governments and health programs are operating at maximum capacity with few, if any, personnel available for administrative tasks. Streamlining reporting requirements and maximizing program flexibilities would enable us to apply for and manage more relief funds to better serve the complex needs of our people.

Question 2. Were (Pueblo) communities able to navigate the IHS and the federal government's COVID-19 response structure in the early days of the pandemic?

Answer. In the beginning it was a challenge for the Santa Fe Service Unit and SCP clinic to effectively respond to the pandemic due to the lack of necessary supplies and inadequate numbers of healthcare and administrative personnel. These deficiencies made it difficult to monitor relief packages, complete application and reporting requirements, and plan for and carry out the allocation of resources among eligible tribal programs. The relief being provided by Congress was robust and greatly appreciated; we did not have the federal technical assistance and internal capacities to navigate this sudden, new, and expansive landscape.

Navigating the early response structure was also difficult because we were being told to prioritize testing and first responder safety but we were not given the tools to do so. Test kits were hard to find, turnaround times for results were lengthy because they had to be sent offsite, and PPE rapidly disappeared. We were underfunded and under-resourced for years before the pandemic, there was simply no way we could respond at the level being asked of us when it finally arrived.

Further, the Santa Fe Service Unit is only a day clinic. It is not a full-fledged hospital and provides only very limited specialty care services. It was not and is not equipped to handle a ravaging pandemic. As a result, our members must seek critical and specialty care from public and private medical facilities outside of the community through the Purchased and Referred Care system.

Additionally, the various funding opportunities available through the HHS, Treasury, CDC, HRSA, IHS, FEMA, and others are critical to addressing the wide ranging impacts of the virus. Unfortunately, each opportunity came with different expenditure restrictions, reporting obligations, deadlines, and other requirements. The moving goal posts associated with the Tribal Relief Fund administered by Treasury was also deeply frustrating.

While efforts emerged to try and clarify these differences through All Tribes and Tribal Leader calls organized by the HHS and White House Council on Native American Affairs, it remains confusing and a barrier to access that continues today.

I do understand Chairman and Members of that Committee that this virus has placed all of us in an unfortunate situation—however through the Power of Prayer and with support from Congress, our hope is to receive continued support for Pueblos and Tribal Nations due to federal treaty and trust obligations and to mitigate the health disparities that plague our communities and place us at high risk for severe effects from the COVID-19 virus.

Question 3. Chairman Chavarria, Director Weahkee's testimony discusses the mental and behavioral health impacts of the COVID-19 pandemic on Native com-

munities. It also mentions that IHS has seen an influx of new patients seeking care for these types of issues.

Have Pueblo Governors seen a similar increase in need for mental and behavioral health services during this pandemic? And do you think Pueblos currently have the resources they need to meet that increased demand?

Answer. Yes, the pandemic has significantly increased the need for mental and behavioral health services in our communities. I have seen first-hand the unfortunate increases in emotional, mental, physical, and social stress on my community. Facility closures, service and treatment disruptions, and prolonged isolation from stress relievers like family and traditional ceremonies are taking a toll across Pueblo Country.

In response to COVID-19, all Pueblo governments exerted our sovereign right to close our businesses, offices, and schools in an effort to protect our most vulnerable members. We also instituted stay at home orders, limited travel, restricted access to tribal lands, and ceased all traditional and communal gatherings, including our feast days.

This isolation has created hardship for many of our members. I have had conversations with grandparents, parents, and children who have expressed the toll this virus has caused upon them.

Not knowing how this will end, when safety will be restored, or what the future may hold has increased instances of depression, anxiety, loneliness, substance abuse, and suicide risk.

I feel the pain of my members, I hurt for them, because as the Governor—along with my administration, tribal council and staff—it is our responsibility to provide comfort, provide guidance, and provide the necessary resources our people need to cope with their issues.

COVID-19 has stolen the ability of our people to see behavioral and mental health specialists (when limited appointments are available), access MAT, check into residential and long-term treatment programs, and engage in traditional healing practices within the community.

What exacerbates the problem is limited to no technological capabilities in Pueblo Country. Not every household has a broadband connection, let alone a computer or even a smartphone to access telehealth services. Many of our people are caught in a dangerous limbo with no in-person and no tele-health options available to them to confront in confidence the trauma being experienced.

The Pueblos do not have the required resources to handle the increased demand we are experiencing for behavioral and mental health services. And while Tribal 638 programs are often more robust in behavioral health provider staffing than the IHS, these programs too have been impacted by COVID closures and restrictions, and often lack updated telehealth equipment and technology, further decreasing patient access during this critical time.

Question 4. Do you believe Tribes would benefit from access to flexible behavioral health funding through creation of Senator Smith's proposal, the "Special Behavioral Health Program for Indians"?

Answer. Yes, I believe Tribes across Indian Country would benefit greatly from Senator Smith's proposed legislation.

I think that taking the best practices learned from the Special Diabetes Program for Indians to create a targeted behavioral health program could be effective in addressing unmet behavioral and mental health needs. SDPI has been broadly successful in reducing incidences of diabetes and diabetes-related conditions in Indian Country through the successful integration of cultural derived and evidence-based health prevention, management and treatment practices. SDPI also provides tribal nations with funding flexibility to tailor their programs to meet local needs.

Carrying this framework over into the behavioral health field would be positive. I would recommend that any funds allocated under this new program include a 638 contracting and compacting option for self-governance tribes. The use of self-governance funding mechanisms allows tribes to maximize federal dollars, build internal capacities, and meet our peoples' needs.

Further, I feel that tribes are better situated to determine the best use of such resources at the local level while still partnering with IHS, SAMSHA, and other federal agencies on tribal consultation, technical assistance, and workforce development (including TCU educational pipelines to support the training of additional behavioral health specialists of Native descent). The Committee may also want to consider an amendment to create a tribal-federal task force to further our partnership in and commitment to addressing this public health crisis.

Addressing behavioral health needs requires an all-hands-on-deck approach that the proposed legislation would advance for the benefit of tribes.

Question 5. Would this pilot program benefit your community, especially during a national health crisis when access to the Internet is absolutely necessary?

Answer. Yes, I believe the proposed legislation would benefit not just my Pueblo but all Tribal Nations both during the pandemic and after.

COVID-19 has brought to glaring light all of the existing technological infrastructure disparities afflicting Indian Country. Our families lack at-home broadband, students lack individual computers or iPads, hospitals have insufficient networks, and entire communities lack fiber optic cables or wireless capabilities.

The right-of-way pilot program proposed in S. 3264 will assist us in addressing each of these barriers by helping us lay the foundation we need for community-wide broadband access. I also feel this crucial piece of legislation will aid in leveraging other technological opportunities such as the short-term 90-day “Special Temporary Authority” through the FCC that allows us to use the spectrum over SCP lands until the tribal priority window is closed and final authorization is granted, by Nov 2nd. Leveraging is key to closing gaps and delivering services on our lands and the pilot program would help us to achieve this goal.

Question 6. How could this Committee help your tribal communities address existing obstacles to reliable broadband service, especially during the coronavirus pandemic?

Answer. While we have many answers for your consideration, I will focus on just a few priorities here.

First, one of the key issues for the Pueblos is increasing flexibility in relation to the E-Rate program administered by the FCC. Currently, the E-Rate program can only be used for tribal libraries to increase their broadband connectivity or bandwidth. However, many of our tribal libraries are not open due to the pandemic and where they are open, the facility space is too small to safely accommodate the many community members that need to access wifi for education, work, and other essential activities.

We urge the Committee to consider, as a temporary measure, authorizing the FCC to expand access to the E-Rate program beyond tribal libraries to other tribally-owned or operated facilities. This simple change would dramatically increase the scope of the E-Rate program and allow us to provide safe, socially distanced, supervised spaces for our students, as well as create opportunities for specialized connectivity hubs—such as an office space solely for elder members’ use or a gym repurposed for community teleworkers.

This temporary expansion could be lifted after the public health emergency is lifted; by which time, hopefully, the initiatives proposed under the Bridging the Tribal Digital Divide Act and other broadband measures would have helped establish the requisite infrastructure to keep programs running under different authorities.

We have made a similar request to the White House through the White House Intergovernmental Affairs staff for an Executive Order that would allow for temporary flexibility on the use of broadband funded by the E-Rate program. However, the response we received was that such flexibilities would need to be granted by Chairman Pai of the FCC because it is an independent agency.

I fully support not breaking the law—however during this unprecedented time, I feel there has to be flexibility provided to utilize existing authorities and infrastructure already in place to solve urgent educational and community needs. I emphasize again that this request is only temporary; we would support a reversion to the current E-Rate restrictions after the public health emergency is lifted.

Additionally, I would be remiss if I did not request that this Committee support an extension of the CRF expenditure deadline set in the CARES Act. A one or two year extension would allow us to plan, develop, and implement so many more services for our people, including in the area of broadband development. Large scale changes require time to take place. We have the funds to support our plans thanks to Congress’s swift action in the stimulus bills; now we need the time to properly carry them out. Please consider extending this pivotal deadline.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR

Question 1. How many Tribes, if any, have used HEARTH Act authority for broadband deployment? If so, has the BIA determined that such authority has resulted in acceleration of broadband in those Tribal communities?

Answer. HEARTH Act authority is only for business leases and does not include rights-of-way (ROWs) or grants of easement, which is the primary transaction type utilized for broadband activities. However, there are 50 tribes with approved

HEARTH Act regulations for business lease purposes. In November 2020, Indian Affairs approved its 60th HEARTH Act application.

The BIA does not have necessary data, such as the number of homes served by HEARTH Act decisions, to determine if HEARTH Act authority has resulted in acceleration of broadband in tribal communities.

Question 2. Does the BIA currently gather data on barriers to rights-of-way approvals on Tribal lands? If so, please explain.

Answer. No. ROW information in the Trust Asset and Accounting Management System (TAAMS) includes information on when ROWs were entered, approved, pending, cancelled, or withdrawn. Data on barriers to ROW approval is not collected in TAAMS.

However, the Office of Indian Energy and Economic Development and the Assistant Secretary Indian Affairs' Management Division are currently working on identifying barriers to broadband infrastructure development beyond rights-of-way approvals.

Question 3. What protections are in place, or should be, to ensure that trust land and resources are protected in broadband deployment on Tribal lands?

Answer. The BIA and other federal agencies have regulatory enforcement mechanisms to protect and ensure that trust lands and resources are protected when processing ROWs or leases. The BIA regulatory requirements for Indian landowner consent, determination of fair market value, surveys, and posting of a bond, among other requirements inherent in the ROW or lease process protect trust land and resources and afford the Indian landowners an opportunity to agree or disagree to the proposed use.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN HOEVEN TO
BUREAU OF INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR

Question 1. Can the Department of the Interior identify other tribes who may be similarly impacted by the Non-Intercourse Act?

Answer. Because this is an issue affecting tribally owned lands that are not held in trust or restricted fee, the Department does not keep records of title or transfer of ownership for such lands. However, it is an issue of interpretation that originates from outside the federal government, therefore it is fair to conclude that any tribe lacking specific legislation regarding the Non-Intercourse Act could be similarly impacted.

Question 2. The Department of the Interior's written testimony supports a more general fix to the Non-Intercourse Act. Can the Department provide examples of legislative language that would broadly address the issue?

Answer. Should a standalone bill be proposed to more broadly address the issue, we would recommend that such proposed legislation include, at a minimum, language similar to the Acts referenced in the question above. We would also recommend that the legislation specifically define the Indian tribal entities to which it applies. We would further recommend that such legislation should only apply to interests in real property that is not either: (1) held in trust by the United States for the benefit of such Indian tribal entity, or (2) held in restricted fee status for the benefit of such Indian tribal entity.

***RESPONSES TO THE FOLLOWING QUESTIONS FAILED TO BE
SUBMITTED AT THE TIME THIS HEARING WENT TO PRINT***

WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
HON. TIMOTHY NUVANGYAOMA

Question 1. The Bridging the Tribal Digital Divide Act would establish a Tribal Deployment Advisory Committee for Tribal leaders to make recommendations to Congress on how to improve the deployment of broadband services. The idea behind the Advisory Committee is to improve how Congress learns about broadband needs in Tribal communities, and to act on them through legislation. Do you believe establishment of this advisory committee would help the Hopi Tribe address existing obstacles to reliable broadband service? If so, how?

Question 2. As mentioned at the hearing, the COVID-19 pandemic has revealed a number of disparities facing Tribes.

a. What barriers has lack of universal broadband access posed for Pueblos as they attempt to respond to the COVID-19 pandemic?

b. Would the Bridging the Tribal Digital Divide Act help address any of those barriers you mentioned in response to question (2)(a)? And, if so, how?

I am deeply concerned by reports that IHS may have been under-prepared to respond to an active public health emergency caused by an infectious disease at the start of the COVID-19 pandemic, including lacking comprehensive public health emergency protocols and standard practices in place.

c. Do you believe your Tribe was able to easily navigate the IHS and the federal government's COVID-19 response structure in the early days of the pandemic? Or, were Hopi's response and mitigation efforts negatively impacted by disorganization within and among federal agencies?

d. Do you have any recommendations for other actions IHS or other federal agencies could take to prepare for a more efficient response to public health emergency in the future?

Question 3. IHS Director Weahkee's testimony discusses the mental and behavioral health impacts of the COVID-19 pandemic on Native communities and mentions that IHS has seen an "influx" of new patients seeking care for these types of issues.

a. Has the Hopi Tribe seen a similar increase in need for mental and behavioral health services during this pandemic?

b. Do you think your Tribe currently has the resources it needs to meet that increased demand?

c. Do you believe Tribes would benefit from access to flexible behavioral health funding proposed by S.3126, the Native Behavioral Health Access Improvement Act?

