

**EXAMINING THE COVID-19 RESPONSE IN NATIVE
COMMUNITIES: NATIVE HEALTH SYSTEMS ONE
YEAR LATER**

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

APRIL 14, 2021

Printed for the use of the Committee on Indian Affairs



U.S. GOVERNMENT PUBLISHING OFFICE

45-086 PDF

WASHINGTON : 2021

COMMITTEE ON INDIAN AFFAIRS

BRIAN SCHATZ, Hawaii, *Chairman*

LISA MURKOWSKI, Alaska, *Vice Chairman*

MARIA CANTWELL, Washington

JON TESTER, Montana

CATHERINE CORTEZ MASTO, Nevada

TINA SMITH, Minnesota

BEN RAY LUJAN, New Mexico

JOHN HOEVEN, North Dakota

JAMES LANKFORD, Oklahoma

STEVE DAINES, Montana

MIKE ROUNDS, South Dakota

JERRY MORAN, Kansas

JENNIFER ROMERO, *Majority Staff Director and Chief Counsel*

T. MICHAEL ANDREWS, *Minority Staff Director and Chief Counsel*

CONTENTS

Hearing held on April 14, 2021	Page 1
Statement of Senator Cantwell	44
Statement of Senator Cortez Masto	46
Statement of Senator Daines	54
Statement of Senator Hoeven	51
Statement of Senator Lankford	42
Statement of Senator Luján	48
Statement of Senator Murkowski	2
Statement of Senator Schatz	1
Statement of Senator Smith	40

WITNESSES

Daniels, Sheri-Ann, Ed.D, Executive Director, Papa Ola Lōkahi	28
Prepared statement	30
Murillo, Walter, Board President, National Council of Urban Indian Health ...	21
Prepared statement	23
Onders, Robert, M.D., Administrator, Alaska Native Medical Center	33
Prepared statement	34
Smith, Hon. William, Chairperson, National Indian Health Board	9
Prepared statement	11
Toedt, Rear Admiral Michael, M.D., Chief Medical Officer, Indian Health Service	4
Prepared statement	5

APPENDIX

Response to written questions submitted by Hon. Ben Ray Luján to:	
Hon. William Smith	65
Rear Admiral Michael Toedt	63
Response to written questions submitted by Hon. Brian Schatz to Rear Admi- ral Michael Toedt	57

EXAMINING THE COVID-19 RESPONSE IN NATIVE COMMUNITIES: NATIVE HEALTH SYSTEMS ONE YEAR LATER

WEDNESDAY, APRIL 14, 2021

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

The Committee met, pursuant to notice, at 2:43 p.m. in room 628, Dirksen Senate Office Building, Hon. Brian Schatz, Chairman of the Committee, presiding.

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

The CHAIRMAN. Good afternoon.

Last month, we passed the one-year mark since the World Health Organization declared COVID-19 a global pandemic. Two dates in March 2020 stand out to me; March 2nd, the first-known COVID-19 case documented in a Native community, and March 18th, the first known COVID-19 related death of a Native American.

In just 16 days, everything had changed. The coronavirus was no longer an abstract threat; it was real, it was in Native communities; and it posed one of the greatest threats to Native American health in more than a century.

Despite decades of underfunding and almost zero access to critical pieces of our national health infrastructure, Native health systems did their best to rise to the challenge. In short order, these systems mobilized and set up one of the most complex joint public health emergency responses in our shared histories. They rebuilt data and logistics systems. They formed new partnerships. They started the rollout of some of the most successful vaccine campaigns in the Country, and they continue to work every day to keep Native communities safe.

It really is remarkable how Native health systems have overcome long odds, considering how under-resourced they were to begin with. It took a global pandemic for us to step up. Over the past year, Congress has provided more than \$9 billion in emergency health supplemental funding for tribes, urban Indian organizations, the Indian Health Service and Native Hawaiian health systems. Two-thirds of that funding came as a direct result of President Biden's American Rescue Plan and this Committee's work to enact it. This historic funding is proof positive that help is here,

that we understand our trust responsibilities, that we can do the right thing.

But this hearing is an opportunity to go one step further, to look at the lessons learned one year later, and to improve how Federal agencies work with Native communities, so that if or when the next pandemic hits, our Native health systems won't have quite as steep of a hill to climb.

Before I turn to the Vice Chair, I want to extend a warm welcome and aloha to Dr. Daniels and my thanks to our witnesses for joining us today. I look forward to hearing the unique perspectives of each of you as we have this conversation.

Vice Chair Murkowski?

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

Senator MURKOWSKI. Thank you, Mr. Chairman. Naghe nduninyu, in the Koyukon Athabaskan language, this means welcome, or even better, precious you came. How often do say, it is precious that you came? So it is a beautiful way of welcoming.

I do appreciate the hearing today. As you point out, we are a year-plus into this pandemic. We are seeing some positive signs, certainly can't let up. Last year at this time, Alaska, like so many, was beginning those preliminary steps, the public health measures, to work to slow the spread of the virus. But for so many of our Native communities, particularly in remote villages, that lack basic sanitation infrastructure, where there is no running water, no flush toilets, even basic safeguards like washing your hands was pretty close to impossible.

This lack of basic resources, what most of us take for granted, but this, we certainly believe, helped produce or certainly added to the cause of more than 13,000 American Indians and Alaska Natives who tested positive for coronavirus in Alaska this past year.

Historically, pandemics have been very hard on our Native peoples. Alaska Natives represented 80 percent of Alaska's death toll from the 1918 Spanish flu, 80 percent. Unfortunately, we continue to see this trend with the coronavirus. According to the CDC, American Indians and Alaska Natives are among the highest rates of all races to experience a death associated with it. In Alaska alone, Alaska Native account for 37 percent of the State's total COVID-19 deaths.

Another complicating factor is the high prevalence for serious disease and other health conditions. As you know and many of us on this Committee have worked to provide for not only the funding but for the reauthorization for the Special Diabetes Programs for Indians, we know that we must do more when it comes to dealing with health disparities amongst our Native peoples.

The coronavirus pandemic has created major challenges by Native health care systems across the Country and revealed long-standing deficiencies in infrastructure, resources, and staff, which we know we need to work on. It is also important to recognize some of the bright spots, and it is important to focus on some of the things that have been accomplished in a good way.

Alaska tribes operate their health care system through a multi-party compact. They have led the Nation in implementing tribal

self-governance. The Alaska area also made the decision to receive their vaccines through the State rather than IHS. In fact, the Alaska Native Medical Center was the first Alaska facility to receive the COVID vaccine and two days later, they administered its first dose to a long-time physician there.

With the Alaska Tribal Health Care System, coordinating with the State, Alaska has been leading in terms of number of vaccinations. Alaska now has 44 percent over the age of 16 that are vaccinated with at least one dose, and over 40 percent of those vaccinated were administered through the tribal health system. In other parts of the State, we have seen some pretty incredible numbers. Nearly 59 percent of Yukon Kuskokwim's eligible population has received their first dose; half are fully vaccinated. In the Bering Straits region, 67 percent of eligible adults have received at least one dose.

So with today's hearing, I think it is going to be helpful to know what actions IHS has taken on the pandemic since they last testified before this Committee in July, especially with the vaccination efforts.

Then finally, Mr. Chairman, over the last year we have heard from Native communities about the ongoing needs surrounding maintenance and improvements to existing facilities, development of more water and sanitation infrastructure, expansion of certain authorities and services, including tele-health, to provide better health care. So I look forward to hearing more about these needs are going to be addressed.

I would like to briefly introduce two Alaskans that are testifying before the Committee today. The first is Dr. Robert Onders, who is the Administrator for the Alaska Native Medical Center. Dr. Onders is an all-around great guy, let's just put it at that. He has provided incredible leadership at ANMC during the pandemic.

We are also fortunate to have the Honorable William Smith, who is the National Indian Health Board Chairperson. Mr. Smith is an Alaskan, he was born in Cordova. He is Vice President of the Valdez Native Tribe. He is a Vietnam veteran, and we absolutely thank him for his service and his leadership within NIHB as well.

Mr. Chairman, I have also been made aware that Rear Admiral Toedt is retiring after 30 years of service. So we certainly want to thank him for his service and congratulations on a well-deserved retirement.

I am looking forward to the comments this afternoon.

The CHAIRMAN. Thank you, Vice Chair Murkowski.

Are there any members wishing to make an opening statement?

If not, we will turn to our witnesses. They are Rear Admiral Michael Toedt, M.D., Chief Medical Officer of the Indian Health Service; the Honorable William Smith, Chairperson of the National Indian Health Board; Walter Murillo, Board President, National Council of Urban Indian Health; Dr. Sheri-Ann Daniels, Executive Director, Papa Ola Lōkahi, from Hawaii; Dr. Robert Onders, Administrator, Alaska Native Medical Center.

I want to remind our witnesses that your full written testimony will be made part of the official hearing record. Please keep your statement to no more than five minutes, so that members may

have time for questions. This is especially important because we do have a 3:30 series of votes.

Rear Admiral Toedt, you may begin.

**STATEMENT OF REAR ADMIRAL MICHAEL TOEDT, M.D., CHIEF
MEDICAL OFFICER, INDIAN HEALTH SERVICE**

Dr. TOEDT. Thank you. Good afternoon, Chairman Schatz, Vice Chair Murkowski, and members of the Committee. Thank you for the opportunity to testify on the Indian Health Service's continued efforts to respond to and mitigate the impact of the coronavirus in Native communities.

Over the past year, the IHS has worked closely with our tribal and urban Indian organization partners, State and local public health officials, and our fellow Federal agencies to coordinate a comprehensive public health response to the pandemic. Our number one priority has been the safety of our IHS patients and staff as well as tribal community members.

Let me begin by discussing efforts to distribute and administer vaccines. IHS, tribal and Urban Indian Organization health programs receiving vaccines for distribution through the IHS jurisdiction have administered over 1 million doses as of April 5th. This achievement is despite the challenges IHS faces in terms of the predominantly rural and remote locations we serve and the infrastructure challenges those communities face.

IHS remains committed to vaccine availability for all individuals within our health system. I will note that out of an abundance of caution, IHS has paused all Johnson and Johnson or Janssen vaccine administration. We are doing this to allow the FDA and CDC to review data after reports of six female recipients in the U.S. developed a rare but severe type of blood clot.

Since mid-December 2020, the IHS has distributed over 1.6 million vaccine doses of the FDA-authorized COVID-19 vaccines. IHS has shipped vaccine directly to 293 IHS, tribal, and urban Indian organization health care facilities, and used a hub and spoke model to ensure all 352 facilities that are coordinating vaccines through the IHS jurisdiction receive those vaccines.

IHS is grateful to Congress for supporting our efforts through the passage of several COVID-19 related laws that provided additional resources, authorities and flexibilities that have helped the IHS workforce continue to provide critical services throughout the pandemic. The American Rescue Plan Act, in particular, makes a historic investment in Indian Country. The Act provides \$6.1 billion in new support funding to IHS, tribal, and urban Indian health programs to combat COVID-19, expand health services, and recover critical revenues.

Over the last year, the IHS has marked considerable achievements. We developed a COVID-19 data surveillance system and an IHS COVID-19 website to share critical health information, important COVID-19 vaccine information and updates, and we disseminate clinical guidance, training and webinars. The IHS National Supply Service Center distributed over 84 million units of PPE and other coronavirus-related products to IHS, tribal, and urban Indian organization health care facilities at no cost, including 2.6 million testing swabs and transport media.

IHS dramatically increased our use of tele-health. IHS is currently in the process of procuring an additional cloud-based tele-health platform to complement our existing solutions and distribute tele-health funds to sites for equipment and devices to improve access for more interactive tele-health encounters.

The pandemic also highlighted the challenges and risks posed by our current health IT architecture, which created significant barriers to the rapid response needed for COVID-19. Our informatics and technology staff made changes to the systems for COVID-19 testing, diagnosis, and vaccination documentation and reporting. Staff in the field were able to implement these changes into clinical workflows. This experience has validated and reinforced IHS's commitment to the modernization of our health IT infrastructure.

In addition to supporting tribes to ensure they are able to supply water to their communities during the COVID-19 outbreak, an important aspect of the IHS COVID-19 response, the IHS deployed nine teams of public health service commission corps officers in support of the Navajo Nation to improve access to safe water points and help ensure a means to safely transport water for in-home drinking and cooking.

As we work toward recovery, we are committed to working closely with our stakeholders and understand the importance of working with partners during this difficult time.

Thank you again for the opportunity to speak with you today. I am happy to answer questions the Committee may have.

[The prepared statement of Admiral Toedt follows:]

PREPARED STATEMENT OF REAR ADMIRAL MICHAEL TOEDT, M.D., CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE

Good afternoon Chairman Schatz, Vice Chairman Murkowski, and Members of the Committee. Thank you for the opportunity to testify on the Indian Health Service's (IHS) continued efforts to respond to and mitigate the impact of the Coronavirus in Native communities and vaccinate Native communities during the Coronavirus pandemic.

Responding to and Mitigating the Impact of the Coronavirus Pandemic

Over the past year, the IHS has worked closely with our Tribal and Urban Indian Organization (UIO) partners, state and local public health officials, and our fellow Federal agencies to coordinate a comprehensive public health response to the pandemic. Our number one priority has been the safety of our IHS patients and staff, as well as Tribal community members.

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

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

I am grateful to Congress for supporting our efforts through the passage of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Eco-

conomic Security (CARES) Act; the Paycheck Protection Program and Health Care Enhancement Act, the Coronavirus Response and Relief Supplemental Appropriations Act, and now the American Rescue Plan Act. These laws have provided additional resources, authorities, and flexibilities that have helped the IHS workforce continue to provide critical services throughout the pandemic and also permitted the IHS to administer over \$9 billion to IHS, tribal, and urban Indian health programs to prepare for and respond to Coronavirus. These resources have helped us expand vaccinations, available testing, public health surveillance, and health care services. Moreover, they support the distribution of critical medical supplies and PPE in response to the pandemic. The American Rescue Plan Act in particular makes a historic investment in Indian Country. The Act provides \$6.1 billion in new funding to support IHS, Tribal, and urban Indian health programs to combat COVID-19, expand services, and recover critical revenues.

It has been over a year now that IHS and our dedicated workforce has been responding to the COVID-19 Pandemic. Over the last year, the IHS has marked considerable achievements. The IHS COVID-19 Incident Command Structure was stood up to establish communication protocols to ensure comprehensive situational awareness and efficient deployment of resources. We instituted reporting mechanisms to become a central information repository for the IHS COVID-19 response. We developed a COVID-19 data surveillance system and the IHS COVID-19 website to share critical health information, important COVID-19 vaccine information and updates, and we disseminate clinical guidance, training, and webinars. We provide assistance to the IHS and Tribal facilities through Critical Care Response Teams and Tele Infection Control Assessment and Response assessments.

We are detecting COVID-19 through screening and state-of-the-art lab testing. We have distributed a total of 830 Abbott ID NOW rapid point-of-care analyzers, as well as 1.9 million rapid COVID-19 tests. The IHS National Supply Service Center (NSSC) has also distributed over 84 million units of PPE and other Coronavirus response related products to IHS, Tribal, and UIO (I/T/U) health care facilities at no cost, including 2.6 million testing swabs and transport media. As of April 4, 2021, we have performed 2,215,027 tests in our American Indian and Alaska Native communities. Of those tests, 190,810 (9.3 percent, cumulative data) have been positive.

The IHS increased coordination with Federal partners to streamline access for I/T/U supply requests to the Strategic National Stockpile. A PPE request tracking system was developed and IHS staff were placed in liaison functions to ensure oversight on I/T/U requests. The IHS burn rate calculator for tracking PPE has been implemented to improve the data quality. A guide on ordering/requests process for Emergency Management Points of Contact has been completed and posted for ongoing strategic purposes. NSSC has supplied testing kits to all Area requests, a new contract with AbbottID has started, and they are shipping directly to sites.

The IHS has a sufficient supply of therapeutic agents currently authorized or approved by the FDA for the treatment of COVID-19, including remdesivir and the combination monoclonal antibody products, and is distributing them to I/T/U health care facilities upon request. The IHS National Pharmacy and Therapeutics Committee provides clinical guidance to Areas and facilities regarding COVID-19 emerging treatments and, through its Pharmacovigilance program, also monitors medication safety in our service population.

During the pandemic, the IHS faced life-threatening medical surges that required additional acute care and Intensive Care Unit beds. The IHS and U.S. Department of Veterans Affairs (VA), Veterans Health Administration, signed an Interagency Agreement that set forth certain terms and conditions governing the arrangement for the standardized coordination and delivery of health care and other services between VA and IHS during disasters, public health incidents, and other emergencies.

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

In April 2020, IHS expanded the use of an Agency-wide videoconferencing platform that allows for telehealth on almost any Internet-connected device and in any setting, including patients' homes. Around the same time IHS also permitted the emergency use of certain commonly available mobile apps to enable the provision of services remotely while minimizing exposure risk to both patients and staff. These authorities, along with the actions taken by the Centers for Medicare and Medicaid Services to allow payment for previously non-billable services, made it possible for IHS to dramatically increase our use of telehealth from an average of under 1,300 visits per month in early 2020 to a peak of over 40,000 per month in June

and July of that year. More recent data suggests a plateau of around 30,000 monthly telehealth visits. It is important to note that on average, about 80 percent of telehealth encounters across IHS are conducted using audio only, largely related to the limited availability of technologies and bandwidth capacity in the communities we serve across the country. IHS is currently in the process of procuring an additional cloud-based telehealth platform to complement our existing solutions and distribute telehealth funds to sites for equipment and devices to improve access for more interactive telehealth encounters.

EHR and Facilities Modernization

As we, the IHS, expanded our use of technology in the telehealth area, the pandemic also highlighted the challenges and risks posed by the decentralized and distributed health information technology architecture currently in use at IHS. While our facilities use a capable, nationally certified electronic health record (EHR) system, the fact that it is internally developed by IHS and is installed separately at hundreds of locations nationwide created significant barriers to the rapid response needed for COVID-19. We are extremely proud of how our informatics and technology staff made changes to the system to support COVID-19 testing, diagnosis, and vaccination documentation and reporting, and how the field was able to implement these changes into clinical workflows. However, we know that those activities would have been much more streamlined in an updated technology environment.

This experience has validated and reinforced IHS' commitment to the modernization of our EHR system and health information technology infrastructure. IHS is grateful for the funding for EHR modernization provided by Congress in the CARES Act, the FY2021 appropriation, and the American Rescue Plan Act, which will allow us to proceed with the foundational steps in this important multi-year effort. In accordance with the language of the FY2021 appropriation, IHS plans to inform the appropriate Congressional committees in the near future to outline our planned approach to EHR modernization.

The IHS effort to improve the EHR system underscores the need to replace outdated facilities. Aging medical facilities impede medical innovation. Modern hospitals are packed with complex equipment with high electrical requirements. Contemporary hospitals are designed to provide clean, reliable power to ensure that patient care is uninterrupted. The difficulty in retrofitting older hospitals with modern technology is that the massive concrete structure tends to absorb Wi-Fi signals, representing a significant challenge to wireless equipment.

In addition, the pandemic highlighted some of the difficulties that older facilities pose to delivering health care services. It is the IHS' policy to use the physical environment to help prevent and control the spread of infection. This past year has shown that outdated facilities' patient flow often did not allow for social separation and that waiting areas are not sized or structured for social distancing. Optimally, the infected and non-infected would be separated, and patients would flow in one direction through the facility. This is not possible in some IHS facilities, which resulted in limiting appointments, renovation of space, or providing temporary space outside of the facility to separate patients.

Vaccinations—Allocations and Administration

IHS developed a vaccine strategy led by the IHS Incident Command Structure and the designated IHS Vaccine Task Force. This effort was informed by the Federal Vaccine Response Operation (FVRO) and aligned with the Centers for Disease Control and Prevention (CDC), FVRO, and Tribal stakeholder input. HHS and IHS participated in Tribal consultation and urban Indian confer in development of the plan, and a final IHS Vaccine Plan was published on November 18, 2020.

Working with tribal communities, I/T/U health programs receiving vaccines for distribution through the IHS jurisdiction have administered 1,029,647 doses as of April 5. This achievement is despite the challenges IHS faces in terms of the predominantly rural and remote locations we serve and the infrastructure challenges those communities face. The IHS reached its goal to administer 1 million COVID-19 vaccines by the end of March (administering 1,007,002 doses as of March 31, 2021) after surpassing its goal of administering 400,000 vaccines by the end of February. In February and March, 260,000 supplemental vaccine doses were sent to Indian Country. IHS remains committed to vaccine availability for all individuals within our health system. This Federal vaccination effort is possible because of strong partnerships with tribal and urban Indian health facilities. At IHS, we know that Tribal Nations are in the best position to determine the needs of their citizens.

Information on the number of COVID-19 vaccines administered across the IHS can be found at <https://covid.cdc.gov/covid-data-tracker/#vaccinations>, and there is a Federal entities section under the map. The IHS is working diligently with our

CDC partners to report and validate vaccine administration data as quickly as possible. IHS estimates the current number of people vaccinated may be higher than reflected in the validated data on the CDC COVID Tracker. Communicating accurate and timely information remains a priority for the IHS.

Since mid-December 2020, the IHS has distributed 1,562,837 vaccine doses of the Food and Drug Administration authorized Pfizer-BioNTech, Moderna, and Johnson & Johnson/Janssen COVID-19 vaccines. IHS has shipped vaccine directly to 293 I/T/U facilities and used a hub and spoke model to ensure all 352 facilities that are coordinating vaccine through the IHS jurisdiction receive vaccine. The table below shows the total number of vaccine doses distributed and administered per IHS Area as of April 5, 2021.

COVID-19 Vaccine Distribution and Administration by IHS Area

Area	Total Doses Distributed*	Total Doses Administered**
Albuquerque	112,155	97,271
Bemidji	118,105	85,214
Billings	51,015	32,565
California	179,285	83,254
Great Plains	107,150	62,750
Nashville	74,867	45,197
Navajo	246,065	183,651
Oklahoma City	432,410	268,566
Phoenix	155,500	109,095
Portland	77,285	55,874
Tucson***	9,000	6,210
TOTAL	1,562,837	1,029,647

*Distributed Data Source: IHS National Supply Service Center, includes total doses ordered and anticipated to be delivered by April 2, 2021.

**Administered Data Source: CDC Clearinghouse data from Vaccine Administration Management System (VAMS) and IHS Central Aggregator Service (CAS). Data in the CDC Clearinghouse reflects prior day data. Data may be different than actual data as there are known CDC data lags and ongoing quality review of data including resolving data errors.

***The Tucson Area vaccine administration data is currently being validated.

Note: Alaska Area—all tribes chose to receive COVID-19 vaccine from the State of Alaska.

COVID-19 related data are reported from I/T/U facilities, though reporting by Tribal and UIOs is voluntary. The table below shows the number of cases reported to the IHS through 11:59 pm on April 4, 2021.

COVID-19 Cases by IHS Area

IHS Area	Tested	Positive	Negative	Cumulative percent positive *	7-day rolling average positivity *
Alaska	565,977	11,566	480,985	2.3%	0.8%
Albuquerque	91,714	8,079	62,838	11.4%	5.2%
Bemidji	152,191	10,576	138,064	7.1%	7.0%
Billings	96,601	7,360	85,879	7.9%	3.3%
California	76,191	7,784	65,310	10.6%	2.9%
Great Plains	138,161	14,096	123,535	10.2%	3.8%
Nashville	73,823	5,980	66,956	8.2%	4.0%
Navajo	238,530	31,389	163,002	16.1%	3.0%
Oklahoma City	473,229	60,186	408,007	12.9%	3.0%
Phoenix	172,323	23,559	147,923	13.7%	2.9%
Portland	110,752	7,491	102,925	6.8%	5.7%
Tucson	25,535	2,744	22,638	10.8%	5.4%
TOTAL	2,215,027	190,810	1,868,062	9.3%	2.9%

* Cumulative percent positive and 7-day rolling average positivity are updated three days per week.

Access to Clean Water

Supporting Tribes to ensure they are able to supply water to their communities during the COVID-19 outbreak is an important aspect of the IHS COVID-19 response. Access to water is critical for hand washing and cleaning environmental surfaces to help break the virus' chain of infection and reduce the pressure on the IHS health care delivery system, which is a critical concern.

To address this concern, the IHS over the past year deployed nine teams of 40 U.S. Public Health Service Commissioned Corps Officers in support of the Navajo Nation to improve access to safe water points. This work included surveying the availability of safe water points across 110 Chapters over 27,000 square miles. The survey identified 59 locations where additional water points were needed. Following the survey, the teams completed water points site installation designs, construction/beneficial use inspections, and operation and maintenance trainings at these locations. The installation of these water points resulted in a reduction in round trip travel distance from 52 miles to 17 miles and was completed within 6 months.

In addition to increasing the number of water points, the mission helped ensure a means to safely transport water for in-home drinking and cooking. This was achieved by providing 107 Chapters over 37,000 water storage containers to be distributed to each resident living in a home with no piped water. Water disinfection tablets, to boost water disinfection levels in the water storage containers, were also provided to Chapters as needed based on the field team measured water point disinfection levels. These innovative actions will help to improve the stored water quality and reduce the risk of gastrointestinal illness to water point users.

The teams also worked to increase public awareness of water service availability and developed creative public health outreach materials describing the importance of the water service use through a multimedia campaign (online, print newspaper, and radio) broadcast across the Navajo Nation. This included assisting the Navajo Nation in developing a website, which includes an interactive map of the water points, to communicate the location, hours of operation, and Chapter contact information. Officers developed outreach materials highlighting the importance of accessing water at regulated water points and promotion of safe water storage practices.

We look forward to continuing our work with Tribal and Federal partners. As we work towards recovery, we are committed to working closely with our stakeholders and understand the importance of working with partners during this difficult time. We strongly encourage everyone to continue to follow CDC guidelines and instructions from their local, state, and Tribal governments to prevent the spread of COVID-19 and protect the health and safety of our communities. Thank you again for the opportunity to speak with you today.

The CHAIRMAN. Thank you very much.

We will now move on to the Honorable William Smith, Chairperson of the National Indian Health Board.

STATEMENT OF HON. WILLIAM SMITH, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD

Mr. SMITH. [Greeting in Native tongue], Chairman Schatz, and Vice Chair Murkowski, and members of the Committee.

On behalf of the National Indian Health Board and the 574 sovereign, federally recognized American Indian and Alaska Native tribal nations we serve, thank you for the opportunity to be a witness and provide this testimony.

One year later, our Nation faces a COVID-19 pandemic that has continued to ravage our people disproportionately. It has been highly publicized how the pandemic has exposed our disparities in Indian Country: crowded homes with no options to quarantine safely, lack of access to safe water and sanitation facilities, aging and inadequate health facilities and staffing, non-existent public health or behavioral systems, and no access to internet to allow telehealth, remote work, or distant learning.

The CDC has reported that the presence of a chronic health condition such as Type II diabetes, obesity, and heart disease increases one's risk for severe COVID-19 illness. Each of these chronic health conditions painfully impact our people. As of April 11th, the Indian Health Service has reported over 191,000 positive COVID cases. The CDC reported we are 2.4 times more likely than non-Hispanics, white people, to die from COVID-19 infections.

There are nearly 6,200 American Indian and Alaska Native reported deaths related to COVID-19 complications since the pandemic was declared, a number which is likely understated. Nearly 60 percent of these deaths are from New Mexico, Arizona and Oklahoma combined. In my home State of Alaska, 37 percent of the State's deaths were reported to be Native.

A key success story in the dark times has been including tribes and IHS as the jurisdictions for vaccine distribution. As of April 12th, there have been 1.63 million vaccines distributed through IHS, and over 1 million doses have been put into arms. For instance, Alaska's success in vaccine is steeped in the tribes having the sovereign ability and self-determine to exercise flexibility. Some of our tribal communities in Alaska have reached a 90 percent vaccination rate among the seniors and included Natives and non-Native residents.

Various tribes in Oklahoma have opened up their vaccine efforts to the communities, regardless of IHS eligibility. Federal data shows that Native Americans were getting the vaccine at a higher rate than all but five States by the end of February, 2021.

H.R. 1319, the American Rescue Plan, provides unprecedented investment in Indian Country and Indian health. With over \$6 billion being injected into Indian health, tribal and urban systems, we are encouraged to witness the funds' efforts and improvements to care, facilities, and lives. National Indian Health Board is grateful for this investment and thankful for those in Congress who support the funds' inclusion.

While the American Rescue Plan provides much-needed support for Indian Country ongoing requests, there is so much more work left to be done. We call on Congress to provide full funding and mandatory appropriation for the Indian Health Service. It is the most chronically underfunded Federal health care system and the only one not exempt from government shutdowns or continuing resolutions.

Congress must further prioritize tribal water and sanitation infrastructures. Approximately 6 percent of tribal households lack access to running water. When asked to wash their hands to keep them safe from COVID-19 some tribal members cannot do this for the lack of clean, running water.

Additionally, there must be continued support for tribal mental and behavioral health, access to broadband on tribal lands, creation of sustainable tribal health workforce, and expanding tribal self-governments across the entire Federal Government.

To close, consider this. During the 1918 Spanish flu pandemic and the 2009 H1N1 pandemic, Native people died at four times the rate of all other races combined. We are left to fend for ourselves and die. We can no longer wait. Our people are dying, our women and youth are going missing and being murdered, our communities lack resources to fight substance abuse and provide much-needed behavioral health service, our diabetics would rather stay at home and die than drive all day to receive treatment from a dialysis center hours away. Our elders, the tribal keepers of our culture, don't have access to assisted living or long-term care service. Our public health system is addressing pandemic like COVID-19 are non-existent. The Federal Government needs to do better at this moment.

I am grateful for the members of Congress and for your actions to support Indian Country. I urge you to prioritize tribes and tribal communities further as you continue to provide relief from the COVID-19 pandemic and beyond. Please remain with us to enhance the ITU system to ensure it never happens to Native people again.

[Phrase in Native tongue.] Thank you for holding today's hearing, and for inviting the National Indian Health Board to testify. I am looking forward to your questions. Thank you.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF HON. WILLIAM SMITH, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD

Chairman Schatz, Vice Chairwoman Murkowski, and members of the Committee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally-recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, thank you for the opportunity to submit testimony. The recommendations outlined in this testimony encompass critical policy needs to help protect and prepare AI/AN communities in response to the current COVID-19 pandemic. These are necessary for the Indian health system to be fully functional to address the pandemic and other related critical health care priorities. NIHB has identified several policy priorities for Indian Country within the jurisdiction of the Committee that we urge you to address:

1. Provide Full Funding and Mandatory Appropriations for the Indian Health Service
2. Prioritize Tribal Water and Sanitation Infrastructure
3. Increase Support for Tribal Mental and Behavioral Health
4. Provide Greater Health Care Access and Financial Support for I/T/U Facilities
5. Create a Sustainable Tribal Health Workforce
6. Increase Telehealth Capacity in Indian Country while Expanding Broadband Access
7. Establish a 21st Century Health Information Technology (HIT) System at IHS
8. Expand and Strengthen the Government-to-Government Relationship with the Federal Government and the Tribes & Expand Self Governance

The Reality of Broken Treaties

We continue to bear witness and experience the alarming obstacles to our everyday lives resulting from this unprecedented crisis. In a matter of weeks, COVID-19 reshaped the very fabric of our economy, our society, the way we conduct business, relationships and our personal livelihoods—in some ways, permanently. The past year has been a profoundly uncertain and challenging time; and also times of profound opportunity to achieve redress of hundreds of years of injustices, which are the children of colonization.

Today, our nation is confronted by the COVID-19 pandemic that continues to disproportionately ravage the most marginalized among us, and Indian Country has been right at the center of the pandemic. In order to understand how to address and overcome these challenges and realize the opportunity for transformation before us, we must first insist on an honest reckoning of our history. The challenges we face today—most recently evidenced through the impacts of COVID-19 on Tribal communities—are the fruits of colonization. This system of exploitation, violence and opportunism is the foundation on which this Nation was constructed. Despite the poor social determinants of health most frequently found in the Indigenous and other communities of color—circumstances that proceed from hundreds of years of colonization—we are often blamed for our poor circumstances. What our communities are experiencing during this COVID-19 pandemic is simply the expected outcome of this historical truth.

Centuries of genocide, oppression, and simultaneously ignoring our appeals while persecuting Our People and our ways of life persist—now manifest in the vast health and socioeconomic inequities we face during COVID-19. The historical and intergenerational trauma our families endure, all rooted in colonization, are the

underpinnings of our vulnerability to COVID-19. Indeed, we tell our stories of treaties, Trust responsibility and sovereignty—over and over—and it often appears the listeners are numb to our historic and current truths. But the truth does not change; that is the ground we stand on. We hear baseless stories about how “dirty Indians” are causing the outbreaks, or how private hospitals are refusing to accept referrals to treat Our People. These same sentiments echoed across all previous disease outbreaks that plagued Our People from Smallpox to HIV to H1N1. This begs the painful question: what has changed?

The underpinnings of colonization may finally be loosening as a consequence of the exposed neglect, abuse, bad faith and inequities AI/AN People have experienced during this pandemic. But it did not start with COVID-19. This pandemic and the way it is ravaging our Peoples is exposing the consequences of hundreds of years of US policy predicated on broken promises with the Indigenous Peoples of this land.

Health Inequities Create Additional Risks from COVID-19

The solemn legacy of colonization is epitomized by the severe health inequities facing Tribal Nations and AI/AN Peoples. When you compound the impact of destructive federal policies towards AI/ANs over time, including through acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and the outlawing of traditional ways of life, religion and language, the inevitable results are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country.

Chronic and pervasive health staffing shortages—from physicians to nurses to behavioral health practitioners—stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 GAO report found an average 25 percent provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas (GAO 18-580). Lack of providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective and culturally indifferent, at best—inept at worst. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that—at 37 years. In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care.

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

When you compound the impact of broken treaty promises, chronic underfunding, and endless use of continuing resolutions, the inevitable result are the chronic and pervasive health disparities that exist across Indian Country. These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do. Indeed, AI/AN health outcomes have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.¹

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.² In addition, AI/ANs have the highest uninsured rates

¹South Dakota Department of Health. Mortality Overview. Retrieved from <https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf>

²Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.

(25.4 percent); higher rates of infant mortality (1.6 times the rate for Whites);³ higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50 percent higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

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

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

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

Impact of COVID-19 and Vaccine Efforts in Indian Country

As of April 10, 2021, IHS has reported 191823 positive COVID-19 cases, with a cumulative percent positive rate of 9.2 percent across all twelve IHS Areas.⁴ However, IHS numbers are highly likely to be underrepresented because case reporting by Tribally-operated health programs, which constitute roughly two-thirds of the Indian health system, are voluntary. According to data analysis by APM Research Lab, AI/ANs are experiencing the second highest aggregated COVID-19 death rate at 51.3 deaths per 100,000. The CDC reported on March 12, 2021, AI/ANs were 3.7 times more likely than non-Hispanic white people to be hospitalized and 2.4 times more likely to die from COVID-19 infection. Reporting by state health departments has further highlighted disparities among AI/ANs.

- According to the Centers for Disease Control and Prevention (CDC), AI/AN People are 1.7 times (70 percent) more likely to be diagnosed with COVID-19 when compared to non-Hispanic white people
- According to the CDC, AI/ANs are 3.7 times (370 percent) more likely to require hospitalization when compared to non-Hispanic white people
- According to the CDC, AI/ANs are 2.4 times (240 percent) more likely to die from COVID-19-related infection when compared to non-Hispanic white people.
- There have been 6,206 AI/AN deaths related to COVID-19 complications since the pandemic was declared. Nearly 60 percent of these deaths are from New Mexico, Arizona, and Oklahoma⁵
- In Alaska, 37 percent of the total state's deaths are reported to be AI/ANs⁶

³Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

⁴Indian Health Service. COVID-19 Cases by IHS Area. <https://www.ihs.gov/coronavirus/>

⁵National Indian Health Board. March 17, 2021 CDC Provisional Death Count of AI/ANs, 5,981 US, with State Deaths, percent of State Deaths and percent of US Deaths. <https://public.tableau.com/profile/nihb.edward.fox#!/vizhome/CDCMarch1720215981AIANDeathsfromCOVID19/March172021CDCProvisionalDeathCountofAIANs5981USwithStateDeathsofStateDeathsandofUSDeaths>

⁶National Indian Health Board. March 17, 2021 CDC Provisional Death Count of AI/ANs, 5,981 US, with State Deaths, percent of State Deaths and percent of US Deaths. <https://public.tableau.com/profile/nihb.edward.fox#!/vizhome/CDCMarch1720215981AIANDeathsfromCOVID19/March172021CDCProvisionalDeathCountofAIANs5981USwithStateDeathsofStateDeathsandofUSDeaths>

- The disparity in COVID-19-related death rates is not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the largest disparities. Among AI/ANs aged 20–29 years, 30–39 years, and 40–49 years, the COVID-19-related mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts⁷
- Across 23 states, the cumulative incidence rate of laboratory-confirmed COVID-19 infections was 3.5 times (350 percent) higher among AI/ANs persons than that of non-Hispanic white persons⁸

Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS,⁹ Tribal governments have innovatively found ways of maximizing third party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third party collections can constitute up to 60 percent of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third party reimbursement shortfalls ranging from \$800,000 to \$5 million per Tribe, per month. In a hearing before House Interior Appropriations on June 11, 2020, former IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30–80 percent below last year’s collections levels, and that it would likely take years to recoup these losses.

The COVID-19 pandemic has highlighted the weaknesses and gaps in public health infrastructure in Indian Country, and vaccine distribution has shown similar results. Tribal governments were forced to rely upon the vaccine dissemination channels created by the federal government. Tribal governments were forced to choose between receiving any one of the available vaccines through either the state in which they reside or through IHS, rather than providing the vaccine directly to the Tribes themselves. This sidestepping of the government-to-government relationship can and should be avoided in the future.

H.R. 1319, The American Rescue Plan, provides \$600 million specifically for vaccine activities in Indian Country. As of April 5, 2021, there have been nearly 1.563 million vaccines distributed through IHS, and over 1 million doses have been administered. The latest number from IHS regarding the number of vaccines administered by the tribes who received the vaccine through states is 178,000 doses. NIHB is optimistic how this funding will impact this continued effort in eradicating the disease.

For some states in the country, vaccine administration, or “shots in arms,” have been less than ideal. However, Tribal government vaccine rollouts have been far outpacing their state counterparts. Regardless of how a Tribe obtained the vaccines, once they had them in hand, Tribes were able to get the doses in the arms of their citizens faster and more efficient than most of their surrounding communities and states. For instance, the state of Alaska had vaccinated 91,000 people at the end of January 2021 and 10,000 of those shots were administered to Tribal patients. Various Tribes in Oklahoma has done so well in vaccinating their citizens, they have recently opened their vaccine efforts to the community, regardless of if they are IHS eligible or not. Anyone in Oklahoma can now receive the vaccine through the tribe. For the Rosebud Sioux Tribe, they have been vaccinating those in their community nearly double the rate of South Dakota.¹⁰ In an analysis by the AP, federal data showed Native Americans were getting vaccinated at a higher rate than all but five states by the end of February 2021.¹¹

⁷ Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons—14 States, January–June 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1853–1856. DOI: [http://dx.doi.org/10.15585/mmwr.mm6949a3external icon](http://dx.doi.org/10.15585/mmwr.mm6949a3external%20icon)

⁸ 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 Per capita spending at IHS in FY 2018 equaled \$3,779 compared to \$9,409 in national health spending per capita; \$9,574 in Veterans Health Administration spending per capita; and \$13,257 per capita spending under Medicare.

¹⁰ NPR. Why Native Americans Are Getting COVID-19 Vaccines Faster. <https://www.npr.org/2021/02/19/969046248/why-native-americans-are-getting-the-covid-19-vaccines-faster>

¹¹ AP. Native Americans embrace vaccine, virus containment measures. <https://apnews.com/article/native-americans-coronavirus-vaccine-9b3101d3064427bc519833017b4737d>

Systemic Barriers in COVID-19 Response

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

One reason is because in all but the latest COVID-19 relief packages, the federal government decided to use competitive grant making as a means of distributing funds to Tribes. To apply for competitive grants, you need staff to put together an application. Tribes that were lower resourced found themselves having to use a skeleton staff to put together applications in order to have access to funds that they needed in order to provide care for their people. If Tribes could not pull together these resources, they were excluded from being able to apply for these pots of money.

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

Instead, a more effective way to distribute aid to Tribes would be through a fixed funding formula that ensures sufficient, recurring, sustainable funding reaches all Tribal Nations. Doing so would allow Tribes to know that the funding was coming to them, how much they were getting, and be able to plan to utilize that money to help their citizens. It would have also alleviated the burden on Tribes to use their staff to apply for grant funding and allowed them to use their limited resources to treat the issue at hand. We were pleased, for the first time, Congress provided a dedicated, standalone section to Indian health in the American Rescue Plan. This type of mechanism in the law is precisely what Indian Country has been asking for and avoids competitive grants altogether.

Another issue was the insufficient notice of funding opportunities. Many Tribes were not told what opportunities were available or how they would be able to access the funding. Given the Trust Responsibility, we would expect HHS to take special care to ensure that Tribes know of these opportunities and are able to submit any required documentation within a timely manner. Tribes were also forced to deal with agencies with whom they had little experience or knowledge. For example, in the initial funding allocations, aid to Tribes was distributed through the CDC and not IHS. This, in turn, created a delay in receiving funding as the CDC had to create a mechanism to either distribute the funding themselves or transfer the money to IHS. However, in the American Rescue Plan, funds were directed to flow through IHS, who already has an existing relationship with tribes to release these funds more efficiently and effectively.

We have felt deeply troubled by the systemic barriers that historically impeded the federal government's response to this crisis. As sovereign governments, Tribal Nations have the same inherent responsibilities as state and territorial governments to protect and promote the public's health. Tribes were largely left behind during the nation's development of its public health infrastructure, and Tribal health systems continue to be chronically underfunded. As a result, many Tribal public health systems remain far behind that of most state, territorial, and even city and county health entities in terms of their capacity, including for disease surveillance and reporting; emergency preparedness and response; public health law and policy development; and public health service delivery. However, the American Rescue Plan provided unprecedented investments to Indian Country, especially regarding Indian health. With over \$6 billion being injected into the I/T/U systems, we are encouraged to witness the effects of this funding and the improvements that will be made to care, facilities, and AI/AN Peoples' lives. But we must ask ourselves, what has led us up to this point? Additionally, CDC must continue its trajectory of making meaningful and sustainable direct investments into Tribal communities for public health—thus further closing the gap in the disparities of lower health status, and lower life expectancy of AI/AN Peoples compared to the general population. We are thankful for the Members of this Committee and the continued support they have given Indian Country through this pandemic and all the support you have provided to our communities to end this pandemic.

Recommendations

The U.S. must continue to honor its trust and treaty obligations in its response to COVID-19. Thus far, the IHS has secured billions in emergency aid from Congress and through inter-agency transfers from HHS. These investments were necessary, but nowhere near sufficient, to stem the tide of the pandemic. NIHB is delighted to see more than \$6 billion secured in the American Rescue Package for Indian health with maximum flexibility and no expenditure deadline. This funding nearly doubles the annual discretionary budget of IHS and will go so far in the continued response to the pandemic, as well as rebuilding our communities. NIHB is pleased to see Indian health prioritized in so many areas often overlooked, such as lost third party billing, IHS facilities improvements, additional Purchased/Referred Care (PRC) dollars, dedicated funding to information technology and telehealth access, and potable water delivery. In swift fashion, the administration has already conducted Tribal consultation and urban Indian confer. This came less than a week after the legislation became law and they begin to disseminate this supplemental funding. While the American Rescue Plan provides much needed to support to Indian Country's ongoing requests, the pandemic is far from over and there is work still left to be done:

1. Provide Full Funding and Mandatory Appropriations for the Indian Health Service

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

Tribal treaties are not discretionary. The IHS budget should not be discretionary either. Congress must work to provide an appropriately scaled and sustainable investment targeted toward primary and preventative health, including public health services, for Tribes to begin reversing the trend of rising premature death rates and early onset of chronic illnesses, including the comorbidities that increase the risk of death due to the novel coronavirus.

Congress will never achieve full funding of IHS through the discretionary appropriations process given the restrictive spending caps of the Interior, Environment and Related Agencies Appropriations account. The Interior account has one of the smallest spending caps at only \$36 billion in FY 2020, making it extremely difficult to achieve meaningful increases to the IHS budget. While the IHS budget increased by roughly 50 percent between FY 2010 and FY 2020, those increases largely only kept pace with population growth, staffing funding for new or existing facilities, and rightful full funding of contractual obligations such as Contract Support Costs (CSC) and 105(l) lease agreements. The slight year-to-year increases have not even kept full pace with annual medical and non-medical inflationary increases, translating into stagnant healthcare services, dilapidated healthcare facilities, severe deficiencies in water and sanitation infrastructure, and significant workforce shortages.

Tribes call on the 117th Congress to take decisive steps to accelerate health gains in AI/AN communities, while preserving the investments and health improvements achieved over these past several years. To do this, Congress must enact a budget for IHS that is bold, effective, and contains important policy reforms to ensure that AI/ANs experience the highest standard of care possible. Funding IHS at \$12.759 billion in FY 2022, as recommended by the TBFWG, will instill trust among Tribal leaders that the Administration is truly committed to working directly with Tribes to fulfill treaty obligations for healthcare and build a more equitable and quality-driven Indian health system.

- Phase in full funding of the Indian Health Service and enact a Fiscal Year 2022 IHS Budget in the amount of \$12.759 billion, as recommended by the IHS Tribal Budget Formulation Workgroup as the first step toward full funding.
- Fund a Tribally-driven feasibility study in order to determine the best path forward to achieve mandatory appropriations for IHS.

- Enact mandatory appropriations and advanced appropriations for the Indian Health Service annual operating budget.
- Enact indefinite, mandatory appropriations for the 105 (l) lease line item and Contract Support Costs (CSC) outside of the IHS budget.
- Insulate IHS from the effects of budget sequestration, shutdowns, and stopgap measures through advance appropriations.
- Permanently reauthorize the Special Diabetes Program for Indians (SDPI) at a minimum of \$250 million with automatic annual funding increases tied to the rate of medical inflation.

2. Prioritize Tribal Water and Sanitation Infrastructure

Approximately 6 percent of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide. In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of “honey buckets” that are disposed in environmentally hazardous sewage lagoons. Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30 percent of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households roughly 71 times higher than the cost of water in urban areas with municipal water access. When asked to wash their hands to keep them safe from COVID-19, some tribal members are unable to do so from the lack of clean, running water.

Human health depends on safe water, sanitation, and hygienic conditions. COVID-19 has highlighted the importance of these basic needs and illustrated the devastating consequences of gaps in these systems, including the spread of infectious diseases. The lack of access to safe drinking water and basic sanitation in Indian Country negative impacts the public health of AI/AN communities.

- Increase funding for infrastructure development that can address deficiencies in water and sanitation in Indian Country, including for the IHS’s Sanitations Facilities Construction.
- Increase Tribal set-asides for the safe and Clean Drinking Water State Revolving Funds.

3. Increase Support for Tribal Mental and Behavioral Health

AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before the COVID-19 public health emergency began, and many of these challenges have gotten worse under the pandemic, especially for Native youth. A 2018 study found that AI/AN 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.¹² According to the CDC, suicide rates for AI/ANs across 18 states were reported at 21.5 per 100,000—3.5 times higher than demographics with the lowest rates.¹³ Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved historical and generational trauma, alongside contemporary trauma.

- Enact the Native Behavioral Health Access Act, ensuring funding will reach every Tribe in a Tribally designed and approved formula, rather than competitive grant, and allowing Tribes to receive the funding through self-determination contracting or self-governance compacting mechanisms.
- In coordination with Tribes, establish trauma-informed interventions to reduce the burden of substance use disorders including those involving opioids.
- In coordination with Tribes, incorporate behavioral health assessments such as Adverse Childhood Experience (ACE) into IHS and provide funding for Tribal health programs to do the same.
- Authorize reimbursement for additional provider types that render behavioral health services through Medicare and Medicaid, including Professional Coun-

¹²Swaim 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

¹³2 Leavitt 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>

selor, Licensed Marriage and Family Therapist, and similar types of providers that are currently excluded.

- Create set aside, non-competitive funding for Tribes in all general funding streams to support behavioral and mental health initiatives.

4. *Provide Greater Health Care Access and Financial Support for I/T/U Facilities*

Medicare and Medicaid play an integral role in ensuring access to health services for AI/AN people and provide critically important funding support for the Indian health system overall. In fact, in many places across Indian Country, these Centers for Medicare and Medicaid Services (CMS) programs allow for Indian health system sites to address medical needs that previously went unmet as a result of underfunding of the Indian health system. The role of these CMS programs in Indian Country goes beyond advancing general program goals and meeting the needs of individual healthcare consumers. As an operating division of the United States Department of Health and Human Services (HHS), CMS owes a Trust Responsibility to the Tribes, as that solemn duty runs from the entire federal government to all federally-recognized Tribes.

In addition to the benefits these programs provide to enrollees, Medicare and Medicaid also supports the I/T/U system by enabling facilities to collect third party revenue. Third party revenue significantly contributes to the financial stability of Indian health system clinics and hospitals. According to a 2019 report by the Government Accountability Office,¹⁴ between Fiscal Year 2013 and Fiscal Year 2018, third party collections at IHS and Tribal facilities increased by \$360 million, with 65 percent coming from Medicaid, a substantial portion by any measure. Moreover, data show that the number of AI/ANs with Medicaid increased from 1,458,746 in 2012 to 1,793,339 in 2018. The 334,593 increase in Medicaid coverage is a 22.94 percent increase over 2012. In 2018, 33.55 percent of all AI/ANs had Medicaid compared to 29.55 percent in 2012. During that same period, Medicare collections grew 47 percent from \$496 million in FY 2013 to \$729 million in FY 2018. To ensure financial health, Indian Country must protect and strengthen access to third party revenue within the Indian health system.

- Authorize Medicaid reimbursements across all states to allow Indian health system providers to receive Medicaid reimbursement for all mandatory and optional services described as “medical assistance” under Medicaid and specified services authorized under the Indian Health Care Improvement Act (IHCIA)-referred to as Qualified Indian Provider Services-when delivered to Medicaid-eligible AI/ANs.
- Create an optional eligibility category under federal Medicaid law providing authority for states to extend Medicaid eligibility to all AI/ANs with household income up to 138 percent of the federal poverty level (FPL).
- Extend full federal funding through a 100 percent Federal Medical Assistance Percentage (FMAP) rate for Medicaid services furnished by Urban Indian Organizations (UIOs) to AI/ANs.
- Clarify that AI/AN exemptions from mandatory managed care applying to plans enacted through state plan amendments (SPA) also apply to all waiver authorities.
- Amend Section 105(a)(9) of the Social Security Act in order to clarify the definition of “Clinic Services” and ensure that services provided through an Indian health care program are eligible for reimbursement at the OMB/IHS all-inclusive rate, no matter where service is provided.
- Exempt AI/ANs from any additional restrictions, such as work requirements, that may be placed on Medicaid access.
- Exempt IHCPs from any measures, such as limiting retroactive eligibility, that are designed as a cost-saving measure for the state

5. *Create a Sustainable Tribal Health Workforce*

The Indian Health Service (IHS) and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: physician 34 percent; pharmacist 16 percent; nurse 24 percent; dentist 26 percent; physician’s assistant 32 percent, and advanced practice nurse 35 percent. Current vacancy rates make it nearly impossible to operate a quality health care program. With competition for primary care physicians and other practitioners at an all-time high, the sit-

¹⁴ See <https://www.gao.gov/assets/710/701133.pdf>

uation is unlikely to improve soon. The IHS cannot meet workforce needs with the current strategy. In order to strengthen the healthcare workforce, IHS and Tribal programs need investment from the federal government—to educate, to recruit, and to expand their pool of qualified medical professionals.

- Make the IHS Scholarship and Loan Repayment Program tax-exempt.
- Focus on providing aid to students from Tribal communities so they can return to them and expand the program so that it includes additional provider types eligible for the funding.
- Create new and additional set aside funding for Tribal medical residency programs; and require a Tribal set aside within the annual Medicare funding of Graduate Medical Education (GME) for require service to Tribal communities.
- Provide funding for better incentives for medical professionals who want to work at IHS and Tribal sites, including support for spouses and families, and better housing options.

6. *Increase Telehealth Capacity in Indian Country while Expanding Broadband Access*

According to a 2019 Federal Communications Commission (FCC) Report, only 46.6 percent of homes on rural Tribal lands had access to a fixed terrestrial broadband at standard speeds, an astounding 27 points lower than non-Tribal lands. This is an unacceptable disparity and contributes to the difficulties that Tribes have had in addressing the COVID-19 pandemic. The lack of broadband access presents multiple barriers for Tribes. It inhibits their ability to fully realize the benefits of telehealth. The expansion of telehealth during the COVID19 pandemic and its lasting effects have increased the importance of broadband as a public health issue. In addition to its public health implications, the lack of broadband access also presents a barrier to economic development, especially in an era where remote work is becoming adopted more widely.

Tribes have been unable to take full advantage of recent federal regulatory flexibilities in use of telehealth under Medicare. Because the new flexibilities would sunset at the conclusion of the public health emergency, it is economically and financially unfeasible for many Tribes to make costly investments into telehealth infrastructure and equipment for a short-term authority. While mainstream hospital systems have largely made a seamless transition to telehealth, Tribes once again remain behind due to lack of historical investment.

- Fund a study of Tribal lands to determine where broadband access gaps exist and the best technologies to address them.
- Fund the broadband expansion in Tribal lands in order to help address the disparities between rural Tribal and non-Tribal lands.
- Allocate funding directly to Tribes to provide for the expansion of telehealth.
- Permanently extend the existing waiver authority for use of telehealth under Medicare.
- Retire telehealth restrictions to allow for continuation of telehealth beyond the national emergency context.

7. *Establish a 21st Century Health Information Technology (HIT) System at IHS*

HHS provides the technology infrastructure for a nationwide healthcare system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS Health Information Technology (HIT) also supports the mission critical healthcare operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than 100 applications.

A properly resourced IHS HIT program directly supports better ways to: (1) care for patients; (2) pay providers; (3) coordinate referral services; (4) recover costs; and (5) support clinical decisionmaking and reporting, all of which results in better care, efficient spending, and healthier communities. The Resource and Patient Management System (RPMS)—used by IHS and many Tribal health programs—depends on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types.

In recent years, many Tribes and several UIOs have elected to purchase their own commercial-off-the-shelf (COTS) systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and allow for smoother navigation and use. As a result, there exists a growing patchwork of EHR platforms across

the Indian health system. When the VA announced its decision to replace Vista with a COTS system in 2017 (Cerner), Tribes ramped up their efforts to re-evaluate the IHS HIT system and explore how Veterans Health Administration (VHA) and I/T/U EHR interoperability could continue. Tribes have significant concerns about Tribal COTS interoperability with RPMS, and the overall viability of continuing to use RPMS.

- Provide funding needed to establish a fully functional and comprehensive health IT system for the Indian health system that is fully interoperable with Tribal, urban, private sector, and Department of Veterans Affairs (VA) HIT systems.
- Offset costs for Tribes that have already expended to modernize their system in the absence of federal action.
- Provide additional time for Indian health system providers to comply with CERT 2015.
 - Current legislative language only allows for five years of exemptions. It will take more time for IHS get the RPMS system CERT 2015.

8. *Expand and Strengthen the Government-to-Government Relationship with the Federal Government and the Tribes & Expand Self Governance*

The Indian Health Service (IHS) is the only agency within HHS that retains authority to establish self-determination contracting or self-governance compacting (as those terms are defined under the Indian Self-Determination and Education Assistance Act) agreements with Tribal Nations and Tribal organizations. However, not all IHS programs are subject to ISDEAA agreements.

For example, Tribes are barred from receiving IHS behavioral health grants (i.e., Methamphetamine and Suicide Prevention Initiative/Domestic Violence Prevention Initiative) under ISDEAA agreements. All IHS programs and funds should be allocated to Tribes under ISDEAA agreements. Tribes also call on the federal government to expand self-determination and self-governance authority across all of HHS. Additionally, authorizing interagency transfer of funds from other HHS operating divisions to IHS is the best interim step, given that IHS is currently the only agency with ISDEAA authority.

As background, in 2000, P.L. 106–260, included a provision directing HHS to conduct a study to determine the feasibility of a demonstration project extending Tribal self-governance to HHS agencies other than the IHS. The HHS study, submitted to Congress in 2003, determined that a demonstration project was feasible. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696—Department of Health and Human Services Tribal Self-Governance Amendments Act—that would have allowed these demonstration projects. A second study was completed in 2011 by the U.S. Department of Health and Human Services Self-Governance Tribal Federal Workgroup that noted additional legislation would be needed for the expansion. Despite these findings supporting expansion of Tribal self-determination and self-governance, Congress has yet to act legislatively.

Allowing Tribes to enter into self-governance compacts with HHS and its operating divisions would mean that federal dollars are used more efficiently because resources in Tribal communities, which are often small, could be more easily pooled and would allow Tribes to organize wrap-around services to better serve those who have the greatest need. Self-governance allows Tribes to extend services to larger populations of eligible American Indians and Alaska Natives, leveraging other opportunities more efficiently than the federal government. It also leads to better outcomes because program administrators are in close contact with the people they serve, making programs more responsive and effective.

The most prominent example where the maximum self-governance is needed is the Special Diabetes Program for Indians (SDPI). Established by Congress in 1997, SDPI addresses the disproportionate impact of type II diabetes in AI/AN communities. It is the nation's most strategic and effective federal initiative to combat diabetes in Indian Country. SDPI has effectively reduced incidence and prevalence of diabetes among AI/ANs and is responsible for a 54 percent reduction in rates of End Stage Renal Disease and a 50 percent reduction in diabetic eye disease among AI/AN adults.¹⁵ A 2019 federal report found SDPI to be largely responsible for \$52 million in savings in Medicare expenditures per year.¹⁶ As a direct result of SDPI, a

¹⁵ https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/SDPI2020Report_to_Congress.pdf

¹⁶ https://aspe.hhs.gov/system/files/pdf/261741/SDPI_Paper_Final.pdf

recent study found that the prevalence of diabetes in AI/AN adults decreased from 15.4 percent in 2013 to 14.6 percent in 2017.¹⁷

Congress was able to secure the cost savings to pay for a three-year extension of SDPI through the end of FY 2023. The SDPI reauthorization did not include a critical legislative amendment to permit Tribes and Tribal organizations to receive SDPI awards pursuant to Title I contracting or Title V compacting agreements under ISDEAA. This technical change would prevent any administrative delays in implementation of the 638 provision, and further clarify the purpose of the new authority. By specifically citing certain sections of P.L. 93–638, the technical change would ensure that IHS awards SDPI funds to those Tribes and Tribal organizations that elect to receive SDPI funds through the 638 mechanism. This would guarantee that Tribes and Tribal organizations receive all administrative and operational resources entitled to them under the 638 mechanism, including access to Contract Support Costs (CSC).

- Enact a permanent expansion of Tribal self-determination and self-governance across all agencies within HHS and affirm that all programs at IHS are eligible to be contracted and compacted.
- Expand and codify all Tribal Advisory Committees (TAC) to ensure Tribes have a voice within all operating divisions that provide funding to Tribal governments and communities.
- Authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93–638 contracts and compacts.
- Wherever permissible, create direct funding to Tribes and avoid grant mechanisms which cause Tribes to compete against other Tribes or against well-resourced states, cities, and counties.
- Streamline reporting requirements to reduce burdens on Tribal nations receiving funding.

Conclusion

Our treaties stand the test of time. They are the Supreme Law of this land. If a nation's honor and exceptionalism is a measure of its integrity to its own laws and creed, then one must look no further than the United States' continued abrogation of its own treaties to recognize that its honor is in short supply. Every square inch of this nation is Our People's land. As the sole national organization committed to advocating for the fulfillment of the federal government's trust and treaty obligations for health, we will always be dedicated to bringing into fruition the day where Our People can state with dignity that the United States held true to its solemn word. Ideally, fulfillment of trust and treaty obligations should be without debate and the U.S. should honor its promises. These lands and natural resources, most often acquired from us shamefully, are the bedrock of U.S. wealth and power today.

In closing, we thank the Committee for the continued commitment to Indian Country and urge you to further prioritize Indian Country as you continue to provide relief regarding the COVID–19 pandemic. We patiently remind you that federal treaty obligations to the Tribes and AI/AN People exist in perpetuity and must not be forgotten during this pandemic. We thank you that American Indians and Alaska Natives will continue to be prioritized to receive the vaccine, have sufficient funds to build and maintain a public health infrastructure, and the full faith and confidence of the United States Government will further be committed to this nation's first citizens to eradicate this disease. As always, we stand ready to work with you in a bipartisan fashion to advance health in Indian Country.

The CHAIRMAN. Thank you very much for your very compelling testimony.

Next, we have Mr. Walter Murillo, Board President of the National Council of Urban Indian Health.

STATEMENT OF WALTER MURILLO, BOARD PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Mr. MURILLO. Good afternoon. My name is Walter Murillo, I am a member of the Choctaw Nation of Oklahoma. I also serve as the

¹⁷ <https://www.ihs.gov/newsroom/ihs-blog/april-2020-blogs/new-study-shows-decrease-in-diabetes-prevalence-for-american-indianand-alaska-native-adults/>

Board President for the National Council of Urban Indian Health, and I am the CEO of Native Health in Phoenix.

Today, I will share the experiences of the 41 urban Indian organizations in the Country during the COVID-19 pandemic. Let me start by saying thank you to the Committee and members here who have worked tirelessly to help equip the Indian health system with essential resources.

As you know, the trust responsibility does not end at the borders of the reservation, and the responsibility for health care doesn't, either. Native Health and 40 other UIOs have risen tremendously to the challenges of the last year. The UIO line item going into the pandemic was only \$57.7 million for 41 UIOs to serve over 70 percent of the American Indian and Alaska Natives that reside in urban areas.

Plus, the Indian health care system and UIOs have never been properly fully funded. We started from an extreme deficit when the pandemic hit. We faced many challenges beyond the pandemic as well. Two UIOs had fires, another endured an earthquake, and our Minneapolis UIO is at the center of civil unrest. Ten UIOs in California dealt with wildfires and air quality issues.

Despite these challenges, we kept our doors open as best we could, with only four UIOs temporarily closing because they did not have PPE for their staff. Urban Indians have been an afterthought for far too long. UIOs receive only \$672 per patient per year. This is unacceptable.

For example, in Baltimore, the UIO also operates a facility a Boston. Their total combined budget is less than \$1 million. That is to run two facilities in two different States. Because they are designated as an outreach and referral facility, they were not even able to access vaccines for patients until last week.

These past 12 months have reminded us not only how resilient our people are, but also highlighted how critical our Indian health care system is to the lives of American Indians and Alaska Natives, no matter where they live. Tragically, we have planned too many funerals and lost far too many family members and members of our communities in urban areas who have been isolated from their homelands.

Native deaths continue to be the highest in the world, and we are not out of the woods yet. As of now, UIOs have been providing testing and vaccines for an outpouring of community members. To date, UIOs have tested over 65,000 people and have administered over 72,000 doses of vaccine.

We have stepped up to help other systems as well. One UIO in Montana vaccinated 180 teachers, and in the State of Washington, they shared vaccines with the NAACP. We have also partnered with other local organizations. Native Health in Phoenix has been proud to partner with Maricopa County to provide services to residential facilities and the local tribal communities and tribal enterprises, as well as the association of food bank staff.

UIOs have responded to the pandemic, and responded to the increased demands for our regular services, like behavioral health, food, and other social services. Many have added tele-health. Congress has made enormous strides for UIOs, enacting medical malpractice coverage for our health care workers through expansion of

the FTCA, and enabling UIOs to be reimbursed for services that we already provide to veterans.

Yet, parity issues remain a significant barrier for UIOs. The Federal Government's trust responsibility is to pay 100 percent of Medicaid costs for American Indians and Alaska Natives, including urban Indians, and was intended to help the severely underfunded Indian Health Service system. For the first time ever, the government will pay 100 percent FMAP for services provided at UIOs, but this last only two years.

This is something I have been fighting for for over 20 years. We need this enacted permanently.

Another issue is the restriction prohibiting UIOs from using our COVID-19 funds to make critical repairs or upgrades to our HVAC and sanitation systems. We continue to experience long bureaucratic discussions that last weeks, even months, even to make minor upgrades to our facilities as a result of the COVID-19 pandemic.

We ask for your support of a new bill that will permanently fix this provision meant to help UIOs have more resources, not fewer. We also need an urban confer policy with the Department of Health and Human Services and Indian health serving agencies for any issues that affect Indian Country, especially in urban areas. This pandemic has taught us that not having a confer policy means agencies have no formal mechanism or requirement to receive our input on policies that impact us. We would like to adhere to the phrase, no policies about us without us.

Finally, the most important thing you can do is to fully fund the Indian Health System by providing \$205 million for the Urban Indian Health line item in fiscal year 2022. That is what is included in the tribal budget recommendations. We need to push forward on permanent 100 percent FMAP for Indians and pass advance appropriations.

Thank you for the opportunity to share our experiences. I have provided my written testimony, and I am happy to answer any questions.

[The prepared statement of Mr. Murillo follows:]

PREPARED STATEMENT OF WALTER MURILLO, BOARD PRESIDENT, NATIONAL COUNCIL
OF URBAN INDIAN HEALTH

My name is Walter Murillo, and I am a member of the Choctaw Nation of Oklahoma. I serve as the Board President of the National Council of Urban Indian Health (NCUIH) and I am the CEO of Native Health in Phoenix. Today, I will share the experiences of the 41 urban Indian organizations (UIOs) in the country in responding to the COVID-19 pandemic. Let me start by saying thank you to Chairman Schatz, Vice Chair Murkowski, Members of the Committee and your staff who have worked tirelessly to help equip the Indian health system with essential resources.

NCUIH represents 41 UIOs in 77 facilities across 22 states. UIOs provide high-quality, culturally competent care to urban Indian populations, constituting more than 70 percent of all American Indians and Alaska Natives (AI/ANs). UIOs were recognized by Congress to fulfill the federal government's health care responsibility to Indians who live off of reservations. UIOs are a critical part of the Indian Health Service (IHS), which oversees a three-prong system for the provision of health care: IHS facilities, Tribal Programs, and UIOs. This is commonly referred to as the I/T/U system.

COVID-19 Impact on Urban Indian Organizations

Native Health and the other 40 UIOs have risen tremendously to the challenges of the last year. Our annual budget for FY20 was \$57.7 million for 41 UIOs to serve the over 70 percent of American Indians and Alaska Natives that reside in cities. Because the Indian health care system and UIOs have never been properly funded, we started from an extreme deficit going into the pandemic. In fact, we faced significant additional obstacles unrelated to COVID-19 as well: two UIOs had fires, another endured an earthquake, our Minneapolis UIO was at the center of civil unrest, and 10 UIOs in California dealt with wildfires and air quality issues. Despite these additional challenges, we kept our doors open as best we could, with only four UIOs temporarily closing because they did not have PPE for their staff.

Urban Indians have been an afterthought for far too long. This is something we're far too used to in the Indian health care system and even more so as an urban Indian health provider. We are asking Congress to prioritize the fulfillment of its trust obligation through the full funding of the Indian health system and urban Indian organizations.

In many ways, the past 12 months have reminded us not only how resilient our people are, but also highlighted how critical our Indian health care system is to the lives of American Indians and Alaska Natives. Tragically, we have planned many funerals and lost far too many members of our communities. Native deaths continue to be the highest in the world and we're not out of the woods yet, which is why Congress must continue to prioritize Indian Country for annual and future pandemic response packages.

Vaccines Distribution by UIOs

We always knew that UIOs would serve a vital role in hard-to-reach communities and UIOs have gone above and beyond to stretch their limited budgets in order to serve their communities during this unprecedented pandemic. UIOs have continuously provided services in the hardest hit urban areas during the entire pandemic. Over half a million AI/AN people live in counties that are both served by UIOs and have the greatest number of COVID-19 deaths and new cases.

UIOs have overcome significant barriers to support their communities in responding to COVID-19. For instance, although planning for the vaccine distribution began last fall, without an urban confer policy at the Department of Health and Human Services, UIOs were excluded in all national communications regarding Indian health facilities deciding between distribution through the state or through IHS, leading to inconsistent messaging and forcing numerous UIOs to make a decision of the utmost importance immediately.

In addition, the only UIO that serves the Baltimore-Washington area—an outreach and referral facility (as deemed by IHS) operating on an annual budget of less than \$1,000,000—only began to receive vaccines this week, despite months of coordination that even saw several other UIOs offering to fly out staff to administer vaccines to the Baltimore-Washington Indian community.

Our programs have been providing COVID-19 vaccines for an outpouring of community members. Urban Indians in our areas have been able to come to our facilities rather than traveling long distances to reservations by plane to get vaccinated. In fact, we are seeing record numbers of patients that we hope to retain following the pandemic, which will require adequate levels of funding. Nearly every UIO has complimented IHS and their Area Office for their work on vaccine distribution.

UIOs have also filled the gaps that exist in the federal government as it relates to care for Native Veterans. In one community, Native Veterans stood in lines for hours at the VA and were ultimately turned away—refused service and told to “go to the urban Indian clinic” instead. The VA is funded drastically higher than Indian health and UIOs, yet UIOs are the ones stepping up to help them. We have also stepped up to help other systems: one UIO in Montana vaccinated 180 teachers, another shared vaccines with the NAACP and a local LatinX organization, and many have partnered with other local organizations to reach other vulnerable communities hit by COVID-19.

Although UIOs have stretched every resource to respond to the pandemic, the central problem remains: years of underfunding do not allow us to fully meet the needs of our communities. We need to capitalize on this opportunity while we have the engagement from our community members. And we need our partners in Congress to make that happen.

Successes in the Past Year

We have made enormous strides including enacting medical malpractice coverage for our health care workers and enabling UIOs to be reimbursed for services that we've been providing to veterans, as well as the American Rescue Plan that included

two years of 100 percent FMAP for services provided at UIOs (a priority I've been working on for over 20 years).

The supplemental funding from COVID-19 relief have enabled UIOs to make significant changes, which have included: optimizing the dental clinic to meet CDC guidelines, reconfiguring facilities to enable social distancing, hiring staff, funding a vaccine location facility, creating communication and PSA campaigns to increase vaccine acceptance, purchasing of PPE and medical supplies, purchasing a pod for testing, creating contact tracing programs, hiring behavioral health staff for increased workload of anxiety and depression from COVID-19, creating a weather-appropriate outside testing space, upgrading electronic health records to accurately and effectively enter vaccine and testing data, installing a new HVAC, purchasing a mobile unit for testing, new training for staff, and expanded behavioral health including victim services. We must continue this pattern of success by getting closer to adequate funding of UIOs.

Request: \$200.5 million for Urban Indian Health in FY22

While the American Rescue Plan provided the largest investment ever for Indian health and urban Indian health, it is important that we continue in this direction to build on our successes of the past year. The single most important problem remains the same and that is for the federal government to establish a baseline of funding that meets the actual need for health care for Natives. The average national health care spending is around \$12,000 per person; however, Tribal and IHS facilities receive only around \$4,000 per patient. UIOs receive just \$672 per IHS patient—that is only 6 percent of the national health care spending average. That's what our organizations must work with to provide health care for urban Indian patients. The federal trust obligation to provide health care to Natives is not optional. The Tribal Budget Formulation Workgroup recommendation for the Indian Health Service budget for FY22 is just under \$13 billion with \$200.5 million for urban Indian health—a step in the right direction towards achieving full funding (calculated this year at \$48 billion and \$749.3 million, respectively).

Each year, tribes and urban Indian organizations dedicate countless days to preparing a comprehensive document of recommendations related to the annual budget for Indian health, but Congress and the Administration have failed to provide the funding requested. With the ongoing conversations about equity and prioritizing tribal consultation and urban confer, it is important that our leaders are actually listening to our recommendations.

Request: Extend Full (100 percent) Federal Medical Assistance Percentage for UIOs Permanently

The federal government has long recognized that the Medicaid program supplements the IHS system, and that it's consistent with the trust responsibility for the federal government to pay 100 percent of Medicaid costs for American Indians and Alaska Natives, including urban Indians.

Because services provided at UIOs have not been reimbursed by the federal government at 100 percent, UIOs receive less third-party funds, limiting their ability to collect additional reimbursement dollars that can be used to provide additional services or serve additional patients. In the I/T/U system, only UIOs have been excluded from the 100 percent FMAP rate. In effect, the federal government only covers 100 percent of the cost of Medicaid services for AI/ANs receiving those services at an IHS or tribal facility and skirts full responsibility if an individual happens to receive the service in an urban area. 100 percent FMAP reimbursement has enabled: (1) IHS and Tribes to receive higher rates for services, (2) IHS and Tribes to provide additional services, and (3) states to reinvest the money they have saved into the Indian health system. UIOs providing services to tribal members residing in urban areas are unable to receive these benefits because the services they provide are not included in the 100 percent FMAP policy. The American Rescue Plan Act temporarily authorized 100 percent FMAP for services at UIOs for the next two years, however, the need for 100 percent FMAP is continuous and does not end when the pandemic ends. We urge the Senate Committee on Indian Affairs to act to pass permanent 100 percent FMAP for UIOs this year.

Request: Remove Facilities Restrictions on UIOs

Unfortunately, a restriction prohibits UIOs from using our IHS funds to make critical repairs or upgrade HVAC and sanitation systems—this even included supplemental COVID-19 funds. With your help, the last two bills enacted allowed UIOs to finally use COVID-19 funds to make COVID-19 related repairs and upgrades that were badly needed. However, we continue to experience long bureaucratic discussions that last weeks, and even months, to make even minor upgrades to our fa-

cilities. We hope that a new bill will help fix this provision meant to help UIOs have more resources, not fewer.

Facility-related use of funds remains the most requested priority for UIOs. UIOs do not receive facilities funding, unlike the rest of the IHS system. One UIO stated that facility funding would enable them to create a space that allows for social distancing during smudging healing activities. Another UIO stated that “our facility remains in dire need of support for updates and remediation so we may pursue a safe space.” Not only is this lack of funding detrimental to facility sanitation, it also drastically reduces the number of patients UIOs can see due to social distancing, furthering compounding health issues of Indian Country.

These restrictions, which are outlined in Section 509 of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1659), extend beyond COVID-19—they prohibit our health care providers from making any renovations using IHS funds solely because they are Urban Indian Organizations. This provision limits renovation funding to facilities that are seeking to meet or maintain Joint Commission for Accreditation of Health Care Organizations (TJC) accreditation (only 1 of 41 even have this type of accreditation), leaving most UIOs forced to use their limited third-party funds for necessary facility improvements. Thankfully, our advocates on this Committee were able to assist with loosening restrictions regarding infrastructure upgrades as they related to the COVID-19 pandemic. We are working on a permanent legislative fix to the facilities restrictions and ask for your support of that bill when introduced.

Request: \$21 Billion for Indian Health Infrastructure including UIOs

For the upcoming infrastructure package, we request \$21 billion in infrastructure funds for the Indian health system. We were disappointed to see that the Biden plan did not include any money for Indian health infrastructure. The LIFT Act from the House Energy and Commerce Committee currently includes \$5 billion for Indian health infrastructure, however, UIOs are not currently eligible for that funding as written. We have informed the Committee and will push for an amendment but encourage this Committee to further pursue \$21 billion for Indian health infrastructure that includes UIOs.

Many UIO facilities are well beyond their anticipated and projected lifespan, the need to adequately fund the upkeep is essential to prolonging the usability of such facilities. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is compromised. A national investment in Indian health facilities construction funding continues to be a long-term discussion of need despite the recent investment of \$600 million through the American Rescue Act, UIOs continue to be excluded and are unable to receive funding from the IHS Health Care Facilities Construction Priority program, the Maintenance & Improvement IHS budget line item, or participate in the agency’s Joint Venture Construction Program. Moreover, UIOs are even restricted from using their limited IHS appropriation for facilities. As a result, UIOs have had to take out loans and collect donations in order to build and maintain health facilities for a growing population. UIOs thus must spend millions to build, repair, and maintain their facilities—millions that could be going to increased services for their patients. Many UIOs are in aging buildings—for example, the facility in Denver, CO is in a more than 50-year old building.

Without access to facilities funding like that available to IHS and tribal facilities, UIOs must use their already limited resources on facilities. Equitable construction and facility support funding for UIOs can be accomplished by including language authorizing a new budget line item to address UIO infrastructure needs. Allowing the continued deterioration of critical health facilities goes against the mission of the Indian Health Service and Urban Indian Organizations to provide quality healthcare to all American Indians and Alaska Natives. When patients and providers lack access to well-functioning infrastructure, the delivery of care and patient health is always compromised.

Request: Establish a UIO Confer Policy for HHS

Under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, in 2000, all government agencies were mandated to submit procedures to consult with tribes when implementing policies that have Tribal implications. Unfortunately, this Executive Order as written did not include Urban Indian Organizations. Currently, only IHS has a legal obligation to confer with UIOs. It is imperative that the many branches and divisions within HHS and all agencies under its purview establish a formal confer process to dialogue with UIOs on policies that impact them and their AI/AN patients living in urban centers. Urban con-

fer policies do not supplant or otherwise impact tribal consultation and the government-to-government relationship between tribes and federal agencies.

We commend IHS for the agency's invaluable partnership and tireless efforts to disseminate resources to Tribes and UIOs as expeditiously as possible. Unfortunately, funds were needlessly tied up for weeks—and in more than one instance, months—by other agencies, thereby creating unnecessary barriers to pandemic response at UIOs. Compounding on this, only IHS has a statutory requirement to confer with UIOs, which has enabled other agencies to ignore the needs of urban Indians and neglect the federal obligation to provide health care to all AI/ANs—including the more than 70 percent that reside in urban areas. In fact, NCUIH has only been able to coordinate conversations with the VA, CDC, and other agencies by involving IHS due to a lack of urban confer. This is not only inconsistent with the government's responsibility but is contrary to sound public health policy. Agencies have been operating as if only IHS has a trust obligation to AI/ANs, and that causes an undue burden to IHS to be in all conversations regarding Indian Country in order to talk with agencies. It is imperative that UIOs have avenues for direct communication with agencies charged with overseeing the health of their AI/AN patients, especially during the present health crisis.

Request: Include UIOs in Advisory Committees with Focus on Indian Health

When UIOs are not expressly included within a statute enabling them to participate in tribal advisory workgroups or committees, they are prohibited from participating in a voting role or excluded altogether. UIO inclusion in critical advisory committees on Indian health is necessary to reflect the reality of much of the AI/AN population, as more than 70 percent of AI/ANs living in urban centers today. Without explicit inclusion of UIO representation in statute, workgroups using the Federal Advisory Committee Act (FACA) intergovernmental exemption exclude UIO leaders in their charters by default.

For UIO leaders to participate in advisory committees that directly impact their provision of health care services to AI/AN patients, Congressional action is needed.

Request: Include UIOs in the National Community Health Aide Program

Although UIOs are eligible for the Community Health Aide Program (CHAP) under the national expansion policy IHS implemented pursuant to authorization in the Indian Health Care Improvement Act (IHCIA), and IHS officially initiated Urban Confer on CHAP with UIOs in 2016, IHS changed its position in 2018 and further excluded UIOs from the consultation and confer process. IHS asserts that UIOs are excluded simply because they are not explicitly included in specific statutory language. UIOs are eligible for other similarly situated programs under IHCIA, including the Community Health Representative program, and Behavioral Health and Treatment Services programs. UIOs are explicitly named in the statement of purpose in IHCIA, included throughout its Subchapter 1 on increasing the number of Indians entering the health professions and to assure an adequate supply of health professionals involved in the provision of health care to Indian people. Some states, such as mine here in Arizona, already have laws on the books reflective of UIOs being eligible for CHAP. Furthermore, CHAP is a fully proven program and utilizing it as permissible within the entire Indian health system will increase the availability of health workers in AI/AN communities. It is therefore imperative that Congress fix this oversight and clarify that UIOs are indeed eligible for CHAP so they may begin to participate in this vital program.

Request: Advance Appropriations

The Indian health system is the only major federal provider of health care that is funded through annual appropriations. For example, the Veterans Health Administration (VHA) at the Department of Veterans Affairs (VA) receives most of its funding through advance appropriations. If IHS were to receive advance appropriations, it would not be subject to government shutdowns, automatic sequestration cuts, and continuing resolutions (CRs) as its funding for the next year would already be in place, and the provision of critical services would not be jeopardized by these unrelated budgetary disagreements.

According to the Congressional Research Service, since FY1997, IHS has only once (in FY2006) received full-year appropriations by the start of the fiscal year. Last year, during the pandemic ravaging Indian Country, Congress enacted two continuing resolutions. When funding occurs during a CR, the IHS can only expend funds for the duration of a CR, which prohibits longer-term, potentially cost-saving purchases. In addition, as most of the Indian health services provided by tribes and UIOs under contracts with the federal government, there must be a new contract re-issued by IHS for every CR. Instead, IHS was forced to allocate resources to con-

tract logistics twice in the height of the pandemic when the resources could have better spent equipping the Indian health system for pandemic response.

In addition, lapses in funding can have devastating impacts on patient care. During the most recent 35-day government shutdown at the start of FY 2019 -the Indian health system was the only federal healthcare entity that shut down. UIOs are so chronically underfunded that during the 2018–2019 shutdown, several UIOs had to reduce services, lose staff or close their doors entirely, forcing them to leave their patients without adequate care. In a UIO shutdown survey, 5 out of 13 UIOs indicated that they could only maintain normal operations for 30 days without funding. For instance, Native American Lifelines of Baltimore is a small clinic that received five overdose patients during the last shutdown, four of which were fatal. Shutdowns mean deaths in our communities. We urge this Committee to support the President's request for advance appropriations for the Indian Health Service including UIOs.

Conclusion

These requests are essential to ensure that urban Indians are properly cared for, both during this crisis and in the critical times following. It is the obligation of the United States government to provide these resources for AI/AN people residing in urban areas. This obligation does not disappear amid a pandemic, instead it should be strengthened, as the need in Indian Country is greater than ever. We appreciate your support for urban AI/ANs in the Consolidated Appropriations Act, American Rescue Plan Act and request your support of the policy requests contained herein. We urge you to honor the trust obligation and provide UIOs with all the resources necessary to protect the lives of the entirety of the AI/AN population, regardless of where they live.

The CHAIRMAN. Thank you very much.

Next, we have Dr. Sheri-Ann Daniels, Executive Director of Papa Ola Lōkahi. Welcome, and aloha.

STATEMENT OF SHERI-ANN DANIELS, Ed.D, EXECUTIVE DIRECTOR, PAPA OLA LŌKAHI

Dr. DANIELS. Aloha, Chairman Schatz, Vice Chair Murkowski and members of the Senate Committee on Indian Affairs.

Mahalo nui, thank you for the invitation to testify on behalf of Papa Ola Lōkahi and Native Hawaiian health. I am really humbled to present insights on the COVID–19 response in our Native Hawaiian community. Also, your work is critical to the self-determination of indigenous peoples in the United States to perpetuate Native cultures and practices. Thank you so much for your successful efforts to ensure that Native Hawaiians were finally included in the American Rescue Plan Act, as well as your continued support for Federal programs that benefit Native Hawaiian families and communities.

Papa Ola Lōkahi and the Native Hawaiian Health Care Improvement Act was actually created through Federal statute in the original Native Hawaiian Health Care Act of 1988. POL is a 501(c)(3) non-profit organization responsible for the coordination and maintenance of a comprehensive health care master plan called E Ola Mau.

We also train Native Hawaiian health care professionals, serve as a clearinghouse for Native Hawaiian health data and research, and provide oversight and coordination of policies, support the five Native Hawaiian health care systems which provide direct and indirect health services on islands within the State of Hawaii. We also protect and perpetuate traditional Native Hawaiian cultural healing practices and engage with partners serving Native Hawaiian health throughout all 49 States within the U.S. Our functions are very similar to those within organizations like the National In-

dian Health Board and the National Council of Urban Indian Health.

Our Native Hawaiian Health Care Improvement Act stands among the trust responsibilities to Native Hawaiians that are recognized by the United States. The other two areas include housing and education. Numerous Congressional policies specifically acknowledge or recognize that Native Hawaiians have a special trust relationship as indigenous people who never relinquished their right to self-determination.

This past year, the pandemic's response has truly demonstrated that the health needs of Native Hawaiians were and are not among the standing emergency priorities, both on the Federal, State and county levels. What we have heard today from the other witnesses applies across all our Native communities, from our tribes, to our urban Indians, to our Native Hawaiians, and they show the negative impacts that the lack of resources has done over the decades of health services.

However, we continue to show resiliency. For example, our Native Hawaiian health care systems were able to pivot their service provisions and reach deeper into their respective communities through components such as tele-health services expansion, adding.

But it wasn't only that. It was going back to basics, making sure food was distributed, increasing our engagements with our kupuna, our elders, which tested our systems' ability to leverage their resources and to fund those initiatives. Because those initiatives are not covered. They are not billable services.

But as a community, culturally, we recognize that health includes more than just physical health, that it encompasses and involves having access to food, clean water, resources on education and stable housing. That community engagement was critical from the start during this pandemic for us, which we stated time and time again. Unfortunately, we weren't listened to until now. And now it appears that that might be temporary.

However, we have never stopped maintaining the role that our cultural values and beliefs have in working with our communities. We have built a community-driven coalition and have actively engaged through the Native Hawaiian Pacific Islander Hawaii COVID Response Team. We have over 60 organizations statewide.

It is not just in Hawaii. We have partnered nationally with our membership and our other partners to make sure what is happening across other Native communities.

In retrospect, could we do different? Absolutely. Did we learn new things? Did we confirm what we already knew? Yes. Are we willing to holomua, to move forward in unity so that we can impact change? Yes. And we choose to do this and serve our community to the support of culturally appropriate and sound practices regardless of what might be lacking. And we do that unapologetically. Because it is about the collective of our community versus the individual.

We have reaffirmed and built new relationships with and within our communities. It might not be perfect, but it has reignited the purpose in sustaining these reciprocal relationships that are built on trust. That is important. We keep hearing the word trust.

Moving forward, we are hoping that this Committee really looks to explore pathways that identify direct Federal funding mechanisms for Native Hawaiians, naming the Native Hawaiian Health Care Improvement Act as an eligible entity and relevant notice of funding opportunities, create direct consultation between Native Hawaiians and other Federal agencies.

That direct access to agencies such as CDC, OMH, SAMHSA, could help provide opportunities that increase capacities for Native Hawaiians and can reach into communities. Because we recognize even though we are here to serve Native Hawaiians, we serve non-Natives as well.

To update OMB 15 standards that require new revisions on the data that is collected, that we are no longer assigned together with other ethnicities, that we can stand alone, that we are not erased. And furthermore, to create a robust enforcement of those standards, especially for ethnic minorities which are often easily ignored by States, in not collecting data on us or further disaggregating the data on us.

To have a better understanding of contextual health data related to the social determinants of health, housing, employment, food, education and more, and its role in understanding not only COVID impacts on Native Hawaiians, but health impacts in general.

We also ask the Committee to support permanent authorization of all Native Hawaiian acts: health, housing, and education. It is prudent to not only learn lessons from difficult times, but also commit to change what may prevent or mitigate future changes.

Again, mahalo piha for this time to share and I look forward to answering any questions from the Committee.

[The prepared statement of Dr. Daniels follows:]

PREPARED STATEMENT OF SHERI-ANN DANIELS, ED.D, EXECUTIVE DIRECTOR, PAPA
OLA LŌKAHI

Mahalo nui (Thank you) for the invitation to testify on behalf of Papa Ola Lōkahi (POL) and Native Hawaiian health. I am grateful to be here to present some highlights on the COVID-19 response in the Native Hawaiian community to the Committee. Your work is critical to the self-determination of Indigenous peoples in the United States to perpetuate Native cultures and practices. Thank you also for your successful efforts to ensure that Native Hawaiians were included in the American Rescue Plan Act, as well as your continued support for federal programs that benefit Native Hawaiian families and communities.

Papa Ola Lōkahi and the Native Hawaiian Health Care Improvement Act

Created through federal statute in the original Native Hawaiian Health Care Act of 1988 (currently the Native Hawaiian Health Care Improvement Act (NHHCIA)), POL is a 501(c)(3) non-profit organization that is responsible for the coordination and maintenance of a comprehensive health care master plan for Native Hawaiians; training of relevant health care professionals; serving as a clearinghouse for Native Hawaiian health data and research; and providing oversight, coordination, and support to the Native Hawaiian Health Care Systems (NHHCSs), which provide direct and indirect health services to the islands of Kaua'i, Moloka'i, Lana'i, Maui, O'ahu, and Hawai'i.

POL and the NHHCIA stand out among the trust responsibilities to Native Hawaiians that are recognized by the United States, similar to the trust responsibilities to Native Americans and Alaska Natives. Congressional policies that uplift Native Hawaiians in areas such as education, housing, language, and more have served to fulfill these trust responsibilities. Over 150 Acts specifically acknowledge or recognize that Native Hawaiians have a special political and trust relationship as Indigenous people who never relinquished the right to self-determination.

COVID-19 and Native Hawaiian Health

The pandemic response this past year has demonstrated both old and new barriers that demand timely, yet thoughtful, action for public health and safety. Simultaneously, the response of the Native Hawaiian community during the first year of the pandemic has demonstrated how community-driven efforts during unprecedented crisis can lead to innovative and effective solutions. We will highlight a sample of the discussions, partnerships, strategies and movements this past year in which Papa Ola Lōkahi has participated to response to the COVID-19 pandemic.

Generally, the five NHHCSs were able to pivot their service provision through enhanced telehealth. The losses in revenues were sudden and major. Thanks to the forethought of Congress over the last several years, increases in annual appropriations to the NHHCSA somewhat sheltered the NHHCSs. However, the first year of pandemic response demonstrated the health needs of Native Hawaiians are not among the standing emergency priorities of either the State or Counties. Thus, the NHHCSs and other Native Hawaiian health organizations, which are relatively small health providers, may be better served with direct federal funding mechanisms.

Specifically naming POL and the NHHCSs as eligible entities in relevant Notice of Funding Opportunities would better expand access to resources to Native Hawaiian communities, and better enable our staff to identify and prepare grant application efforts. Direct access to agencies such as the Centers for Disease Control and Prevention (CDC), Office of Minority Health (OMH), Substance Abuse and Mental Health Services Administration (SAMHSA) would provide opportunities for the NHHCSs to increase their capacity.

The first year of pandemic response also brought to light the need for Native Hawaiian consultation with federal health agencies to understand health needs during immediate, long-term emergency response, and overall. Native Hawaiian communities continue to face stark choices due to the complex and inter-related impacts of social determinants of health, such as unemployment, food insecurity, and the “digital divide” that contributes to disparities in work and educational opportunities as well as telehealth access. Absent consultation relationships with relevant federal agencies, POL has had little ability to communicate the disparate needs reported by the NHHCSs. Despite record-breaking relief bills from Congress, the precedence of funding Asian American (AA) organizations to then act as gatekeepers for Native Hawaiians and Pacific Islanders has resulted in delayed, if any, funding support reaching Native Hawaiians.

The NHHCSs were able to respond to community needs to the extent possible through relevant outreach and enabling services, as well as new innovations in engagement and community response. In the future, health equity may be well served through direct consultation between Native Hawaiians and federal agencies.

Challenges and Successes During COVID-19 and Beyond

Salient to the discussion of the first year of COVID-19 response are the health issues that frame challenges to COVID-19 response, successes celebrated by the Native Hawaiian community, and the sustainability of these innovations. It is prudent to not only learn lessons from difficult times, but also commit to change what may prevent or mitigate future challenges. Below, we discuss three key areas—virtually all of which were identified prior to the pandemic—that we believe will increase how informed, timely, and capable the NHHCSs and the health system at large may be in the future, in addition to how to leverage successes from pandemic response for Native Hawaiian communities.

1. Data Governance and Infrastructure

The 1997 update to the Office of Management and Budget Directive (OMB) 15, “Race and Ethnic Standards for Federal Statistics and Administrative Reporting,” which disaggregated the “Asian or Pacific Islander” race category into two major groups, “Asian” and “Native Hawaiians and Other Pacific Islanders,” was a key policy change to ensure that Native Hawaiians—as well as Pacific Islanders—were more accurately represented and understood in all areas, including health. However, the data difficulties after the initial surge of pandemic activity in the State of Hawai‘i in March 2020 demonstrated that OMB 15 requires new revision as well as more robust enforcement to improve the understanding of ethnic minorities, including Native Hawaiians. In addition, the importance of understanding contextual health data on the social determinants of health (housing, employment, and food security, educational opportunities, and more) also played a large role in understanding the specific COVID-19 impacts on Native Hawaiians.

Without changes to federal data standards, the NHHCSs have limited ability to demonstrate a full and nuanced “picture” of Native Hawaiian health writ large, but

especially during emergencies such as COVID-19. Many variables reported by the NHHCSs to federal agencies capture simple data counts, such as the number of people who received a type of service or participated in a program. The statistics that these data create do not capture the deeper nuances of Native health, which creates a dilemma when Native health systems try to demonstrate effective use of funds or identify Native priorities.

Recommendations for transforming data to better understand and serve Native Hawaiians were reported in February 2021 in the report *Data Justice: About Us, By Us, For Us*,¹ a joint publication of POL and the Hawai'i Budget & Policy Center. These recommendations had large overlap with COVID-19 health equity recommendations in a March 2021 report, *COVID-19 in Hawai'i: Addressing Health Equity in Diverse Populations*.² Though focused on data needs and recommendations in a state context, the majority of the report recommendations apply to federal policies as well, including the need for regular consultation, meaningful standardization of data completeness and accuracy across agencies and public programs, evaluation, and more.

2. NHHCIA Legislative Changes

The first year of pandemic response served as a serious example of how current NHHCIA language prevents the NHHCSs from fully responding to community needs in a timely and meaningful way during crisis. Though the NHHCSs were generally able to pivot to telehealth and other innovations, which have now expanded to include vaccination efforts, the limitations posed by NHHCIA on matching funds during a crisis that resulted in lowered revenues for all health providers—both Native and non-Native—capped the ability of NHHCS leadership to provide proportionate servicing overall as well as the timeliness of response activities.

POL is grateful for the support of the Hawai'i Congressional delegation for the work to revise and reauthorize the NHHCIA so that Native Hawaiian health resources reach parity with other health facilities and providers. As pandemic response shifts into recovery, the need for all Native health systems to be able to act is paramount for the protection and health of Native communities.

3. Collective Impact and Partnership Successes

The successes of the NHHCSs and Native Hawaiian organizations were achieved through coalition-based efforts, often in solidarity with Pacific Islander organizations. POL was able to access and re-distribute federally-sourced resources like personal protective equipment, sanitation items, and more. The NHHCSs identified partners to assist in response efforts such as food and diaper distribution and more recently, vaccination distribution in Native Hawaiian communities. The connections strengthened or created during the first year of pandemic response and the results of collective efforts, despite their effectiveness and utility to improve Native Hawaiian health—and community health, as Native Hawaiians live among larger groups—remains underrated. It is our understanding that the CDC has recently identified some of the contact tracing efforts for Pacific Islanders as a pilot project worth further investigation; we believe that other work in the Native Hawaiian and Pacific Islander pandemic response also demonstrates successful, sustainable, and culturally appropriate practices that can be scaled and potentially applied to other health issues affecting Native Hawaiians.

Mahalo to all the members of this committee for the opportunity to share these stories.

The CHAIRMAN. Mahalo, Dr. Daniels.

Next, and final testifier, we have Dr. Robert Onders, Administrator, Alaska Native Medical Center.

¹Kauahikaua, L. and Pieper-Jordan, S. (2021). "Data Justice: About Us, By Us, For Us." Hawai'i Budget & Policy Center and Papa Ola Lōkahi. Available at <https://static1.squarespace.com/static/5ef66d594879125d04f91774/t/60514869451e1d09b75e4317/1615939719621/Data+Justice+Report+Interactive.pdf>

²Hawai'i State Department of Health (2021). "COVID-19 in Hawai'i: Addressing Health Equity in Diverse Populations." Disease Outbreak Control Division: Special Report. Available at <https://hawaiiicovid19.com/wp-content/uploads/2021/03/COVID-19-Race-Ethnicity-Equity-Report.pdf>

**STATEMENT OF ROBERT ONDERS, M.D., ADMINISTRATOR,
ALASKA NATIVE MEDICAL CENTER**

Dr. ONDERS. Thank you, Mr. Chair, and Vice Chair Murkowski. It is great to see you as well. Thank you for this opportunity to provide testimony to the Committee.

Alaska Native Tribal Health Consortium is a statewide tribal health organization that serves all 229 tribes and all Alaska Native and American Indian individuals in Alaska. Alaska Native Tribal Health Consortium and South Central Foundation co-manage Alaska Native Medical Center, the tertiary care hospital for all Alaska Native and American Indian people in the State. That is where I serve as administrator.

My testimony, as provided in the written comments, will focus on three areas: to give a brief overview of the response to the COVID-19 pandemic in Alaska through the tribal health system, lessons learned over the past year, and what we feel is needed going forward.

Our response had some key components that I think showed the strength of the tribal health system. I think this is common with other people who have provided comments here today. Communication and collaboration were key in this response. We were dealing with situations of scarce resources, limited information and needed coordination. The tribal health system is incredibly strong because of the established connections at the tribal leadership levels, like Chief Smith, at clinical directors and physician levels, at pharmacist levels, at community health aide levels. Across the entire system, we have those established communication channels.

And with our partners like Dr. Toedt and the Indian Health Service and Ms. Dotomain, the Alaska Area Director, those channels were essential in our response.

The other component that was essential and became obvious is, our system is mission-driven and public health minded. The people that I work with, the nursing staff here at the hospital, the physician staff, the support staff, our partners in Indian Health Service, the tribal leaders, everyone went beyond and above the call of duty to respond when needed. We were constantly standing up new operations and dealing with challenges throughout this.

Our response, I can categorize at least right now, in three areas. Early on, testing was key. Alaska was fortunate, being a little bit geographically isolated and western on our geography, to be able to learn from other areas. We quickly identified testing would be key. So we mobilized that across communities at many levels. In the local areas, they implemented it in an incredible fashion.

Rural Alaska communities are incredibly creative in finding solutions. I felt our need or our responsibility was to give them the tools they needed to respond. They did that with extensive testing to limit the spread. That limiting of spread allowed us to delay the onset in Alaska, allowed better therapies to be developed so that we could respond better when the surge came.

For Alaska, I think particularly for Alaska Native Medical Center, that surge came in November and December, when we were seeing high volumes of COVID patients. It was extremely challenging in the hospital setting. One hundred twenty of AMC's 170 rooms are double occupancy rooms. The waiting room in the emer-

gency room is about a 20 by 20 space, where we do 50,000 to 60,000 visits per year. The facility is extremely space challenged.

We knew that before COVID, but COVID highlighted that challenge. Having two patients in every room is extremely challenging with you are dealing with something like COVID, where people may not know of symptoms for five to seven days after admission. It required us to test everyone in the hospital every three days in order to try to prevent spread. And this is not the community standard of how a hospital facility should be built.

The key highlight in my mind in the response is the vaccination effort. I think a key component of this, as was mentioned by other speakers, was that need and recognition of Indian health services and tribes as a unique jurisdiction that allowed for local flexibility and a response with the administration of the vaccine that was extremely successful in Alaska.

As we look for lessons learned as well as future direction, I reflect on the H1N1 pandemic in 2008 and 2009. What we determined at that time with Alaska Native people and American Indian people, with a significant disproportionate burden in that time period, was a lot of the challenges were inadequate infrastructure. Inadequate water and sewer, inadequate housing, inadequate clinical access. What we are seeing with COVID is the same challenges.

So both the lessons learned and I think the takeaways for the Committee is, we need resources for adequate water and sewer infrastructure in rural Alaska. We need resources for adequate housing infrastructure in rural Alaska. We need resources for adequate access to health care, both at the tele-health component with broadband accessibility, but also just with infrastructure. I would hate to see another 10 years go by and we see the same reflection on why Alaska Native people had a disproportional burden of another pandemic because these issues are unaddressed.

So thank you again for the opportunity to provide testimony on the experience of the tribal health system in Alaska in responding to COVID, and those three critical areas that we need further investment in.

Thank you.

[The prepared statement of Dr. Onders follows:]

PREPARED STATEMENT OF ROBERT ONDERS, M.D., ADMINISTRATOR, ALASKA NATIVE MEDICAL CENTER

My name is Dr. Robert Onders. I serve as the administrator for the Alaska Native Medical Center (ANMC) in Anchorage, Alaska. It is my privilege to provide testimony on behalf of the Alaska Native Tribal Health Consortium (ANTHC).

ANTHC is a statewide tribal health organization that serves all 229 tribes and all Alaska Native and American Indian (AN/AIs) individuals in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AI people in the state.

My testimony will focus on three areas: (1) the Alaska Tribal Health System response to the COVID-19 pandemic; (2) lessons learned over the past year; and (3) what is needed going forward.

Tribal COVID-19 response and needs

Tribal health organizations across Alaska have long established relationships with each other, as well as with State and federal officials, so throughout this pandemic our response has been coordinated and cooperative with good communication channels. Discussions regarding how best to use scarce resources have been held as a

group to ensure the maximum benefit. We believe that it is the inclusion of, and cooperation with, the tribal health system that has allowed Alaska to be effective in combatting the pandemic.

The Alaska tribal health system has mission driven and public health minded governance, leadership, and staff. Over and over again, our people responded to the quickly changing, and often difficult, conditions. Our dedicated staff, along with State and federal support, allowed us to quickly stand-up testing sites, open up an Alternate Care Site to expand our hospital capacity, dedicate a wing of our hospital to COVID-19 patients, and open vaccination clinics.

Our response to the pandemic can generally be categorized into three phases—early identification, response to surges, and vaccinations.

For early identification and eradication, we knew that there would be great challenges if COVID-19 entered into rural communities, as the conditions in these communities—lack of access to higher level healthcare, inadequate sanitation, and overcrowded multigenerational housing—have not significantly improved since the 2008–2009 H1N1 pandemic. Although, thankfully, the effects of H1N1 were comparatively small, AN/AI people still experienced 4 times higher cases, hospitalizations, and mortality during that pandemic. So, we knew that testing and early identification would be key in our response to this far more serious pandemic. The support of our congressional delegation and the tribal-federal relationship were key in getting recognition of the need for an increased investment in testing in rural Alaska and gaining access to testing supplies early on. Timely testing was essential to address the geographic isolation of many of our communities, which are off the road system and only have limited access by plane or boat.

The October–November–December surge of cases in Anchorage eventually spilled over into rural Alaska, despite the extensive mitigation measures put in place in those communities. The surge also highlighted the inadequate capacity of ANMC. ANMC was already overcrowded with adult inpatient occupancy rates running over 90 percent before COVID-19. COVID-19 overwhelmed our inpatient capacity, requiring conversion of patient housing to an Alternate Care Site. Adding additional inpatient space was complicated because 120 of ANMC's 170 inpatient rooms are double occupancy rooms.

Such a high level of inpatient utilization is almost unheard of in today's healthcare market and increases the difficulty in preventing the spread of infectious disease. In response, we tested every inpatient every 3 days. It has also made it very challenging to allow family and other caregivers into rooms, as we would now have two households in a single room. Other, non-tribal, neonatal intensive care units in Anchorage have private rooms where mothers can stay with their child. At ANMC, the babies are grouped together and mothers cannot stay continuously at the hospital. This situation presents an incredible challenge with COVID-19, and is a travesty for a facility that delivers more AN/AI babies than any other hospital in the country.

The recognition of Indian Health Service (IHS) and tribes as a separate jurisdiction from states, along with the separate IHS vaccine allocation, was critical in ramping up vaccinations in tribal communities throughout Alaska. Tribal health has been a model for getting the vaccine mobilized quickly. We have a comprehensive system that has inpatient, outpatient, and primary care services in a single system, which allows for subject matter experts and resources to be allocated to the vaccination process in a manner not available to most systems. Our Cerner Electronic Health Record already was interfaced with the State of Alaska VacTrack system for other immunizations so the documentation and ordering processes were already familiar to everyone.

One year later: key takeaways

Inadequate Water and Sewer infrastructure

The silent crisis in rural Alaska communities is still present. Sanitation service in many Alaska Native communities has long been lacking, but the pandemic has highlighted how essential adequate sanitation is for our communities.

The importance of adequate sanitation to prevent skin and respiratory infections is very clear. CDC studies have documented that skin and respiratory infections, in rural Alaska communities without sanitation service to homes, are 5 to 11 times higher than the national average. Adequate water and sewer services are especially critical now, since COVID-19 is a respiratory disease whose spread can be prevented by hand washing and avoiding close contact with others. Lack of water service in these rural Alaska villages creates extreme challenges in practicing two of the most basic prevention techniques.

Of the 190 Alaska Native communities, 32 are still unserved, lacking in-home water and sewer. These communities typically have a washeteria building (combina-

tion water treatment plant, laundromat, toilets and showers) that the entire community uses. Most of these communities haul their water from the washeteria to their home in a 5-gallon bucket, and haul their sewage from their home in a different 5-gallon bucket.

The latest IHS Sanitation Deficiency System data show a need of nearly \$3 billion for sanitation construction projects in Indian Country, with \$1.8 billion of that need in Alaska. Sanitation facilities construction funding needs to be greatly increased this year and in future years to address the inadequate sanitation services in AN/ AI communities.

Inadequate housing infrastructure

Inadequate housing presents an additional challenge to protecting rural and isolated communities during the pandemic, where the prevalence of multi-family and multi-generational housing makes social distancing very difficult. The latest assessment by Alaska Housing Finance Corporation shows that Alaska has twice the national average of overcrowded homes, with rates as high as 12 times the national average in some rural, predominantly Alaska Native communities. Western regions of the state are extremely overcrowded, with the Bering Straits region experiencing 37 percent overcrowding and severe overcrowding, compared to the national average of just 3 percent overcrowding.

Overcrowded housing is most prevalent in communities that are already under the greatest threat from COVID-19, because they have fewer transportation options available to seek higher-level medical care and less access to adequate sanitation services.

What is needed to combat pandemics going forward

On many levels the tribal health response to the pandemic has been excellent, but in Alaska, Alaska Natives still experienced a mortality rate that is 4 times that of the white population. Many factors contribute to reducing the impact of COVID-19, and it can often be difficult to discern the most effective measures, but in many Alaska Native communities the infrastructure is lacking to provide the foundational measures in preventing a pandemic, particularly adequate sanitation and housing.

This pandemic highlighted the need to bring the Alaska Native Medical Center up to the industry for standard facility space requirements for patient safety. We need to transition away from shared patient rooms, high occupancy rates which limit surge capacity, and limiting spaces where outpatient and inpatient services are combined into single locations. The Alaska Native Medical Center was opened in 1997 and was in desperate need for expansion prior to the COVID-19 pandemic. The pandemic further exposed the vulnerabilities created by not addressing this need. We need funding to expand inpatient capacity for facilities such as ANMC that serve entire states/regions.

Tribal communities that are unserved, or underserved, with sanitation services must be provided with the facilities to provide these services. Funding is key toward addressing the \$3 billion in sanitation facilities need estimated by IHS, but the 32 unserved communities in Alaska will not be served unless federal and state agencies make a commitment to be more flexible in addressing the unique situations of these communities.

The lack of housing and resultant extreme overcrowding we see in rural Alaska, has significant negative impacts on containing COVID-19, and other infectious diseases.

As previously stated, the vaccine allocation through IHS to tribal health programs has literally been a life saver. We were rapidly able to vaccinate many of our Alaska Native people and communities. Alaska now has 43.5 percent of the over age 16 population vaccinated, and over 40 percent of those vaccinations were administered through the tribal health system. It is essential that the IHS vaccine allocation continue, and that it be rapidly utilized if the need for booster shots that address new variants arises.

Thank you for the opportunity to provide testimony on the experience of the tribal health system in responding to COVID-19 and what is needed to better equip us as we continue to battle this pandemic.

The CHAIRMAN. Thank you very much to all of our testifiers.

I will begin with Dr. Toedt. Dr. Toedt, can you explain why HHS applies the Federal trust responsibility to Native Hawaiians and health care systems differently? Let me provide you a couple of glaring example of unequal treatment.

Congress provided \$9 billion to support Native health systems, tribal, urban Indian, Native Hawaiian, during COVID. All funding dedicated for tribal and urban Indian allocation through IHS has gone out without requiring a funding match. But HRSA prepares to allocate the first dedicated funding for Native Hawaiian health care centers, as it does that, it appears that the agency is considering requiring a funding match or a formal request for a waiver.

Second, on the Federal Tort Claims Act coverage, the Federal Government extends FTCA coverage to all three branches of IHS in recognition of its trust responsibility. Last Congress, HHS and HRSA opposed my legislation to provide parity for Native Hawaiian health care centers.

So what is going on here, and how are we going to fix it?

Dr. TOEDT. Thank you, Senator Schatz. You are exactly right. Under current law, the Native Hawaiian health system is not a part of the Indian Health Service, Indian health system. HRSA, Health Resources and Services Administration, administers the Federal program for Native Hawaiian health centers pursuant to the Native Hawaiian Health Care Act and other agencies within DHHS also serve Native Hawaiians. We are committed to working with the Senate and would be happy to make sure that we can do all we can to improve access to all indigenous persons.

Senator SCHATZ. Thank you. I just want to be clear. We are all familiar with the statutory architecture here. Some of it is a dispositional question. The question is, are you going to try to get to equal treatment? And your position, as I understand it, under the law, is to be a liaison, an ambassador on behalf of Native peoples to other agencies.

So do we have your commitment to work through these issues with Papa Ola Lōkahi, with myself, with the Committee?

Dr. TOEDT. Absolutely, yes, sir. You have our commitment.

The CHAIRMAN. Thank you very much.

Dr. Daniels, reportedly only 15 percent of Native Hawaiian and Pacific Islanders have received at least one vaccine dose, despite the fact that they account for 40 percent of the State's COVID cases. I guess the question that I want to ask is about disaggregation of data. Because as we see the case counts coming in, there is a fair amount of good disaggregation of data among Asian Americans, Pacific Islanders, and Native Hawaiians.

This sort of basket of different communities is sort of not informative for how we are going to address whether or not this is vaccine hesitancy, whether this is a question of not being able to get online, whether this is geographic or transportation issues. It is just hard when we can't disaggregate the data.

So could you give us some guidance on how we can move in the direction of a kind of common platform for the disaggregation of health data, so that we can make use of this? These categories are so broad as to be not particularly actionable.

Dr. DANIELS. Thank you, Chair.

I think it goes back to OMB 15, and how they designate how data is collected. Currently, Native Hawaiians are combined with Pacific Islanders. At minimum, OMB 15 asks the States to collect the data. We know in the State of Hawaii, our Governor has an-

nounced or stated that the date piece is kind of behind in what we know has been done in terms of vaccination rollouts.

But also, when we are combined with another group, there has to be that second layer of further disaggregating the data, so that we can see where NHs truly stand in comparison to, for example, Pacific Islander or in some cases and in some States, also with the Asian Americans. Many States didn't even separate NHPs throughout this pandemic. So the fact that Hawaii did and then further disaggregated it during the positive cases, they haven't been able to do that for the vaccination rollout.

The other thing to note is we did not have options. Our Native Hawaiian health care systems were not identified as being able to receive vaccines directly, like community health centers were. We are now starting to partner, we are partnering with the Department of Health and other partners that get the vaccine to be able to push it out into our communities. So right there, there is already a system barrier to allowing the Native Hawaiian health care systems that access.

We also know that when States created their own tier systems, even though Native Hawaiians were identified as a priority population in the National Academy of Medicine's vaccination prioritization, that did not roll out in the State's plan and tiering. We were not included in that. We were at the table, but we were not listened to in adding into the tiers.

When we talk about life expectancy, we know Native Hawaiians have a life expectancy of 76 years, 73.9 for men. What that means is when they are vaccinating 75 and older, you are not capturing our community.

So it is all those different factors that create the not-perfect storm for us.

The CHAIRMAN. Thank you very much, Dr. Daniels. I have just observed that the problems that she is describing I am sure exist in Alaska and across Indian Country. We are, it seems to me, moving from a period of vaccine shortages to perhaps a challenge with demand and with deployment. Trust is going to be one of the key elements in deploying the vaccine. Obviously, the people who have gotten vaccinated were the people most anxious to get vaccinated, or the most able to get vaccinated, either because of their ability to move themselves around their community or their ability to sign up in an online forum as soon as it became available.

But the next tranche is going to be harder. We are going to need community partners to help us to get to herd immunity.

Vice Chair Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Just to follow on your point there, I am reading from an article that came out outlining the Native health providers vaccination success story. One of the statements that is made here is that the cultural value of sharing and taking care of one another is one that I think is so shared by our Native populations. The journalist goes on to share the real tragedies that still remain from 1918, where children who lost their parents in the pandemic, boys and girls who grew up not knowing what their last name was because everyone in the family had died and not being able to have that.

So making sure that we have learned from that, making sure that culturally we are taking care of one another and working to address the concerns that you have raised about hesitancy.

I do think it was helpful to hear from so many who provided testimony today of the partnering that has been going on with vaccines. In the State of Alaska, I know very early on through the IHS system, as Dr. Onders has outlined, we were able to establish a sharing, a partnering with the Department of Defense to get testing to those within the DOD.

I want to direct a question to you, Dr. Onders, and I really appreciate what you have outlined in terms of the lessons learned, the focus on inadequate infrastructure, specifically water, sewer, housing, tele-health, broadband, so that as we move forward this is not just a lesson in history but we have learned from it and built better health care infrastructure.

There was a recent announcement from IHS that there is an allocation, the allocation of \$95 million for tele-health needs from the CARES Act. I guess the question I am going to ask of you is how is ANMC best leveraging the dollars to expand tele-health around the State. There are some services that are not currently being provided that you would seek to build out with this.

How do we take advantage of not only these funds that are coming from CARES, but the future dollars that will be coming from the American Rescue Plan, to help address the infrastructure inadequacy that you have pointed out so well?

Dr. ONDERS. Thank you for the question. We have not yet received a portion of the \$95 million for tele-health dedicated from IHS, but we are working extensively in this area in anticipation of that funding as well as other funding in that area.

As you are well aware, the tribal health system has been a leader in providing tele-health services, just because of the geography and the remoteness and the need for travel in order to see that. But what we saw in COVID, there is great opportunity for extending [background noise] —

Senator MURKOWSKI. You have a day job, too, we appreciate that.

Dr. ONDERS. I do think there is a great opportunity to expand access to tele-health. Particularly what we saw is in-home services have been extremely receptive to individual patients. So what we have done is developed increasing kind of standard procedures related to in-home tele-health as well as training that is required in order to facilitate those visits going smoothly.

The key piece that I think is missing though is that broadband availability. I can speak personally because I spend a fair bit of time in Nome as well. To get equivalent service in Nome that I have in Anchorage for \$80 per month is over \$400 per month. So even though broadband may be “available” in certain areas, it is not affordable for most people. As well as the 40 percent of Alaska villages rely on 2G connectivity.

So the ability to potentially deliver home services I think requires that infrastructure investment in broadband as well.

Senator MURKOWSKI. We certainly have much more that we need to do there.

Mr. Chairman, I have a question that I would like to direct to both Mr. Onders and to Rear Admiral Toedt, and that relates to

what may be under consideration as we are looking at these variants that we are seeing, greater prevalence, not only in my State but around the Country. Just very quickly, if you can let the Committee know what if anything our Native health care system is doing to prepare, either for another potential wave of infections or variants that we might not be seeing much activity yet.

Dr. ONDERS. Thank you, Senator Murkowski, I might start. I think vaccination is still key in the response to the variants. From what we know, though, the effectiveness of the vaccine in doing the major component of preventing hospitalization and mortality in many of the variants is still controlled by vaccination. As the Chairman mentioned, I think in Alaska we are particularly interested in kind of the harder to reach individuals that really require a trusting relationship in order to receive the vaccine, and/or get to the access to do that.

So within the tribal health system in Alaska for vaccine, we are implementing in-hospital vaccination, so ensuring that anyone who comes into our hospital who has not received a vaccine, we have that discussion and we offer them the vaccine while they are here for other reasons. Because they may not have the capacity or may not be able to schedule independently for that visit. As well as the harder to reach populations that may require that trusting relationship, and discussion with the provider, in order to take up the vaccine.

So from my standpoint, the biggest thing we need to do to combat the variants is increase vaccination. Although rural Alaska has done an incredible job, here in Anchorage, a hub community, the vaccination rate still is lower than we would like. That creates a risk for rural Alaska.

Senator MURKOWSKI. Mr. Chair, I am well over my time. But I had also asked Rear Admiral Toedt if he had a response on variants.

Dr. TOEDT. Yes, just briefly. I want to concur with Dr. Onders. But I want to add to that that it is also important that we consider vaccination part of the continuum of our preventive efforts, and that we continue with mask wearing, with social distancing, with hand washing. These things continue to be important. And that we don't neglect testing. It is so important to continue testing not only to determine what types of variants are circulating, but also to make sure that we keep control of surveillance and understand where the virus is spreading.

So I will add to that, and agree with Dr. Onders.

Senator MURKOWSKI. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Senator Smith.

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

Senator SMITH. Thank you very much, Mr. Chair, and Vice Chair Murkowski. I appreciate this hearing very much.

I want to just first say that I would like to associate myself with the concerns raised by Chair Schatz regarding the importance of parity and equity for Native Hawaiians on liability coverage. I just want you to know that I look forward to working with Senator

Schatz and all of you to extend these same benefits to Native Hawaiians.

I would like to start with a question for Mr. Murillo about urban indigenous communities. Then if I have time, I want to ask a question about data and sharing data to Mr. Smith. Let me just then start with you, Mr. Murillo.

In Minnesota, our tribes are doing an exceptional job, like in many places in the Country, to vaccinate their members on tribal lands and also reaching out to urban indigenous communities. I had the opportunity not so long ago to be with Chair Cathy Chavers with the Bois Forte Band to see their new mobile vaccine clinic in the Twin Cities. Using resources from the CARES Act they were able to purchase an ambulance and repurpose this for a mobile vaccination unit. This has been great.

But of course, not everybody has the capacity to reach their members in this way. We know that we need to make sure that Congress is providing sufficient health care resources directly to urban indigenous communities, so that they have access to the care that they need.

So Mr. Murillo, could you tell me whether you think that we are doing enough? What in particular do you think we need to do more of and better to support the health care needs of urban indigenous communities, certainly during COVID but also longer term?

Mr. MURILLO. Thank you, Senator Smith, for that question. I think that in terms of the COVID response, carving out dedicated funds for Urban Indian health programs has been very helpful. I think where there have been issues with that is the lack of flexibility on the use of those funds. Sometimes that is as a result of the appropriation act itself, but sometimes it is existing regulation that prevents us from doing certain things.

For example, facilities. Facilities, the requirement in legislation, in the law, requires that we seek JCAHO accreditation even though many of us are accredited by other bodies, CARF, or AAAHC. We are unable to use those funds for facilities, even existing funds that we have in our regular line item. That is a flaw, I think, in legislation, in the law, that could be easily changed.

I think also extension of FTCA has been very helpful to us in terms of reaching outside of our facilities and the ability to provide vaccines out into the community. Also, I believe FMAP will also help with that. We have seen in many States, like in Arizona, where the emergency waiver for providing 100 percent FMAP for the administration of vaccine has been very helpful in terms of reaching out to parts of our communities.

So in other cases, with the lack of flexibility, it was very unclear early on as to whether or not we could use these funds for mobile units, funds that had to be directed through the CDC, for example. It was unclear whether we could use that for mobile units. But in subsequent funds under the ARPA, the flexibilities have greatly expanded. We are thankful for that.

Senator SMITH. Thank you. That is great. I think those are some great suggestions that I hope we can all think about as we look at how to make sure that we have enough flexibility so that you can do the work that you need to do.

I have about a minute left. Let me ask this question specifically about data. One of the most important functions tribal governments have had over the past year has been your role as public health authorities. In order to do this work, of course, you need to have access to data.

We learned last summer through news outlets that several Federal and State health care agencies were refusing to give tribal governments access to data about COVID-19 cases near tribal lands. They were giving this data, CDC was giving this data to States, but not always to tribes, even though it seems the law is quite clear on this matter.

So we went to work on this. I am grateful for the chance to work with Senator Murkowski and many others on this Committee to introduce the Tribal Health Data Improvement Act, which would clarify that the CDC has a responsibility to share data and encourage that data sharing. We are going to be reintroducing that bill soon. It did not pass last year.

In just a few seconds, Mr. Smith, would you just tell me a little bit about how you see this issue, and what you think we need to do to strengthen this data sharing?

Mr. SMITH. Thank you for that. We have asked for direct access to data through the Indian Health Service and CDC within Alaska. Among the tribes where data is in fact 85 percent of the programs operated on the sharing data system, this system is [indiscernible] misstated by the ANTHC. Regarding the vaccines, we do not partner with the State of Alaska, or the VaxAct [phonetically] system.

Senator SMITH. Okay. I think we are going to continue to work on this. I appreciate that very much. Thank you, Madam Chair.

Senator MURKOWSKI. [Presiding] Thank you, Senator Smith. Senator Lankford is next.

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

Senator LANKFORD. Thank you very much for that.

Let me first say thank you to the Committee staff and your leadership and the folks at IHS. We passed last year the Urban Indian Health Providers Act, I know that is something several members worked together on to be able to get done. We got that done, got that passed, and on March 22nd, IHS notified all the Urban Indian facilities that they are officially covered with the tort claims as well. We appreciate the rapid engagement on that and the information that has gone out, and the hard work of some of the Committee staff and of IHS to be able to get that done. We appreciate that very much.

I do want to do a follow-up question for Walter on that in particular, to be able to find out how that is working and how the implementation is going for that tort claims coverage now.

Mr. MURILLO. Thank you, Senator Lankford. I know that FTCA coverage is a final lynchpin in helping to achieve parity for the two Oklahoma Urban Indian health programs. We are happy that they have it.

We are also happy, this is a good example to show of the necessity for IHS to confer with Urban Indian health programs, something that doesn't exist with other operatives within HHS, and the

benefit it has, so that we can have open communications and the rapid nature of its deployment with Urban Indian health programs has been a plus. So we see that that can work, and it does work, especially with FTCA.

Now, we are awaiting some FAQs and other implementation aspects of tort claims coverage. But we are very happy with the response, and the rapid nature of it that the Indian Health Service has done in informing and having that applied to Urban Indian health programs. We would like to see that replicated in the other operating divisions within HHS, and HHS's help in terms of a confer policy for Urban Indian health programs.

Senator LANKFORD. Thanks, Walter. You are welcome to come back to Oklahoma any time, the door is always open to be able to come back home on that.

I do want to do a follow-up question. Senator Smith had asked you specifically about some of the facilities funding, from some of the COVID emergency dollars that came. You said there were some issues and some things that needed to be clarified in legislation or appropriations language to be able to help fix some of that. Do you have a specific recommendation on that?

Mr. MURILLO. Sure. I think changing the accreditation, which is an admirable goal, and a goal that we all have that run clinics, but to specifically align that with JHACO. It hurts facilities like Native Health in Phoenix that are accredited through the AAAHC. We are an accredited agency, but we can't use our funds for facilities.

I think that is a problem born in the law that can be easily changed. I think that will apply not just to the pandemic but also other times. It hurts us in that urban programs also include the inpatient alcohol and substance abuse programs. Their capacity is diminished by as much as 80 or 90 percent without the ability to make adjustments to their facilities. Those programs just could not see those and provide those much-needed services in Indian Country.

Senator LANKFORD. Thank you. That is helpful to be able to get on the record as well.

Mike, I want to ask you a little bit about the administration of the vaccine and the distribution of the vaccine as it has gone to tribes all over the Country. In Oklahoma, in particular, in the distribution that has happened to Native locations across my State, they have been extremely efficient in getting the vaccine out, not only just receiving the vaccine, but actually getting it into arms.

We have, just as a point of reference, tribes in Oklahoma have vaccinated more people than Washington, D.C. has vaccinated people. There have been a lot of folk who have been vaccinated through the tribes in Oklahoma and they have done a very good job being able to get that vaccine out. Once they have received it, it is not sitting in storage. It is getting into arms very, very rapidly on that.

The process for distributing the vaccines to different tribes, how is that allocation working right now? Where are you seeing strengths and weaknesses? What can we do to continue to improve that in the weeks ahead?

Dr. TOEDT. Thank you, Senator Lankford, for the question. I want to concur with you that the tribes, through their sovereignty,

have been doing a fantastic job. I think that one of the things that has been most successful in the Indian Health Service jurisdiction is the respecting of tribal sovereignty and allowing tribes to do what they do best.

So what we want to do is, we have moved from a push system where we are designating how much each area gets, and then each area is working with tribes to designate how much they get, to actually turn things around and have a pull system, whereby the sites that are working under our jurisdiction are pulling that vaccine forward. So they are able to order how much they need.

We certainly give advice to keep an inventory of at least a one to two week supply. We have hosted some webinar trainings with the vaccine points of contact in the area to demonstrate this changeover to a pull system. To date, we have been able to fulfill all of the requests from the facilities after switching to this system.

So we think that respecting that tribal sovereignty and giving them the ability to make those operational decisions about how much vaccine they need is going to improve things going forward.

Senator LANKFORD. Thank you all.

Senator MURKOWSKI. Thank you, Senator Lankford.

Senator Cantwell.

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

Senator CANTWELL. Thank you, Madam Chair. I want to thank the witnesses, particularly Mr. Murillo. You might have heard me clapping when you said that you wanted to see full 100 percent FMAP funding. You also just in your answers to previous questions talked about this enabled you the one-time fix for this, that we were able to get in a previous CARES package, to provide more vaccines.

But I wondered if you or Dr. Daniels, to me this issue is just an inequity. It is something that has occurred, but I don't understand the logic. If we are giving 100 percent FMAP funding to Indian Health Care systems, to a hospital, why aren't you giving 100 percent FMAP funding to Urban Indian health? It is a formula that if we are doing this based on the delivery of health care, it should be the same, whether you are urban or rural. It also affects, obviously, Native Alaskans as well.

So I don't know if Dr. Daniels or Mr. Murillo, if you want to comment on that. I think we are going to have another shot at a discussion here, at least in the President's proposal, to increase and support the health care delivery system. I certainly would want to get this corrected and made permanent once and for all.

So if either of you could comment on that.

Mr. MURILLO. Thank you, Senator, for that question.

Yes, the 100 percent FMAP would help equalize the serious funding shortage we have in Urban Indian health programs, access to enhanced rates, or even initiatives done by certain States, whether it is Minnesota, South Dakota, Washington State, or even in Arizona. Certain initiatives that the tribes and IHS facilities are a part of, because of 100 FMAP through the state Medicaid programs, are denied to Indians living in urban areas?

Senator CANTWELL. Why, Mr. Murillo? There is no reason why. Somebody can give me a technical answer that, oh, because they weren't included in the Social Security Act language. But there is no reason to distinguish between giving health care to a tribal member in an urban hospital or a rural hospital or facility.

Mr. MURILLO. Thank you, Senator, I absolutely agree. When folks move to the urban areas, they don't leave their disease and their health conditions behind. Those need to be treated just the same whether they be on a reservation or an IHS facility.

Senator CANTWELL. Dr. Daniels, do you have anything to add to that?

Dr. DANIELS. Yes, thank you, Senator.

I think for Native Hawaiians there are a couple of pieces. It is not just FMAP, which we are very appreciative of, but it is also the tort. We don't have that. So when we look at our colleagues, both in tribal and urban, we are like way down the rung. When we look at language in our Act currently, we actually have to cost-share 20 percent of our dollars.

So not only do our systems have to deliver services, but they also have to find matching dollars to deliver those services to our community. That is already an added, another added challenge and layer of issue.

So when we are talking about tort and FMAP, we are also looking at 20 percent matching. We are looking at all of those things. I wish I had the answer on the technical. But it is not there.

So the fact that we are even at this sharing space today is a step forward. This is huge. So however we can provide information to the Committee to help move things forward and create parity with our partners, with our colleagues, urban and tribal, we definitely want to do that.

Senator CANTWELL. I think we have to raise our voices. I think we have to tell people that this is what exists. I don't think people even understand what it is about. It is complex and it sounds—but it is not complex. The United States Government has decided that it is going to fully fund the health care of Native Americans on a 100 percent match because of tribal sovereignty. So that is it, end of story.

So it doesn't matter whether you are in a rural hospital or you are in an urban setting. You deliver the full funding. The only thing that might be a glitch is that somebody likes to fall back on this Social Security Act and only one was mentioned. But that is a technical issue. That is not the substance.

Anyway, I think Urban Indian health is suffering. We do our best in Seattle, we do our best all over the United States. But it is suffering. They deserve the same equity as a tribal member, as Mr. Murillo was saying, they have the same health care challenges, they have the same issues. There is no reason not to give them parity.

So we will be working on this, and I appreciate everybody's attention to try and help correct this once and for all. Thank you.

Senator MURKOWSKI. Thank you, Senator Cantwell.

Senator HOEVEN. If Senator Hoeven is not ready, is not on the line, we will go to Senator Cortez Masto.

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

Senator CORTEZ MASTO. Thank you. First of all, let me just say I am so grateful to each of you and your organizations for the unbelievable time and effort that you have put toward helping Native communities fight this pandemic. It has been a long year, and I appreciate your tireless commitment to serving the needs of Indian Country.

Rear Admiral Toedt, let me start with you. One of the things that I have heard from tribal communities over the course of the pandemic was that the amount of information coming from the Federal Government was difficult to process and act upon. It was hard to keep up with the volume of calls and recommendations, and for smaller tribes, much of that work falls to just a handful of people.

So as we begin to distribute the resources and guidance that Congress made available under the American Rescue Plan, I do want to emphasize that the use of robust, centralized technical assistance and feedback loops is essential. I have heard from Nevada's tribal communities that something as simple as a central calendar for consultation meetings would be helpful to avoid agencies scheduling multiple calls for the same window, and ensure that this information is easily accessible.

Admiral Toedt, can you speak to some of the lessons learned from this pandemic and how to improve communications between tribal nations and Federal agencies?

Dr. TOEDT. Yes, thank you so much, Senator Cortez Masto. You hit the nail on the head, and actually, if you were to not have led me to communications, I would have gone there anyway. Communications is so important and is one of the biggest lessons learned.

I will say that as you pointed out, having the opportunity for discussion, having robust consultation and urban confer, making sure that we do that with every major funding or major decisions that are undertaken by the agency. But really across government, we have heard from tribes that they value the consultation and confer process.

But then as you pointed out, also having opportunities for conversations including when we get down to the technical assistance level and having that feedback. We did implement an incident command system at headquarters, and we established a regular tempo of weekly or biweekly calls, depending on the tempo of the activity that was going on. We found that to be very helpful. I would consider that a best practice.

Your points about centralizing communication and avoiding confusion such as calendars, including all of this type of information, is one that we will include in our lessons learned. I appreciate your bringing that up.

Senator CORTEZ MASTO. Thank you. Do any other panel members have any ideas or thoughts on better communications strategies or tools? Just curious.

All right. If not, let me move on to mental health. This is an area that I have been concerned about as we emerge from the public health emergency. It is one I have mentioned before in this Committee. That is the impact that this pandemic has had on the men-

tal health and well-being of our Native families. I have seen it in my communities. People are struggling with everything from loneliness and isolation to substance abuse to the anxiety that comes with economic hardship.

Now, the American Rescue Plan is a critical first step to getting families back on their feet. It was important that we put funding in there to address the mental health and well-being.

Dr. Daniels, let me start with you. Can you describe some of the issues brought on by the stress of the pandemic, particularly around behavioral health and wellness? What are tools and resources that might help our Native communities to address these issues?

Dr. DANIELS. Thank you, Senator, for the question. What we are seeing in all Native communities are similar, the stress around housing, economics, employment, education. It doesn't necessarily only focus on health, it is all of these other silos that unfortunately, for our communities, all weave together. So there is that.

I believe that for a lot of our communities, we saw this, not just now, we saw this six months ago, eight months ago. So when we are asking for resources and support, it is on top of how do we provide PPE to communities, how do we make sure they have food and the basic necessities, how do they have access for all these things as well as dealing with a lot of the chronic conditions that our communities were already facing before COVID.

So the ARPA monies, I think, can be used to help infuse that. But then I think the question becomes, how do we move forward. We are still kind of in this space of the COVID. We haven't even lifted our heads up to start to plan ahead. I think that is going to be the real test, is how do we start planting seeds now so that we can start dealing with the mental health wave, not just the COVID wave, the mental health wave that is moving forward.

So how do we start messaging to our communities about seeking support? I know for a lot of our communities it is easier said than done. It is easier to say, okay, go and contact somebody you know to talk to, or seek these services. But for a lot of our communities, particularly for Native Hawaiians, the need to connect, the need to look somebody in the eye to help them navigate through this, is going to be very critical, which in many cases has been very counter to what we have been told.

So not only do we have to navigate with our communities, but we are also navigating the system and what the guidelines are in engaging our communities.

So, yes, tele-health is an amazing opportunity. But how do we help our communities understand how to use it? We are relying on the younger generation to help the older generation. But again, we have to have a point of contact, at least for our communities. We need to have that connection. That is part of the trust, the trust of provider and community, provider and person. I think we have all said that.

So I think mental health is a growing tsunami waiting to happen. I think we all look at each other and other Native communities and what is happening there. I know for us, we do look at what is happening, or what is being put by the Indian Health Board. We are looking at South Central. We are looking at what

our other colleagues or other Native communities are doing, and we try to apply that.

Senator CORTEZ MASTO. Thank you. I know my time is up, but I do want, I cannot stress enough, yes, we need to address everything that you have talked about. I do want to make sure we are hearing from you on what resources and tools and what we can do here in Congress to support your behavioral health needs in our Native community. Not even before this pandemic, but during the pandemic, which has, really what I have seen, magnified some of those issues. We are going to have to deal with them as we come out, open our doors again and really kind of fight to beat this pandemic.

Thank you again, thank you all for being here.

The CHAIRMAN. [Presiding] Thank you.

Is Senator Hoeven available for questions? If not, Senator Luján.

**STATEMENT OF HON. BEN RAY LUJÁN,
U.S. SENATOR FROM NEW MEXICO**

Senator LUJÁN. Thank you, Chair Schatz, and Vice Chair Murkowski, for holding this hearing on the Response of Native Health Systems to the COVID-19 pandemic. Thank you to each and every one of our witnesses for joining today.

Dr. Toedt, the Indian Health Service has played an instrumental role in the Federal response to the COVID-19 pandemic. Just last month, you announced IHS had reached its goal of administering over 1 million vaccines to IHS beneficiaries. That was ahead of schedule. I am proud to note that the Navajo Area and Albuquerque Area IHS regions have distributed over 315,000 vaccines as of last week, and administered 280,000 doses, nearly one-third of the total administered across all IHS sites.

This is truly remarkable and a testament to your hard work and partnership with tribes, Federal agencies and Congress. As an example, I would like to highlight your quick response to an issue my office raised regarding the Institute of American Indian Arts, a tribal college in my State. IAIA was not included in the population estimates the IHS and States submitted to CDC in their pre-planning. As a result, it was uncertain how the school would procure vaccines for students and staff before returning to in-person learning.

I am glad to report that now IAIA is among those tribal colleges and universities that have been able to vaccinate on campus, students and staff, thanks to the coordination of IHS with our office.

Dr. Toedt, what is your new goal this month for fully vaccinated administration rates?

Dr. TOEDT. Thank you so much, Senator Luján. We did set a new goal for April. Rather than focusing on just number of shots, we are focusing now on the percent of the adult population that is fully vaccinated. So our new goal is to have fully vaccinated 44 percent as a minimum for our active adult patients.

You have heard some communities are already higher than that. But we have some communities that are not that high. So that is one of our areas of focus there, is to bring everyone up, to have all ships rise and make sure that as an agency that we have fully vaccinated 44 percent of our adult patients.

Senator LUJÁN. I also want to say I applaud and appreciate the work you are doing to ensure that there is more acceptance and support on college campuses as well. Thank you for that.

Dr. Toedt, I appreciate that IHS is providing weekly updates to the public and Congressional offices on its testing and vaccine rates broken down by area office. However, I am concerned that IHS does not have the same data available on at tribe by tribe basis. You stated in your testimony that COVID-19 related data reporting from tribes and Urban Indian organizations is voluntary.

Does IHS currently provide vaccination data disaggregated by tribe?

Dr. TOEDT. Thank you for that question also. So the vaccine data is not available by tribe or tribal affiliation. We do have the vaccine distributed to our IHS, tribal or Urban Indian facilities. However, the vast majority of those serve more than one tribal population. So they serve individuals who come from various tribes or nations.

So we do have the ability to share that information with the individual service units and the areas. But we don't have the ability to break it down by tribe or tribal affiliation.

Senator LUJÁN. I would like, Mr. Chair, for us to work together to find out why, and what is needed to do that. The reason is, many States, including my own, have had difficulty reporting state-wide vaccine rates without specific State data vaccination data.

Does IHS report State specific vaccination data to every State immunization registry?

Dr. TOEDT. Thank you for that question as well. Per the CDC COVID-19 program agreements, IHS reports the administration data to the CDC according to that jurisdictional guidance. Our jurisdictions can do that through two different pathways. That can be through the electronic health record, which is then aggregated in IHS and sent to CDC, or alternatively through the BAMS system.

However, there is not a requirement to report it to the ITU's respective State immunization registry. Some of our facilities, ITUs, included already have automated processes in place for routine immunizations to transmit to the State immunization registry. So where we can do that, we do that. However, in this case, COVID-19 vaccine administration data would be reflected in the immunization State registry, but it is not universal.

Senator LUJÁN. Mr. Chair, this is another area I hope we can have some success to identify the challenges that IHS faces to provide more granular vaccine data to States. On the immunization side, it is my understanding many States have the data but are not able to do more finite analysis, because it is not disaggregated.

As my time expires, I hope, Mr. Chair, to be able to explore what IHS is doing with the total cost of their IHS data base on water projects and how IHS also has the responsibility to share with us how many households do not have access to running water, and do not have access to electricity. That way we can ensure that we are getting 100 percent connectivity when it comes to electricity, running water, wastewater, and broadband.

I will submit those into the record, Mr. Chair, so that way I don't take more time today. I thank our witnesses and look forward to

working with all of you to make a positive difference here. Thank you for your time today. I yield back.

The CHAIRMAN. Thank you very much.

I just have one final question for Dr. Toedt. Dr. Toedt, this time last year, IHS was not sure how many ventilators or hospital beds it had. IHS's strategic medical supply stockpile consisted of a few million possibly expired N95 masks. IHS's electronic health record systems couldn't actually track real time COVID activity within its user population.

So I would like you to walk us through how IHS has adjusted the way it prepares for public health emergencies since the COVID-19 pandemic began. For instance, improvements to health record systems, interagency coordination, and PPE availability and access. I want you to talk us through how you think we will be better prepared the next time.

Dr. TOEDT. Thank you, sir. That is a broad question, and I appreciate it. Let me see if I can break this down.

Certainly in terms of our institutional capacity and system changes, we recognize that there are some areas where we were very successful. But there were things that we had to do during the pandemic that certainly for the next round we will take as lessons learned to have them well in advance of the next pandemic.

Chief among those are Federal partnerships. During the pandemic we had instances where we couldn't provide the necessary goods either because we couldn't procure them, because they weren't available, or through ordinary sources of supply, or there were medical surges where access to care, life-threatening emergencies were causing the need for those types of PPE and ventilators and so forth that were in short supply.

So planning for these things far in advance, but also I would say maintaining the capacity to do that. That takes funding and resources. So that is something that we can certainly invest in.

I would say that with respect to Federal partnerships, also working with the VA, in September we put an agreement in with the VA, with a national reimbursement agreement for the VA for direct health care services to include services delivered through telehealth. We also in October with the VA signed an interagency agreement setting forth the arrangement for coordination and delivery of health services. When IHS or tribal facilities are experiencing surges, IHS is able to work with the VA to secure beds, additional bed status.

In terms of tele-health, we certainly had successes, because we expanded our video conferencing system and we were able to see more patients by tele-health. But the vast majority of our tele-health visits were by telephone rather than by video equipment. That is mainly because of that last mile. The person on the other end doesn't necessarily have the bandwidth or the capability to do a tele-health visit.

So a lot of successes, but challenges there. I think building that infrastructure in tribal communities so that we have broadband access for our patients will help, certainly, with the tele-health.

The EHR modernization, having pandemic-highlighted challenges and risks posed by our aging health IT architecture, and certainly we are grateful for the funding for EHR modernization that was

provided by Congress in the CARES Act. We will put that to good use to build the foundational steps in this important multi-year effort.

Our aging facilities, just as Dr. Onders stated, facilities were built many years ago. The average age of a facility in IHS is something around 37 years, and some are much older. In these older facilities, the standards for infection control, for patient flow, for separation of patients, for even waiting areas and so forth, those facility-based standards, we need to invest in our facilities in order to make the changes necessary to be prepared for future pandemic.

So that is just a sample of some of the changes, to be responsive to your question. If I have not been fully responsive, I would be glad to take any follow-up questions.

The CHAIRMAN. Doctor, that is an excellent summary. I will offer a couple of thoughts.

First of all, let's work together on tele-health. Let us know what you need. When I was the ranking member of the subcommittee that does appropriations for VA, we made a ton of progress in this area. I also over the many years have been the lead author of the Connect for Health Act, which is the biggest and most bipartisan health care bill that has passed over the last eight years. Tele-health is popular because it improves the quality of care and increases access while reducing costs.

So let's give you all of the tools and resources that you need to expand tele-health.

Just on the EHR, HER transformation, also from my experience with VA, and trying to integrate those systems between VA and DOD, this can turn into a monster, logistically, in technological terms, bureaucratically and in terms of cost. So let's make sure that as you endeavor, even if it is just the first steps, that you gather some lessons learned from VA and DOD, and make sure that this doesn't turn into costing two or three times as much as originally planned and taking two or three times as long as originally planned.

We are already spending billions of dollars on an EHR architecture. We may, I don't know, but we may be able to piggyback on that architecture since the Federal Government has already purchased it.

So let's work together on those two items as well as the other things that you delineated in your response to me.

And the final Senator is Senator Hoeven.

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

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

I will start out, for each of the witnesses, what has been the biggest challenge in Indian Country with the COVID pandemic? Then lessons learned, what have we learned about how to be better prepared for the future? Admiral Toedt, if you would like to start.

Dr. TOEDT. Yes, Senator Hoeven, thank you.

I would say that the biggest challenge that we faced is really our existing, preexisting conditions, the fact that American Indians and Alaska Natives suffer disproportionately from diabetes, from challenges of hypertension, from asthma, from obesity. These condi-

tions, which predispose American Indians and Alaska Natives to poorer outcomes, as well as the upstream causes of those diseases. So the social determinants of health, the lack of infrastructure, sufficient access to healthy foods, access to education and jobs in these communities. That was the number one challenge, is addressing a pandemic on top of these disparities and social determinants of health and the resulting disparities in preexisting health conditions.

And then in terms of the lesson learned and the path forward, I would say that we really learned that by having strong partnerships with tribes, leveraging their sovereignty and their ability to be most responsive to their communities, I think has been one of the greatest successes.

We utilized, of course, our National Service Center and our IHS vaccine task force and our centralized ability to distribute. But it was really that tribal sovereignty, working with sovereign nations and tribal leaders, as well as Urban Indian organizations, that made it successful. Thank you.

Senator HOEVEN. Thank you, Admiral.

Chairman Smith?

Mr. SMITH. Thank you. As I said in my remarks, the key success to the vaccine rollout has been including tribes and IHS as a jurisdiction for vaccine distribution. By allowing tribes to exercise self-government and make decisions for their people, tribes have been able to coordinate and distribute the vaccine and get them into the arms faster than any other surrounding communities. This has been a perfect example of how and why self-governance and self-determination works.

In previous public health emergencies, tribes were left to fend for themselves with little or no resources from the government. While those previous emergencies were not the same level of emergencies as was the widespread COVID-19, this time around tribes were prepared. This is because tribes were declared a jurisdiction, directly receiving the vaccine, and were provided needed flexibility, ensuring that they could exercise self-governance and make decisions that were best for all the people to receive the vaccines.

One of the things we need to look at, because when you talk about the veterans, it is really kind of sad that the veterans and the VA up in Alaska were one of the last go-round to get the shots. Even all our people in harm's way should have got the vaccines.

When we talk about mental health, if I am listening correctly with what President Biden is saying that he is going to be bringing all the troops home from Afghanistan, there is going to be a big surge for tele-health needs. Our brothers and sisters coming home, they are going to need all the help they can get. The Indian Health Service and the VA still needs to be working together to help all.

Thank you very much.

Senator HOEVEN. Thank you.

Mr. Murillo?

Mr. MURILLO. Thank you. I think some of the challenges that we have seen have been things inherent in the law right now that don't give Urbans the same authority that it does IHS facilities or tribal facilities. Things like facilities, infrastructure building and the ability to change our facilities.

Also, the administration of vaccine is something that, in a pandemic, the authority to use Indian Health Service funds to administer that vaccine to nonbeneficiaries is there for Indian Health Service facilities and tribal programs, but not for Urbans. So that is very harmful in a pandemic.

Also, some of the restrictions that are there, this is not through the Indian Health Service lack of trying, but simply the law, that limited the ability to use some of those funds to give us supplies. I am happy that the Indian Health Service found a work-around for that, and provided supplied at no cost to Urbans.

I think some of the lessons learned that we can take from this is the fast action of the Indian Health Service and their ability to confer with Urban Indian health programs. As I said earlier in a response to a question, we would like to see that repeated across many operatives in HHS that serve Indian Country that includes urban areas.

Tele-health also I think is one of the lessons learned. Pivoting to tele-health, especially in behavioral health, has been tremendous, a tremendous help. Again, with solving that problem of that transportation barrier, and access to care, we created a new problem, the infrastructure problem was having that telecommunication available to American Indians and Alaska Natives. In urban areas, that might mean while the infrastructure is there, is it affordable? Do they have minutes to even use the phone to call in or to receive a text message for an appointment reminder?

So that is where I would leave on lessons learned.

Senator HOEVEN. Dr. Daniels?

Dr. DANIELS. Thank you for the question. I think for Native Hawaiians it really goes back to the lack of understanding about trust responsibilities on all levels. So we have the same issues around chronic health conditions, we have a lot of the same issues as my colleagues here, both in tribal as well as urban spaces.

So the difference here in our thread is the lack of understanding about trust responsibility, not only on the Federal level, but especially at the State level.

I think the success, though, not to ponder on the not good, but the success is that our communities continue to show resiliency. If we don't have that, if we don't have hope, how do we continue to move forward as a community to try to uplift?

Thank you.

Senator HOEVEN. Thank you. Dr. Onders?

Dr. ONDERS. Thank you, Senator, for the question. When the pandemic started, I went back and looked at 2008 and 2009. There was a research article published on the H1N1 pandemic. There are some authors here on campus with the CDC Arctic Investigations Program as well as ANTHC that authored that paper. Because at that time, there were four times higher mortality rates seen in Alaska Native and American Indian people with the H1N1 pandemic.

It pointed to the same things that Dr. Toedt and others have mentioned: lack of adequate water and sewer, lack of adequate housing, preexisting conditions as a result of generations of trauma and systemic racism, lack of access to adequate health care. I think

you could cross out H1N1 and put COVID in this now 13, 14 years later, to say the same thing.

So from a lessons learned standpoint, I think if we are going to address those challenges that we saw both in the previous pandemic and this pandemic, I think that aspect of tribal sovereignty that was mentioned that was extremely successful for vaccine could be used in that same mechanism to address these infrastructure problems that create the preexisting risks.

Senator HOEVEN. Thank you very much to all of you.

Thank you, Mr. Chairman. I am sorry for going over my time. I appreciate it.

The CHAIRMAN. Thank you. Senator Daines?

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

Senator DAINES. Chairman Schatz, thank you.

Last week the Acting Director of IHS was out in Great Falls, Montana. Great Falls is home, in fact, to our newest federally recognized tribe in the Nation, and that is the Little Shell Tribe. It was a long battle. I fought alongside the people of the Little Shell Tribe for years to achieve Federal recognition and establish this very important government-to-government relationship.

That is why I have to say it was very disheartening to hear that during the Acting Director's recent visit to Montana, no official notice or information was provided to Little Shell in advance of the visit. The most recent, newest federally recognized tribe, no advance notice. This government-to-government relationship demands more than this treatment, when a head of a Federal agency that is dedicated to tribal issues travels to the city or reservation where a federally recognized tribe is headquartered.

Now, what adds insult to injury here, the Little Shell Tribe's headquarters are right there in Great Falls. There should be outrage, and an official invitation to meet on this very important government-to-government basis. It is unacceptable, and the Little Shell have fought for recognition for far too long to simply be an afterthought for IHS.

Admiral Toedt, can you and your staff commit to relaying these concerns I have articulated here with how the Little Shell Tribe was treated during the Acting Director's visit?

Dr. TOEDT. Yes, Senator Daines, I will definitely take the message back to leadership for their awareness. When planning these visits, we do our best to coordinate with our Federal and tribal leaders with as much advance notice as possible. Arranging visits during this time is more challenging than usual. We appreciate the patience and support of all who helped with the visits last week.

We deeply respect all of our tribal partners, and were honored to have an opportunity to meet with the Little Shell.

Senator DAINES. Thank you. While they are the most recently federally recognized tribe, it wasn't like it just happened in December. It was a year ago, plus, when we got the legislation signed by the President.

I thank you for that response, and I hope that other tribes are treated with the respect they deserve, as IHS continues to visit tribes throughout Indian Country.

Admiral Toedt, I was very pleased to see the one millionth vaccine distributed in Indian Country last week. It is a very important milestone. As you stated in your testimony, IHS has faced infrastructure challenges in rural and remote communities. We certainly understand that in Montana.

We know that the outdated or sometimes non-existent infrastructure in Indian Country has caused tribes to be hit exceptionally hard by COVID. Certainly, the infection rates and mortality rates have been much higher than the general populations in Montana.

Admiral Toedt, can you elaborate on effective ways that might address the problems with infrastructure in Indian Country that we could then in a fiscally responsible manner target to areas where we have the greatest need?

Dr. TOEDT. Yes, Senator, thank you for the question.

I think the theme continues that the most effective way is to do this with tribal consultation. We have to make sure to continue to consult with tribes and confer with Urban Indian organizations.

The IHS received \$9 billion in six supplemental appropriation bills since March 2020. This is amazing and unprecedented support for Indian Country. So thank you for that. These funds are predominantly available to prevent, prepare for and response to the COVID-19 pandemic. To date, we have directly allocated \$2.9 billion in COVID funding from five of the six appropriation bills, and we have announced all allocations from those funds in a Dear Tribal Leader letter and Dear Urban Indian Organization letter. All of those allocations were finalized with the input of tribal and Urban Indian organization leaders, collected through tribal consultation and urban confer.

Senator DAINES. Thanks, Admiral Toedt. I will tell you, it is particularly important, as you mentioned, that it is a bottoms up driven kind of a prioritization, that our tribal leaders know where they need the resources. I appreciate your listening to their voice as you prioritize where these investments should be made.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you very much.

If there are no more questions for our witnesses, members may also submit follow-up written questions for the record. The hearing record will remain open for two weeks, and I want to thank all of our witnesses for their time and their testimony.

This meeting is adjourned.

[Whereupon, at 4:28 p.m., the hearing was adjourned.]

A P P E N D I X

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO REAR ADMIRAL MICHAEL TOEDT

Question 1. As mentioned at the hearing, I am deeply concerned that IHS entered the COVID-19 pandemic without the necessary resources and preparations in place. Prior to the COVID-19 pandemic, did IHS have an emergency plan in place to ensure continuity of operations in the event of a pandemic involving a highly infectious disease? If so, please provide an overview.

Answer. The Indian Health Service (IHS) had a continuity of operations plan (COOP) in place prior to the COVID-19 pandemic. The existing plan focused on agency steps necessary for responding to major emergency events, including pandemics, which might disrupt agency operations. As recently as 2019, the IHS participated in a Department of Health and Human Services (HHS) COOP exercise focused on how HHS and the federal government would manage a nation-wide pandemic influenza response. The exercise examined emergency coordination and communication across agencies, local and state pandemic influenza response challenges, federal government capabilities and available resources to support local and state response efforts, and continuity of essential functions by a dispersed workforce in the event major administrative offices were inoperable.

All IHS hospitals and clinics are required to have emergency plans in place that include localized flu/pandemic response. Plans cover emergency responses necessary to sustain critical health care services while protecting the safety of employees and patients. These plans were crucial for enabling the IHS to address immediate COVID-19 response. However, a pandemic of the magnitude encountered with COVID-19 was not foreseen in existing COOP and emergency plans.

Question 1a. Please describe any analysis IHS has undertaken to evaluate its COVID-19 response to date and the results of those efforts.

Answer. During the course of the IHS COVID-19 response, the Agency has prioritized continual evaluation of response activities to appropriately adjust for evolving needs. The IHS conducted a review of activities completed in the first 100 days of formal response that outlined key activities tied to the IHS COVID-19 Action Plan. This review and resulting report provided detailed accomplishments, outcomes, and opportunities for improvement and enhanced engagement.

In November 2020, the IHS began interviewing IHS Area Office and Headquarters leadership, as well as the IHS Incident Command Structure staff, to produce a report of lessons learned and considerations that will be used for longer-term emergency preparedness planning. The IHS now conducts biweekly reviews of activities related to the IHS COVID-19 Action Plan, and produces quarterly reports detailing response activities. Throughout the pandemic response, the IHS has collected surveillance data and performed predictive analyses to inform planning and response efforts in the IHS Areas.

Question 1b. What changes—if any—has IHS made to its medical supply acquisition protocols and procedures to ensure the Service will have strategically necessary stockpiles and supply acquisition plans in place for public health emergencies moving forward?

Answer. The IHS National Supply Service Center (NSSC) expanded its operations at the beginning of the response to allow for the mass procurement and distribution of critical personal protective equipment (PPE) and other COVID-19 related items to all IHS, tribal, and urban Indian (ITU) health facilities nationwide. The NSSC is a fee-for-service comprehensive supply management program that oversees pharmaceutical and medical supply chain logistics for the agency. Supplemental appropriations allowed the NSSC to procure and distribute PPE, supplies, test kits, and related materials at no cost to ITU health programs nation-wide.

The NSSC has its own in-house quality assurance, procurement, finance, warehouse, and inventory management teams to ensure high quality, safe products are distributed to ITU facilities in an efficient, equitable, and accountable manner. The

NSSC also works closely with other government agencies and operations such as the Federal Emergency Management Agency, HHS Office of the Assistant Secretary for Preparedness and Response, Defense Logistics Agency, and Countermeasure Acceleration Group to procure and coordinate the timely delivery of products to ITU health facilities. To date, NSSC has distributed 84 million units of COVID-19 related products (PPE, lab, therapeutics), including 2.6 million test swabs and transport media.

The IHS is developing a strategic plan to increase its supply chain procurement and logistics capabilities. This will include additional staff, inventory management systems, increased space and improvements at existing supply centers, and the addition of regional supply centers that provide the ability to manage, store, and distribute a six-month supply of product and equipment necessary for an emergency response. The IHS has also issued Agency-wide guidance on how to avoid price gouging and ensure that only safe and high-quality products are procured.

Question 1c. What improvements does the Service believe are necessary to better ensure continuity of operations moving forward? And, does IHS need additional resources to implement those improvements?

Answer. As a public health agency, emergency response is an integral part of IHS operations. The COVID-19 public health emergency has highlighted several opportunities for improvement including:

- enhancing preventative activities such as contact tracing and data surveillance and analytics,
- establishing proactive longer-term plans and partnerships that enable more efficient staffing and resource augmentation in times of acute need,
- expanding the public health workforce and creating capacity for dedicated emergency response personnel,
- continuing to increase availability of telehealth services, and
- building out the IHS NSSC's stockpiling capacity and warehouse footprint.

The COVID-19 public health emergency also amplifies resource disparities across the Indian health system. The IHS has received over \$9 billion in one-time, supplemental appropriations, which have been essential for supporting the extreme demands on health care and related services to meet shorter-term pandemic response. However, recurring annual funding is needed to make longer-term systemic improvements and sustain readiness.

Question 2. At a hearing on COVID-19 response and mitigation last year, I spoke with former IHS Director Weahkee about the need to expand telehealth access.¹ He informed me that IHS saw an 11-fold increase in use of telehealth services in the initial four-months of the COVID-19 pandemic. I understand, since that time, IHS has completed a telehealth provider survey. Please summarize the findings from this recent IHS telehealth survey.

Answer. The IHS Telehealth Survey for IHS Providers was open from October 20, 2020, through November 11, 2020. There were over 375 Federal respondents who participated in the survey. The majority of responses were from Physicians, Nurse Practitioners, and Counselors/Social Workers. Almost sixty percent (60 percent) of the respondents noted they provided telehealth visits each week (ranging from one visit up to 100 visits). Forty-one percent (41 percent) of the respondents' noted at least one telehealth visit was performed using telephone (audio) only in a typical week. The significant majority agreed or strongly agreed telehealth improved access to care, improved the health of patients, and that patients seemed satisfied.

The respondents identified value in offering telehealth services such as behavioral health, specialty care, primary care, chronic illness care, urgent care and more. Eighty-three percent (83 percent) of the respondents shared through qualitative analysis of themes that their experience with telehealth had value. Only seventeen percent (17 percent) of the respondent's qualitative themes noted telehealth as not having value. Some examples provided in the survey addressed telehealth limitations and that some specialties require in-person patient examination and care/treatment. Respondents also indicated that improvements were needed for infrastructure, equipment, and telehealth platforms. Further, respondents noted that lack of bandwidth and other limitations on connectivity, as well as outdated hardware and software were challenges that need to be addressed. Despite these issues,

¹Evaluating the Response and Mitigation to the COVID-19 Pandemic in Native Communities: Hearing on S. 3650 Before the S. Comm. on Indian Affairs, 116th Cong. 29 (2020)(response to question from Sen. Brian Schatz by Michael Weahkee, Director, Indian Health Service).

respondents identified telehealth as an important tool that generally made access to health visits possible during the pandemic.

Question 2a. What additional resources would IHS need to sustain and expand telehealth services for the Native communities it serves, directly or through a Tribal Health Program or Urban Indian Organization?

Answer. The IHS has relied on telehealth to continue offering health care services during the pandemic, when many facilities reduced their hours or closed their doors to prevent the spread of COVID-19. In April 2020, IHS extended the use of an Agency-wide video conferencing platform that allowed telehealth on almost any Internet-connected device in any setting, including patients' homes.

As a result, the IHS dramatically increased its use of telehealth from an average of less than 1,300 visits per month in early 2020 to a peak of over 40,000 visits per month in June and July of that year. On average, about 80 percent of the telehealth encounters across IHS are conducted using audio only, primarily due to the limited availability of technologies and bandwidth capacity in the communities served.

The IHS received \$95 million for telehealth in the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and a portion of \$140 million from the American Rescue Plan Act can also be used for telehealth activities.

Question 2b. What benefits has IHS experienced as a result of the temporary loosening of Medicare telehealth restrictions made possible by the CARES Act as well as other state actions to expand telehealth coverage?

Answer. During the public health emergency, the IHS has significantly increased the use of telehealth to enable the continuation of health services while limiting face-to-face visits according to COVID-19 safety precautions. Medicare waivers and flexibilities implemented as a result of the pandemic have made it easier for beneficiaries to access care through telehealth and enabled the IHS to bill for these telehealth services, which were previously not payable. Before the COVID-19 public health emergency (PHE), only 15,000 fee-for-service beneficiaries each week received a Medicare telemedicine service. Preliminary data show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees received a Medicare telemedicine service during the PHE. For instance, there are approximately 270 services currently included on the list of Medicare telehealth services, including more than 160 that were added on a temporary basis during the COVID-19 public health emergency. The list of eligible telehealth services is published on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

Under Medicaid, States have a great deal of flexibility with respect to covering services via telehealth. CMS provided a toolkit at <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf> for States to identify the policy topics that should be addressed in order to facilitate widespread adoption of telehealth services. In addition to the Medicare waivers and flexibilities, IHS has also leveraged state efforts to expand Medicaid coverage and access to telehealth such as: allowing new services to be delivered via telehealth, expanding the provider types that may deliver services via telehealth, expanding the types of technologies used to deliver telehealth, and requiring payment parity for services delivered via telehealth as compared to face-to-face services. For instance in Arizona, effective March 18, 2020 until the end of the COVID-19 public health emergency declaration, Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, health plans may not discount rates for services provided via telehealth and telephonically as compared to contracted rates for "in-person" services. In addition, all services that are clinically able to be furnished via telehealth modalities will be covered by AHCCCS throughout the course of the COVID-19 emergency.

Question 2c. Would Native health systems benefit from making some of these temporary telehealth changes permanent?

Answer. These flexibilities have been beneficial to Native health systems during the PHE, and we expect they would continue to do so in the future. For example, removing the geographic restrictions that limited telehealth services to specific rural areas and certain locations such as physicians' offices and hospitals has increased access to care and continuity of care in Indian country. This is especially beneficial in rural areas, those areas with provider shortages, and for individuals who might have other barriers, like lack of access to public and private transportation.

Also, the use of audio-only equipment to furnish audio-only telephone Evaluation and Management (E/M), counseling, and educational services has been vital during the PHE. The IHS serves many of the most rural, sparsely populated and technologically underserved locations in the country. These areas and the families living in them often lack both the connectivity and the technology (smartphones/computers) to participate successfully in video-dependent encounters. At the same time,

these individuals who experience high rates of many chronic health conditions, often live many miles from their healthcare facilities and may lack reliable transportation. As noted, people without any transportation (public or private) are benefiting from telehealth with the current flexibilities.

The IHS will continue to work with the Department to better understand the impacts of telehealth flexibilities during the PHE on access, quality-including patient experience-of care, and value. We look forward to working with members on these important issues to deliver the best care possible to Indian Country.

Question 3. At that same hearing, former IHS Director Weahkee and National Indian Health Board Secretary Lisa Elgin testified about the impacts that inadequate infrastructure in Native communities had on their COVID-19 response.² What is the current backlog of IHS maintenance and improvement, sanitation facilities construction, health care facilities construction, and equipment needs?

Answer. With regard to Health Facilities Construction, the priority projects have an unfunded balance of \$2.0 billion. The total need as reported in the 2016 report to congress is \$14.5 billion. A new report to congress is due in 2021.

Maintenance and Improvement funding is used to correct a portion of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) deficiencies annually though minor and major projects. The FY 2020 BEMAR identified at FY 2020 IHS and Tribal healthcare facilities is \$944.9 million. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately \$700 million. IHS is using a Computerized Maintenance Management System (CMMS) to manage medical equipment/devices/systems and to prioritize replacement. The average life expectancy is approximately six to eight years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six to eight-year life would require approximately \$100 million per year.

Sanitation Facilities Construction

The IHS Sanitation Deficiency System identifies a Feasible Project Cost Estimate of \$991 million. Costs for providing piped water and sewer facilities to American Indian and Alaska Native homes located in remote locations with harsh climates and unusual subsurface conditions are extremely high. The Sanitation Facilities Construction Program recognizes that piped water and sewer projects for these homes are not currently economically feasible, and while these piped water and sewer projects are included in the Total Database Estimate, they are not included in the IHS Feasible Project Cost Estimate.

The Total Database Estimate for Sanitation Facilities Construction is over \$3 billion, for over 230,000 American Indian and Alaska Native homes that need some form of sanitation facility improvement. There are currently over 1,600 projects identified in the IHS Sanitation Deficiency System to serve those homes.

Indian Health Service and Tribal Health Care Facilities' Needs Assessment

The IHS Health Care Facilities Construction program supports the construction of new and replacement health care facilities across Indian Country. The last Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress was transmitted to Congress in 2016. It identifies a \$14.5 billion estimated funding need for IHS and Tribal health care facilities. This amount includes the \$2.1 billion in construction projects remaining on the Health Care Facility Construction Priority List, which the IHS is statutorily required to complete before spending appropriated funding on additional construction projects. The Health Care Facility Construction Priority List was established in 1993. An updated facilities needs assessment is due to Congress in 2021.

Equipment

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment and systems to assure the most accurate health diagnosis. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately \$700 million.

²Id. at 31-32, 49-50, etc. (statements of Michael Weahkee, Director, Indian Health Service, & Lisa Elgin, Sec'y, Nat'l Indian Health Board).

Today's medical devices and systems have an average life expectancy of approximately six to eight years. The average six-year lifecycle combined with rapid technological advancements means that medical equipment replacement is a continuous process that requires the replacement of aging equipment and equipment that does not meet newer technological standards, to enhance the speed and accuracy of diagnosis and treatment. To replace equipment at IHS and Tribal health facilities at the end of its six-year life would require approximately \$100 million per year, growing at an approximate 2 percent inflation rate per year.

Question 3a. Does the response provided in (a) include the needs of Tribal Health Programs and Urban Indian Organizations?

Answer. The IHS facilities-related reports include the needs of Tribal Health Programs, to the extent that these programs have shared their needs with the IHS. For example, many Tribal Health Programs that directly operate their health programs through Indian Self-Determination and Education Assistance Act (ISDEAA) compacts and contracts provide input for BEMAR and health care facilities construction needs, but do not provide direct input for medical equipment or Sanitation Facilities Construction needs.

To date, the IHS facilities-related reports do not include data on the needs of Urban Indian Organizations (UIOs). However, the IHS will have better data on the facility-related needs of UIOs in the near future. As part of the Consolidated Appropriations Act, 2021, the IHS received \$1 million for a new study of infrastructure needs for facilities run by UIOs. The UIO infrastructure study will be the first step towards identifying the most critical deficiencies for UIOs and formulating a comprehensive action plan.

Question 3b. Does IHS have an estimate of how much funding would be needed to fully complete its electronic health record modernization efforts?

Answer. Investment in modernization of the IHS electronic health record (EHR) system, the Resource and Patient Management System (RPMS), represents a significant opportunity to improve health care in Indian Country and the health status of American Indians and Alaska Natives. The current IHS EHR is over 30 years old, and the Government Accountability Office identifies it as one of the 10 most critical federal legacy systems in need of modernization. A full replacement of the RPMS is broadly supported by IHS, tribal, and urban Indian health programs.

The current IHS EHR system is built on the Department of Veterans Affairs (VA) Information Systems and Technology Architecture (VistA) system, which will soon be replaced by a modernized VA and Department of Defense (DOD) EHR. Without the VA's continued support of VistA, the IHS lacks the resources and capacity to maintain the RPMS's aging code alone. The system cannot be supported over the next decade, nor sustained with the current hardware and network.

The IHS relies on its electronic health record for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing for over \$1 billion public and private insurance for reimbursable health care services each year.

Replacing the IHS EHR will be a multi-year, multi-billion-dollar effort. Estimating the total cost of the IHS EHR modernization project is difficult at this time due to the early stage of the project. As implementation steps progress, estimates will be refined.

The IHS has recently completed a request for information from industry partners to support a final acquisition plan. While the IHS will need a significant infusion of funding to select and implement a new EHR solution in all sites currently operating RPMS, the level of ongoing annual support post-implementation is expected to be a fraction of that cost.

The IHS needs to build an EHR system, to support the unique aspect of providing health care services to American Indians and Alaska Natives. The IHS has partnered with the VA and DOD to implement lessons learned and best practices. In addition, the IHS is in the process of piloting a key connection to the VA/DOD health information exchange, which would support interoperability between the new IHS system and the new VA/DOD system.

Question 4. According to IHS, the Service's overall vacancy rate of 21 percent remained stable from February through May of 2020.³ Has the Service's overall vacancy rate increased since then?

Answer. Yes. Prior to the pandemic, the IHS vacancy rate was 21 percent. As of January of this year, the vacancy rate is 24 percent.

While we expected that the COVID-19 pandemic would impact IHS vacancy rates, human resources flexibilities available during the public health emergency

³Id. at 87 (response to written questions submitted by Sen. Tom Udall, V. Chairman, S. Comm. on Indian Affairs, to Michael Weakhee, Director, Indian Health Service).

likely mitigated this impact. The Office of Personnel Management (OPM) authorized the following flexibilities to expedite hiring and address short-term staffing needs to respond to the pandemic:

- Excepted service temporary appointments,
- Emergency dual compensation salary offset waivers for re-employed annuitants, and
- Direct hire authority to 32 additional occupations at IHS.

In addition, OPM establishes Hazardous Duty Pay and Environmental Differential Pay categories that IHS has applied to certain frontline staff in IHS hospitals and clinics to compensate them for unusually hazardous working conditions.

Question 4a. Have provider vacancy rates within each IHS service area fluctuated during the course of the COVID-19 pandemic?

Answer. The following chart provides a comparison of vacancy rates for IHS Areas. The vacancy rates are captured only for IHS federal sites. It was expected that the COVID-19 pandemic would impact vacancy rates at IHS, but vacancy rates would likely have been much higher without the COVID-19 human resources flexibilities offered during the public health emergency, as discussed in the response to the previous question.

IHS Vacancy Rates by Area

IHS Area	February 2020	January 2021
Alaska	unavailable	15 percent
Albuquerque	26 percent	23 percent
Bemidji	30 percent	28 percent
Billings	30 percent	35 percent
California	18 percent	29 percent
Great Plains	22 percent	24 percent
Headquarters	20 percent	14 percent
Nashville	22 percent	21 percent
Navajo	17 percent	22 percent
Oklahoma City	16 percent	14 percent
Phoenix	24 percent	27 percent
Tucson	19 percent	29 percent
Portland	24 percent	25 percent

Question 4b. Have there been any changes in vacancy rates within specific clinical staffing categories (e.g., doctors, physician's assistants, nurses, etc.) throughout the course of the pandemic?

Answer. The following chart provides a comparison of vacancy rates for critical healthcare occupations within IHS federal sites. It was expected that the COVID-19 pandemic would impact vacancy rates at IHS, but vacancy rates would likely have been much higher without the COVID-19 human resources flexibilities offered during the public health emergency, as discussed above.

IHS Vacancy Rates by Position Type

Discipline	February 2020	January 2021
Physician	26 percent	28 percent
Physician Assistant	26 percent	20 percent
Pharmacist	14 percent	15 percent
Nurse	28 percent	34 percent
Advance Practice Nurse	24 percent	27 percent
Engineer	24 percent	24 percent
Behavioral Health	31 percent	35 percent
Dentist	23 percent	21percent

Question 4c. Has the percentage of contract staff working in IHS facilities increased over the past year?

Answer. There is no immediate report available to identify the number of contractors, both medical and administrative, at IHS facilities. IHS has been working to identify costs for certain contract providers on a monthly basis; however, this was

not fully implemented until November 2020. Therefore, the IHS is unable to compare data over the past year.

Question 4d. What steps—if any—is IHS taking to prevent provider and staff “burn out” due to the increased demands placed on them by the COVID-19 pandemic?

Answer. The IHS has maintained a focus on the health and safety of its workforce throughout the COVID-19 response. In addition to promoting the use of existing employee assistance programs, the IHS developed additional resources to support staff during the pandemic.

The IHS TeleBehavioral Health Center of Excellence (TBHCE) tele-education program provides training to health care providers working in the IHS, Tribal, and urban Indian health system. In response to COVID-19, the TBHCE offered several trainings to prevent provider compassion fatigue, burnout, and to support providers dealing with loss. Additional information can be found at: <https://www.ihs.gov/tele-education/>. Examples of specific trainings include:

- Compassion Fatigue On-Demand (self-paced) Course,
- Grief and Loss Webinar Series: Supporting Providers Dealing with Loss,
- IHS COVID-19 Response Webinar Series: Compassion Fatigue: Additional Risks when Serving Vulnerable Populations During a Pandemic, and
- IHS COVID-19 Response Webinar Series: Supporting the Mental Health of Healthcare Workers during COVID-19.

Question 4e. Does IHS need additional resources to attract and retain its workforce? If so, please describe the types of resources needed?

Answer. The IHS continues to face challenges in recruiting and retaining highly qualified staff. To IHS 2022 budget request includes increases in funding for the IHS Scholarship and Loan Repayment Programs. The additional funding will allow IHS to offer additional scholarships to American Indian and Alaska Native students pursuing degrees in health care and in return the students complete a service commitment with IHS. Additional funding for the IHS Loan Repayment Program will allow IHS to fund more applicants and expand the program to fund additional eligible health care occupations. Loan repayment recipients also complete a service commitment. Both these programs are highly effective in recruiting and retaining IHS’ health care workforce.

Question 5. During the hearing, you were asked to explain why HHS and HRSA apply the federal trust responsibility to Native Hawaiians and their healthcare systems differently than HHS and IHS apply the federal trust responsibility to American Indian and Alaska Natives and their health care systems. While I am aware that Native Hawaiian health care programs and American Indian and Alaska Native health care programs are authorized under separate statutes, that architecture does not limit the federal trust responsibility of the United States to one agency within HHS.

Please describe the agency’s active and planned efforts to follow up on your commitment to work within HHS to better educate the Department (as well as other agencies) about the trust responsibility to Native Hawaiians, and the need for parity in treatment between various health care programs administered by HHS that serve Native communities? In particular, please include any efforts to educate on the unequal treatment I mentioned during the hearing, e.g., matching fund requirements, no Federal Torts Claim Act coverage, and a lack of direct access to vaccines for the Native Hawaiian Healthcare Systems?

Answer. The IHS responsibility for providing health care to American Indians and Alaska Natives (AI/AN) is grounded in the government-to-government relationship and does not, under current statutory authorities, include the provision of services to Native Hawaiians. Information about other HHS programs that benefit Native Hawaiians is available from the other HHS operating divisions that administer such programs (i.e., Health Resources and Services Administration, the Administration for Children and Families, and the Administration for Community Living). The IHS has shared these questions with the appropriate HHS operating divisions and leadership since Native Hawaiian issues and activities are not under its purview or expertise.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO
REAR ADMIRAL MICHAEL TOEDT

Question 1. What is IHS doing to ensure vaccine acceptance rates increase on Tribal College and University campuses and in Bureau of Indian Education schools?

Answer. The IHS is working with the Bureau of Indian Education (BIE) and Tribal Colleges and Universities (TCUs) to ensure students and staff are provided with the opportunity to be vaccinated. Early in the COVID-19 vaccination effort, the BIE provided the IHS with lists of estimated teacher and staff numbers for K-12 schools and TCUs. This information was included in IHS vaccine planning efforts, and the IHS provided BIE with information about the nearest IHS-operated facility or tribal health program providing vaccinations for K-12 staff and TCU staff and students. The BIE reported a K-12 school staff vaccination rate of over 70 percent, and they believe it could be higher based on time and attendance records.

To promote vaccine acceptance, IHS continues to disseminate federal resources and materials, such as the HHS *We Can Do This* and the Office of Minority Health #VACCINEReady campaigns, including toolkits and materials specific to American Indian and Alaska Native communities. The COVID-19 Vaccine Toolkit for Institutions of Higher Education (IHE), Community Colleges, and Technical Schools CDC was released on May 24, 2021 and was shared with BIE for further distribution across their network. Additionally, IHS continues to provide vaccine administration support, outreach, and sharing of best practices across the health care system.

On May 13, 2021 the IHS began vaccinating children ages 12 years and older with the Pfizer COVID-19 vaccine, consistent with the Advisory Committee on Immunization Practices recommendation and the U.S. Food and Drug Administration (FDA) expanded emergency use authorization. The IHS is working closely with the BIE to encourage collaboration with the nearest IHS-operated facility or tribal health program providing COVID-19 vaccinations. Currently BIE is assessing school dismissal dates for the summer, as well as back-to-school dates in the fall to potentially coordinate vaccination events on site at the facilities, if desired by the school. BIE-operated K-12 schools primarily remain remote, but approximately $\frac{1}{3}$ resumed classes in a hybrid model (partial on site, partial online). Approximately 20 percent of Tribally Controlled Schools resumed onsite learning, and approximately 35 percent are operating in a hybrid model. The remainder remain in a remote/distance learning environment. BIE and IHS are developing plans for fall back-to-school, including collection of COVID-19 and routine vaccination documentation, advance parent/guardian consents for all vaccines, and potential on-site vaccination events. The IHS does not track school specific vaccination rates or vaccine acceptance rates of students and staff but will continue to provide outreach and education to tribal communities including schools. The IHS and BIE have coordinated COVID-19 response efforts since early January 2021. Bi-weekly meetings being increased to weekly to ensure the needs the BIE COVID-19 needs are addressed.

Question 2. You state in your testimony that COVID-19 related data reporting from Tribes and Urban Indian Organizations is voluntary. What challenges and barriers does IHS face to providing Tribe-specific vaccination data?

Answer. The IHS coordinates vaccine distribution for IHS-operated facilities and facilities operated by tribal health programs and urban Indian organizations that have chosen the IHS jurisdiction for vaccine distribution (I/T/Us). Tribal health programs and urban Indian organizations entered into Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Program Agreements—Vaccines Coordinated through IHS. As part of these agreements, each I/T/U must report vaccine administration data, including the required data elements, such as race and ethnicity, to the CDC by the pathways determined by the IHS jurisdiction. Data may be submitted via the Vaccine Administration Management System, a CDC platform, or via the I/T/U's electronic health record data transmission file. The required data elements do not include reporting administration data by tribe or tribal affiliation for the jurisdictions, including IHS. Therefore, the IHS is unable to report comprehensive vaccination data by tribe.

Question 3. I also note that many states, including my own, have had difficulty reporting statewide vaccination rates without state-specific vaccination data. Many states have this data but are not able to do more finite analyses because it is not disaggregated by geography, ethnicity, or site and there is duplication with states' own vaccine registries. What challenges does IHS face to providing more granular vaccination data to states?

Answer. The IHI-operated facilities and facilities operated by tribal health programs and urban Indian organizations that have chosen the IHS jurisdiction for vaccine distribution, per CDC COVID-19 Vaccination Program Agreements, must submit data elements for all administered vaccines. For example, this includes race, and ethnicity, and details about the products, including the lot, product, and other facility details. This IHS jurisdiction data is transmitted to the CDC and de-identified. The IHS jurisdiction data is sent from the CDC and is displayed on the HHS-supported platform, Tiberius, in aggregate. The state jurisdictions, as of the week

of April 26, 2021, had visibility of IHS data for their specific state, which can be viewed at the state or zip code level. In general, IHS reviews state-specific data requests on a case by case basis to ensure patient data is de-identified and protected.

Question 4. Your testimony discusses the work that IHS has done to increase access to clean water on Navajo Nation during the pandemic. What would IHS be able to do with \$2.6 billion in appropriated funding, available until expended, to address the long-term water infrastructure challenges and deficiencies on Tribal lands?

Answer. The IHS Sanitation Facilities Construction (SFC) program uses the Sanitation Deficiency System (SDS) to track water and sanitation needs in American Indian and Alaska Native communities. Currently, the SDS reports a backlog of \$991.4 million in economically feasible projects. That number grows to nearly \$3.09 billion when taking into account economically infeasible projects. Economically infeasible projects are those that have a “per home cost” above a State or geographic region-specific threshold.

An appropriation of \$2.6 billion to the IHS SFC program would support approximately 1,173 sanitation facilities projects to provide water, wastewater, and solid waste facilities serving American Indian and Alaska Native homes and communities. Of the 1,173 projects that could be supported with a \$2.6 billion appropriation, 762 are economically feasible, and 411 are economically infeasible. This analysis is based on the project cost estimates included in the IHS SDS at the end of calendar year 2020, after subtracting the projects estimated to be funded with the FY 2021 IHS facilities appropriation.

It is important to note that if Congress were to appropriate \$2.6 billion to the IHS SFC program, 592 of these projects would require non-IHS resources totaling \$512 million to complete the full scope of identified need. These 592 projects include activities that are not legally eligible for IHS SFC program funding. These non-eligible activities include the cost to serve non-tribal homes, commercial, industrial, agricultural establishments, nursing homes, health clinics, schools, and hospital quarters. Tribal communities with non-eligible activities can use their own resources, or leverage other federal, state, and local funding sources to support the full scope of their projects.

Question 5. What percent of feasible and infeasible projects does IHS estimate it would be able to complete with \$2.6 billion in appropriated funding?

Answer. There are 1,457 projects in the Sanitation Deficiency System, of which 925 are economically feasible and 532 are economically infeasible. With \$2.6 billion in appropriated funding, the IHS would be able to complete 762 feasible projects, or 82 percent of all feasible projects and 532 infeasible projects, or 77 percent of infeasible projects.

Question 6. How long does IHS estimate it would take to complete the feasible projects identified on its most recent deficiency list?

Answer. At current funding levels, the average duration of a Sanitation Facilities Construction project is four years.

Question 7. What number and percent of these feasible water and wastewater projects are located in New Mexico?

Answer. There are a total of 96 feasible projects benefiting American Indian homes in New Mexico. This represents 10 percent of the total feasible projects.

Question 8. How many households would be served in New Mexico if the IHS were able to complete all feasible projects identified on its most recent deficiency list?

Answer. If all 96 feasible projects were completed, 21,098 American Indian homes would benefit from the facilities provided.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO
HON. WILLIAM SMITH

Question 1. I was glad to see President Biden’s Fiscal Year 2022 budget include an advance appropriation for IHS in 2023, an issue that I know National Indian Health Board has been working on for over a decade. Your testimony highlights the importance of budget certainty and advance appropriations for IHS to advance health outcomes for Native communities. Should the federal government enact legislation to permanently provide advance appropriations for IHS and the Bureau of Indian Affairs?

Answer. The Indian health system faces chronic challenges that are made worse by endless use of continuing resolutions (CRs) and the persistent threat of government shutdowns. Of the four federal health care programs, IHS is the only one not protected from government shutdowns and CRs. This is because Medicare/Medicaid receive mandatory appropriations, and the Veterans Health Administration (VHA)

receive advance appropriations starting a decade ago. In September 2018, the Government Accountability Office (GAO) issued a report (GAO-18-652) that noted “uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs.”

Year after year, the federal government has failed AI/ANs by drastically underfunding the IHS far below the figures outlined by the IHS National Tribal Budget Formulation Workgroup (TBFWG). For example, in 2018, IHS spending for medical care per user was only \$3,779, while the national health care spending per capita was \$9,409—an astonishing 60 percent difference. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Tribal communities. While the average life expectancy is 5.5 years less for all AI/ANs than it is for other Americans, some Tribal communities have a life expectancy of up to 20 years less than the average American. Tribal treaties are not discretionary, and the IHS budget should not be discretionary either.

The federal budget is a reflection of the extent to which the United States honors its promises to American Indian/Alaska Native people to provide for basic government and health services. However, since 1998 Congress has not enacted federal appropriations bills in a timely manner, thus hampering Tribal programs budgeting, recruitment and retention of personnel, the provision of services, facility maintenance, and construction efforts. Most concerning, the lack of timely funding for key federal programs that serve Tribal Nations endangers health, life, safety and education of beneficiaries and facilities.

Advanced appropriations would protect these services from future lapses in appropriations and ensure they do not count against spending caps. IHS funds many critical public services for Tribal Nations, including hospitals and clinics. Moving federal Indian programs such as IHS to the advance appropriations process will protect Tribal governments from cash flow problems that regularly occur due to delays in the enactment of annual appropriations legislation.

Question 2. What impact will advance appropriations have on IHS and its ability to improve health outcomes for Native communities and Tribal Nations, especially during the pandemic and beyond?

Answer. Since FY1997, IHS has once (in FY2006) received full-year appropriations by the start of the fiscal year. As a consequence, IHS activities generally have been funded for a portion of each year under a continuing resolution (CR). Receiving its funding under a CR has limited the activities that IHS can undertake, in part because IHS can only expend funds for the duration of a CR, which prohibits the agency from making longer-term, potentially cost-saving purchases.

Currently, over 60 percent of funding appropriated for the IHS is administered by Tribes in carrying out health programs under the Indian Self-Determination and Education Assistance Act (ISDEAA). Tribally-operated health programs are disproportionately affected by disruptions in federal appropriations since they rely on IHS funding transferred through ISDEAA contracts and compacts, but are not authorized the same emergency authorities granted to federal agencies during a lapse. Under a CR, these contracts can be issued only for the duration of the CR and must be reissued for each subsequent CR (or when full-year appropriations are enacted). This can be a time-consuming process for both IHS and Tribes, which may divert resources from other needed activities.

Advance appropriations for the IHS could ensure continuity of health care provided to American Indian and Alaska Native people, especially in the event of a lapse in appropriations. During regular order, it could enable timely and predictable funding for IHS-funded programs. Advance appropriations could mitigate the effects of budget uncertainty on the health care programs operated across the Indian health system. The IHS could disburse funds more quickly, which could enable IHS, Tribal, and urban Indian health program managers to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. This planning stability could reduce unnecessary contract and administrative costs. Funding continuity could also alleviate concerns from potential recruits, especially health care providers, about the stability of their employment.

During the most recent government shutdown in 2019, which lasted 35 days, IHS was the only federal health care program directly harmed. The impact was devastating, yet entirely avoidable. Tribal facilities lost physicians because they could not keep working without pay. Doctor visits could not be scheduled because administrative staff were furloughed. Tribes took out private loans to be able to help pay to keep the lights on at their clinic. Contracts with private entities for sanitation services and facilities upgrades went weeks without payment, threatening Tribes' credit and putting patients' health at risk. Tribal leaders shared how administrative staff volunteered to go unpaid so their Tribe had resources to keep physicians on

the payroll. These are just a few examples of the everyday sacrifices that widen the chasm between the health services afforded to AI/ANs and the nation at large.

Over the past two decades, only once has Congress passed the Interior budget on time—in FY 2006. Every other year, IHS has been subject to either short-term or full-year CRs or faced a government shutdown. The inevitable results are the chronic and perverse health disparities across Indian Country. Advance appropriations for IHS is a necessity to ensure patient health is not comprised in the event of Congress's failure to enact a budget each year. It is long past due.

