HOUSE COMMITTEE ON
NATURAL RESOURCES
RANKING MEMBER BRUCE WESTERMAN

To: Subcommittee for Indigenous Peoples Republican Members
From: Subcommittee for Indigenous Peoples Committee Staff; Ken Degenfelder (Ken.Degenfelder@mail.house.gov) and Rob MacGregor (Robert.MacGregor@mail.house.gov)
Date: Monday, March 22, 2021
Subject: Oversight hearing titled "A Year in Review: The State of COVID-19 in American Indian, Alaska Native, and Native Hawaiian Communities —Lessons Learned for Future Action"

The Subcommittee for Indigenous Peoples will hold an oversight hearing titled "A Year in Review: The State of COVID-19 in American Indian, Alaska Native, and Native Hawaiian Communities —Lessons Learned for Future Action" on Tuesday, March 23, 2021, at 1:00pm online via Cisco WebEx.

Member offices are requested to notify Rob MacGregor by 4:30pm on Monday, March 2, 2021, if their Member intends to participate. Submissions for the hearing record must be submitted through the Committee's electronic depository at HNRCDocs@mail.house.gov. Please contact David DeMarco (DavidDeMarco@mail.house.gov) or Everett Winnick (Everitt.Winnick@mail.house.gov) should any technical difficulties arise.

I. KEY MESSAGES

- COVID-19 has had a profound impact on Native American and Alaska Native communities as they are among the most at risk health demographics.

- Congress has appropriated more than $35 billion through six supplemental appropriation measures to help American Indians and Alaska Natives respond to the COVID-19 pandemic.

- In February 2021, Democrats failed to hold a mark-up and ceded the Natural Resource Committee's jurisdiction over Indian healthcare to the Budget and Rules Committees in constructing Speaker Pelosi's $1.9 trillion "progressive" spending bill.

- While robust resources are needed to assist native communities in combatting the COVID-19 pandemic, the Natural Resources Committee has a responsibility to conduct oversight into how previously appropriated funds are being spent by the Indian Health Service (IHS), an agency that remains on the Government Accountability Office's (GAO) high risk list for waste, fraud, abuse, and

mismanagement.

II. WITNESSES

- **The Honorable Rodney Cawston**, Chairman, Confederated Tribes of the Colville Reservation, Nespelem, WA [Republican Witness]
- **Dr. Charles Grim D.D.S., M.H.S.A.**, Secretary, Department of Health, Chickasaw Nation, Ada, OK [Republican Witness]
- **Mr. Larry Curley**, Executive Director, National Indian Council on Aging
- **The Honorable William Smith,** Alaska Area Representative, National Indian Health Board, Washington, D.C.
- **Ms. Francys Crevier**, CEO, National Council of Urban Indian Health, Washington, D.C.
- **Mr. Adrian Stevens,** Acting Chairman, Board of Directors, National American Indian Housing Council, Washington, D.C.
- **Ms. Carmen "Hulu" Lindsey,** Chair, Office of Hawaiian Affairs, Washington, D.C.

III. BACKGROUND

The Indian Health Service (IHS) is an agency of the U.S. Department of Health and Human Services (HHS) which provides healthcare to approximately 2.6 million American Indians and Alaska Natives (AI/ANs) through 605 hospitals, clinics, and health stations on or near Indian reservations.[1] The agency is headquartered in Rockville, Maryland, and is composed of 12 regions, or "Areas," each with a separate headquarters.[2] The agency offers "direct-service" healthcare, meaning care provided by federal employees, and it also acts as a conduit for federal funds for tribes that have utilized the Indian Self-Determination and Education Assistance Act (ISDEAA)[3] to independently operate their health facilities. The IHS also administers programs for Indians in urban areas. IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care in 37 States.[4]

The Snyder Act of 1921[5] provides the basic authority for the federal provision of health services and benefits to Indians because of their federally-recognized tribal status. The modern statutory basis and framework for the federal provision of health care to Indians

[1] Indian Health Service Budget Justification FY 2021 at CJ-1. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf
[2] The twelve areas of the IHS include: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson.
[3] 25 U.S.C. 5304 et seq.
[4] Indian Health Service Budget Justification FY 2021 at 2. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf
[5] 25 U.S.C. 13.

is under the Indian Healthcare Improvement Act (IHCIA).[6] This law was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act.[7] As noted, the Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes tribes to assume the administration and program direction responsibilities that are otherwise carried out by the federal government through contracts, compacts and annual funding agreements negotiated with the IHS.[8] In Fiscal Year 2019, more than $2.4 billion of IHS appropriations were administered by a tribe or tribal organization through contracts or compacts and related agreements.[9]

COVID-19 Impact on Tribal Communities

COVID-19 has had a severe impact on Native American and Alaska Native communities. According to the Centers for Disease Control and Prevention (CDC), age-adjusted COVID-19 hospitalization rates among AI/ANs are second only to Hispanic or Latinos at 554.2 per 100,000.[10] As of December 2020, the age-adjusted AI/AN COVID-19 mortality rate was 55.8 deaths per 10,000 compared to 30.3 deaths per 100,000 for White persons.[11] Some tribes have been impacted more than others. For example, during the beginning months of the COVID-19 pandemic the Navajo Nation saw the highest per capita COVID-19 infection rate in the United States.[12] According to the IHS the Navajo Nation still has the highest cumulative percent positive at 16.5 percent while the Alaska IHS Area has a cumulative percent positive of 2.4 percent.[13] As of March 15, 2021, the total cumulative percent positive across the twelve IHS regions is 9.5 percent.[14] Nationwide cumulative percent positive rate is 9.7 percent.[15]

According to the CDC, people with chronic obstructive pulmonary disease (COPD) and type 2 diabetes are at higher risk for COVID-19. AI/AN populations are disproportionately impacted by these underlying health conditions. In 2017, the CDC reported that age-adjusted percentages of COPD were highest among AI/ANs (11.9 percent vs 6.2 percent across all populations).[16] Similarly, in 2017 it was reported that AI/ANs experienced the highest diabetes prevalence at 15.1 percent, at more than double the percentage for non-Hispanic Whites.[17]

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[6] 25 U.S.C. 1611 et seq.
[7] PL 111-148.
[8] PL 93-638.
[9] Indian Health Service Budget Justification FY 2021 at CJ-185. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf
[10] https://bit.ly/3qNWJEo, updated Dec 10, 2020.
[11] https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a3.htm, 12/11/20
[12] https://bit.ly/3qYgskF, 7/8/20.
[13] *COVID-19 Cases by IHS Area*, https://www.ihs.gov/coronavirus/
[14] Id.
[15] https://covid.cdc.gov/covid-data-tracker/#vaccinations
[16] Wheaton AG, Liu Y, Croft JB, et al. Chronic Obstructive Pulmonary Disease and Smoking Status — United States, 2017, https://www.cdc.gov/mmwr/volumes/68/wr/mm6824a1.htm
[17]Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2018. LTSS Research: Diabetes in Indian Country. At 2. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/pdf/Emerging-LTSS-Issues-in-Indian-Country-Diabetes-in-Indian-Country-Annotated-Literature-Review.pdf

Before the COVID-19 pandemic, the IHS has had significant issues, spanning decades, with its personnel processes, medical credentialing system, fiscal accountability, and other operations. For example, the federally run IHS facilities within the Great Plains Area (GPA) have been plagued by extremely low-quality health care, and the GPA headquarters office has been accused of impropriety, nepotism, and corruption.[18] In 2010, the Senate Committee on Indian Affairs (SCIA) released a report highlighting the deficiencies inside the GPA which included: misconduct, poor performance, missing or stolen narcotics, reduced health care services, significant backlogs in billings and claims, and discouraging employees from communicating with Congress.[19] The issues in the GPA are seen as indicative of the issues of the agency as a whole. Beginning in March 2017 and continuing today, the GAO listed Indian Health in its biennial "high risk list." Programs listed in the report are federal programs most vulnerable to waste, fraud, abuse, and mismanagement, or that need transformative change.[20] Democrats and the IHS largely blame many of these issues on a lack of funding, but Congress has increased IHS funding almost every year since the 2010 and problems still persist.

Another challenge for tribes dealing with COVID-19 is a lack of adequate infrastructure. Many tribes are in locations with limited transportation, medical, and communications infrastructure. In fact, according to a 2019 Federal Communications Commission (FCC) report, individuals residing on tribal lands are nearly 4.5 times more likely to lack any terrestrial broadband internet access as those on non-tribal lands.[21] As a result, some tribal patients are unable to access telehealth, and tribal students are unable to access the same distance learning opportunities available to other Ameicans.

Furthermore, COVID-19 has had a devastating impact on tribal economies. According to the Harvard Project on American Indian Economic Development (HPAIED), before the COVID-19 pandemic, Tribal governments and businesses employed 1.1 million people and supported over $49.5 billion in wages, with Tribal gaming enterprises alone being responsible for injecting $12.5 billion annually into Tribal programs. During the six week period (through May 4, 2020) whereby all 500 Tribal casinos were closed in response to COVID-19 mitigation guidelines, Tribal communities lost $4.4 billion in economic activity, 296,000 individuals were put out of work totaling nearly $3 billion in lost wages.[22] Simultaneously, the oil and gas industry, which is important to many tribes, began to suffer from the collapse of commodity prices.[23] According to the National Indian Health Board (NIHB), over 193,000 AI/ANs have become uninsured as a result of COVID-19 job losses, with the vast majority of these individuals (72 percent) lacking access to IHS as well.[24]

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[18] https://republicans-naturalresources.house.gov/uploadedfiles/markup_memo_--_h.r._5874_06.13.18_2.pdf, 6/8/18.
[19] U.S. Senate. Committee on Indian Affairs. In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area, December 28, 2010. 111th Congress. ("Dorgan Report").
[20] https://www.gao.gov/assets/gao-17-317.pdf, February 2017.
[21] Federal Communications Commission, Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018, 5 (May 2019).
[22] Meister Economic Consulting. Coronavirus Impact on Tribal Gaming, http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming .
[23] https://bit.ly/30Pg1P9, 7/8/20.
[24] National Indian Health Board. Estimating Covid-19 caused increases in Uninsured AIANs due to job loss,

Federal Response

The Trump administration's response to tribal communities impacted by the COVID-19 pandemic was primarily carried out by the IHS and the Federal Emergency Management Agency (FEMA). Despite longstanding systematic issues within the IHS prior to the COVID-19 pandemic, the Trump administration was able to find success through prioritizing tribal engagement, which greatly expedited agency response and vaccine development.

On March 13, 2020, President Trump declared a nationwide emergency pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C 5121 et seq., Stafford Act). As part of this declaration, all state, local, tribal, and territorial (SLTT) partners became immediately eligible for FEMA Public Assistance (PA) Category B, emergency protective measures as authorized by section 403 of the Stafford Act and funded by the Disaster Relief Fund. Such assistance includes, but is not limited to, funding for tribal medical centers, Alternate Care Facilities, non-congregate sheltering, community-based testing sites, disaster medical assistance teams, mobile hospitals, emergency medical care, and the transportation and distribution of necessary supplies such as food, medicine, and personal protective equipment (PPE).[25] After the President's emergency declaration, all 50 states, 5 territories, the District of Columbia, and the Seminole Tribe of Florida were approved for Major Disaster Declarations, which covered every single tribal government in the country.

Tribal governments have parallel paths through which they can seek assistance from FEMA. They can either request to be direct recipients under the nationwide emergency declaration, or they can seek assistance as a direct recipient or subrecipient under a State's Major Disaster Declaration. Tribal governments also have the option to request a specific Major Disaster Declaration directly to the President through FEMA.[26]

In keeping with the Stafford Act, FEMA allocates funding to cover 75 percent of costs, and tribal governments are responsible for the remaining 25 percent. In the beginning stages of the COVID-19 pandemic, many state and tribal governments requested adjustments to the 75:25 cost-share ratio due to the economic hardship and loss of tax revenue associated with the pandemic. On April 30, 2020, NIHB sent a letter to President Trump calling on him to waive the cost-share requirements for all Tribal Nations who request assistance to respond to COVID-19.[27] The Stafford Act authorizes the President of the United States to increase the federal cost share to 90 percent if warranted, as determined by FEMA, using a per capita formula for small, impoverished communities.[28]

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https://www.nihb.org/covid-19/wp-content/uploads/2020/09/National-Indian-Health-Board-Comments-on-NAS-Draft-COVID-VACCINE-Documen.._.pdf .

[25] https://bit.ly/3r2v2rL, 7/1/20.

[26] PL 113-2.

[27] https://bit.ly/3vrGOiJ, 4/30/20.

[28] 42 U.S.C. § 5133 ("the President may contribute up to 90 percent of the total cost of a mitigation activity carried out in a small impoverished community"); 44 CFR § 201.2, "Definition of Small and impoverished communities": must be a community of 3,000 or fewer individuals, the community needs to be economically disadvantaged and have high unemployment rates. The way of distinguishing economically disadvantaged is that that per capita annual income cannot exceed 80 percent of the national per capita income and then the local rate must exceed by 1

To help tribal governments affected by COVID-19, the Department of the Treasury announced in June 2020 that COVID-19 Relief Fund dollars, provided under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, could be used to pay for cost share requirements under the Stafford Act.[29] In February 2021, President Biden issued a Presidential Memorandum to waive all Federal cost-share requirements for assistance provided by FEMA under the Stafford Act.[30]

In response to the COVID-19 pandemic, FEMA provided expanded services in support of tribal governments across the country by dedicating Tribal Liaisons in each of the ten FEMA regional offices. Additionally, FEMA Regions, with the support of federal partners, hosted weekly meetings and conference calls with tribal leaders and tribal emergency managers to answer questions during the pandemic response. FEMA dedicated a permanent National Tribal Advisor Desk on March 15th to further support coordinated federal response efforts to support tribes during any major disaster or emergency activation within FEMA's National Response Coordination Center (the NRCC) – which is in FEMA Headquarters.[31]

The IHS outlines in its "Covid-19 Response 100 Day Review Executive Summary" all of the actions it took to respond to the outbreak of the COVID-19 pandemic.[32] Some of the actions highlighted in the Executive Summary include: guidance, recommendations, information dissemination, data surveillance and publication, expanded telehealth opportunities, informational webinars, PPE tracking and distribution, guidelines on hiring, leave and pay authorities, and tribal consultation for federal programs and funding.

In April 2020, the IHS expanded use of an agency-wide videoconferencing platform that allows for telehealth on almost any device and in any setting, including in patients' homes. Since April's telehealth expansion, the IHS has experienced a greater than eleven-fold increase of telehealth visits, from roughly 75 telehealth visits per week on average to 907 videoconferencing telehealth visits per week on average.[33] Also in April 2020, HHS purchased the "ID NOW COVID-19" rapid point-of-care test, developed by Abbott Diagnostics Scarborough Inc., for state, territorial and tribal public health labs.[34]

In May 2020, IHS began distributing Remdesivir to IHS federal and tribal hospitals based on requests and the number of patients with COVID-19 who were hospitalized or in an ICU at the time. Remdesivir is an investigational antiviral medicine that has been used under an emergency use authorization to treat certain people with COVID-19 and has shown in a clinical trial to shorten the time to recovery in some people.[35] In the summer of

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percentage point the average yearly national unemployment rate.

[29] https://bit.ly/3tuERAm, 7/1/20.

[30] Presidential Memorandum for the Secretary of Homeland Security and the Administrator of FEMA. 2/2/21. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/02/02/memorandum-maximizing-assistance-from-the-federal-emergency-management-agency/

[31] https://bit.ly/3rTMwHL, 7/1/20.

[32] https://bit.ly/3qUCPHG.

[33] https://bit.ly/38M2vQT, 7/1/20.

[34] https://bit.ly/3vz2sla, 4/6/20.

[35] https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/IHSFactSheet_Remdesivir_05212020_Updated.pdf

2020, the IHS announced a new Critical Care Response Team of expert physicians, registered nurses, and other health care professionals. This team provides urgent lifesaving medical care to COVID-19 patients admitted to IHS or tribal hospitals. These expert medical professionals train the frontline health care professionals on information available for the management of COVID-19 patients, and other critically ill patients.[36]

Vaccine Development

Operation Warp Speed (OWS) was initiated by President Trump in May 2020 and was led by HHS and the Department of Defense (DOD) to support multiple COVID-19 vaccine candidates speed up development. President Trump called on the agencies to work with vaccine candidates to develop 300 million doses of COVID-19 vaccine by January 2021. While viewed as an outstanding success, OWS was not able to meet its lofty goal. However, as of January 2021, five of the six OWS vaccine companies had started commercial scale manufacturing of COVID-19 vaccines and OWS officials reported that as of January 31, 2021, companies had released 63.7 million vaccine doses.[37]

Ultimately, OWS facilitated the first emergency use authorization (EUA) for a COVID-19 vaccine in just under 7 months – a process which usually takes 5-10 years. Unfortunately, after calling for unity in his inaugural address, President Biden made a partisan political decision to retire and rename OWS. Andy Slavitt, a senior adviser to the White House's COVID team, credited the Trump administration's OWS for spurring the development of a COVID vaccine at an unprecedented pace.[38]

Moncef Slaoui, scientific head of OWS and a Democrat, recently said that, "Warp Speed was absolutely visionary to put together science, government, the military, and the private sector and just give us full empowerment. It was the right thing to do." Slaoui also called the Biden administration's vaccine rollout a "dismal failure."[39]

Vaccine Distribution

IHS has followed CDC recommendations for vaccine release, including prioritization of health care workers and residents of long-term-care facilities. IHS provided the first vaccine dose to 100 percent of its health care work force and residents of long-term-care facilities not accounted for by the Centers for Medicare and Medicaid Services. Health facilities are receiving the remainder of the Pfizer, Moderna and Johnson & Johnson/Janssen doses to vaccinate the next priority populations based on Advisory Committee on Immunization Practice (ACIP) guidelines.[40]

- Vaccine deliveries in the twelve IHS regions as of March 15, 2021: **761, 646**[41]

[36] https://bit.ly/3tlSeT8, 7/1/20.
[37] https://www.gao.gov/products/gao-21-319, 2/11/21.
[38] https://www.politico.com/news/2021/03/11/slavitt-trump-operation-warp-speed-475310. 3/11/21
[39] https://bit.ly/3vzUKav, 1/25/21.
[40] https://www.ihs.gov/coronavirus/vaccine/distribution/, https://bit.ly/2Qdl7Tp,
[41] https://www.ihs.gov/coronavirus/

- National vaccine deliveries as of March 18, 2021: **116 million**[42]

Congressional Action

As of December 2020, Congress had passed five supplemental appropriation acts to combat COVID-19 throughout the country, providing an additional $3 billion to IHS on top of the FY 2021 appropriation of $6.2 billion. In February 2021, Congress passed the American Rescue Plan Act, which provided $30 billion to be directed to Indian Country. Of the $30 billion, approximately $6.1 billion was provided to the IHS.

For a further breakdown of funds received in response to COVID-19, **click here**.

Key Republican Arguments

While increases to many IHS accounts are well supported, there remains a deep need to conduct proper oversight over the agency as to how funds are, and will be, spent. Congress has provided an immense amount of funding during the COVID-19 pandemic. Accountability and transparency must be adhered to by the Biden Administration. Funding increases will not continue to be sustainable over the long run and Congress must do more to address programmatic and systemic issues within the IHS system to provide a reliable healthcare delivery system.

[42] https://covid.cdc.gov/covid-data-tracker/#vaccinations