US HOUSE OF REPRESENTATIVES ENERGY & COMMERCE COMMITTEE
HEARING ON IHS & TRIBAL HEALTH, JULY 8, 2020
TESTIMONY OF DR. CHARLES GRIM, SECRETARY OF HEALTH
CHICKASAW NATION DEPARTMENT OF HEALTH

Introduction

Chairman Pallone, Ranking Member Walden, and Members of the Committee, thank you for holding this critical hearing on "Addressing the Urgent Needs of our Tribal Communities." On behalf of the Chickasaw Nation and the patients we serve, I submit this testimony for the record.

I am Dr. Charles Grim, Secretary of Health for the Chickasaw Nation. I am a native of Oklahoma and a citizen of Cherokee Nation. I am a retired Assistant Surgeon General and Rear Admiral (upper half) in the Commissioned Corps of the United States Public Health Service (USPHS). I graduated from the University of Oklahoma College Of Dentistry in 1983. I am board certified in Dental Public Health and a Fellow in the Academy of General Dentistry. In addition I hold a master's degree in health services administration from the University of Michigan.

Prior to joining the Chickasaw Nation Department of Health leadership, I served for 10 years in various leadership roles for the Cherokee Nation tribal health system, ultimately serving as their Executive Director. Prior to that I was appointed by President George W. Bush and received unanimous Senate confirmation as the Director of the Indian Health Service (IHS) from 2002-2007. I have served 37 years in Indian Health positions, 26 years for the federal government and now 11 years with self-governance tribes.

As Secretary of Health, I serve as the executive in charge of a tribal health system that includes the 72 bed Chickasaw Nation Medical Center, three outpatient health clinics, an EMS service, revenue cycle, facilities management, and a host of public health, nutrition and community health programs. Quality health care is provided to a patient population in excess of 90,000 in a 13 county tribal service area, however patients receiving care come from communities throughout the United States.

Since this is a broad based hearing on "Addressing the Urgent Needs of Our Tribal Communities", and due to my background and leadership experiences both within the Indian Health Service and working directly for Tribes, I have chosen to submit an extensive written testimony dealing with some of the most urgent issues across the Indian Health sector.

Included in this testimony are sections on:
  I.   Chickasaw Nation
  II.   Indian Health Care System
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I. Chickasaw Nation

From migration to what is now Mississippi, Kentucky, Alabama and Tennessee in prehistoric times to the purchase of the new homeland in south-central Oklahoma in the mid 1800's, the Chickasaw culture and heritage have always had roots in nature and the elements.

Revered in ancient times as "Spartans of the Lower Mississippi Valley," the first contact with Europeans was with Hernando de Soto in 1540. Living in sophisticated town sites, the Chickasaws possessed a highly developed ruling system complete with laws and religion. They conducted a successful trade business with other tribes and with the French and English, and lived largely an agrarian lifestyle, but were quick to go to battle if necessary. They allied with the English during the French and Indian War. Some historians give the Chickasaws credit for the United States being an English-speaking country.

The Chickasaw people moved to Indian Territory during the "Great Removal," on what was called the "Trail of Tears." Other tribes forced to relocate were the Cherokee, Choctaw, Creek and Seminole, called the "Five Civilized Tribes" because of their highly developed ruling systems. The Chickasaws were one of the last to move. In 1837, the Treaty of Doaksville called for the resettlement of the Chickasaws among the Choctaw tribe in Indian Territory. In 1856, the Chickasaws, in order to restore direct authority over their governmental affairs, separated from the Choctaws and formed their own government.

Tribal leaders established the capital at Tishomingo, adopted a constitution and organized executive, legislative and judicial departments of government with the offices filled by popular election. Many Chickasaws became successful farmers and ranchers. Chickasaws built some of the first schools, banks, and businesses in Indian Territory.

After Oklahoma statehood in 1907, the President of the United States appointed the principal officers of the Chickasaw Nation. In 1970, Congress enacted legislation allowing the Five Civilized Tribes to elect their principal officers. In 1983, a new Chickasaw constitution was adopted.

Today, the Chickasaw Nation is economically strong, culturally vibrant and full of energetic people still dedicated to the preservation of family, community and heritage. Since the 1980s, tribal government has focused on building an economically diverse base to generate funds that will support programs and services to Indian people. Business has flourished, programs and services have grown, and the quality of life for all Chickasaws has been greatly enhanced.

The Chickasaw Nation's current three-department system of government was reestablished with the ratification of the 1983 Chickasaw Nation Constitution. The elected officials provided for in the Constitution believe in a unified commitment, whereby government policy serves the common good of all Chickasaw citizens. This common good extends to future generations as well as today's citizens.

The structure of the current government encourages and supports infrastructure for strong business ventures and an advanced tribal economy. The Chickasaw Nation uses new technologies and dynamic business strategies in a global market.

As in times past, the Chickasaw work ethic is very much a part of everyday life today. Monies generated in business are divided between investments for further diversification of enterprises and support of tribal government operations, programs and services for Chickasaw people. This unique system is key to the Chickasaw Nation's efforts to pursue self-sufficiency and self-determination, which helps ensure that Chickasaws stay a united and thriving people.

The mission of the Chickasaw Nation is to enhance the overall quality of life of the Chickasaw people. The vision is to be a nation of successful and united people with a strong cultural identity. The Chickasaw Nation lives its core values that guide all its activities to support the mission and vision. The ten core values are: the Chickasaw people, cultural identity, servant leadership, selflessness, can do attitude, perseverance, stewardship, trust and respect, loyalty, honesty and integrity and teamwork.

Chickasaw Nation Department of Health
The Chickasaw Nation Department of Health (CNDH) is one of nine departments of the Chickasaw Nation. In 1994, the CNDH was compacted to become a tribally operated health care organization. Direct, primary care health services are provided to all federally recognized American Indian and Alaska Native (AI/AN) persons.

The Chickasaw Nation Medical Center (CNMC) in Ada is a state-of-the-art 405,000 square foot facility that provides the following services:

Inpatient Medicine	Psychiatry	Acute Care & Intensive Care
Optometry	Inpatient and Outpatient Surgery	Dental
Obstetrics & Gynecology	Medical Family Therapy	Primary Care
Physical Therapy	Pediatrics	Laboratory
Imaging Services	Pharmacy	Audiology

The CNDH has satellite clinics in Ardmore, Purcell and Tishomingo. The Chickasaw Nation offers a variety of nutrition-focused programs and services in five Nutrition Centers in Ada, Ardmore, Purcell, Tishomingo, and Duncan. WIC services are also available in Pauls Valley, Sulphur and Tishomingo.

The CNDH has 1,700 employees. The medical staff consists of:
- 192 MD/DO (Physicians)
- 20 DDS/DMD (Dentists)
- 2 DPM (Podiatrists)
- 10 OD (Optometrists)
- 44 APRN (Nurse Practitioners)
- 28 PA (Physician Assistants)

In 2019, the CNMC served more than 5,421 inpatient admissions and 930 births. Excluding pharmacy and ancillary visits, the CNDH saw the following on an outpatient basis:
- 405,760   CNMC, Ada
- 132,173   Ardmore Clinic
- 84,645   Purcell Clinic
- 70,373   Tishomingo Clinic
- 693,131   Total Outpatient Visits

The emergency department, which includes all service levels, saw 45,005 patients. The pharmacy served 392,806 customers and 1,884 endoscopies and 3,008 operating room procedures were performed. In total, over 1.1 million visits occurred within the CNDH in 2019.

II. Indian Health Care System

Health care for AI/ANs often comes from a system that is separate from that of mainstream America. The IHS is the federal agency with primary responsibility for the nationwide multi-billion dollar Indian health care system in fulfilling the United States' trust obligation to provide health care for AI/AN people. In the attempt to fulfill the federal trust responsibility and meet the health care needs of AI/AN people, the IHS and tribes have developed a system of hospitals, clinics, field stations, and other programs which serve approximately 1.9 million of the Nation's 3.3 million AI/ANs. The roots of all of this activity lie in the federal trust responsibility. From the beginning, tribal sovereignty, government-to-government relations between tribes and the US, and tribal autonomy have existed as common themes underlying federal-Indian relations. In addition, a unique federal trust responsibility has grown as a result of the relations between the federal government and tribes.

In exchange for the vast amounts of land that treaties transferred from tribes to the federal government, the government promised to provide, among other things, health care to Indians. Federal law recognizes that the original treaty stipulations on health care serve as a basis for a federal obligation to provide for Indian health care.

During the 1800s, the US Army took steps to curb infectious diseases among tribes living in the vicinity of military posts, in order to protect its soldiers and neighboring non-Indians. This was the first provision of health services to American Indians by the federal government. The first Congressional appropriation specifically for Indian health care was in 1832, which authorized the purchase and administration of smallpox vaccine.

The War Department was initially in charge of Indian affairs. Indian health care passed from the military and missionaries to civilian control in 1849, when the Bureau of Indian Affairs (BIA) was transferred from the War Department to the newly formed Department of the Interior (DOI). At this time, Native Americans were being placed on reservations which meant increasing risk of disease due to poor living conditions. By 1880, only 77 physicians were serving the entire American Indian population in the United States and its territories. The move to reservations had harmful health effects, in part because it often created a shift away from traditional diets. It became increasingly difficult or impossible to hunt and gather traditional foods and medicines. Many of the health problems faced by AI/AN people today, such as diabetes, cancer, and heart disease, are related to shifts from traditional dietary patterns to a diet heavy in fats and carbohydrates.

Eventually, actions were taken to improve AI/AN health services. Congress passed the Snyder Act in 1921, providing explicit legislative authorization for federal health programs for Indians by mandating the expenditure of funds for "the relief of distress and conservation of health … [and] for the employment of … physicians … for Indian tribes." This provided the first formal authority for federal provision of health care services to members of all federally recognized tribes. BIA health care services received another boost in 1926 when physicians from the Commissioned Corps of the USPHS were first assigned to Indian health programs.

In 1955 Congress transferred total responsibility for Indian health from the DOI to the United States Public Health Service (USPHS). The legislation stated that "all facilities transferred shall be available to

meet the health needs of the Indians and that such health needs shall be given priority over that of the non-Indian population."

Along with the civil rights movements and American Indian Movement of the 1960s and 1970s came a shift from the policy of termination towards self-determination for American Indian tribes. In the early to mid-1970s, Congress passed several laws designed to strengthen and restore tribal sovereignty: the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) and the Indian Health Care Improvement Act of 1976 (P.L. 93-437).

The "Self-Determination Act" directs the Secretary of the DOI and the Secretary of the Department of Health and Human Services (DHHS), upon the request of any Indian tribe, to enter into self-determination contracts or compacts with tribal organizations. Congress made self-governance a permanent program in 2000, through P. L. 106-260.

The Indian Health Care Improvement Act (IHCIA) addressed the continuing lag of Indian health behind that of the general population, setting forth a national goal to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy."

Today, acting under the broad authorization of the 1921 Snyder Act, the Congress appropriates funds to IHS to fulfill the federal government's trust responsibility to provide health care services to AI/AN people. **Few would argue that the amount of funds appropriated adequately fulfills that responsibility, particularly in light of the demonstrable disparities in health status between AI/AN people and other population groups.**

Today, Tribal Governments have three choices of how to have these health services provided. The first choice is to have their health services provided by the Federal Government, primarily through the agency, the IHS. The second choice for Tribes is to contract with the IHS for those programs or services they wish to provide for their own members. And the third choice Tribes have is to choose to assume, through compacts, the total operation and control over their health systems from the IHS; we refer to those Tribes as Self-Governance Tribes. As of January 2020, approximately $2.4 billion or 41% of the IHS budget is going directly to Self-Governance Tribes, representing more than 360 of the 574 federally recognized Tribes, to fund services and programs.

Oklahoma City Area Indian Health Care System
The Oklahoma City Area (OCA) IHS is one of the 12 Area (regional) offices of the IHS and serves the states of Oklahoma, Kansas, a portion of Texas, and Richardson County, Nebraska. Forty-three tribes are represented within the Area with 38 in Oklahoma, 4 in Kansas, and one in Texas. In FY 2019, the OCA user population was 388,486--the largest user population in IHS representing 23.4% of the total. The OCA is the lowest funded IHS Area per capita. The IHS, Tribal, and Urban (I/T/U) health systems within the Area manage 8 hospitals, 59 health centers (which includes 3 urban health clinics), 1 school health center, and 1 regional youth alcohol and substance abuse treatment center. The large number of tribal health care facilities and programs is a strong reflection of the partnership and cooperation within the OCA to fulfill the existing health care needs of our community.

III. COVID-19 Impact on the Indian Health Care System
Our nation is gripped by the most unprecedented public health crisis in generations. As of July 5, 2020 there are over 2.9 million COVID-19 cases nationwide and over 132,000 COVID-19 deaths, according to

the Centers for Disease Control and Prevention (CDC). Public health data continues to demonstrate that not only are new cases not subsiding, they are dangerously increasing in countless jurisdictions nationwide. According to the CDC, on July 3, the United States recorded 57,718 cases - the highest number of cases reported in a single-day since April 6. In a data analysis from Kaiser Family Foundation, from June 11 to June 25 a total of 26 states reported increased COVID-19 cases including many with large AI/AN populations including Arizona, Oklahoma, Michigan, Nevada, Wisconsin, Washington, Wyoming, Montana, California, and Oregon.

And similar to every prior public health crisis, there are disparate and disproportionate impacts on underserved and marginalized communities, and Indian Country is at the epicenter. According to CDC, people with chronic obstructive pulmonary disease (COPD), type 2 diabetes, and chronic kidney disease are at higher risk for a more serious COVID-19 illness. AI/AN populations are disproportionately impacted by all three of these underlying health conditions.

The evidence that what we all feared is not hard to find as we see deaths mounting in Tribes with some of the nation's highest rates of diabetes. It is important to note that all these underlying conditions not only increase the likelihood of hospitalization and death, but will linger long after the hospital stay of those who do recover. The costs of all this care is an added financial burdened to an already overwhelmed and underfunded health care system.

Not only is the health and lives of AI/ANs at risk, but so too is their financial status impacted by the disproportionate incidence of COVID-19. As many as an estimated 42,000 AI/ANs in Oklahoma lost their jobs due to the pandemic (as of May 2, 2020) and with it as many as 25,000 lost their health insurance coverage. The recently passed initiative in Oklahoma to expand Medicaid will come too late to provide coverage for these recently unemployed due to COVID-19.

As of July 3, 2020, the IHS reported 21,093 positive cases of COVID-19. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribal health programs, which constitute roughly two-thirds of the Indian health system, is voluntary. **According to data analysis by APM Research Lab, AI/Ns are experiencing the second highest aggregated COVID-19 death rate at 36 deaths per 100,000. The CDC reported on June 6, 2020 that age-adjusted COVID-19 hospitalization rates among AI/ANs are higher than any other ethnicity, at 194 per 100,000.** Reporting by state health departments has further highlighted disparities among AI/ANs.

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

The COVID-19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID-19, the Indian health system was beset by an average 25% clinician vacancy rate, and a hospital system that remains over four times older than the national hospital system. Limited intensive care unit (ICU) capacity to address a surge of COVID-19 cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services.

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

underdeveloped. **Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.**

In a new peer-reviewed study of 287 Tribal reservations and homelands, **COVID-19 cases were found to be 10.83 times more likely in homes without indoor plumbing.**

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

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

IV. Chickasaw Nation Response to COVID-19
The Chickasaw Nation Governor Bill Anoatubby, declared a state of emergency on March 17, 2020. During this pandemic response the CNDH has partnered with local communities, region, state, and nation as well as other health care, business and federal partners to be able to offer services to all persons needing care while continuing to provide robust services to current patients.

The COVID-19 pandemic arrived in Oklahoma at almost the same time as many CNDH employees and patients were returning from spring break. Simultaneously, while many Chickasaw Nation industry businesses were scaling back to essential services only, the CNDH was rapidly converting its operation to be able to serve its patients, employees and the community during the pandemic.

Within the span of less than two weeks, the majority of in person visits were converted to virtual visits using a variety of online electronic platforms. An employee screening process was initiated for all CNDH health employees and then for all Chickasaw Nation employees returning from annual leave and/or who were having symptoms of possible COVID-19 infection, or who had known or possible exposure to persons infected with COVID-19. Many of these employees and family members were directed to self-quarantine or referred for definitive testing.

A daily CNDH employee and patient screening process was introduced at all CNDH facilities to screen employees for temperature and symptoms and exposure to COVID-19. Restrictions on visitors and guests entering CNDH facilities were introduced to reduce unnecessary exposure of patients and health care workers to those potentially infected with COVID-19.

A COVID-19 call center was introduced to triage patients and employees with potential symptoms and/or contacts of COVID-19 to medical care. A COVID-19 clinic was developed to help see persons with symptoms and close contacts. Emergency standards of care and treatment protocols were initiated through the CNDH Medical Executive Committee.

CNDH immediately set up testing tents throughout the Chickasaw Nation at the CNMC, Ardmore, Purcell and Tishomingo Clinics. We stood up testing sites at some of our larger businesses to have massive employee testing before employees returned to work. To date we have tested over 25,000 patients, employees and community members serving both AI/AN and non-natives. As part of the COVID-19 legislative packages, we initially received five of the Abbott ID Now rapid test instruments; since then we have received three more through IHS's distribution. We also ordered one of the Cepheid instruments, Hologic Panther, Abbott Alinity and Biofire which has the ability to do rapid testing and antibody testing. We are currently developing our antibody testing plan.

CNDH and Chickasaw Nation also stood up their Incident Command teams (ICT) and integrated with local, state, national, IHS, CDC, Federal Emergency Management Agency (FEMA), and Department of Defense (DoD) emergency operations. The Chickasaw Nation state of emergency declaration was immensely helpful in assuring social distancing, stay at home and quarantine orders and allowed the CNDH health system greater flexibility to defer some elective care and utilize alternative delivery models. The emergency order also allowed the CNDH to provide care to serve broader communities.

CNDH developed a gating criteria and prioritization matrix utilized by the demobilization unit for phased reopening timelines. When the gating criteria established is met it triggers the phased reopening timelines for each CNDH departments. The prioritization matrix helps guide recommendations as to which CNDH departments should be prioritized to open earlier in the phased timeline or those departments that should be delayed to open at a later date. As CNDH continues to progress through the natural evolution of the COVID-19 pandemic, it is important that a public-health based strategy is continued to limit viral spread and measureable milestones are utilized as a guide to implementing a phased reopening of operations for the CNDH.

The establishment of the demobilization team coincided with the, April 16th, 2020, release of President Trump's plan for reopening the United States. This plan is used by state Governors to assist with the planning for reopening at the state and or regional level. The released plan (https://www. whitehouse.gov/openingamerica/#criteria) uses a phased approach for lifting mitigation measures for individuals, communities, and the business sectors.

Following these guidelines released from the White House, Oklahoma Governor, Kevin Stitt outlined a vision on April 22, 2020, for reopening some businesses starting April 24, 2020. Many other businesses previously deemed "non-essential" were allowed to reopen on May 1, 2020, so long as they adhere to social distancing and sanitation recommendations. The three tiered approach to reopening businesses statewide had Oklahoma back to business as usual by mid-June, so long as the state continues to manage the number of COVID-19 cases and hospitalizations.

CNDH continues to utilize innovative methods such as virtual visits and work from home options to maintain patient services for the safety of employees, patients, and community members.

Because of the swift action and declaration by Governor Anoatubby to close all non-essential business and offices in the 13 county area in the Chickasaw Nation, we have a very low positive prevalence rate (approximately 300 positives to date).

V. Indian Health Care System Funding
The Indian health system faces significant funding disparities when compared to other Federal health care programs**. Overall, per capita spending within IHS is just $4,078, while the national average per**

capita spending is $9,726, making IHS the most chronically underfunded federal health care entity nationwide and thus severely ill-equipped to respond to COVID-19. The historic allocations of resources appropriated to the IHS have created significant inconsistencies throughout the system.

Over the years, allocation methodologies have created a disparity of available resources by line items when reflected in a per capita amount. Within the IHS, the OCA has historically had the lowest funding per capita amongst the Areas in overall IHS funding, in FY 2019 the OCA per capita amount is $2,075.

Therefore, the Chickasaw Nation health care system funding is comprised of various revenue streams. Due to the limited amount of funding we receive from the IHS, third party revenue is a major source of funding for our health care system.

IHS Funding
The historic allocations of resources appropriated to IHS by line items are distributed by the Agency using various methodologies. Over the years, these allocation methodologies have created a disparity of available resources by line items as reflected when attributing a per capita amount by line item by the Area Offices. The OCA has been historically in the bottom 25% and one of three Areas receiving the lowest for Hospitals and Clinics (H&C), Mental Health (MH), Alcohol/Substance Abuse (A/SA) and Purchased/Referred Care (PRC).

Delivery of care is substantially complicated when the direct services system is funded at the third lowest level overall and at the lowest level for services needed outside the health care system. Additionally, the OCA does not receive sufficient resources to provide an infrastructure for delivery of an adequate level of service for ambulatory care. As a result, patients make multiple outpatient visits for needs that should be addressed by referring a patient within the PRC system.

Third Party Funding
A new American Hospital Association (AHA) report released on June 30, finds that the financial strain facing hospitals and health systems due to COVID-19 will continue through at least 2020, with total losses expected to be at least $323 billion in 2020. The report estimates an additional minimum of $120.5 billion in financial losses, due in large part to lower patient volumes, from July 2020 through December 2020, or an average of $20.1 billion per month. These estimates are in addition to the $202.6 billion in losses the AHA estimated between March 2020 and June 2020 in a report released last month.

The report also says the projected losses still may underrepresent the full financial losses hospitals will face in 2020, as the analysis does not account for currently increasing case rates in certain states, or potential subsequent surges of the pandemic occurring later this year.

COVID-19 has greatly impacted the finances of many health care facilities. **Workload comparisons for CNDH show a decrease of approximately 46% as compared to the same time period in 2019. Projected decreases in third party revenue for the rest of this fiscal year is approximately $25 million as compared to the same time period in 2019.**

VI. Funding Priorities of the Indian Health Care System:
Despite the funding already provided for Indian health care, including the COVID-19 funding packages, there remains great needs. The following funding priorities would address some of those needs:

- **Fiscal Year (FY) 2021 funding for IHS budget - $9.1 billion**
  - o The Tribal Budget Formulation Workgroup (TBFWG) Recommendation
  - o Lack of an enacted FY 2021 IHS budget by September 30, 2020, the Indian health care system will be left unprepared to tackle a potentially stronger wave of COVID-19 infections in the fall and winter months ahead.
  - o It is imperative that IHS not be subject to another continuing resolution or face the threat of another government shutdown in these unprecedented times.

- **Enact Advance Appropriations for IHS**
  - o Advance Appropriations would help honor the federal trust responsibility and help ensure that the federal government meets its obligations to the Tribes in the event that Congress cannot enact a new budget by the start of each fiscal year.
  - o Furthermore, as noted in the 2018 GAO report (GAO-18-652), "…uncertainty resulting from recurring continuing resolutions and from government shutdowns has led to adverse financial effects on tribes and their health care programs."
  - o Advance appropriations would help provide much better continuity and stability of care, resulting in better health outcomes for AI/ANs. Moreover, it would allow for more efficient use of appropriated dollars by removing budgetary restrictions that force IHS to neglect long-term planning and focus limited resources on the most imminent health needs. In addition, it would ensure parity between IHS and the VHA – both of which have the federal charge to provide direct care services.
  - o We have been encouraged about the efforts to authorize advance appropriations for Indian programs, including the hearings last spring on two pieces of legislation that have bipartisan support. H.R. 1128 – Indian Programs Advance Appropriations Act; and H.R. 1135 – Indian Health Service Advance Appropriations Act of 2019.
  - o Chickasaw Nation supports every IHS account being subject to advance appropriations, as each IHS account directly impacts patient care. We also believe authorizing advance appropriations for Indian programs would bolster continuity of care, enable greater long-term planning, improve the stability of the Indian health system, and reduce health disparities

- **Pass H.R. 2680 – Special Diabetes Program for Indians Reauthorization Act of 2019** – The Chickasaw Nation supports H.R. 2680 and the 5 years of guaranteed funding for the Special Diabetes Program for Indians (SDPI) at an increase to $200 million, but we urge that the House bill include language authorizing Tribes and Trial organizations to receive SDPI awards through 638 contracting and compacting agreements as outlined in the Senate bill, S. 3937.
  - o The SDPI is the only program that has effectively reduced incidence and prevalence of diabetes, and is responsible for a 54% reduction in rates of End Stage Renal Disease and a 50% reduction in diabetic eye disease. In a 2019 federal report, SDPI was found to be largely responsible for $52 million in savings in Medicare expenditures per year.
  - o Despite its documented success, since September 30, 2019, SDPI has gone through four short-term extensions, with the most recent extension occurring under the CARES Act. SDPI is currently set to expire on November 30, 2020.
  - o This bipartisan bill would provide 5-years of guaranteed funding for SDPI at an increase to $200 million per year overall. This represents the first increase to SDPI in over sixteen years, and the longest reauthorization in over a decade.
  - o Significantly, S. 3937 would also authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 self-determination and self-governance contracting and

compacting agreements, thus allowing for greater local Tribal control over the life-saving program.

- o **The Chickasaw Nation requests the following language addition to H.R. 2680:**

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

- **Water and sanitation development across IHS and Tribal facilities - $1 billion**
  - o In order to stem the tide of the COVID-19 pandemic in Indian Country, it is essential that Congress make meaningful investments in water and sanitation development across IHS and Tribal facilities.
  - o According to the 2018 IHS Sanitation Facilities Infrastructure Report, roughly $2.67 billion is needed to bring all IHS and Tribal sanitation facilities to a Deficiency Level 1 designation.

- **Telehealth, electronic health records and health information technology (IT) infrastructure development - $3 billion**
  - o Limitations in the availability of AI/AN specific COVID-19 data are contributing to the invisibility of the adverse impacts of the pandemic in Indian Country within the general public. Senior IHS officials, including Chief Medical Officer Dr. Michael Toedt, have stated publicly that existing deficiencies with the IHS health IT system are inhibiting the agency's ability to adequately conduct COVID-19 disease surveillance and reporting efforts.
  - o Lack of health IT infrastructure has also seriously hampered the ability of IHS and Tribal sites to transition to a telehealth-based care delivery system. While mainstream hospitals have been able to take advantage of new flexibilities under Medicare for use of telehealth during the COVID-19 pandemic, IHS and Tribal facilities have not because of insufficient broadband deployment and health IT capabilities.
  - o **It is critical that Congress provide meaningful investments in health IT technologies for the Indian health system to ensure accurate assessment of AI/AN COVID-19 health disparities and equip Indian Health Care Providers with the tools to seamlessly provide telehealth-based health services.**

VII. Legislative Priorities of the Indian Health Care System
- Authorize Indian Health Care Providers (IHCPs) to receive Medicaid reimbursement for all medical services authorized under the IHCIA – called "Qualified Indian Provider Services" – when delivered to Medicaid-eligible American Indians and Alaska Natives
  - o Currently, IHCPs only receive reimbursement for health services authorized for all providers in a state. Therefore, although IHCIA authorizes medical services such as long-term care and mental/behavioral services that are crucial for Tribal communities to respond to COVID-19, an IHCP will not be reimbursed for these services if they are not covered by the state Medicaid program.
  - o Because of chronic underfunding of IHS, many Tribes utilize third party collections from payers like Medicaid to constitute up to 60% of their healthcare operating budgets. But without the authority to bill for services already authorized under federal law, it is further straining Tribal COVID-19 response efforts.

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

- Enact Certain Sections of the Bipartisan CONNECT to Health Act
  - o The bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (S. 2741) was introduced in October 2019 and has the broad support of over 100 health organizations.
  - o Section 3 of the CONNECT to Health Act would provide the U.S. Department of Health and Human Services (HHS) with the ability to waive certain telehealth restrictions outside of the national emergency context. These waivable restrictions include limitations on provider types, technology, geographic area, and services. These are critical authorities to ensure flexibility in delivery of mental and behavioral care.
  - o Section 8 of the CONNECT to Health Act would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization which make it very difficult to deliver mental and behavioral health care.
  - o Originating site requirements currently mandate that a patient be in a particular location such as a physician's office, hospital, or other specified clinical setting. These requirements prevent patients from being able to receive mental and behavioral health services from their homes, community centers, or other non-clinical locations.
  - o In addition, Sections 4, 5, 7, and 14 of the CONNECT Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expands the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian health system.

- Include Pharmacists, Licensed Marriage and Family Therapists, Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to Indian Health Care Providers
  - o There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country. Because of this shortage, Indian healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists
  - o LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, clinical social workers, and psychologists do. Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including tobacco cessation, and medication-assisted treatment (MAT) for substance use disorders.
  - o All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead.
  - o This deprives Indian Health programs of critically needed federal reimbursement for vital healthcare services to AI/ANs, which is critical to an effective COVID-19 response.

- Permanently Extend Waivers under Medicare for Use of Telehealth

- COVID-19 has dramatically increased the need to connect patients to their providers through telehealth for medical and behavioral health services. In response, CMS has temporarily waived Medicare restrictions on use of telemedicine.
- Yet for many Tribes that lack broadband and/or telehealth capacity and infrastructure, it is not financially feasible to purchase expensive telehealth equipment for a short-term authority.
- Making permanent the telehealth waivers for both video and audio-based telehealth services would ensure that the telehealth delivery system remains a viable option for delivery of essential medical, mental and behavioral health services in Indian Country, and helps close the gap in access to care

VIII. Indian Health Care System Challenges
   a. Workforce Development:

The Chickasaw Nation like many other parts of the United States continue to experience shortages in finding healthcare workers. Specialists like Emergency Room Physicians, General Surgeons, Primary Care Physicians, etc. are difficult to recruit and entice to move to more rural parts of Oklahoma.

All IHS and tribal health care facilities experience chronic clinical provider shortages for both primary and specialty care services. Lack of provider availability significantly lowers our capacities to deliver timely and quality health care to Tribal citizens.

In 2018, the Government Accountability Office (GAO) published a report, "INDIAN HEALTH SERVICE: Agency Faces Ongoing Challenges Filling Provider Vacancies (GAO-18-580)," estimating the vacancy rates at federal IHS sites, as follows: Physicians - 34%; pharmacists - 16%; nurses - 24%; dentists - 26%; physicians - 32% and advanced practice nurses - 35%.

The IHS system competes with the private sector, as well as the Veterans Administration in recruiting and maintaining health providers. However, there are a few tools available to the IHS and Tribes that provide unique advantages in recruitment, principal among them – the IHS Scholarship and the IHS Loan Repayment Program (LRP). We need comprehensive efforts to encourage AI/ANs to enter into health careers including resources to increase access to federal and state scholarships and loan repayment programs.

While a major focus is to create a pipeline of AI/AN students entering health care careers, there are many factors, including long-term support and educational infrastructure that have to be addressed. **The GAO report noted that a total of $48.3 million was the need to fund both Year 1 and Year 2 of the loan applicants in FY 2016, therefore IHS was only able to fund 437 out of 939 applicants.** In 2017, a total of 1,267 providers, about 8 percent of the federal IHS workforce, were receiving IHS loan repayments. IHS is not able to pay for the loans of all providers who request it due to limited funding. According to IHS's FY'2019 budget justification, in fiscal year 2017, 412 providers employed by IHS who applied for loan repayment, did not receive one.

Due to unmet health care needs, outpatient IHS, Tribal and Urban Indian facilities are automatically designated as FQHCs and therefore, Health Professional Shortage Areas (HPSAs). In addition, Tribes are automatically designated as population HPSAs. Automatic HPSA designations do not expire, but Health Resources Services Administration (HRSA), asks that designations be updated to ensure that the score is accurate. The benefits of the score includes improving access to primary care, dental and mental health providers through the loan repayment for National Health Service Corp (NHSC) providers.

HRSA announced to Tribal Leaders in 2019, that it is going to modernize the HPSA designation process as well as update the Auto-HPSAs in 2020. In advance of the changes HRSA recommended that facilities update their information and include the data requested (demographic data, access to fluoridated water and rates of alcohol and substance abuse).

Another concern is that some states do not allow Tribal health centers to be eligible sites for the State Loan Repayment Program (SLRP). States receive these funds from HRSA's Bureau of Health Workforce (BHW). In order to be eligible, the service site must implement a sliding fee scale. Tribal health centers do not have policies to implement a sliding fee scale therefore disqualifying the provider from utilizing the SLRP at a tribal facility.

In addition to major funding increases being needed to address workforce development in Indian country for scholarships and expand loan forgiveness options, we also recommend that the inclusion of health managers and administrators in the professions be eligible to apply for these funds. In Indian health care systems, these are vital positions. Other measures must be addressed to increase recruitment and retention of professionals and institute comprehensive efforts to encourage AI/ANs to enter into health careers. For example, Tribes supported amending Internal Revenue Service (IRS) statutes to fully exclude IHS scholarships and loans from an individual's taxable income. Updating clinical and administrative Grade Salary (GS) levels to enhance IHS salaries making them competitive with the Veterans Administration is also sought. Lastly in light of HRSAs proposal to modernize Auto-HPSA designations, a deeper dive into the impact of the policy change is needed.

To begin addressing the challenges we face in workforce development, we began a Family Medicine Residency program in 2018. One of the most challenging parts of development of such a program is funding. Administered by HRSA, the Teaching Health Center Graduate Medical Education (THCGME) program was established to improve access to physician services in low-income and underserved communities. Many of the communities served by the program are located in federally designated HPSAs. The program was authorized by the Bipartisan Budget Act of 2018 at $126.5 million per year. Even though tribes are eligible to apply, of the 56 THCGME grants in 2018, only two were at Tribal health facilities.

The Chickasaw Nation would recommend Congress to permanently authorize and fund the THCGME program. In that appropriation, Congress should include at least a $50 million direct set-aside for new or existing Tribal medical residency programs to address chronic physician shortages in the Indian health system. This set-aside would help ensure funding availability for Tribal facilities, which receive an automatic HPSA designation. Direct funding would also further the federal trust responsibility to provide health care in AI/AN communities.

    b.   Health Care Facilities Construction Program:
In 1991, there were 149 health facility proposals submitted for construction projects to the Health Care Facilities Construction Program (HCFCP). These proposals represented the highest priority needs as determined by the IHS twelve Area offices; however, they did not reflect the total need for health facilities construction in Indian Country.

All proposals submitted were evaluated using the HFCPS methodology for Phase I, resulting in about 30 being selected for Phase II review. In 1992, following the completion of the Phase II evaluation, Area offices were asked to work with Tribes and local communities to prepare a detailed Program

Justification Document (PJD) for each project advancing for Phase III review. After a PJD was approved, each project was placed on the IHS Priority List in the order of its approval. The last of these projects was added to the Priority List in 2008.

Ensuring that these 17 facilities on the Priority List rank highest in the IHS report of need is consistent with the recent instruction in the amendments to the IHCIA that the priority of facilities identified under the existing HFCPS be protected. Of the 17 health care facilities on the existing priority list, all but two, which were grandfathered onto the list, were added using this process. The two California Youth Regional Treatment Centers (YRTC) on the current list were not added as part of this process, but were added to comply with Section 708 of the IHCIA. Section 708 directs IHS to construct one YRTC in each Area except California, which is to receive two facilities.

The 2019 facilities appropriation allowed IHS to partially fund all of the remaining projects on the 1992 grandfathered priority list. Five IHS Areas are receiving funding for planning, design and/or construction of projects off the grandfathered priority list:

Project	IHS Area
Salt River PIMC Clinic NE	Phoenix
Phoenix Indian Medical Center, Hospital & Clinics	Phoenix
Bodaway Gap Clinic, AZ	Phoenix
Alamo Navajo Clinic, NM	Albuquerque
Pueblo Pintado Clinic, NM	Albuquerque
Whiteriver Hospital, AZ	Phoenix
Gallup Hospital, NM	Albuquerque
Albuquerque West Clinic	Albuquerque
Albuquerque Central Clinic	Albuquerque
Rapid City Clinic, SD	Great Plains
Sells Clinic, AZ	Tucson

The amendments to the IHCIA direct that the priority of projects on the current priority list be protected; therefore, the 17 projects on the existing Priority List are the highest ranked in the IHS estimate of need. Section 301 of IHCIA directs that the priority of projects on the current Priority List be protected, as follows:

> The priority of any project established under the construction priority system in effect on the date of enactment of the IHCIA shall not be affected by any change in the construction priority system taking place after that date if the project—
>
> (i) was identified in the fiscal year 2008 Service budget justification as—
>> (I) 1 of the 10 top-priority inpatient projects;
>> (II) 1 of the 10 top-priority outpatient projects;
>> (III) 1 of the 10 top-priority staff quarters developments; or
>> (IV) 1 of the 10 top-priority Youth Regional Treatment Centers;
> (ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or
> (iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary
>> (I) on the initiative of the Secretary; or
>> (II) pursuant to a request of an Indian tribe or tribal organization.

The Indian Health Care Improvement Reauthorization and Extension Act, S. 1790 as reported & included in H.R. 3590, specifically states:

> Subtitle C – Health Facilities
> Sec. 141. Health Care Facility Priority System
> Amends sec. 301 of current law to direct the Secretary, through IHS, to maintain a health care facilities priority system which shall be developed in consultation with tribes and tribal organizations; with opportunity for nomination to the priority list at least once every three years or other appropriate frequency; the Service/non-Service facilities operated under contracts/compacts pursuant to ISDEAA are fully and equitable integrated into the health care facilities priority system. Includes reporting requirements to Congressional authorizing committees no later than 1 year after the date of enactment of this Act describing the comprehensive, national, ranked list of all health care facilities.
>
> Amends current law by directing the Secretary to maintain a facilities priority system and sets certain requirements for the priority system. Also amends current law to include new report requirements.
>
> Sec. 142. Priority of Certain Projects Protected
> Sec. 301 in current law is amended to protect certain projects on the priority list on the date of enactment of this Act. It stipulates the priority status of projects on the facilities construction priority list on the date of enactment (March 23, 2010) is not affected by any changes made to the priority system thereafter.

The HCFC Appropriations are the primary source for new or replacement healthcare facilities. The number, location, layout, design, capacity and other physical features of healthcare facilities are essential for:
- Eliminating health disparities
- Increasing Access
- Improving patient outcomes
- Reducing O&M costs
- Improving staff and operational efficiency
- Increasing patient and staff safety
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates

The absence of an adequate facility frequently results in either treatment not being sought or sought later prompted by worsening symptoms and/or referral of patients to outside communities which significantly increases the cost of patient care and causes travel hardships for many patients and their families.

At the current rate of HCFC appropriations (~$240 million/year), a new facility in 2019 would not be replaced for 200 to 250 years.
- To replace IHS facilities every 60 years (twice a 30 year design life6), would need HCFC appropriations of ~$700 million/annually.

- An annual HCFC appropriations of ~$800 million would increase capacity to 88% in 25 years with a 60-year replacement cycle.
- **IHS would need HCFC appropriations of ~$750 million/annually to match the U.S. expenditures in healthcare facility construction**.
- Without a sufficient, consistent, and re-occurring HCFC appropriation the entire IHS system is unsustainable.

The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress (2016 Facility Needs Assessment Report) total estimated cost for new and replacement facilities is over $14.5 billion.

    c.   Joint Venture Construction Program

Section 818 of the IHCIA, P.L. 94-437, authorizes the IHS to establish joint venture projects under which Tribes or Tribal organizations would acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years.

The IHS Joint Venture Construction Program (JVCP) began in 1992 as a demonstration and is one of the most successful, expedient and cost effective means of providing new and replacement facilities in the Indian health system. It is a successful partnership of Tribes funding the construction and often equipment, with the IHS committing to request Congressional appropriations for 85% of the staffing and operations.

In contrast, the conventional HCFC Program of the IHS has not been open to new projects since the mid-1990s and the existing list will take many decades to complete at the current rate of Federal appropriations. There are currently no facilities in Oklahoma on the list, and it is simply not a viable option for Tribes located in Oklahoma.

Participants in this competitive program are selected from among eligible applicants who agree to provide a facility to IHS. The facility may be an inpatient or outpatient facility. The Tribe must use Tribal, private or other available (non-IHS) funds to design and construct the facility. The Tribe must also equip the facility. In return, the IHS will submit requests to Congress for funding for the staff, operations, and maintenance of the facility per the JVCP agreement. Appropriations are requested by IHS following the selection and upon determining the estimated completion dates of successful projects.

The Chickasaw Nation is very serious about our accepted obligation of improving healthcare facilities for the delivery of health services. This obligation not only benefits Indian people but the community, state and nation. In keeping with this mission the Chickasaw Nation has proven this by building the CNMC which opened for services August 1, 2010. The 370,000 square-foot, 72-bed medical center is nestled on a 200 acre site in Ada, Oklahoma. The Chickasaw Nation invested over $148,000,000 to build and equip this breath taking facility. Even as the medical center was in the final stages of completion, the Chickasaw Nation had already committed to replacing the existing 22 year old Ardmore Health Center and the 40 year old Tishomingo Health Center with new and expanded facilities as a partner with the IHS through the JVCP. That commitment has been fulfilled through the completion of a new $32,000,000 facility in Ardmore and a $26,000,000 facility in Tishomingo.

The last competition for the JVCP was opened and closed at the end of 2019. On May 8, 2020, the IHS Director issued a press release stating that the IHS has selected five projects for new or expanded health care facilities through the IHS JVCP. The five selected projects include:

Tribe	Type of Facility	IHS Area	Location
Chickasaw Nation	Outpatient	Oklahoma City	Newcastle, OK
Chugachmuit	Outpatient	Alaska	Seward, AK
Confederated Tribes of Colville Reservation	Outpatient	Portland	Omak, WA
Southeast Alaska Regional Health Consortium	Inpatient	Alaska	Sitka, AK
Three Affiliated Tribes	Outpatient	Great Plains	Newtown, ND

The JVCP requires the selected tribe to fund the construction and equipment for the selected project. In fall of 2019 when the latest round of applications was solicited, the tribes submitted proposals with the full intent of funding the construction and equipment of the proposed facility, if selected. However, since that time and unforeseen by anyone, the economy has taken a sharp downturn. The current situation in the US has poised an economic hardship on all operations of tribes.

It is with great respect during this most difficult time, that we ask Congress to consider funding these critical healthcare facilities in Indian Country. These Tribes are equipped to initiate and complete construction of these healthcare facilities in a timely manner and we would like to ensure that none of these newly selected JVCP facilities go without funding to complete.

Therefore, our specific request is for construction and equipment appropriation of the five selected critical healthcare facilities identified above, with the expectation that the IHS will request the appropriation for staffing and operations through the established process.

d. <u>Maintenance and Improvement</u>:

Maintenance and Improvement (M&I) funds are the primary source for maintenance, repair, and improvements for IHS and tribal health care facilities. Funding infrastructure maintenance is central to the delivery of and access to quality health care service. Recent Congressional increases to M&I provided for some major repair projects. However, the M&I budget is funded at just over half of need to effectively maintain the physical condition of IHS-owned and tribally-owned healthcare facilities – which further distresses the backlog in essential maintenance and repairs, totaling nearly $650 million.

The average age of IHS health care facilities is ~40 years, with only limited recapitalization in the plant due to a growing Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). Comparatively, the average age, including recapitalization and reinvestment, of U.S. private sector hospitals is approximately 10 years. Failure to fully fund BEMAR exacerbates the overall quality of and access to care across the entire IHS Health System. New facility construction is similarly underfunded and physical plants are not being replaced. Therefore, sustainable funding is essential to ensure functional health care facilities that meet building/life safety codes, conform to laws and regulations and satisfy accreditation standards.

Given the underfunded situation, IHS and Tribes have been forced into a deferred maintenance scenario which is the practice of postponing maintenance activities in order to postpone costs, meet budget funding levels, or realign available budget monies. The failure to complete needed repairs will lead to asset deterioration resulting in higher costs, asset failure, and health and safety implications. Geaslin's Inverse-Square Rule for Deferred Maintenance says that maintenance deferred until failure will cost 15 fold the repair value or the original value squared. We are concerned that unless a substantial infusion of M&I funds are provided in the FY2021 budget cycle, that we will not be able to perform many required maintenance and improvement projects and this will cause irreparable harm to many IHS and

Tribal facilities. **We recommend a significant increase to maintain existing IHS and Tribal facilities and to address the backlog of nearly $650 million of essential maintenance and repairs**. This increase would support maintenance and improvement objectives including routine maintenance as well as ensuring compliance with accreditation standards of The Joint Commission (TJC) or other applicable accreditation bodies. Investments that improve the patient outcomes, increase access, and reduce operating costs are proven to be cost-effective.

e.   Medical Equipment:

Accurate clinical diagnosis and effective medical treatment depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health outcomes. The IHS and Tribes manage approximately 90,000 biomedical devices at 1,500 federally and tribally operated health care facilities, consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $500 million. Medical Equipment funds provide for:

- Maintenance and repair of existing medical devices;
- Limited replacement of outdated equipment;
- Initial purchase of equipment for Tribally-constructed health care facilities; and
- Leasing of ambulances for the emergency medical services programs.

Medical devices management has become complex as a result of increased sophistication and specialization of equipment, integration with electronic records, and increasing requirements for compliance, safety, reliability and accuracy. Many health care services require special medical equipment to meet their mission. Renewal is necessary to replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment to enhance speed and accuracy of diagnosis and treatment.

Like any medical system in this country, resources are required to repair or replace outdated, inefficient and unsupported equipment with newer electronic health record-compatible equipment. This will enhance speed and accuracy of diagnosis and treatment and reduce referrals to the private sector. Because the average useful life of medical equipment is approximately 6 to 8 years, IHS would require approximately $80 million annually.

In the United States, a facility's annual medical equipment maintenance costs should be between 5% and 10% of medical equipment inventory value, which would equate to $25 to $50 million annually for the IHS.

Therefore, in total, a sustainable medical equipment program for the Indian Health System should be funded in the $100-150 million dollar range annually to cover replacement and maintenance.

f.   Sanitation and Water

Funds appropriated for water supply and waste disposal facilities are under the Sanitation Facilities Construction (SFC) line item.

Projects are cooperatively developed with and transferred to, Tribes which in turn assume responsibility for the operation of safe water, wastewater, and solid waste systems, and related support facilities. The SFC program receives funds for three types of projects:

1.   Water, Wastewater, and Solid Waste facilities for Existing AI/AN Homes and/or Communities;

      a. The sanitation project need for Existing AI/AN Homes and/or Communities at the end of year 2018 was $2.7 billion
      b. There were over 130,000 AI/AN homes at the end of year 2018 that needed some form of sanitation facility improvement.
2. Water, Wastewater, and Solid Waste facilities for New AI/AN Homes and/or New Communities; and
3. Special or Emergency projects.

The IHS SFC Program is responsible for the delivery of environmental engineering services and sanitation facilities to AI/AN. The SFC Program accomplishes its responsibilities through the allocation of available resources to the twelve IHS Area Offices.

The SFC Program goal is to improve the health of AI/AN people by improving the environment in which they live. The SFC Program accomplishes that goal by providing safe water supplies, adequate means of waste disposal, and other essential sanitation facilities. An additional goal is to build tribal capability to operate and maintain the facilities provided in a safe and effective manner to assure continued health protection and benefits into the future.

The IHS Sanitation Deficiency System (SDS) is an inventory of projects developed to address existing sanitation deficiencies in AI/AN communities. It identifies deficiencies, developing projects, and prioritizes projects. All IHS Areas, regardless of how the SFC Program is delivered, must report their sanitation deficiencies in accordance with Sections 1632 (g) (2) and (3) of the Indian Health Care Improvement Act.

The Secretary shall submit a report which sets forth the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community, and the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency or to zero sanitation deficiency. --from Public Law 94-437, Section 302(g)

The types of sanitation facilities projects funded with IHS appropriations generally are spelled out in the language of the appropriation bills and bill reports. In recent years, four types of projects have been defined. They are:
    (1) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), tribes, individual homeowners, or other nonprofit organizations,
    (2) projects to serve existing housing,
    (3) special projects (studies, training, or other needs related to sanitation facilities construction), and,
    (4) emergency projects.

The SFC-SDS Guidance was revised and released for tribal consultation in 2018 and finalized for implementation in FY2020. Critically important elements of SDS that effect project funding, such as the classification of the deficiency levels, were not subject to consultation. The lower the deficiency level, the fewer points assigned to the SDS project; low-scoring SDS projects are usually not funded due to limited SFC funds.

Funds from the Regular and Housing Support category cannot be spent on projects supporting new and like-new construction, which is the largest part of the Housing Support category. Regular funds make up

a greater proportion of the total SFC funding allocation. This unfairly underfunds the IHS Oklahoma City Area and more specifically the Chickasaw Nation, which has a higher share of projects in the Housing Support category. The allocation of funds between Regular and Housing Support is made solely in the discretion of IHS Headquarters.

During this time of uncertainty in dealing with the COVID-19 pandemic, it is unthinkable that American Indian communities would not have access to safe drinking water and waste systems. **The Chickasaw Nation alone has a need of approximately $70 million for projects within southeastern Oklahoma that need immediate funds to ensure our citizens and communities have access to safe drinking water and waste systems.**

IX. Mental Health and Substance Abuse Services
Funding increases are needed for both mental health and alcohol/substance abuse services. Funding is specifically needed to implement Section 127 of the IHCIA allowing for the increase of the number of mental health providers and funding training/education; Section 702 to expand behavioral health care for prevention and treatment; Section 704 to provide more comprehensive care through detox, psychiatric hospitalization and community-based education and rehabilitation programs; Section 705 to expand the use and dissemination of a Mental Health Technician Program to serve patients; as well as, Section 715 to expand Behavioral Health research grants to allow tribes to find more asset-based, innovative and effective approaches to address issues like Indian youth suicide. Also there are a few new provisions in the IHCIA (Sections. 707, 708, 710, and 712) such as: Comprehensive Behavioral Health and Treatment Programs, Fetal Alcohol Spectrum Disorders Programs, Long-Term Treatment Programs for Women and Youth.

Current state reimbursement rates are inadequate for small programs to be self-sustaining. **Additional funds would enable the social-behavioral workforce to better serve the population, provide adequate behavioral health training and community educational programs. A significant increase is needed to allow Tribal communities to further develop innovative and culturally appropriate prevention and treatment programs that build upon the resiliency factors and inherent strengths already existing in Tribal communities. AI/A people continue to demonstrate alarming rates of psychological distress throughout the nation. Inadequate funding resources limit Tribes implementing cultural and asset based approaches to address these issues.**

The high incidence of mental health disorders, suicide, violence, and behavior-related chronic diseases among AI/ANs is well documented. Research has demonstrated that AI/ANs do not prefer to seek Mental Health services through Western models of care due to lack of cultural sensitivity; furthermore, studies are suggesting that AI/ANs are not receiving the services they need to help reduce the disparate statistics.

Healthcare has an increasing focus on prevention and wellness, and more must be done to address mental health, which impacts co-morbid conditions and outcomes related to chronic illness. **Increased funding in the area of mental health would allow for expansion of and integration of behavioral health into the primary care clinics so that there is focus on the physical and mental health. It is important to note that the recent increases in behavioral health funding has only been allocated through limited time-sensitive competitive grants**. The grant funded nature is an inefficient funding mechanism that does not support long-term program sustainability and has created haves and have-nots in Indian Country which serves a barrier to address behavioral health crisis and interventions and

does not support an integrated continuum of care. **Mental Health resources must be recurring and allocated equitably across the I/T/U system via a non-grant and non-competitive distribution.**

Coordinated telehealth psychiatric services for complex cases with multiple medications is crucial to patient care. **Funds are needed to support infrastructure development and capacity in tele-behavioral health, workforce development and training, recruitment and staffing, integrated and trauma-informed care, long-term and after-care programs, screening, asset-based approaches, and community education programs.** Mental health program funding supports community-based clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities, as well as address adverse childhood events and historical traumas to break the cycles and conditions that contribute to perpetuating or exasperating poor mental health outcomes.

With regard to addressing mental health crises, afterhours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. The goal in the emergency setting is to stabilize patients, assess and refer to the appropriate level of care. Many communities and areas lack a sufficient number of hospital beds for patients with mental health emergencies requiring further hospitalization, which puts pressure on emergency rooms and urgent care services to provide this care beyond initial stabilization. It is the costliest method of care and, unfortunately, leads to patients not receiving the appropriate level of care and emergency rooms routinely being on divert for regular medical emergencies due to beds being occupied with mental health patients who are waiting for appropriate beds to open up.

Other needs include funding for mental health programs specifically for long-term treatment, housing, and after-care facilities/staffing. For example, displaced or homeless veterans returning home from active duty service, individuals returning home after a long period of incarceration, and/or returning home after substance use treatment will benefit from a transitional living environment that assists them while they readjust to their environment and surroundings. An investment in behavioral health services has shown positive return. For example, treating depression and anxiety has shown from 3.3 to 5.7:1 return on investment in reduced/avoided medical costs, improved productivity, and improved health status.

Closely linked with the issue of mental health is that of alcohol and substance abuse in Tribal communities. Indeed, AI/AN communities continue to be afflicted with the epidemic of alcohol and other drug abuse including, but importantly not limited to, opioid addiction. The 2018 National Survey on Drug Use and Health (NSDUH) found that 10% of Native Americans have a substance use disorder; 4% an illicit drug use disorder and 7.1% an alcohol use disorder.

Funding needs to be flexible to allow comprehensive approaches to address issues like opioid addiction and suicide prevention holistically and comprehensively removing artificial silos and employing inefficient funding mechanisms such as granting to address alcohol and substance abuse.

According to SAMHSA data from 2018, nearly 13% of AI/AN population need substance use treatment, but only 3.5% actually receives any treatment. Current I/T/U alcohol and substance abuse treatment approaches employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, inpatient/residential placements, etc.) as well as traditional healing

techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. **There is also a need for funds to provide alternative treatment modes such as physical therapy, behavioral health and buy-in to pain treatment utilizing alternatives to the overused and abused medications along with development and support of regional treatment centers.**

In FY 2008, Congress appropriated $14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, those funds continue to be allocated through competitive grants, despite Tribal objections. For over a decade, **Tribes have noted that IHS reliance on grant programs is counter to the federal trust responsibility and undermine self-determination tenets.** If an area for example is suffering more from alcohol addictions than from meth or opioids, that area cannot redesign the available programs to meet the needs of that area, due to grant restrictions. Furthermore, because grant funding is never guaranteed, vulnerable communities, with the greatest needs but least capacity, often slip through the cracks. The needed increase must be applied to IHS funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and care to our struggling Tribal members and their families.

The Chickasaw Nation's mental health services, without a blueprint or external guidance, established processes and protocols to begin virtual mental health care delivery in our system. With no identified funding assistance at the time the tribe's mental health providers set out to virtually reach those in need and since initiation have provided over 6000 virtual visits within just a few months. While most patients have accommodated the new modality, it is still difficult for those who are elderly or technologically limited to receive their care. We have been able to receive compensation for the virtual tele-mental health services, but it is unknown for how long.

When SAMHSA did open up an application to apply for emergency COVID-19 dollars to assist specifically with mental health services the ten-day turn around submission time required an immense time dedication from our leadership during a critical time. While we are grateful our application was funded the lack of modification in reporting and data collection requirements for the award period again necessitates a considerable amount of time and logistical coordination. While we understand the need for the data contribution, the requirements during a pandemic compound an already heavy lift. For a second emergency suicide prevention application (SAMHSA), also due within limited time and requiring immense work, we have not been notified of award decisions and the anticipated start date was June 30th.

We have concern about the reduction of patients in crisis presenting to our emergency room in the initial couple of months of COVID-19. Fear and anxiety of COVID-19 exposure likely contributed to patients' hesitancy to seek help, and with limited resources for in-field mobile crisis mental health response we have been unable to get a pulse on how those in most psychiatric need are managing. In the past two weeks we have begun to see the remnants of isolation and disengagement with increased presentation of crises in our health care sites.

The National AI/AN Behavioral Health Strategic Plan provides a comprehensive approach to address alcohol and substance abuse and its tragic consequences, including death, disabilities, families in crisis and multi-generational impacts. IHS, Tribal and urban Indian health alcohol and substance abuse programs continue to focus on integrating primary care and behavioral health services, being more responsive to emerging trends and the instituting best and promising practices that align with culture

and asset-based prevention and treatment. **An infusion of over $500 million is needed to address these devastating issues.**

X. Health Information Technology, Data, Interoperability, Telehealth and Broadband

Health Information Technology - $3 billion over 10 years
IHS provides the technology infrastructure for a nationwide health care 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 health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record 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 decision-making and reporting, resulting in better care, efficient spending, and healthier communities.

Since FY 2020, the TBFWG and the President's Budget for IHS has supported a new budget line specifically for HIT. TBFWG also has recommended a meaningful investment into the IHS HIT system to address the impact of the Veterans Health Administration (VHA) recent decision to transition from its legacy VISTA system to a Commercial Off-the-Shelf (COTS) system. In preparation for future modernization, the DHHS and IHS evaluated the current electronic health record system, the Resource and Patient Management System (RPMS) and, based on the evaluation, developed the Roadmap Report to guide modernization efforts over the next five years. The Roadmap Report lays out a number of opportunities for FYs 20-22, including establishment of a Project Management Office and governance structure, acquisition planning, HIT selection and procurement, implementation planning, and testing.

The Chickasaw Nation acknowledges and fully supports the efforts outlined in the Roadmap Report and appreciates the President's FY 2021 request of $117 million to build on the FY 2019 successes. However, we are very concerned that a more accelerated funding strategy is critical to appropriately and realistically advance the $3 billion 10-year investment which will be needed to allow IHS to either update the current EHR & RPMS suite or initiate an alternatives analysis similar to the VHA. Therefore, we continue to recommend a separate HIT budget line item investment to ensure H&C funds are not diverted to pay for necessary HIT improvements at the expense of direct care for patients. A reasonable adequately-resourced IHS HIT program is critical to ensure quality and safe care as well as to save costs related to inefficient processes and unnecessary duplication of testing and procedures. Continued funding for this project must include substantial, separate investments for HIT modernization to be realized in the face of a change technology and resource environment.

Indian Health Care System Data:
The Chickasaw Nation acknowledges the importance of access to relevant data elements to gather information to utilize in making various leadership decisions.

The majority of the health related data elements are gathered and reported from the health information technology system used by IHS. The information systems that support quality health care delivery are critical elements of the operational infrastructure of hospitals and clinics. The current IHS health information system is called the RPMS, and is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most tribal facilities, from patient registration to billing.

The explosion of HIT capabilities in recent years, driven in large part by federal regulation, has caused the IHS health information system to outgrow the agency's capacity to maintain, support and enhance it. A lack of resources have hindered the IHS in supporting operations and maintenance for the certified RPMS suite. This has resulted in a mass exodus of tribal programs who have opted to seek other commercial HIT solutions which promise to more readily address their needs.

As tribes have moved to COTS systems the reporting certain data elements into the IHS RPMS system have continued, however, there have been many issues with IHS ability to accept and/or reconcile the imported information. These issues result in incomplete data elements that are needed to evaluate workload and other important data metrics to make sound management decisions.

Thus, the problems and issues can only be resolved with the implementation of a new modernized, interoperable HIT system for the whole Indian health care system.

Interoperability
The RPMS – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and has become partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA.

RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA's software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with COTS software products.

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

When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to, through Tribal consultation, key informant interviews, and national surveys, develop a series of next steps and recommendations towards modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problems for Native Veterans' care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution towards increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations.

Now that the VHA is transitioning to the Cerner system, it has worsened concerns around care coordination and sharing of EHRs between I/T/U and VHA systems. The fact is, Native Veterans are suffering today from the lack of health IT interoperability. It is shameful that Native Veterans are put in a position where they have to find their own solutions to streamline EHR sharing, most shockingly exemplified by anecdotes of AI/AN Veterans hand carrying their health records between their IHS and VHA provider.

Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner.

Tribes were pleased to see that the FY 2020 President's Budget included a request for a new $20 million line item in the IHS budget to assist with health IT modernization, and that this request was included in the House-passed FY 2020 Interior Appropriations package. But in comparison, the FY 2020 House Military Construction Appropriations bill budgeted $1.6 billion to assist VHA in its transition. **Ensuring EHR interoperability between I/T/U and VHA health systems will be impossible if Congress fails to establish parity in appropriations for VHA and IHS health IT modernization.**

Telehealth
Telehealth is the distribution of health-related services and information via electronic information and telecommunication technologies. It allows long-distance patient and clinician contact, care, advice, reminders, education, intervention, monitoring, and remote admissions. It remains a critical component in the delivery of care throughout the Indian health care system, especially in light of the COVID-19 pandemic. Telehealth increases local capacity to provide care and medical oversight. It reduces both the cost and stress of travel in medically underserved areas and in a time of isolation and social distancing. Being able to use telehealth and connect to physicians and specialists at larger clinics and hospitals saves lives.

Telemedicine refers specifically to remote clinical services, and is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient). This definition is modeled on Medicare's definition of telehealth services (42 CFR 410.78). Note that the federal Medicaid statute does not recognize telemedicine as a distinct service.

For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient (originating site), and the physician or practitioner (distant site). This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Telephone visits are direct audio only visits between provider and patient and can be very effective in areas where connectivity is an issue. These visits have become more prevalent during the current Public Health Emergency (PHE) to ensure some of our most vulnerable patients are continually monitored by their health care providers.

Virtual visits enable healthcare access to patients who are not able to travel to the provider for specific non-life-threatening injuries or illnesses. This service is a video appointment with a physician that is available to patients with specific symptoms. Virtual Visit is when a provider sees a patient via a real-time video platform (much like facetime), with either the provider and/or the patient being in various sites outside the healthcare facility. Thus, the reason they are classified differently than telemedicine

visits. The encounter is exactly like a face-to-face visit. Medical documentation is done at the time in the EHR patient's chart and it takes about the same time as a face to face encounter.

Current reimbursement models for these types of services lag behind. However, the Oklahoma Medicaid program has incorporated telephonic visits as being reimbursed the same as telemedicine. Medicare reimbursement guidelines vary for each type of service and prior to and after the PHE, but for the most part the reimbursement is inadequate. Private Insurance guidelines vary according to each Insurance carrier.

The Chickasaw Nation recommends that CMS revise their policies to ensure that tribal health care facilities receive the Medicare facility fee (OMB encounter rate) for all telehealth service types, including behavioral health services, whether telemedicine or virtual visits. Healthcare delivery models have been migrating to telehealth platforms over the last few years for several reasons, some of which are:
•	Telehealth delivery of healthcare services saves dollars
•	Telehealth delivery of healthcare services increases patient compliance
•	Telehealth delivery of healthcare services provides greater protection and safety for the most vulnerable patient populations, by safe-guarding them from infectious diseases and viruses

Broadband
The Chickasaw Nation has demonstrated its determination to work towards bridging the digital divide in Indian Country by self-funding the construction of a nearly $26 million dollar fiber network that encompasses its territorial boundaries.

Trace Fiber Networks, LLC, a wholly-owned subsidiary of the Chickasaw Nation, leads the effort of constructing over 300 new route miles of fiber, to be combined with approximately 200 miles of existing fiber builds. In addition to its fiber network, Trace Fiber Networks has worked diligently to acquire the assets necessary to expand access to affordable and reliable broadband throughout south central Oklahoma, including licensed wireless spectrum. While the Chickasaw Nation, and many other government entities across the United States begin to navigate the uncertainty of the Coronavirus outbreak, our mission to bridge the digital divide in Chickasaw Country remains the same.

The emergence of COVID-19 has left many of our Chickasaw citizens struggling to adapt to circumstances that require immediate and reliable access to affordable broadband. The closure of public schools across Oklahoma and the country has exacerbated the so-called "homework gap." Congress has responded to this challenge nationally by dramatically expanding the authorized scope of telehealth and distance learning activities. Legislation has been included in multiple rounds of the COVID-19 FY'20 emergency supplemental appropriations acts. Without specific and direct action by Congress, the promise of these new opportunities could very well pass Indian Country and rural America generally.

In order to further bridge the digital divide in this challenging time, Trace Fiber Networks seeks to pursue a fixed wireless broadband solution to complement its existing fiber network, meaning one that entails a combination of both wireless and wireline technology. Specifically, a combination of wireless towers and buried fiber will not only enhance our ability to provide broadband meeting the Federal Communication Commission's (FCC) definition of 25 mbps up/3 mbps down, but also increase the number of both Chickasaw citizens and non-Chickasaw citizens alike in rural Oklahoma that we are able to serve. We estimate that this solution will allow us to serve up to a total of 15,000 underserved Chickasaw citizens, and up to 100,000 non-Chickasaw citizens. Rural America is often sparsely

populated, and requires the use of a unique combination of wireless and wireline technology in order to adequately expand broadband coverage.

This particular solution will utilize a combination of both temporary Cell-on-Wheel (COW) towers, and permanent wireless towers to which Trace Fiber Networks will then extend its fiber network. **The total cost for the construction of the new wireless towers is valued at just under $27 million dollars, and we respectfully request that Congress consider allocating funding for this investment**. We have identified strategic partners in south central Oklahoma that will allow us to fill over 100 new contractor positions and 20 new permanent employees from individuals who live in the communities we seek to serve, therefore decreasing local unemployment.

Some possible funding solutions are direct grants to tribes to fully fund broadband access construction projects and fixed broadband wireless solutions. These grants could be through the BIA Community & Economic Development or Economic Development (TPA) Broadband; the USDA Rural Utilities Service Distance Learning, Telemedicine and Broadband Program or the VA Rural broadband efforts.

The Chickasaw Nation appreciates this opportunity to testify on these important matters. The Chickasaw Nation is committed to ensuring the highest quality of health care for our citizenry and we look forward to working with each of you in these endeavors to do the same.