Committee on Energy and Commerce

Hearing on
"Addressing the Urgent Needs of Our Tribal Communities"

July 8, 2020

Charles Grim, D.D.S., M.H.S.A., Secretary, Chickasaw Nation Department of Health

The Honorable Anna G. Eshoo (D-CA):

1. I was pleased to learn from your testimony that Trace Fiber Networks, LLC, a wholly owned subsidiary of Chickasaw Nation, is serving members of the Nation. To the degree this information is available and can be made public, could you please share:

    a. How many residents the network serves

    RESPONSE:

    Currently Trace Fiber Networks does not provide residential service. Trace Fiber Networks was designed to connect Chickasaw Nation-owned facilities and provide wholesale transport. The strategy is to provide transport to wireless Internet providers and allow them to provide service to residential customers.

    b. Average prices customers pay

    RESPONSE:

    Currently we are working with two wireless Internet service providers and their average prices are $50-$75.

    c. Average speeds customers experience

    RESPONSE:

    30-50 Mbps

    d. Partnerships with private broadband providers

    RESPONSE:

    Trace is currently working with two wireless Internet service providers to provide retail broadband.

    e. Any issues faced with respect to competition from private broadband providers

RESPONSE:

No, since Trace does not provide retail broadband service.

f. Any federal, state, or local regulatory issues

RESPONSE:

No, however Trace filed with the Oklahoma Corporation Commission, and obtained a data only Certificate of Convenience and Necessity to serve. (CCN)

2. Did Chickasaw Nation create any specific regulatory allowances for Trace Fiber Networks to operate?

RESPONSE:

No

3. Have state or municipal laws or regulations prohibited or inhibited the establishment, operations, or expansion of Trace Fiber Networks or other broadband networks owned or operated by the Nation or partnerships between the Nation and companies?

RESPONSE:

No

a. If so, would the protections in my legislation, H.R. 2785, the *Community Broadband Act*, which protects municipal and Tribal broadband networks from restrictive state laws, provide relief from these restrictive state laws?

RESPONSE:

No, Oklahoma is a deregulated broadband state.

The Honorable Doris O. Matsui (D-CA):

1. Failure to adequately support the Electronic Health Record (EHR) program at the Indian Health Service (IHS) has been a long-standing issue for Indian Country. This lack of investment has limited the ability of Tribal and urban Indian health programs to invest in telehealth infrastructure and acquire EHR systems that are interoperable, community specific, and inclusive of public health information.

a. How have technology barriers impacted the ability of tribal and urban Indian health programs to accurately monitor and treat COVID-19 activity?

RESPONSE:

COVID-19 compounded the already struggling technology limitations tribal and urban Indian health programs work with every day. Unfortunately, patching multiple systems together in an effort to provide safe care to patients is an everyday way of life. COVID-19 forced health care from being conducted in the traditional office or facility setting to a virtual environment. The Centers of Medicare and Medicaid Services (CMS) quickly implemented rules to allow providers to get paid for virtual care in various methods but the current health record we have does not easily allow for these flexibilities. Because of the bulky, outdated EHR, infrastructure is fragile and employees lack confidence in the performance during peak times and times of COVID-19 surges in hospitalizations and testing.

Staff have to manually build databases for COVID-19 screening and testing to trend key data for leaders to make decisions quickly. The EHR does not have the ability to easily do these things nor is it intuitive which often leaves clinicians struggling to care for our patients. The current system lacks intuitive ability to case manage or study specific populations of COVID-19 patients.

Due to lack of investment and support, the EHR system has become complex and burdensome to the point that other tribes come to the Chickasaw Nation for application support issues. We are spending a large amount of time maintaining our environment and serving as a resource to other tribes and therefore find little time to spend on future state integrations and systems.

As a result of COVID-19, the Chickasaw Nation rapidly deployed COVID-19 testing sites to reduce community spread. We were not able to embrace the full functionality of field testing services due to the lack of integration of the EHR to modern laboratory and testing services. Additional human capital was expended creating double entries for specimens for tracking and testing, which strained personnel and ‘normal’ business operations.

All reporting/data reporting activities are scheduled overnight so systems are not burdened.

Extra care had to be placed by all employees, including providers, clinical informatics employees and information technology (IT) staff not to ‘accidentally’ make any changes or alterations which would require a reboot.

- During winter, 2019-2020, the Chickasaw Nation experienced roughly one dozen outages which lasted on average one hour. As a result, the entire department of health was forced to use paper forms.
- While IT staff eventually identified system improvements/modifications, there was always fear that a reboot might be called for due to system modifications.

- While IHS IT was helpful, additional consulting resources were required which commanded substantial time and attention both from Health IT leaders and shared IT services (infrastructure and operational teams).

Technology integration is always an issue with the EHR as it does not 'talk' to other modern medical systems. Additional redundancies had to be built to work around the core systems while also enabling a suite of other technologies/services to exist.

b. Compared to other federal health providers like the Department of Defense (DoD) and Veterans' Administration (VA), are the Indian Health Service, Tribes and urban Indian organizations currently being funded at the levels necessary to upgrade their health IT infrastructure?

RESPONSE:

Absolutely not. An upgrade to health IT infrastructure is very expensive, but absolutely necessary. In 2017 the actual IHS spending per user was only $3,332, compared to veterans medical spending per patient of $8,759. Overall, the IHS is currently funded at approximately 45% of the need, and that is just for services, not including any infrastructure needs. The national tribal budget formulation workgroup for FY2022 recommends $48 billion (based on FY2018 estimate of 3.04 million patients) to fully fund IHS, not including funding for Health IT Modernization Project.

For the Health IT Modernization Project, IHS has estimated it will need $3 billion (based on 25% of VA cost estimates for FY2022) over a few years to fully fund critical infrastructure investments. These funds will directly impact patient care and safety, similar to that afforded the VA and DoD. However, thus far IHS has only received a few million dollars during the annual Interior appropriations cycle. Also, the CARES Act provided IHS with $65 million electronic health record stabilization and support.

The Honorable Ben Ray Luján (D-NM):

1. As you know, American Indians and Alaska Natives (AI/AN) have a higher smoking rate than any other racial/ethnic subgroup. According to the 2018 National Health Interview Survey (NHIS) of adults ages 18 and over, 22.6 percent of AI/AN currently smoke. In comparison, 15.0 percent of Whites, 14.6 percent of African Americans, and 9.8 percent of Hispanics currently smoke. A study of trends from 2002 to 2016 found that while there have been significant downward trends in the smoking rates among all other race/ethnic groups, there was no significant change in the smoking rates of AI/AN's.

    a. Can you discuss what steps the Chickasaw Nation has taken to reduce the use of commercial tobacco, what challenges you have faced, and what additional actions or assistance would help you succeed in reducing commercial tobacco use?

RESPONSE:

Since 2009, the Chickasaw Nation Department of Health (CNDH) has been a tobacco free campus. As with many other properties, the use of tobacco on premises has been restricted. We have engaged in partnerships with the Oklahoma Hospital Association and the Tobacco Settlement Endowment Trust to implement a program Helping Patients Quit Tobacco. This program is evidence-based and gauges readiness to quit while using motivational interviewing techniques to move the dial from ambivalent to ready to quit. Then the CNDH refers those ready to quit tobacco directly to the Oklahoma helpline.

Before this partnership the burden of reaching out to the helpline was solely on the patient. With this project, the referral is directly made to the helpline and the helpline then reaches out and connects with the patient, thus improving the odds of quit attempts and success. This partnership produced the first electronic referral to the helpline in Oklahoma and it was the second electronic referral system established in the United States in 2014.

Since that time, we have created an embedded referral system from our electronic record in all of our clinics and inpatient facilities. Anyone wishing to quit is instantly referred to the helpline for support. We also provide bridge medication for nicotine replacement (NRT) to anyone wishing to quit commercial tobacco to fill the gap between the times the helpline can send NRT to the individual. This creates a seamless period of time to support the person's readiness to quit, without which the individual would likely continue to use commercial tobacco.

We have also expanded our employee medication formulary within our self-funded plan to provide additional medication to help support an employee who wishes to quit tobacco as well. This goes beyond what is provided by the quit line. This began in 2010 when we moved to our new state of the art facility. We have also developed policies that address third hand smoke that are applied to patient, visitors and staff when caring for our citizens. To date, we have referred close to 4,000 individuals to the Oklahoma helpline with our referral system.

The Honorable Tony Cárdenas (D-CA):

1. In California, tribal communities face unique challenges in delivering healthcare. First, in California, there are no IHS hospitals, rather, the tribal communities are served by clinics, often in rural areas. Secondly, communities in California are subject to Public Safety Power Shutoff (PSPS) events in which communities are de-energized to prevent wildfires. For many of the tribal communities in California, the clinics are the only healthcare provider nearby, yet most do not have backup generators to keep the clinics operational during PSPS events. COVID-19 response in these communities during fire season - which has already begun in California – is made nearly impossible without backup generation. These difficulties are compounded due to other factors, such as a lack of refrigeration for medications.

a. Does IHS take into consideration these other factors when determining the allocation of funds? Can you confirm these clinics in California are able to use these funds for the facilities and maintenance uses necessary to adequately respond to the COVID-19 pandemic?

RESPONSE:

The allocation of funding by the IHS is mostly a historical one with the main factor being patient user population. However, various budget line items have various distribution methodologies.

Without knowing the specific information for the facilities referenced above, I defer to my written testimony, which describes the three mechanisms for an Indian health facility to receive funding and each mechanism comes with its own requirements for use of funds:

1. Health services provided by the federal government, primarily through the agency, the IHS. The use of these funds are governed by the IHS appropriations. No Flexibility.

2. Tribes can contract with the IHS for those programs or services they wish to provide for their own members. The use of funds is governed by the IHS distribution. Some Flexibility.

3. Tribes can 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. The use of funds are governed by tribe, within federal requirements. Most Flexibility.

I would add that the IHS has done a very good job of getting the funds Congress has allocated through the various COVID-19 packages out in a timely fashion after appropriate consultation efforts.

b. Can you describe how funding allocations to states are made?

RESPONSE:

Under IHS, there are no funding allocations to states. The IHS is divided into 12 geographical areas of the United States: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson. Each area has a unique group of tribes that they work with on a day-to-day basis and some of these areas are geographically responsible for more than one state. The funds are then distributed, by line item, to these regions which in turn, allocate funds under one of the three overarching methods described above, direct federally operated programs, tribally contracted programs and tribally compacted programs.

c. Please explain how some parts of the country have modern IHS Hospitals, while in other parts of the country rely on Tribal Health Programs for the majority of their health care?

RESPONSE:

Originally, IHS facilities were built in areas with the most patient user populations, based on a federally created master plan. In 1992 the list was closed until all facilities prioritized at that time were completed. That list of facilities compiled by the IHS Health Care Facilities Construction program has not been completed due to inadequate funding.

There are two other mechanisms for constructing new Indian health care facilities:

Joint Venture Construction Program - Section 818 of the Indian Health Care Improvement Act, 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. Participants in this competitive program are selected from among eligible applicants who agree to provide an appropriate 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. In return the IHS will submit requests to Congress for funding for the staff, operations, and maintenance of the facility per the Joint Venture Agreement.

Small Ambulatory Program - Section 306 of the IHCIA, P.L. 94-437, authorizes the IHS to award grants to tribes and/or tribal organizations for construction, expansion or modernization of ambulatory health care facilities. Where non-Indians will be served in a facility, the funds awarded under this authority may be used only to support construction proportionate to services provided to eligible AI/AN people.

d. Is Congress upholding its federal trust responsibilities for health by keeping IHS's funding discretionary? Should IHS receive mandatory appropriations?

RESPONSE:

In addition to fully funding the IHS, tribes assert that full funding for IHS should be under mandatory appropriations. This would further affirm the federal trust responsibility for health which is the direct result of treaties, federal law, and Supreme Court cases. In my opinion, for this to be implemented and in the spirit of tribal consultation, Congress should enact legislation to create a tribally-driven feasibility study to determine the best path forward to achieve mandatory appropriations for IHS.

The Honorable Richard Hudson (R-NC):

1. Throughout North Carolina, we have several federally recognized tribes and those seeking recognition who are facing the wrath of the Coronavirus.

   In my district and the surrounding areas in North Carolina reside the Lumbee Indians. The Lumbee's are recognized by the State of North Carolina but have yet to receive federal recognition. Before the committee today, we are focusing on our tribal communities, the devastating economic and health impacts of the coronavirus and how we can get federal resources to our communities. But what about those we are leaving behind? What about those tribes seeking federal recognition who have overwhelming evidence of their heritage but are lost in the bureaucracy or politics? The Lumbee Indians have been recognized by the State of North Carolina since 1885 and been fighting for federal recognition since 1888. 132 years of fighting. My constituents are hurting and the only reason they are not receiving enhanced federal assistance is because of pure politics.

   I have introduced legislation with my good friend and colleague, G. K. Butterfield, along with a Senate Companion introduced by both North Carolina Senators, which will give full federal recognition to the Lumbee Indians. During a global health pandemic that is ravaging tribal communities, it is time to stop playing politics with people's lives and their lively hoods. This virus does not discriminate on political affiliation. The advancement of this legislation is mission critical. I am committed to the health and well-being of our Native Americans and today I ask my colleagues to support my legislation.

   Federal recognition of the Lumbees would enable focused federal attention on the tribe during this pandemic, in a manner that is tailored specially to the needs of Indians, that is culturally sensitive, and that is respectful of their right to self-determination and self-governance.

   For instance, the IHS (Indian Health Service) is for federally recognized tribes only. The IHS offers critical health care services to American Indians and is one of the lead agencies fighting against the coronavirus.

   a. Does the IHS provide lifesaving treatments?

      RESPONSE:

      Indian health services and treatments are provided through IHS health care facilities, tribal health care facilities and urban Indian health care facilities. The services and treatments provided are unique to each facility. However, all Indian health care facilities strive to provide the highest quality of health care services, which includes various lifesaving treatments.

b. If the Lumbee's were a federally recognized tribe would they have full access to IHS?

RESPONSE:

There are at least two steps the Lumbee's would have to follow once Congress or the administration recognized them as a federally recognized tribal government.

First, they would have to work with the IHS to complete the methodology outlined in *Chapter 4 - New or Restored Federally Recognized Tribes, Part 6 - Services to Tribal Governments and Tribal Organizations*. This helps determine the amount of funds to be requested to support the newly recognized tribe. The appropriation request to Congress will be included in the budget cycle immediately following the new or restored tribe's recognition. The appropriation is composed of personal health care services (see Section 5) to members of the new or restored federally recognized tribe, wrap-around services (see Section 6), and program administration and support services (see Section 7).

Secondly, the IHS has eligibility criteria, which is also outlined in the IHS Manual. These criteria are then further applied to determine eligibility for services and include the following categories:

2-1.2 PERSONS ELIGIBLE FOR IHS HEALTH CARE SERVICES. A person may be regarded as eligible and within the scope of the IHS health care program if he or she is not-otherwise excluded by provision of law, and is:

American Indian and/or Alaska Native. American Indian and/or Alaska Native (AI/AN) descent and belongs to the Indian community served by the IHS program, as evidenced by such factors as:

- Membership, enrolled or otherwise, in an AI/AN federally-recognized tribe or group under federal supervision.
- Resides on tax-exempt land or owns restricted property.
- Actively participates in tribal affairs.
- Any other reasonable factor indicative of Indian descent.

In case of doubt that an individual applying for care is within the scope of the program, as established in 42 C.F.R. § 136.12(b), and the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

Eligible Non-Indians. Care and treatment of non-Indians shall be provided, in accordance with 25 U.S.C. § 1680c, 42 C.F.R. §§136.12, and 136.14, as follows:

- **Children.** Any individual who has not attained 19 years of age; is the natural or adopted child, stepchild, foster child, legal ward or orphan of an eligible Indian; and is not otherwise eligible for health services provided by the IHS, shall be eligible for all health services provided by the IHS on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19

years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the IHS in determining the need for, or the allocation of, the health resources of the IHS. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date of a determination of competency [25 U.S.C. §1680c (a)].

- **Spouses.** Any spouse, including a same-sex spouse, of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the IHS, shall be eligible for such health services if the governing body of the Indian tribe or tribal organization providing such services deem them eligible by an appropriate resolution as a class. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the IHS in determining the need for, or allocation of, its health resources [25 U.S.C. §1680c (b)].
- **A non-Indian woman pregnant with an eligible Indian's child** for the duration of her pregnancy, and through post-partum (usually six weeks after delivery) (42 U.S.C. § 136.12). In cases where the woman is not married to the eligible Indian under applicable law or tribal law, paternity must be acknowledged by either:
  - The eligible Indian, in writing.
  - Determined by order of a court of competent jurisdiction.
- **A non-Indian member of an eligible Indian's household** and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious disease, as stated in 42 C.F.R. § 136.12(a).
- **Other non-Indian beneficiaries** are described in *Part 2, Chapter 4* of the IHM, such as non-Indian employees and veterans, who may also be authorized for limited services, as described in Part 2, Chapter 4 of the IHM.

Purchased/Referred Care (PRC). There are additional eligibility requirements for authorized PRC services [See the Indian Health Manual (IHM), *Part 2, Chapter 3, Contract Health Services (CHS)* and 42 C.F.R. § 136.23] Note: CHS name was changed to PRC.

c. Do you agree the Lumbee's would have more stable health coverage if they were federally recognized?

RESPONSE:

Absolutely. However, IHS congressional appropriations are considered discretionary and subject to annual appropriation changes, such as rescissions, sequestrations, budget caps, budget cuts, etc. This is one of the reasons tribes are requesting the IHS appropriation be considered on the mandatory side of the federal budget, as well as adjusted upwards for equitable spending on health care compared to the rest of the nation and to further address the current inequities in Indian health status.