

Written Testimony – September 29, 2020 – House Interior Appropriations
Francys Crevier, Chief Executive Officer, National Council of Urban Indian Health

My name is Francys Crevier and I am the Chief Executive Officer of the National Council of Urban Indian Health (NCUIH). On behalf of the NCUIH and the Urban Indian organizations (UIOs) we represent, I would like to thank Chair McCollum, Ranking Member Joyce, and Members of the Subcommittee for this opportunity to provide an update on the impacts of the COVID-19 pandemic on urban Indian health. We are here today to respectfully request the following: **an \$80 million UIO facilities line item, \$7.3 million per year over three years for UIO behavioral health funding, and \$20 million for UIO health information technology. Our request totals \$121.9 million, all of which would be allocated through the Indian Health Service (IHS). We also request that UIOs be insulated from unrelated budgetary disputes through a spend faster anomaly so that critical funding is not halted.**

UIOs serve tribal members from all 574 federally recognized tribes and urban Indians as a part of the IHS System, which consists of IHS, Tribally operated facilities and UIOs, or I/T/U. UIOs were created by Congress after the Relocation era in recognition that the trust obligation for healthcare follows Indians off reservations and wherever they go. There are 41 UIOs operating 74 health facilities in 22 states. These facilities ensure that some of the 70% of American Indians and Alaska Natives (AI/AN) living in cities receive culturally competent health care.

UIOs provide a range of services to the urban AI/AN community including primary care, behavioral health services, social and community services, and traditional healing and medicine services. All of these vital services are funded by a single line item in the IHS budget, which constitutes less than 1% of the total IHS budget. This funding shortfall left UIOs with limited resources to address the coronavirus pandemic. As a reminder, the last emergency supplement to Indian Country was on March 27, 2020 in the CARES Act, in which Indian Country received just 0.5% of the total funding – a woefully inadequate amount. Since mid-July, there has been a 51% increase in the number of AI/AN case infections reported by IHS¹, and a roughly 20% increase in hospitalization rates among AI/ANs.² The Centers for Disease Control and Prevention (CDC) reported COVID-19 positive rates among AI/ANs are 3.5 times higher than rates for non-Hispanic Whites.³ Similarly, COVID-19 hospitalization rates among AI/ANs from were 4.7 times higher than rates for non-Hispanic Whites.⁴ This CDC study provides data to illustrate what NCUIH has known for months: American Indians and Alaska Natives are disproportionately contracting, and dying every single day from, COVID-19.

While the funding from the US government is insufficient to match the level of need in Indian Country, the funding previously allocated by this Committee has been a literal lifesaver to urban Indians, enabling our UIOs to coordinate and implement a flu vaccine distribution strategy while upholding updated CDC COVID-19 guidance.

However, the pandemic and the needs of urban AI/ANs continue to evolve as we await the impacts of the second wave. A September NCUIH survey of UIOs revealed that due to the pandemic, 60% of UIOs have had to reduce their hours of operations, leaving urban AI/ANs without culturally competent care when it is needed most. 40% of UIOs reported being unable to provide testing due to lack of supplies, PPE, staff, or another challenge. An Oklahoma UIO

¹ Number of COVID-19 cases reported by IHS increased from 27,233 positive cases on July 19, 2020 to 41,320 cases as of August 30, 2020

² On July 19, 2020, CDC had reported an age-adjusted cumulative COVID-19 hospitalization rate of 272 per 100,000 among AI/ANs; as of August 22, rates among AI/ANs were at 323.6 per 100,000.

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

⁴ Centers for Disease Control and Prevention. COVID View Weekly Summary. Accessed 9/1/2020. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

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reported that they could devote their entire staff to testing all day long due to the current spike in cases there, however, they do not have enough space outside to meet the demand for testing. With only 2 machines available, which require time to reset between tests, they have needed to send tests to outside labs. And, although they partner with the state to perform tests, they are not reimbursed for the cost of tests, which they instead have to use their own limited resources to purchase. 20% of surveyed UIOs that are able to provide testing are unable to meet the level of need in their communities, and due to lack of state support for COVID-19, states and counties are increasing the cost of testing to supplement their lack of appropriations, hitting UIO budgets hard. Some facilities have in clinic testing machines but cannot get access to any tests. None of the UIOs surveyed had the resources necessary to conduct sufficient contact tracing in their communities and none of our UIOs felt that there was sufficient contact tracing in their areas. With flu season in full swing and a COVID-19 vaccine likely months away, UIOs remain in desperate need of opportunities to obtain supplies, testing, and the ability to upgrade their facilities.

The resources Congress has appropriated thus far have enabled UIOs to expand telehealth services and provide patients with care while working to prevent and control the spread of COVID-19. Our programs have been leaders in providing culturally-competent and localized education and prevention materials. Many UIOs have developed and implemented employee screening and employee temperature logs. UIOs successfully developed outdoor COVID-19 and antibody testing sites. These programs were all made possible thanks to the emergency appropriations from this Committee. There is concern about the longevity of these approaches as the seasons change and, in the case of California UIOs, the wildfires continue.

The need for additional Congressional support is especially high for the ten California UIOs, which are continuing to respond to the coronavirus in the midst of the largest wildfire season recorded in California history. Our facilities are trying to create clean air spaces to protect those who have lost their homes or suffer from respiratory conditions. When the air quality is bad, the risk of a respiratory illness and respiratory failure increases. These conditions are exacerbated when combined with the symptoms of the flu or COVID-19. Although creating clean air spaces will potentially reduce the respiratory risks, our facilities do not have the required authority from this Committee to use urban Indian health funds to make facility upgrades unrelated to a specific accreditation (which the vast majority of UIOs do not use). UIOs do not have the money to expand their facilities in order to perform coronavirus tests while maintaining social distancing, requiring them to be creative like conducting tests outside, which is dangerous to do in areas such as California where the air quality is extremely dangerous, or in Phoenix where temperatures frequently exceed 100 degrees.

Unfortunately, the HEROES Act does not seem likely to become law and we support the request outlined in our September 4, 2020 letter to Congressional leadership requesting, alongside NIHB and NCAI, a minimum \$2 billion in emergency funds to IHS for immediate distribution to I/T/U system. We also requested equitable distribution of a COVID-19 vaccine across Indian Country, including a minimum 5% set-aside in vaccine funds for the I/T/U system and passage of the Special Diabetes Program for Indians Reauthorization Act of 2020.

We would like to reiterate how much we appreciate your efforts to correct the shortfalls faced by the I/T/U System by, for example, including a \$64 million line item for UIOs in the HEROES Act. This set-aside would ensure that tribal members living in urban areas would have access to health care without taking money from tribes. It is important that resources be equitable for all tribal members regardless of geographic location so as to slow the spread of this virus. Reducing unnecessary travel by supporting services at UIOs could help reduce the spread of this

virus in vulnerable communities. We urge the Committee to continue to push for the inclusion of the UIO set aside in any emergency relief packages that may emerge this year.

In order to continue to provide culturally competent care to some of the 70% of AI/ANs living in urban areas, NCUIH requests that this **committee allocate \$80 million in facilities funding to UIOs** – to enable them to make long needed upgrades to address gaps that have been exacerbated by COVID-19. The impacts from chronic underfunding of UIOs over decades has prevented UIOs from making necessary improvements now needed to safely address the coronavirus. A recent survey showed that 66% of facilities reported insufficient space for triaging patients or insufficient isolated waiting areas for suspected COVID-19 patients. The same number of UIOs surveyed did not have negative pressure rooms for COVID-19 treatment. This failure of the United States government to AI/ANs is unacceptable during a pandemic. UIOs need to equip their facilities with air purifiers, negative pressure rooms, and trailers for quarantining new residential treatment patients. UIOs are unable to fund these facilities changes because UIOs do not have access to IHS facilities funding, unlike the rest of the IHS system. Not only is this lack of funding detrimental to facility sanitation, it also drastically reduces the amount of patients UIOs can see due to social distancing and other guidance, furthering compounding health issues of Indian Country.

We are grateful for the Committee's inclusion of UIOs in the FY 2021 appropriations budget, especially the \$1 million for a UIO facilities study. UIOs have never been appropriated any funding for facilities, despite it being expressly authorized in the Indian Health Care Improvement Act. This study will not only highlight the urgent need for updated facilities to combat the pandemic but will also provide valuable insight on what further needs the Committee can address in future packages.. Without the funds provided for UIOs by this Committee, the novel coronavirus pandemic's impact on urban AI/ANs would have been significantly more severe. We urge the Committee to push for the inclusion of this study in any emergency relief packages that may emerge this year.

It is imperative that Congress appropriate funds for UIOs to address the significantly increased need for behavioral health services. The Senate GOP proposal for COVID-19 did include \$15 million for I/T/U and we encourage the support of a similar inclusion in this package. Even before the pandemic, AI/ANs residing in urban areas faced significant behavioral health disparities – for instance, 15.1% of urban AI/ANs report frequent mental distress as compared to 9.9% of the general public and the AI/AN youth suicide rate is 2.5 times that of the overall national average.

The COVID-19 pandemic and its unprecedented impacts on society have exacerbated the need for behavioral health services among urban AI/AN communities. For example, more individuals are seeking treatment due to distress caused by COVID-19, and UIOs are trying to keep up with the increased need, with 33% of UIOs surveyed expanding their mental health and substance abuse services. In order to respond to the ongoing mental health crisis, **NCUIH urges Congress to appropriate \$7.3 million per year for three years.**

UIOs also need additional funding for telehealth to continue providing health care services to urban Indians during the pandemic. Our survey showed that some UIOs do not have the capability to provide telehealth services due to the need for telehealth equipment. Many UIOs are unable to conduct telehealth sessions while maintaining patient privacy. UIOs need everything from broadband to computer monitors. 100% of UIO survey respondents stated that they needed additional health information technology staff. UIOs also need funding to provide urban AI/ANs with the technology that makes it possible for them to receive care. **NCUIH respectfully requests that this committee allocate \$20 million for UIOs to build up their information technology.**

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The decades of chronic underfunding I have mentioned to you today have not only left UIOs especially vulnerable to the current pandemic, but it also leads to dire consequences when funding is not available. Because UIOs must rely on every dollar of limited federal funding they receive (in FY 2020, \$57.7 M to fund components of IHS OUIHP and 74 UIO facilities) to provide critical patient services, any disruption in these dollars has significant and immediate consequences. The pandemic has forced UIOs to stretch these funds even further and a lapse in funding during this crisis would have devastating impacts on urban Indian communities. The 2018-2019 government shutdown caused three UIOs to entirely shut their doors. More than half of UIO-respondents to a NCUIH survey reported they could not maintain normal operations for more than 30 days. These impacts were felt absent additional resource constraints and health service needs due to the pandemic.

Put simply, we cannot allow critical health services to go unfunded – especially in the present public health crisis. For the FY 2020 continuing resolution, IHS sought and obtained an exception apportionment for Tribal Health Programs operating under an Indian Self-Determination and Education Assistance Act (ISDEAA) contract or compact. As explained in a November 27, 2019 IHS Dear Tribal Leader and Urban Indian Organization Leader letter, this enabled IHS to pay contracting and compacting Tribal Health Programs their full FY 2019 base Secretarial amounts – which IHS stated it would do “as expeditiously as possible”— but this did not apply to the IHS or UIO components of the IHS system. The decision of IHS to not include or even ask to include UIOs and already-ailing direct service programs in a mechanism to ensure the continuity of care raises questions regarding fiscal responsibility and appropriations priorities. NCUIH requested that should the Administration anticipate that a FY 2021 continuing resolution would likely be necessary to avoid a government shutdown in the fall of 2020, that IHS work with HHS and the Office of Management and Budget to request an exception apportionment for UIOs. Related Freedom of Information Act requests submitted in January 2020 still have yet to be fulfilled. Requests for more information on recent actions related to exception apportionment for FY 2021 have likewise gone unanswered. Other healthcare facilities are already insulated from government shutdowns and there is no reason the IHS system, including Direct Service Tribes and the AI/AN people that depend on it, should face closures due to unrelated budget lapses. **We therefore urge Congress to include a spend-faster anomaly in any FY 2021 budget packages and emergency COVID-19 appropriations** to ensure funds will continue to be available to provide critical health services to AI/AN people at a time when they are needed most. We also wish to remind the Committee of our support for advance appropriations, which would help insulate these facilities from these impacts long term.

These requests are essential to ensure that urban Indians are properly cared for, both during this crisis and in the critical times following. It is the obligation of the United States government to provide these resources for AI/AN people residing in urban areas. This obligation does not disappear in the midst of a pandemic, instead it should be strengthened, as the need in Indian Country is greater than ever. We urge Congress to take this obligation seriously and provide UIOs with all the resources necessary to protect the lives of the entirety of the AI/AN population, regardless of where they live.