Senate Committee on Indian Affairs
Legislative Hearing

S. 1895 - A bill to require the Secretary of Health and Human Services to award additional funding through the Sanitation Facilities Construction Program of the Indian Health Service

S. 1797 - Urban Indian Health Providers Facilities Improvement Act

H.R. 1688, Native American Child Protection Act

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Good afternoon Chairman Schatz, Vice Chairman Murkowski, and Members of the Committee. Thank you for the opportunity to testify on the bills S. 1895, a bill to require the Secretary of Health and Human Services to award additional funding through the Sanitation Facilities Construction Program of the Indian Health Service, S. 1797, Urban Indian Health Providers Facilities Improvement Act, and H.R. 1688, Native American Child Protection Act.

The Indian Health Service (IHS) is an agency within the Department of Health and Human Services (HHS) and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This mission is carried out in partnership with American Indian and Alaska Native Tribal communities through a network of over 687 Federal and Tribal health facilities and 41 Urban Indian Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.6 million American Indian and Alaska Native people annually.

S. 1895

S. 1895, is a bill to require additional funding through the IHS Sanitation Facilities Construction (SFC) Program for the planning, design, construction, modernization, improvement, and renovation of water, sewer, and solid waste sanitation facilities that are funded by the IHS. According to the bill, funding awards will be prioritized in accordance with the IHS Sanitation Deficiency System. The bill authorizes $3 billion in appropriated funds for Fiscal Year (FY) 2022, which will remain available until expended. Of the appropriated funds, $350 million shall be used for additional staffing support.

The IHS SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible American Indian and Alaska Native homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related

diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus. Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene.[1] The SFC Program works collaboratively with Tribes to assure all American Indian and Alaska Native homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2020, IHS funded projects to provide service to 37,771 American Indian and Alaska Native homes. IHS also completed construction on 260 projects with an average project duration of 3.9 years. However, at the end of FY 2020 about 7,140, or 1.8 percent, of all American Indian and Alaska Native homes tracked by IHS lacked water supply or wastewater disposal facilities. About 112,082, or approximately 28 percent, of American Indian and Alaska Native homes tracked by IHS needed some form of sanitation facilities improvements. Many of these homes without service are very remote and may have limited access to health care, which increases the importance of improving environmental conditions.

The total sanitation facility need reported through Sanitation Deficiency System (SDS) has increased approximately $0.52 billion, or 20.2 percent, from $2.57 billion to $3.09 billion from FY 2019 to FY 2020. In FY 2020, the IHS was appropriated $197 million to address sanitation deficiencies and support provision of sanitation facilities to eligible American Indian and Alaska Native homes and communities. The magnitude of the sanitation facility needs increase is due to the IHS implementing a revised prioritization system to indicate the level of project planning. A "tier" system was introduced with the publication of the 2019 SDS Guidelines document. Projects considered "ready to fund" are assigned Tier 1, while projects considered "engineering assessed" are assigned Tier 2. Projects considered Tier 3 are those that are only "preliminarily assessed." Previously many of these projects were not reported to Congress. In FY 2020, there was a total of $0.67 billion in Tier 3 projects, resulting in an increase in the total sanitation facility need reported through SDS.

During FY 2020, 373 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $220 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 143,000 American Indian and Alaska Native people and help avoid over 235,000 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone are estimated to be over $259 million. Every $1 spent on water and sewer infrastructure will save $1.18 in avoided direct health care cost.

Adequate staffing resources are needed to ensure SFC projects are designed and constructed within the SFC Program's national average project duration of 4 years. Since FY 2016, the SFC project funding has increased by nearly 100 percent without any increase in staffing resources. Without associated increases in staffing resources, the IHS SFC Program is being strained to

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

accomplish the required program statutory obligations of sanitation deficiency needs reporting, project design, planning, and provision of technical assistance, and as such we fully expect our project durations to increase beyond 5 – 6 years. Under the President's proposed FY 2022 Budget, the IHS SFC project funds will increase by roughly 60 percent. In addition to the proposed increases in IHS appropriated funds, an assumption is made that the amount of project funds to be directed towards the IHS through appropriations and contributions from other funding sources would double over the FY 2020 levels to $547 million in future fiscal years. The FY 2022 Budget also proposes an increase of $36 million for the Facilities and Environmental Health Support program to support additional staff to implement the proposed funding increases for SFC, Health Care Facilities Construction, Maintenance & Improvements, and Equipment.

S. 1797

S. 1797, Urban Indian Health Providers Facilities Improvement Act, would amend the Indian Health Care Improvement Act (IHCIA), at 25 U.S.C. § 1659, to expand the funding authority for renovating, constructing, and expanding urban Indian organization (UIO) facilities. The bill would delete from existing law the requirement that UIOs may only use IHS funding for renovation, construction, or expansion of facilities to meet or maintain specific accreditation standards.

Current federal law at 25 U.S.C. § 1659 permits the IHS to make funds available to UIOs with contracts or grants with IHS under Title V of the IHCIA to make minor renovations to facilities or construction or expansion of facilities, including leased facilities, but only to assist UIOs in meeting or maintaining accreditation standards of The Joint Commission (TJC). Because of the specificity of the language in Section 1659, the IHS cannot award funds to an UIO to make minor renovations, construct or expand facilities, unless the UIO is doing so to meet or maintain accreditation specifically from TJC.

The IHS enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. An UIO is defined by 25 U.S.C. § 1603(29) as a nonprofit corporate body situated in an urban center, governed by an Urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. § 1653(a). UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

Currently, UIOs seek and maintain accreditation from several health care accreditation organizations, including TJC, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities (CARF). Some UIOs have also achieved recognition as Patient Centered Medical Homes (PCMH), with additional UIOs currently working towards PCMH recognition, as well as AAAHC accreditation. In addition, some UIOs must meet standards from the Centers for Medicare & Medicaid Services and/or their respective state departments of health.

Currently, only 1 out of the 41 UIOs maintain TJC accreditation. Expanding the current authority to be consistent with the authority for other government contractors, rather than limiting it under Section 1659 to only TJC accreditation, would allow UIOs to make renovations, construction, or expansion of facilities necessary to improve the safety and quality of care provided to Urban Indian patients.

A large proportion of Urban Indians live in or near the poverty level and thus face multiple barriers to accessing high quality, culturally relevant health care services in urban centers. They must overcome additional barriers to receiving appropriate care such as lack of culturally appropriate care, lack of respect, lack of visibility, transportation issues, and communication obstacles that often interfere with the delivery of high-quality health care to Urban Indians. Providing UIOs with broader authority, similar to other FAR contractors, to improve their health care facilities will assist in providing the high quality, safe, and culturally relevant health care for the Urban Indian population.

H.R. 1688

H.R. 1688, Native American Child Protection Act, would amend the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et. seq.) (the Act), a statute that, among other provisions, required the Secretary of Health and Human Services, acting through IHS and in cooperation with the Bureau of Indian Affairs of the Department of the Interior (Bureau), to establish the Indian Child Abuse Treatment Grant Program (Program). IHS does not believe Congress has ever appropriated funding to carry out the Program.

H.R. 1688 would replace references to the "Secretary of Health and Human Services" with references to IHS. The bill would amend section 409 of the Act (25 U.S.C. 3208) to expand the scope of the Program. Current law requires that Program grants be provided for the establishment on Indian reservations of treatment programs for Indians who have been victims of child sexual abuse. The bill would expand the scope to treatment programs for Indians who have been victims of child abuse or neglect. The bill would also allow urban Indian organizations to partner with Indian tribes and intertribal consortia in submitting grant applications.

Additionally, H.R. 1688 would amend section 409 of the Act (25 U.S.C. 3208) to require IHS to encourage the use of "culturally appropriate treatment services and programs" in providing grants under the Program. The bill would require IHS to submit a report to Congress, within two years, on the award of Program grants. The report would contain a description of treatment and services for which grantees have used Program funds, and other information that IHS requires. The bill would authorize $30 million per year for fiscal years 2022 through 2027 to carry out the Program.

Finally, H.R. 1688 would amend section 410 of the Act (25 U.S.C. 3209), which currently requires the Secretary of the Interior to establish an Indian Child Resource and Family Services Center within each area office of the Bureau, with staffing for the Centers to be provided in a Memorandum of Agreement with the Secretary of Health and Human Services. The bill would remove references to the Secretary of Health and Human Services, eliminate the requirement for the Memorandum of Agreement, and require the Secretary of the Interior to establish one

National Indian Child Resource and Family Services Center.

The IHS has an important role in improving the lives of native youth. Child maltreatment, a term that encompasses all forms of abuse and neglect, is associated with injuries, delayed physical growth, neurological damage, and death, and is linked with psychological and emotional problems such as aggression, depression, anxiety, low self-esteem, and post-traumatic stress disorder as well as an increased risk for the development of health problems later in life. It is critical to identify and respond to child maltreatment for the health and well-being of children, and it requires a comprehensive approach that integrates health care within a collaborative community response. IHS' efforts include early intervention, screening, assessment, education, and community-based programming to build resiliency among children and youth and to promote family engagement.

One program that focuses on domestic violence prevention is the IHS Domestic Violence Prevention Initiative (DVPI). Through this nationally coordinated grant and Federal award program, mandated through statute, IHS funds $11.2 million annually to 83 tribes, tribal organizations, urban Indian organizations, and Federal programs. The DVPI promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic and sexual violence from a community-driven context. The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, sexual assault examiner programs, and community and school education programs.

From 2010-2015, the DVPI resulted in over 78,500 direct service encounters including crisis intervention, victim advocacy, case management, and counseling services. More than 45,000 referrals were made for domestic violence services, culturally-based services, and clinical behavioral health services. In addition, a total of 688 forensic evidence collection kits were submitted to federal, state, and tribal law enforcement.

While the successful administration of the DVPI has assisted our agency in addressing violence, the program largely assists young adults experiencing intimate partner violence. Although child abuse and neglect often overlaps with intimate partner violence, the program does not specifically focus on treatment and recovery of child abuse and neglect victims. This proposed legislation would expand access to child advocacy center services that are often not available within tribal communities such as pediatric forensic examination services, mental health care providers with advanced training in child trauma, and culturally appropriate activities and services geared toward pediatric patients.

We look forward to continuing our work with Congress on these bills and welcome the opportunity to provide technical assistance as requested by the Committee or its Members. We are committed to working closely with our stakeholders and understand the importance of working with partners to address the needs of American Indians and Alaska Natives. Thank you again for the opportunity to speak with you today.