Testimony of Dr. Sheri-Ann Daniels
Chief Executive Officer of Papa Ola Lōkahi
June 1, 2022

U.S. Senate Committee on Indian Affairs – Field Oversight Hearing
"*Upholding the Federal Trust Responsibility: Funding & Program Access for Innovation in the Native Hawaiian Community"*

Aloha e Chairman Schatz, Vice Chairman Murkowski, and the Members of the U.S. Senate Committee on Indian Affairs ("Committee"),

Mahalo (Thank you) for inviting me to provide remarks on behalf of Papa Ola Lōkahi (POL) and Native Hawaiian health during this field hearing. Your commitment to bringing the table to us is deeply appreciated. In the spirit of the Committee's legacy of strong bipartisanship in honoring the federal trust responsibility owed to American Indians, Alaska Natives, and Native Hawaiians, we want to thank all who have come or contributed to today's field hearing.

POL was created in 1988 to improve the health status of Native Hawaiians through the passage of the Native Hawaiian Health Act, later reauthorized as the NHHCIA. The language of the NHHCIA established a network of health resources, services, and infrastructure for Native Hawaiians through five health service providers, the Native Hawaiian Health Care Systems, and the Native Hawaiian Health Scholarship Program under the coordination and oversight of POL. Mandates for POL include support and coordination of related health services for Native Hawaiians. We are grateful for the support of partners across the State, Native Hawaiian serving organizations (NHOs), and communities who trust POL to support their work.

Chairman Schatz, thank you for your work and commitment to improving Native Hawaiian health and to honoring the federal trust responsibility owed to Native Hawaiians. Your efforts to secure pandemic relief and support for Native Hawaiian health in the American Rescue Plan Act of 2021 (ARPA) and other COVID-19 legislation have bolstered access to services for all Native Hawaiians across the State, and after the grant period finishes in 2023, we look forward to sharing

the stories and data that underscore the critical need for further robust investments to improve Native Hawaiian health.

POL also acknowledges your work in other fields that affect health resource access, community safety, and overall well-being of Native Hawaiians and Hawai‘i residents alike. Your specific attention to the social determinants of health and the factors that facilitate health care delivery, accessibility, and utilization – such as increasing broadband coverage throughout the State – is needed to address the systemic issues in health care. Today, we share the successes made possible by your work that fulfill the mandates of the NHHCIA and address the needs exacerbated or created during the pandemic. In addition, we identify barriers to fulfilling our mandates and ways that federal legislation can continue to uplift Native Hawaiian health.

Background

The Federal Trust Responsibility

Similar to American Indians and Alaska Natives, Native Hawaiians have never relinquished the right to self determination despite the United States' involvement in the illegal overthrow of Queen Lili‘uokalani in 1893 and the dismantling of our Hawaiian government. As such, Native Hawaiians are owed the same trust responsibility as all Native groups in the United States. To meet this obligation, Congress—often through landmark, bipartisan work of this Committee and its Members—has created policies to promote education, health, housing, and a variety of other federal programs that build, maintain, and enhance resources for Native Hawaiians.

Over 150 Acts of Congress expressly acknowledged or recognized a special political and trust relationship to Native Hawaiians based on our status as the Indigenous, once-sovereign people of Hawai‘i. Among these laws are the Hawaiian Homes Commission Act, 1920 (42 Stat. 108) (1921), the Native Hawaiian Education Act (20 U.S.C. § 7511) (1988), the Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11701) (1988), and the Hawaiian Homelands Homeownership Act codified in the Native American Housing Assistance and Self Determination Act, Title VIII (25 U.S.C. § 4221) (2000).

Honoring the Trust Responsibility by Supporting Native Hawaiian Health

The federal trust responsibility extends to all Native Hawaiians—an estimated population of over 300,000 in the State of Hawai‘i alone.[1] POL asks Congress to include Native Hawaiians in federal legislation and programs intended to serve all Native Americans based on the federal trust responsibility. Native Hawaiian inclusion must be clearly defined in statute so that the trust responsibility is understood and implemented in ways that ensure Native Hawaiians receive equitable opportunities as indigenous peoples with a trust obligation.

[1] U.S. Census Bureau. (2019). *2020 American Community Survey 5-Year Estimates Detailed Tables.* Retrieved from https://data.census.gov/cedsci/table?q=b02019&g=0400000US15&tid=ACSDT5Y2020.B02019

We urge Congress to make legislation specific to Native Hawaiian health because without such language, implementation that honors the trust responsibility is subject to interpretation. When the trust responsibility for Native Hawaiians is decided in this manner, it becomes difficult to ascertain whether Native Hawaiian communities receive equitable access to opportunities or benefit from funding as intended. A variety of federal health grants continue to aggregate Native Hawaiians with with Asian Americans and Pacific Islanders, subsume Native Hawaiians as a special population within state programs and block grants, or simply fail to incorporate Native Hawaiians. Such implementation is a fundamental misunderstanding of the federal trust responsibility and Native Hawaiians as a special political group with specific eligibility for federal programs.

For example, Native Hawaiians are disproportionately impacted by sexual violence—including child sexual abuse, sex trafficking, and domestic abuse. We need to break the cycle of violence—which is a result of historical trauma—that harms Native Hawaiian families. There is a problem with the Violence Against Women Act. Tribal nonprofit organizations and Native Hawaiian nonprofit organizations are both eligible for VAWA grants to provide services benefitting Indian and Alaskan Native women but not Native Hawaiians. Native Hawaiian grant eligibility that does not reach Native Hawaiian communities creates confusion and does not fulfill the trust responsibility to Native Hawaiians, and we ask Congress to support the amendments needed to correct legislation intended to be inclusive.

Funding & Program Access

The federal context of Native Hawaiian health today is a combination of limited direct funding that faces various administrative challenges and a structurally inequitable competitive grant system. To carry out Congressional mandates, POL both advocates for increased direct funding to Native Hawaiian health and equity for NHOs pursuing health funding. POL remains of the opinion that Native health should have multiple, stable vehicles of non-competitive funding as part of the federal trust responsibility. POL asks Congress to continue supporting Native Hawaiian health to the extent possible through clear and specific legislation. Native Hawaiian health cannot be legislated into competition with general population needs or Tribal health, not only because those needs have vastly different context, but also because the trust responsibility owed to Native Hawaiian health is not optional. Equity for all Native health efforts must be uplifted, as all Native health falls under federal trust obligation.

Statutory specificity is one way to ensure that the trust responsibility is not diluted in implementation. The success of specific Native Hawaiian health inclusion was exemplified in COVID-19 relief through ARPA. Without this inclusion, NHOs would have the same access to federal resources as the general public, which dismisses the trust responsibility towards Native Hawaiian health. Today, it is not clear what sources of federal funds have reached NHOs both regarding pandemic relief or health resources and programs in general, which prevents POL from gaining insights to guide its future work to carry out Congressional mandates or make data-informed decisions. POL continues to pursue data governance, access, and disaggregation improvements regarding federal, state, and local Native Hawaiian health data.

COVID-19 Pandemic Response

POL Partnerships and Grants. The establishment of POL as a non-profit organization allows eligibility to pursue federal, State, county, and private sources of funding. Since the first shutdown in the State of Hawai‘i in March 2020, POL (both alone and in partnership with community organizations) has successfully applied for or acted as fiscal agent for over $2 million dollars throughout various grants. These grant funds are in addition to the roughly $3.5 million of ARPA funds that POL is funneling to community organizations. POL is committed to pursuing its mandates and mission through multiple funding mechanisms to expand opportunities for Native Hawaiian health. POL has also engaged its Congressional duties by providing the administration for the Hawai‘i COVID-19 Native Hawaiian & Pacific Islander Response, Recovery, and Resilience (NHPI 3R) Team, a coalition of over 60 partners that have engaged on behalf of communities throughout the State of Hawai‘i, from June 2020 to present.

Nā Makawai. Nā Makawai is the name of the initiative that encompasses the work of the five NHHCS, POL, and fifteen Native Hawaiian serving health entities (20 organizations in total) that have received ARPA funding to provide COVID-19 response and recovery services and resources throughout the State of Hawai‘i. ARPA funding is ongoing over the course of a two-year grant period through the Health Resources & Services Administration (HRSA). The first year of funding for ARPA began retroactively on August 1st 2021, and ends on July 31st, 2022. The Notice of Award regarding ARPA funding – a grant document that signals funding has been awarded, because POL was required to submit a grant application for ARPA funds – was received on August 13, 2021, about five months after ARPA was signed into law. Community partners began receiving funding in August and September of 2021.

Notably, ARPA language allowed for funds to be applied towards health workforce, infrastructure, and community outreach and education – critical components of Native Hawaiian health. Given the annual appropriations for federal fiscal years 2021 and 2022 ($20.5 and $22 million, respectively), a $20 million increase in funding across a two-year span increases the total funding to the NHHCIA by approximately half. The full impact has yet to be realized, as funding will be expended through 2023. As of May 2022, POL has expended approximately $1.5 million of ARPA funding to support statewide community partners through the Nā Makawai initiative. The thoughtful flexibility and inclusivity of ARPA language and approved activities through HRSA allowed POL to partner with local organizations across a wide range of programs and services throughout the State of Hawai‘i, which includes:

- direct clinical COVID-19 services (vaccination and testing, mobile care, and mobile events);
- indirect COVID-19 services (outreach, education, and surveillance; statewide referral hotline for various resources); and
- increasing or maintaining resources needed to expand COVID-19 response (workforce, including community health workers; telehealth capacity and electronic medical records).

In addition, the Nā Makawai partners work in COVID-19 relief needs overlap with preexisting needs in the Native Hawaiian community. These include: sustaining comprehensive primary health care; mental/behavioral health; a rural youth program; food insecurity and access programs; and maternal/child care. POL also seeks to connect with health factors that impact clinical needs, so Nā Makawai partnerships have also supported a broadband infrastructure mapping project so that future telehealth projects and programs that rely on broadband accessibility can be informed by and based on high quality, locally collected data.

Implementation Challenges. International supply chain issues continue to slow the implementation and execution of relief efforts. One of the most highly anticipated approved purchases, mobile health units, has an estimated delivery of at or over 12 months. Mobile health units are are particularly valuable in rural areas of the State to buffer geographic maldistribution of health resources and services, and there is no readily accessible short-term, temporary workaround to replace the utility and functional gains that mobile health units provide.

Community partners and State data have continued to report COVID-19 cases rising, which creates system-wide stress. As both the Native Hawaiian community and health workforce experience continued COVID-19 impact, POL urges Congress to continue responding to pandemic needs in the Native Hawaiian community.

Administrative Challenges. POL first engaged with HRSA as ARPA was about to be signed in March 2021 to request immediate engagement, as this was the first direct COVID-19 Native Hawaiian health funding bolus during the pandemic. POL and the NHHCSs agreed that the fastest, most responsive way to address COVID-19 needs for Native Hawaiians was to funnel the appropriation through POL, so that the NHHCSs could focus on on-the-ground activities and for flexibility, as pandemic needs fluctuated in range and intensity. To much dismay, HRSA interpretation of ARPA language, which was attributed to the Office of General Counsel of the Department of Health and Human Services (HHS OGC), required POL to distribute these emergency funds among POL and the NHHCSs, not allowing for the mobility envisioned, despite proactive signaling.

POL was also informed that the NHHCIA matching requirement for the NHHCSs would be applied. POL explained, in meetings and in writing, concern about the interpretation that NHHCIA requirements preempted emergency relief, which seemed counterproductive. HRSA did not provide further comments or a connection to HHS OCG for clarification, instead focusing on requesting that POL provide a waiver letter regarding the matching requirement. POL, in its letter, reiterated concerns that this precedent would affect timeliness. No follow-up was provided.

Despite repeated outreach to HRSA due to community and delegation inquiries in April and May of 2021, and POL's concerns about timeliness, the non-competitive grant application was not published until June. Funding did not become accessible until August. In communications, HRSA responded to POL on May 11th, 2021, with the following explanation:

> *"The money is all from the same source—the American Rescue Plan—but the different groups (e.g., CHCs, look-alikes, Primary Care Associations, etc.) have different submission and reporting requirements and in some cases different*

allowable uses for the money—so we cannot use one mechanism to release it all. So here at HRSA we've had to prepare the different mechanisms to release the money to the various groups, and in many of the cases it requires us to revise electronic systems to be able to capture the information being submitted. These ARP funds have different reporting requirements as well—not only for the award recipients but for HRSA as well—so we need to make sure we have figured out all of the pieces before we release the funding. We have many expedited processes in place to get this funding out as fast as possible, which seem to be working because this ARP funding is going out much faster than our "regular" funding."

In stark comparison, HRSA notifications and technical assistance work regarding ARPA components that applied to the Federally Qualified Health Centers (FQHCs) began as early as March 2021. POL's understanding is that FQHCs were able to access ARPA funding as early as April, four months before ARPA funds were released for Native Hawaiian health. POL is cognizant that other HRSA mechanisms may have been more readily adaptable, as FQHCs and other entities had been eligible for prior COVID-19 relief. In the meantime, POL focused on everything under its own control such as preparing to act swiftly once the funding opportunity application was opened and to operationalize once funding was released.

Federal Medical Assistance Percentage. POL's lack of contacts in the Centers for Medicare and Medicaid (CMS) was a barrier in implementation of ARPA Section 9815 regarding 100 percent Federal Medical Assistance Percentage eligibility for eight fiscal quarters, which started in April 2021 but has yet to begin processing. The work of Senator Schatz to inquire with CMS was deeply appreciated, and POL identifies that this barrier is part of greater administrative challenges facing Native Hawaiian health in general. POL urges the Committee to make a permanent extension to the APRA provision for Native Hawaiian health.

Sustainability. The partnerships created through Nā Makawai demonstrate how an emergency funding bolus can catalyze increased coordination and network building in Native Hawaiian health, but also indicate the level of funding that POL would be able to distribute in NHHCIA annual appropriations to facilitate a stronger network of Native Hawaiian health. POL was able to extend funds to a handful of community organizations and partners who address some of the most immediate vulnerabilities – i.e., the most high need domains of health, geographic areas, or contextual factors that had serious inequities prior to COVID-19 and were exacerbated during 2020 and 2021. As COVID-19 data in the State of Hawai'i indicate that Native Hawaiian disparities are increasing, POL seeks pathways to remain responsive to pandemic needs.

Ongoing Native Hawaiian Health Needs

Although the pandemic has created acute health issues, it has also exacerbated many of the standing system-wide gaps in Native Hawaiian health. These needs, while particularly salient during COVID-19, must become features rather than temporary additions so that Native Hawaiian health is ingrained as a function and not an option. POL urges Congress to examine these needs and address them through legislation wherever possible.

Increased Access to Relevant Agencies. POL finds its Congressional mandate to coordinate and support health services and resources implies connections with all of the operating divisions within the Department of Health and Human Resources, but lacks specific program inclusion or connection to any of the operating divisions besides HRSA. This lack of connectivity creates barriers for POL to advance Native Hawaiian health or implement Congressional successes through direct connection with agencies because HRSA does not administer any other federal programs based on the trust responsibility owed to Native Americans. POL is thus dependent on HRSA to facilitate interagency relations on POL's behalf to carry out coordination efforts. During the pandemic, POL identified the need to have contacts in all relevant agencies.

Recent increase in Native Hawaiian listening sessions and interactions with the Administration is a promising step forward, and we urge this Committee to support a formal engagement process between Native Hawaiians and the federal Departments that administer Native Hawaiian programs so that challenges can be addressed.

Competitive Grants Dilute of Native Hawaiian Trust Responsibility. Simply put: NHO eligibility for federal grant opportunities is nearly always the same as that afforded to the general public, which is dismissive of the trust obligation. Opportunities distributed across multiple divisions and offices in multiple Departments make it difficult to understand what is available and where, putting NHOs at a disadvantage from the start. The competitive grant process is biased towards applications written by experienced grantwriters – which does not indicate community access or support with consistency. The limited resources of NHOs also makes it impossible for NHOs to place resources toward an intensive grant writing process. As Native Hawaiians are less than 1% of the U.S. population, NHO applications in open competitive grants face an immediately disadvantage when large service populations are a desired metric. Thus by design, the system automatically promotes inequity.

Improving Federal Health Data – Governance and Access. Part of the NHHCIA mandates POL to act as a data clearinghouse for Native Hawaiian health, a function that is difficult to achieve without statutory requirements for the entities that create or compile said data. The current NHHCIA does not mandate that federal departments disclose health data to POL, and the standing federal requirements for race/ethnicity data disaggregation are insufficient to identify Native Hawaiian data reliably and accurately in datasets. This system leads to Native Hawaiian health research facing barriers to federal health data. We urge Congress to develop legislative solutions so that Native Hawaiian health data are disaggregated and accessible.

Without changes in governance, POL is left to attempt pursuing independent data use agreements with the various relevant federal, state, and private data sources. Efforts to do this can be both time and cost intensive, and do not guarantee that a data use agreement will be established. Given that uncertainty of investment, POL has examined what other pathways to improve data governance, access, and disaggregation for Native Hawaiian health exist; work during the pandemic has included participating in local partnerships that successfully led to the disaggregation of COVID-19 data in the State of Hawai‘i. POL has also focused on supporting the creation of local Native Hawaiian health data sets and projects, built in partnership with stakeholders and community members. This work includes:

1. Developing a report on State sources of data that pertain to Native Hawaiian health and address modern data needs like race/ethnicity disaggregation, lack of uniformity in data collection, and lack of data access – Data Justice: About Us, By Us, For Us
2. Publishing the E Ola Mau a Mau report, which builds on the original E Ola Mau health report and includes data governance needs;
3. Collecting data on a variety of health topics through an iterative survey, Ka Leo Kaiaulu; and
4. Submitting responses to federal feedback mechanisms that detail needs in the quality and availability of Native Hawaiian health data, such as revision of the Office of Management and Budget (OMB) Directive 15, revisions to the Native Hawaiian Health Care Systems requirements to the Uniform Data System, and the need for Census Bureau products and data that address race/ethnicity at sub-county geographies.

Data is critical in health for myriad reasons and goals. Improvements in disaggregation and access to Native Hawaiian health data require work on multiple fronts, including policy, to make informed decisions in health.

Increased Direct & Inclusive Formula Funding. The NHHCIA appropriation distributed among POL, the five NHHCSs, and the NHHSP is the only vehicle through which the Native Hawaiian Health Care Program receives direct funding and one of the only stable programs to support Native Hawaiian health. Based on the continuing health disparities and challenges facing the Native Hawaiian community, POL urges the Committee to examine other direct funding inclusions for Native Hawaiian health across various domains of clinical care as well as in health infrastructure needs, including but not limited to:

- Mental and behavioral health;
- Chronic diseases such as diabetes, cancer, and heart disease;
- Substance abuse and misuse;
- Suicide prevention, especially for youth;
- Elder care, including programs that support aging in place, facilities needs for assisted living and long-term care, and caregiver resources;
- Maternal and infant health; and
- Sexual violence, including child sexual abuse, sex trafficking, and domestic violence.

POL also urges the Committee to examine how support for traditional healing practices can be uplifted, as these services are not typically included in medical insurance coverage, as well as workforce development, as many Native Hawaiians express a need for culturally sensitive programs that utilize an integrated approach that combines traditional healing and modern health that are administered by Native Hawaiian health professionals.

Native Hawaiian health remains excluded or disadvantaged from majority of programs, funding, or opportunities from any operating division of the U.S. Department of Health and Human

Services and U.S. Department of Justice (e.g. direct funding, set-asides, block grants, specific eligibility in competitive grants). This reflects the struggles in Native health and related programs to address the social determinants of health overall, as the Indian Health Service (IHS) also remains underserved, underscoring that Indigenous health overall must be prioritized by Congress and the Administration to protect Native communities and uplift Native wellbeing.

POL continues to carry forward its mandates and mission, looking to uplift the status of Native Hawaiian health to the highest extent. We urge Congress to examine how some of these issues may be addressed through legislation, and we continue to seek solutions on multiple fronts. We stand ready to do our part to be an active, accountable partner in Native Hawaiian health, and we appreciate the continued work of Congress to do the same. Mahalo nui for the invitation to discuss Native Hawaiian health and the trust responsibility. We look forward to working together.