

S. 1250, S. 1275, AND S. 1333

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

JUNE 13, 2017

Printed for the use of the Committee on Indian Affairs



U.S. GOVERNMENT PUBLISHING OFFICE

27-650 PDF

WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON INDIAN AFFAIRS

JOHN HOEVEN, North Dakota, *Chairman*

TOM UDALL, New Mexico, *Vice Chairman*

JOHN BARRASSO, Wyoming

JOHN McCain, Arizona

LISA MURKOWSKI, Alaska

JAMES LANKFORD, Oklahoma

STEVE DAINES, Montana

MIKE CRAPO, Idaho

JERRY MORAN, Kansas

MARIA CANTWELL, Washington

JON TESTER, Montana,

AL FRANKEN, Minnesota

BRIAN SCHATZ, Hawaii

HEIDI HEITKAMP, North Dakota

CATHERINE CORTEZ MASTO, Nevada

T. MICHAEL ANDREWS, *Majority Staff Director and Chief Counsel*

JENNIFER ROMERO, *Minority Staff Director and Chief Counsel*

CONTENTS

Hearing held on June 13, 2017	Page 1
Statement of Senator Barrasso	11
Statement of Senator Cortez Masto	10
Statement of Senator Daines	44
Statement of Senator Franken	7
Statement of Senator Heitkamp	9
Statement of Senator Hirono	7
Statement of Senator Hoeven	1
Statement of Senator Murkowski	5
Statement of Senator Schatz	4
Statement of Senator Tester	49
Statement of Senator Thune	51
Statement of Senator Udall	3

WITNESSES

Buchanan, Rear Admiral Chris, Acting Director, Indian Health Service, U.S. Department of Health and Human Services	12
Prepared statement	14
Charlie, Mark, President/CEO, Association of Village Council Presidents (AVCP) Regional Housing	67
Prepared statement	69
Crowley, Dr. Joseph P., President-Elect, American Dental Association	22
Prepared statement	23
Difuntorum, Sami Jo, Chairwoman, National American Indian Housing Coun- cil	75
Prepared statement	78
Frechette, Heidi, Deputy Assistant Secretary, Office of Native American Pro- grams, U.S. Department of Housing and Urban Development	54
Prepared statement	56
Harris, Dr. Keith, Director of Clinical Operations, Homeless Programs Office, U.S. Department of Veterans Affairs	59
Prepared statement	61
Kitcheyan, Hon. Victoria, Treasurer, Winnebago Tribe of Nebraska Tribal Council	16
Prepared statement	18
Onnen, Hon. Liana, Vice President, Southern Plains Region, National Con- gress of American Indians (NCAI)	63
Prepared statement	65
Stier, Max, President/CEO, Partnership for Public Service	27
Prepared statement	30

APPENDIX

Allen, Hon. W. Ron, Chairman, Self-Governance Communication & Education Tribal Consortium; Tribal Chairman/CEO, Jamestown S'Klallam Tribe, pre- pared statement	96
American Academy of PAs, prepared statement	89
Begaye, Hon. Russell, President, Navajo Nation and Jonathan Hale, Chair- man, Health, Education & Human Services, Navajo Nation Council, joint prepared statement	102
Cladoosby, Hon. Brian, Chairman, Swinomish Indian Tribal Community, pre- pared statement	123
Danner, Robin Puanani, Chairman, Sovereign Councils of the Hawaiian Homeland Assembly (SCHHA), prepared statement	116

IV

	Page
Department of Hawaiian Home Lands, prepared statement	107
Gundersen Health System, prepared statement	124
Hawaii Congressional Delegation, prepared statement	89
Hodson, Mike, Chairman, Board of Commissioners, Homestead Housing Authority, prepared statement	111
Navajo Housing Authority Board of Commissioners, prepared statement	99
Office of Hawaiian Affairs (OHA), prepared statement	112
Response to written questions submitted by Hon. Jon Tester to:	
Heidi Frechette	130
Dr. Keith Harris	125
United South and Eastern Tribes Sovereignty Protection Fund, prepared statement	104
United States Merit Systems Protection Board (MSPB), prepared statement ...	93
Weston, Hon. Troy "Scott", President, Oglala Sioux Tribe, prepared statement	120
Yazzie,Aneva J., CEO, Navajo Housing Authority, prepared statement	90

S. 1250, S. 1275, AND S. 1333

TUESDAY, JUNE 13, 2017

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:55 p.m. in room 628, Dirksen Senate Office Building, Hon. John Hoeven, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN HOEVEN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. I call the meeting to order.

Today, the Committee will examine three bills in two panels: S. 1250, the restoring accountability to the Indian Health Service Act of 2017; S. 1275, the bringing useful initiatives to Indian land development or the BUILD Act; and S. 1333, the Tribal HUD/VASH Act of 2017.

Regarding Panel 1, on May 25, 2017, Senators Barrasso, Thune and I introduced S. 1250, the restoring accountability to the Indian Health Service Act of 2017. This bill is intended to increase transparency and accountability, improve patient safety and care, and boost recruitment and retention of employees to the IHS.

We introduced this bill again this Congress to begin reversing years of poor health care delivery in some IHS facilities. A significant amount of work by the Committee with the agency, the Government Accountability Office and stakeholders, has been put into this bill and the predecessor bill introduced by then-Chairman Barrasso and Senators Thune, Rounds and McCain.

Nearly one year ago in the last Congress on June 17, 2016, the Committee held a hearing on the predecessor bill, S. 2953. The Acting Deputy Secretary of the Department of Health and Human Services, Mary Wakefield, testified in support of some provision of the bill and gave suggestions on other provisions.

The Committee favorably reported a substitute amendment to address the department's issues. Those changes are also reflected in this bill, along with a few additional provisions.

I look forward to hearing from our witnesses today on this bill as well as improvements. I join everyone on the dais, that we can do better in providing health care to Native communities.

As far as Panel 2, on May 25, 2017, I introduced S. 1275, the BUILD Act, to reauthorize the Native American Housing and Self Determination Act to eliminate duplicative bureaucracy, when multiple agencies are involved in a tribal housing project, and encour-

age new forms of investment by extending leaseholds on trust or restricted lands from 50 years to a maximum of 99 years.

The bill is intended to improve housing conditions within tribal communities by providing greater tribal control over housing development on their lands. We all know what a pressing issue housing is on the reservation.

This Committee has worked for several years to reauthorize the Native American Housing and Self Determination Act, NAHASDA, and improve housing conditions for Indian people. Prior bills have been held up in past Congresses with substantial effort into finding a path forward.

This bill has been held up in the last Congress and the Congress prior to that. We would like to pass it.

As I mentioned to the National American Indian Housing Council's Legislative Conference in February, the BUILD Act is the Chevy model of reauthorization. The engine of the BUILD Act is the reauthorization of the Indian Housing Block Grant which was the centerpiece of NAHASDA when it was first introduced and passed this body back in 1996.

In previous versions of the NAHASDA reauthorization, there were over 20 different pieces of legislation included. Some of them are more controversial than others obviously, but some of the pieces included were lease requirements, program income, rental income caps, total development, maximum project costs, demonstration programs, limitation on use for the Cherokee Nation, the Native Hawaiian Block Grant and other aspects.

Instead of just reintroducing all the past bills, I wanted to take a fresh look at getting a bill across the finish line. I know some of the members on the Committee have expressed their desire to include some of these previous positions in this bill, a different vehicle or a combination of both.

With that, I am willing to work with any member here on finding a path forward. This is one of the reasons why I wanted to have a legislative hearing early on, as we are doing today, so we can roll up our sleeves and work towards finally getting these bills to the President's desk, only after giving everyone opportunity for meaningful input, not only in the housing bill but the other features I just covered.

On June 12, 2017, Senators Tester, Isakson, Udall and myself introduced S. 1333, the Tribal HUD/VASH Act of 2017. This bill is intended to improve the Housing and Urban Development and Veterans Affairs support of housing programs.

This program combines housing and choice of voucher rental assistance for homeless tribal veterans with case management and clinical services provided by the Veterans Administration through the Veterans Administration Medical Centers.

The bill would authorize the Department of Housing and Urban Development and the VA to modify program administration to facilitate the recruitment of VA case managers and create a set aside for rental assistance. The bill would also require the program to be administered in accordance with the Native American Housing Assistance and Self Determination Act, NAHASDA. It would also mandate IHS work cooperatively to provide assistance as requested by HUD or the VA in carrying out the program.

Finally, it would require review and a report by the agencies to be submitted to the congressional committees of jurisdiction.

All three of these are important bills to help Indian people obtain critical services for health care and for housing. I look forward to hearing how we can best advance these measures and get them signed into law.

The Native American people I think have the highest rate of service in our military of any group. We are talking about housing, health care and veterans.

Before we turn to the witnesses, I would like to turn to the Vice Chairman for any comments that you may have, Senator Udall.

**STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO**

Senator UDALL. Thank you, Chairman Hoeven, for calling this legislative hearing today on S. 1250, S. 1275 and S. 1333.

The issues presented in these bills are important to Indian Country and reflect our shared priorities on this Committee. In fact, each of the bills is important enough to merit its own hearing.

S. 1250 would impose sweeping reforms on the Indian Health Service, S. 1275 would reauthorize certain housing programs created by the Native American Housing and Self Determination Act, while imposing changes to that law, training and technical assistance programs and environmental review processes; S. 1333 would authorize the Tribal HUD/Veterans Affairs Supported Housing Program and ensure that our Native veterans receive the housing benefits they assuredly deserve.

These bills would have real and long-lasting impacts on Indian Country and deserve a thorough vetting to ensure that the final product reflects the meaningful consideration of Indian Country's concerns.

I encourage all stakeholders present at this hearing, as well as those listening online, to submit statements for the record. Your input matters.

Touching briefly on S. 1250, I share the goals of achieving accountability, strengthening the workforce and improving quality of care at IHS. The health care crisis facing many IHS facilities in the Great Plains and throughout Indian Country is a concern this Committee takes very seriously.

We must do more beyond tinkering with Federal employment law to address the need for transparency and quality assurance. We must also take care not to jettison well established, constitutional protections in the process of holding IHS leadership and staff accountable at every level.

Let us not overlook the fact that for decades, tribal health care programs have been severely underfunded, which I believe has contributed greatly to the health care crisis we are in today. I look forward to working with Senator Barrasso and the Chairman to make sure this bill addresses IHS issues identified by all tribes and patients in an effective way.

With regard to S. 1275, Mr. Chairman, you and I know that NAHASDA is critically important. The overwhelming need for adequate, safe and sanitary housing in all Native communities is well documented.

That is just as true for Native Hawaiian homesteads as it is for reservations, pueblos and Alaska Native villages. Given that understanding, I was concerned to see that S. 1275 does not include a reauthorization of Title 8. I will defer to my colleague, Senator Schatz, to explain why carving out Native Hawaiian programs from this bill sets a dangerous precedent for his constituents and Indian Country as a whole. We must do all we can to make sure NAHASDA is fully reauthorized for all Native American communities that rely on its housing programs.

Turning to Senator Tester's Tribal Veterans Housing bill, I am proud to join him, VA Committee Chair, Senator Isakson and Chairman Hoeven to sponsor this bill. It is a powerful message to bring together bipartisan leadership from two Senate committees in support of one goal, better serving Native veterans.

S. 1333 represents all the good that can happen when members from both sides of the aisle listen to Indian Country and work together to advance tribal priorities. This body has a rich history of acknowledging that Native issues can rise above beltway party politics. Indeed, I am reminded this Committee accomplishes so much more when it works from the viewpoint that Indian issues are largely bipartisan.

I look forward to continuing this tradition and honoring the special political and trust relationship the United States has with all its indigenous peoples. It is clear to me that any potential changes to the national policy regarding Medicaid and health insurance programs like those contained in the AHCA, will directly impact tribal communities and Native lives.

For the record, I would like to urge the majority on all committees to follow regular order and to hold hearings and seek tribal consultation on any proposal that would cut access to life saving health care programs.

With that, Mr. Chairman, I will yield back.

The CHAIRMAN. Thank you, Senator Udall.

I would invite any other comments at this point.

Senator SCHATZ. Mr. Chairman?

The CHAIRMAN. Senator Schatz.

STATEMENT OF HON. BRIAN SCHATZ, U.S. SENATOR FROM HAWAII

Senator SCHATZ. Thank you, Mr. Chairman.

Thank you for the opportunity to talk about the impact of the BUILD Act. I have a few statements for the record from Native Hawaiian organizations and Native Hawaiian-serving organizations I would like to submit for the record.

The CHAIRMAN. Without objection.

Senator SCHATZ. Thank you.

I would like to welcome leaders from the Hawaiian community including several members of the Office of Hawaiian Affairs in the audience today. They are here to represent the people who would suffer if the BUILD Act were to proceed. Several of them are direct beneficiaries.

With us, we have Robin Danner, the Chairman of the Sovereign Councils of the Hawaiian Homelands Assembly; Coty-Lynne Haia, D.C. Bureau Chief for the Office of Hawaiian Affairs; Sheri-Ann

Daniels, Executive Director, Papa Ola Lokahi; Kawika Riley, Chief Advocate for the Office of Hawaiian Affairs; and Timmy Wailehua, Operations Manager, Office of Hawaiian Affairs, Native Hawaiian Revolving Loan Fund. Thank you all for being here.

The BUILD Act is a serious departure from the way this Committee does business and breaks our longstanding tradition of bipartisanship and standing together. Just last Congress, this Committee reported out a bipartisan NAHASDA reauthorization that included Native Hawaiians. Even the House passed a bipartisan NAHASDA reauthorization that included Native Hawaiians.

The BUILD Act is a dramatic departure from the norm. By leaving out Native Hawaiians, this bill is an attack on my State and my people. It dishonors the legacies of Daniel K. Inouye and Daniel Akaka and threatens the future work of the Committee.

The Committee has always been a bastion of bipartisanship. For decades, American Indians, Alaska Natives and Native Hawaiians have stood together on behalf of all Native people. We have had our challenges on the Floor and I am sure we will continue to face more but we have never faced this kind of attack in Committee.

There is a reason for that. That is because most everything that comes out of the Committee depends on unanimous consent on the Floor. That is just how we work and how we get things done. That solidarity is being strained and it is unfortunate in the extreme. I worry it is the beginning of the end of the Committee's productivity.

Serving Native Hawaiians is foundational to my service in the Senate. It is why I made Native Hawaiians the subject of my maiden speech on the Senate floor. It will be difficult to maintain the unanimity of this Committee's work, the work we rely on, when my people are being left out.

I strongly urge this Committee to preserve the spirit of bipartisanship by changing course and including Native Hawaiians going forward.

Thank you, Mr. Chairman.

The CHAIRMAN. Are there other opening statements? Senator Murkowski.

**STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA**

Senator MURKOWSKI. Thank you, Mr. Chairman.

I must first start by thanking the Committee for moving out S. 825, the Southeast Alaska Regional Health Consortium Land Transfer Act of 2017. I was not here but you did a fine job in moving that. I appreciate that. I know the people of SEARHC appreciate that as well.

I want to thank you both for having this hearing today and focusing on some very foundational issues. As you mentioned, health care and housing our veterans really is so important.

I would like to welcome Mark Charlie to the Committee today. Mark is Yupik. He is a member of the Native Village of Tununak. He serves as the present CEO of the Association of Village Council Presidents Regional Housing Authority in Bethel.

As you will hear from Mark, AVCP Housing is the tribally-designated housing entity of southwest Alaska responsible for 51

tribes. His team has a pretty tough job in providing housing in a very remote and very, very costly area where weather can be a deciding factor if you can even build or not in any given year.

Today, Mark is going to be providing testimony on both the BUILD Act and on the Tribal HUD/VASH Act. This is a long way to come and I appreciate his willingness to be here. I do agree very strongly with Mark that we must find a way to reauthorize NAHASDA and continue to support this very important program.

I want to tell my colleague from Hawaii that I remain dedicated and willing to work with him, with other members of the Committee and members of the Senate to try to find the best route to do this.

As you noted, Senator Schatz, Alaska Natives and Native Hawaiians have been allies and friends in many different areas. Sometimes it can be difficult to work through the issues but I think continued effort, conversation, dialogue and a willingness to get there is important. Know that I remain dedicated to do just that. I think this is important to Alaska Natives, to those across Indian Country and certainly to Native Hawaiians.

I also want to thank you, Senator Hoeven and Senator Udall, as well as Senators Isakson and Tester, for the work on the Tribal HUD/VASH Act. It is really an important program and one I would hope we can all get behind.

We have run into some challenges in Alaska in implementation, so I hope we will hear from President Charlie, HUD and the VA on how we get there as well.

Thank you again for the hearing and I thank all the witnesses for coming a long way and doing a good job.

The CHAIRMAN. Thank you, Senator Murkowski, for your comments.

I will turn to other opening statements in a moment but I want to respond to both Senator Schatz, and it seems appropriate following Senator Murkowski, as you are the Chair of the Subcommittee on Interior and EPA.

We have included in the BUILD Act the things that we felt there was no objection to so that we would be able to move the bill. Left out are things where we have had objections. I am not opposed to adding things if we can get enough support to move the bill.

As I said to Senator Schatz directly, I am certainly open to working with him and finding a way to advance the bill. Not only that, in fact, I have offered to you, Senator Schatz, in addition to moving the BUILD Act, that I would work with Senator Murkowski to get funding for Native Hawaiians through the appropriations bill. You and I are both members of the Appropriations Committee.

I understand that is not exactly what you want but I just want to make sure the record is clear that I am trying to be of assistance and trying to get this legislation passed. If there is some way to do it, even in a multistep process, I am trying to work on that, including approaching Senator Murkowski about getting it funded through the appropriations process.

Again, I am trying to solve the challenge we face in getting legislation advanced. As Senator Murkowski said, we will keep working on it but the NAHASDA bill, the BUILD Act, is \$650 million for housing in Indian Country. It includes the Native Alaskans be-

cause of the status Native Alaskans have. We have a challenge and that has not been done yet for Native Hawaiians.

I understand that you may perceive it differently. All I want to be clear on is that I am trying to find a way to advance the housing legislation and that I am open to ideas that enable us to do that. I know Senator Hirono is here to probably have the same discussion.

I wanted to make that a part of the record. It seems timely because Senator Murkowski has been very helpful in saying if there is another way to solve this challenge, she is more than willing to help.

Senator MURKOWSKI. I might just note, Mr. Chairman, that your Ranking Member is also my Ranking Member on the Interior Appropriations Committee.

The CHAIRMAN. I have always found him to be extremely helpful, so I am pretty sure he would roll up his sleeves and help as well. Senator Franken.

**STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA**

Senator FRANKEN. I would just like to associate myself with Senators Schatz and Murkowski. This covered Native Hawaiians before and I think it should do it again. I appreciate your willingness to work toward that end with both Senator Murkowski and Senator Udall. I trust that will get done.

Thank you.

The CHAIRMAN. Other opening statements?

Senator HIRONO. Mr. Chairman?

The CHAIRMAN. Senator Hirono.

**STATEMENT OF HON. MAZIE K. HIRONO,
U.S. SENATOR FROM HAWAII**

Senator HIRONO. Thank you very much.

I am not a member of this Committee. Thank you so much for allowing me the opportunity.

This Committee holds important jurisdiction over matters involving indigenous people. I am here to speak against S. 1275 in its current form. Our indigenous peoples are the American Indians, Alaska Natives and Native Hawaiians. These are our original peoples.

As members of this Committee, you are aware of the experiences and challenges of Native peoples, including the history of decimation and prolonged subjugation by the Federal Government. This history is one of the reasons the Federal Government has enacted laws intended to help our indigenous peoples and recognize our government's trust responsibilities to them.

While I am not a member of this Committee, I am here because the matters you are discussing today are very important for the Native Hawaiian community. I am here to share my serious concerns over the decision to exclude Native Hawaiian housing programs in S. 1275, the Bringing Useful Initiatives for Indian Land Development Act, also known as the BUILD Act.

As this legislative vehicle to reauthorize the Native American Housing Assistance and Self Determination Act, also known as

NAHASDA, the BUILD Act is an opportunity to support all Native communities.

The BUILD Act, however, strips out Title 8, which includes the Native Hawaiian Housing Block Grant and 184(a), Native Hawaiian Home Loan Guarantee Programs. By omitting Native Hawaiian housing programs, the BUILD Act strikes a blow not only to the 37,000 Native Hawaiians who could directly benefit from their inclusion, but also strikes a blow to the over 500,000 Native Hawaiians in our Country.

This is about much more than just stripping out Native Hawaiian housing programs from a bill. At a time when we see us against them perspectives rising in our Country, we cannot allow divide and conquer tactics to undermine collaborative efforts to bring people together.

Sadly, intended or not, the BUILD Act is an example of dividing Native peoples. This bill threatens strong alliances and partnerships Native communities have forged over decades. I understand suggestions have been made to Native tribes that supporting Native Hawaiian programs may jeopardize funding for their own programs.

I strongly oppose those suggestions and I believe that dividing Native communities is, frankly, unconscionable. The history of our government's treatment of Native peoples is not a proud one. For Native Hawaiians, this includes illegal overthrow of the Hawaiian monarchy in 1893.

Today, Native Hawaiians, like other Native peoples across the Country, continue to face high levels of poverty, lower educational attainment, and lack of affordable housing. For those who do not recognize Native Hawaiians as an indigenous people or oppose Native Hawaiian programs, I would ask that you learn more about their history and experiences.

Today's hearing would have been an excellent opportunity for members of this Committee to learn more about Native Hawaiians, their history, and how Federal housing programs have made a real difference in their lives. Unfortunately, no Native Hawaiians or Native Hawaiian organizations were invited to testify on the BUILD Act, but they are here. They are sitting in the audience; they are watching; and they are listening.

Many of you on the Committee are long-time advocates for indigenous peoples. You are aware of their history and why Congress enacted programs that promote better health, quality education, and access to housing for their communities, programs that provide opportunities for growth and sustained strength.

Without these programs, the progress made in their communities would have been harder and taken longer to achieve. That is why reauthorization of NAHASDA, including Native Hawaiian housing programs, is so important.

All of our Native people, American Indians, Alaska Natives and Native Hawaiians, should be treated with equal respect. That certainly extends to supporting programs that benefit all our Native peoples and communities.

For these reasons, I ask this Committee to restore reauthorization for Native Hawaiian housing programs in NAHASDA. I ask

you to do the right thing and welcome the opportunity to work with you to find a path forward.

I would also like to submit a longer statement for the record on behalf of the Hawaiian Congressional Delegation signed by Senators Schatz and myself and Representatives Hanabusa and Gabbard in opposition to the BUILD Act in its current form.

Mr. Chairman, I do thank you for your openness in going forward so that our Native peoples can be treated with the respect they deserve.

The CHAIRMAN. Thank you, Senator Hirono.

Again, I want to make clear that I am not holding it up. If we pass the bill out with it in, my expectation is, unless we can figure out something, we will end up with the same result we have had the last two Congresses, that we will move the bill out of Committee and that will be it.

We were not able to move it across the floor in the last Congress or the Congress before, so I am trying to find a solution. We have not precluded not including it in the bill, we just have to find a way to move it forward or we are just going to move it out of Committee.

I am very sensitive to Senator Schatz's talking about the bipartisanship of this Committee. I think that is very important. I want to do everything I can to preserve it, but we are confronted with the situation of having either a bill we can move out of Committee with the provision in but we cannot move across the floor or putting the provision in the bill in Committee but then we have to somehow figure out how we can advance it.

That is why I offered the appropriations process but I am open to other ideas. Obviously, this is a work in progress. We are looking for solutions. Whoever has a great solution, as Ross Perot used to say, I am all ears.

Senator Heitkamp.

**STATEMENT OF HON. HEIDI HEITKAMP,
U.S. SENATOR FROM NORTH DAKOTA**

Senator HEITKAMP. Mr. Chairman, thank you.

I know the motivation here is to get a bill and to get a housing program and move it forward.

Ben Franklin once famously said, "If we don't all hang together, surely we will hang separately." I think NAHASDA and the Native Hawaiian provision has been a long history of weaving together a compromise. When we start pulling it apart, I can assure my good friends, Senator Hirono and Senator Schatz, will provide equal resistance to what we have seen in the last two Congresses if we exclude Native Hawaiians. We are between a rock and a hard place.

I surely will do everything that I can. I think one of the most critical challenges we face in Indian Country, especially in our neck of the woods, is housing and the lack of affordable, quality, good housing. We should all be working together to prevent these problems in the future.

Thank you, Mr. Chairman.

The CHAIRMAN. That is it exactly, because we are talking about reauthorizing \$650 million for housing in Indian Country. It is

something we want to move. Figuring out how to do it is very important.

Senator CORTEZ MASTO. Mr. Chairman, if I may?

The CHAIRMAN. Senator Cortez Masto.

**STATEMENT OF HON. CATHERINE CORTEZ MASTO,
U.S. SENATOR FROM NEVADA**

Senator CORTEZ MASTO. Thank you.

I appreciate the conversation and bipartisanship here. As a new member, you may not realize that although I represent Nevada, a desert State, believe it or not, Nevada is home to the largest number of Hawaiians in the Country outside of Hawaii. This is an important issue for my constituents and something I will be advocating for as well.

I appreciate the opportunity to work with you to address the housing needs of my constituents in Nevada.

The CHAIRMAN. Senator, are you saying that Hawaiians are coming to Nevada rather than Nevadans going to Hawaii? Is that what I heard you say?

Senator CORTEZ MASTO. Absolutely correct. There are a good number of them coming into southern Nevada, so much so that when Senator Schatz comes to Las Vegas, they recognize him more so than I think in his State. Yes, this is an important issue, I believe, for so many reasons. I look forward to the opportunity to work with you.

Thank you.

The CHAIRMAN. Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman. I will be really brief. I appreciate the conversation and the goodwill here.

What Senator Heitkamp said is really exactly right which is that what we are doing here is trying to accommodate the fact that we cannot get cloture or we are not going to be able to get unanimous consent, because there will be members who will oppose NAHASDA on the basis of it including Native Hawaiians.

I think it is really clear that you are not going to get unanimous consent for this bill on the basis of it not including Native Hawaiians. The solution, on the floor, is to get cloture. The way to get cloture is for us to work together on a bipartisan basis and get to 60.

I will just add that because of the unique time we are in, normally the primary commodity in the Senate is Floor time, but the cupboard is bare. There is not a lot of legislation flying off the shelf. We are cooking up votes to come up with for Mondays and Wednesdays, a lot of assistant secretaries and a lot of judgeships that are going 93 to 5 and such.

We actually, I think, have a pathway to get floor time for this. I know it will be an effort to get to 60, but with your support and Senator Murkowski, and I hope for Senator Sullivan and others support, we might be able to get to 60.

The solution is not to accommodate one person's filibuster and force the other side to filibuster. I think we are between a rock and a hard place. The only solution is cloture. I think we can do it.

The CHAIRMAN. I appreciate that. Again, we have not in the last two Congresses, but I am not ruling out any options at this point.

We will keep working. Again, that is part of the reason we are having the early hearing so that we have more time to work on it.
 Senator Barrasso.

**STATEMENT OF HON. JOHN BARRASSO,
 U.S. SENATOR FROM WYOMING**

Senator BARRASSO. Thank you very much, Mr. Chairman.

I appreciate your holding this hearing today to consider legislation on a number of topics, none more important than tribal health care.

For decades, the Indian Health Service has failed to deliver even basic standards of care. In 2010, former Chairman Dorgan began an investigation that resulted in the infamous and often cited Dorgan Report.

The issue of the Indian Health Service revealed widespread staffing issues, expired medical credentials, and we heard about exceptionally poor delivery of the services. These issues, reported more than seven years ago, still exist within the Indian Health Service.

During my time as chairman of this Committee, we all spent a great deal of time working on issues related to the quality of care at the Indian Health Service. As both a doctor and a Senator, I find the level of dysfunction completely unacceptable.

Not only does the United States Government have a trust responsibility that they much fulfill, but failures of the Indian Health Service should never result in the loss of life. Yet, stories of unnecessary patient deaths have dominated Indian Health Service oversight hearings for years.

Ms. Kitcheyan, I appreciated hearing your story when you testified before this Committee last year. I appreciate you traveling here to be with us again today. Your story and those like it make it obvious why I joined with Senators Hoeven and Thune in introducing the bill before us today. Restoring accountability in the Indian Health Service is not just the name of the legislation, but also the goal of this Committee, in a bipartisan way, in any action we take related to health care.

The bill addresses recruitment and retention of high quality staff. It addresses shortcomings in the process to remove problem staff, requires improvement of metrics that will measure Health Service delivery, and makes significant changes to credentialing to allow for better, faster patient treatment.

Chairman Hoeven, I appreciate the leadership you and Senator Thune have shown on this issue over the years. The bill and the care it seeks to improve have real implications for daily life in Indian Country.

Though there is no silver bullet, the need is clear. Across the Country, across the Country, interest in improving the Indian Health Service has led to countless comments on the bill so far, in addition to those we are here to receive today.

I see suggestions for additional ways to address the many shortcomings at the agency and they continue to arrive. I look forward to working with you, the witnesses, and the Administration to advance meaningful change.

Again, thank you, Senator Hoeven. Thank you to the witnesses for traveling to be with us today.

The CHAIRMAN. Thank you, Senator Barrasso.

Thank you for your work both as the former chairman of this Committee and also as a physician on this important issue and your commitment, which I think is such a huge priority, to strengthen IHS and provide better health care services throughout Indian Country.

We have our first panel and will now ask for their testimony.

Ranking Member, did you have anything else before we go to testimony?

Senator UDALL. No.

The CHAIRMAN. We will go to testimony.

I want to welcome all of you. We have with us Rear Admiral Chris Buchanan, Acting Director, Indian Health Service, U.S. Department of Health and Human Services; the Honorable Victoria Kitcheyan, Tribal Council Treasurer, Winnebago Tribe of Nebraska; Dr. Joseph P. Crowley, President-Elect, American Dental Association; and Max Stier, President, Partnership for Public Service.

Thanks to all of you for being here. Admiral, why don't you start?

STATEMENT OF REAR ADMIRAL CHRIS BUCHANAN, ACTING DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. BUCHANAN. Good afternoon, Chairman Hoeven, Vice Chairman Udall, and members of the Committee.

I am Chris Buchanan, an enrolled member of the Seminole Nation of Oklahoma. I am the Acting Director of the Indian Health Service. I am pleased to be here and have the opportunity to testify before the Senate Committee on Indian Affairs on S. 1250, the Restoring Accountability in the Indian Health Service Act of 2017.

The mission of IHS, in partnership with American Indians and Alaska Natives, is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level. Providing quality health care is our highest priority. We share the urgency of addressing longstanding, systemic problems that hamper our ability to fully carryout the IHS mission.

In November 2016, we launched our Quality Framework and Implementation Plan to strengthen the quality of care that IHS delivers to patients we serve. Since November 2016, IHS has made substantial progress in implementing the Quality Framework and addressing many of the challenges you have identified in your proposed legislation.

The Quality Framework guides how we develop, implement and sustain an effective quality program that improves patient experiences and outcomes. We are doing this by strengthening the organizational capacity and ensuring the delivery of reliable, high quality health care at IHS direct service facilities.

The new IHS credentialing system will streamline credentialing and facilitate the hiring of qualified practitioners, as well as privileging and performance evaluation of IHS practitioners. It will allow the local and area offices to perform these functions in alignment with the Centers for Medicare and Medicaid Services' conditions of participation and accreditation standards for governance of hospitals and ambulatory care facilities.

We will pilot in four IHS areas in July 2017 and implement it across the remaining IHS areas by the end of 2017.

Ensuring timely access to care requires that we develop standards for wait times for appointments, as well as for time spent in the provider's offices and that we benchmark against clear standards.

Agency-wide standards for wait times are also in development to ensure accountability at the highest level. To improve transparency and access to quality of care, IHS is implementing a performance accountability dashboard. This includes reporting on patient wait times, pilot testing of dashboards and associated data collection is targeted for this summer.

Strengthening governance and leadership at all levels of IHS is essential to ensure quality health care. IHS now requires a standardized governance process and use of a standard governing board agenda across all IHS areas with federally-operated facilities.

The first leadership training class to prepare selected individuals to serve in leadership positions at the service unit area and headquarters levels was launched on June 6 with 34 participants.

IHS faces significant recruitment challenges due to remote, rural locations of our health care facilities and area offices. IHS is implementing various strategies to increase recruitment and retention. Global recruitment is one strategy we have implemented for a streamlined approach to filling critical provider vacancies at multiple locations.

Applicants only need to apply at a single vacancy announcement and can be considered for multiple positions throughout the Country. Recruiting for critical positions by using a single announcement to recruit for multiple positions is showing promise. Now, IHS has priority access to new commissioned Corps applicants. This allows IHS to make first contact with these applicants in an effort to recruit and fill health professional vacancies throughout IHS.

Also, IHS facilities can use the National Health Services Corps' scholarship and loan repayment incentive to recruit and retain primary care providers. As of April 2017, 472 NHSC recipients are currently part of our workforce serving in IHS, tribal and urban facilities.

These actions demonstrate that IHS is taking its challenges seriously and is continuing to take assertive and proactive steps to address them. IHS is prepared to provide technical assistance on specific authorities proposed in S. 1250.

Despite all of the challenges, I am firmly committed to improving quality, safety and access to health care for American Indians and Alaska Natives in collaboration with HHS, our partners across Indian Country and Congress. We look forward to working with the Committee on this legislation as it moves through the legislative process.

I am happy to answer any questions the Committee may have. Thank you.

[The prepared statement of Mr. Buchanan follows:]

PREPARED STATEMENT OF REAR ADMIRAL CHRIS BUCHANAN, ACTING DIRECTOR,
INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee. I am Chris Buchanan, an enrolled member of the Seminole Nation of Oklahoma and Acting Director of the Indian Health Service (IHS). I am pleased to have the opportunity to testify before the Senate Committee on Indian Affairs on S. 1250, the Restoring Accountability in the Indian Health Service Act of 2017. I would like to thank you, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee for elevating the importance of delivering quality care through the IHS.

IHS plays a unique role in the Department of Health and Human Services (HHS) because it was established to carry out the responsibilities, authorities, and functions of the United States to provide healthcare services to American Indians and Alaska Natives. The mission of IHS, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides comprehensive healthcare delivery to approximately 2.2 million American Indians and Alaska Natives through 26 hospitals, 59 health centers, 32 health stations, and nine school health centers. Tribes also provide healthcare access through an additional 19 hospitals, 284 health centers, 163 Alaska Village Clinics, 79 health stations, and eight school health centers.

Providing quality healthcare is our highest priority. We share the urgency of addressing longstanding systemic problems that hamper our ability to fully carry out the IHS mission. In November 2016, we launched our 2016–2017 Quality Framework and Implementation Plan to strengthen the quality of care that IHS delivers to the patients we serve. Implementation of the Quality Framework is intended to strengthen organizational capacity to improve quality of care, improve our ability to meet and maintain accreditation for IHS direct service facilities, align service delivery processes to improve the patient experience, ensure patient safety, and improve processes and strengthen communications for early identification of risks. The Quality Framework will be reviewed and updated at least annually in partnership with Tribes.

The HHS Executive Council on Quality Care (the Council), which was stood up in November 2016, provides support to IHS by identifying and facilitating collaborative, action-oriented approaches from across the Department to address issues that affect the quality of healthcare provided to American Indians and Alaska Natives we serve. The Council includes leadership from 12 HHS Staff and Operating Divisions. The Council's mission is to support IHS' efforts to develop, enact, and sustain an effective quality program—to improve quality and patient safety in the hospitals and clinics that IHS administers. This may include providing technical assistance to bolster quality and safety, identifying solutions to address workforce recruitment and retention challenges, seeking creative solutions to infrastructure needs, and enhancing stakeholder engagement. The Council partners with HHS leadership and staff in policy implementation.

Since November, 2016, IHS has made substantial progress in implementing the Quality Framework and in addressing many of the challenges you have identified in your proposed legislation.

Strengthening Organizational Capacity

The Quality Framework guides how we develop, implement, and sustain an effective quality program that improves patient experience and outcomes. We are doing this by strengthening our organizational capacity, and ensuring the delivery of reliable, high quality healthcare at IHS direct service facilities.

We recently awarded a contract for credentialing software that will provide enhanced capabilities and standardize the credentialing process across IHS. The new system will streamline credentialing and facilitate the hiring of qualified practitioners as well as, privileging and performance evaluations of IHS practitioners. This will help ensure the quality and safety of care delivered in IHS Federal Government hospitals and health centers. We are on course with the implementation of this medical credentialing system. We expect to test it in four IHS Areas in July 2017, and plan to implement it across the remaining IHS Areas by the end of 2017. Our agency credentialing policy is in the process of being updated.

Ensuring timely access to care requires that we develop standards for waiting times for appointments, as well as for the time spent in the provider's office, and that we benchmark against clear standards. IHS Service Units currently collect patient wait time data to track the patient care experience as part of the Improving

Patient Care program. Agency-wide standards for wait times are also in development. To ensure accountability at the highest level, and to improve transparency about access to and quality of care, IHS is implementing a performance accountability dashboard. This includes reporting on patient wait times. Pilot testing of the dashboard and associated data collection is targeted for this summer.

Strengthening governance and leadership at all levels of the IHS system is essential to assuring quality healthcare. IHS now requires a standardized governance process and use of a standard governing board agenda across all IHS Areas with federally-operated facilities. The first leadership training class to prepare selected individuals to serve in leadership positions at the Service unit, Area, and Headquarters levels was launched June 6th with 34 participants. In addition, IHS has begun implementing a leadership coaching and mentoring program in the Great Plains Area as new leaders are recruited.

Workforce Strategies

IHS faces significant recruitment challenges due to the remote, rural location of our healthcare facilities and Area offices. To make a career in IHS more attractive to modern healthcare practitioners, IHS is implementing various strategies to increase recruitment and retention. Global recruitment is one strategy we have implemented that allows for a streamlined approach to filling critical provider vacancies at multiple locations. Applicants only need to apply to a single vacancy announcement and can be considered for multiple positions throughout the country. Recruiting for critical positions by using a single announcement to recruit for multiple positions is showing promise.

IHS continues the successful partnership with the Office of the Surgeon General to increase the recruitment and retention of Commissioned Corps officers, and most recently the IHS has been given priority access to new Commissioned Corps applicants. This allows IHS to make the first contact with these applicants in an effort to recruit them to fill health professional vacancies throughout IHS. This new effort began in May, and we can provide periodic updates on this effort. IHS also continues to partner with the National Health Service Corps (NHSC). Use of NHSC allows IHS facilities to recruit and retain primary care providers by using NHSC scholarship and loan repayment incentives. As of April 2017, 472 NHSC recipients are currently part of our workforce serving in IHS, tribal and urban facilities.

These actions demonstrate that IHS is taking its challenges seriously, and is continuing to take assertive and proactive steps to address them.

S. 1250

S. 1250 proposes specific authorities to aid us in elevating the health of American Indians and Alaska Natives to the highest level. IHS is prepared to provide the Committee technical assistance on the legislation and I would like to provide additional technical comments on various sections of the bill.

Section 101 would address the need for IHS to offer more flexible and competitive benefits to recruit employees by establishing a comparable pay system as allowed under Chapter 74 of Title 38. IHS appreciates the authority we already have to use the pay flexibilities under Chapter 74 of Title 38. We are working with OPM, OMB, and other affected agencies to explore ways to enhance utilization of our current pay authorities to enhance our ability to recruit and retain high quality staff.

Section 102 requires a Service-wide centralized credentialing system to credential licensed health professionals who seek to provide healthcare services at any Service facility. IHS supports the use of a standard system for credentialing. We are implementing a national system for credentialing as well as privileging and evaluating performance of IHS practitioners. Our new system will allow the local and/or Area offices to perform these functions in alignment with the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and external accreditation standards for governance of hospitals and ambulatory care facilities.

Section 104 would make certain healthcare management or healthcare executive positions eligible professions for loan repayment awards, in exchange for non-clinical service obligations. Management expertise is very important in a health system as large as IHS.

Section 106 addresses IHS authority to remove or demote employees. IHS has existing authorities to implement adverse employment actions.

Section 107 requires IHS to develop and implement standards to measure the timeliness of care at direct-service IHS facilities. As described above, IHS is in the process of establishing agency-wide standards for wait times to each federally-operated service unit. A process for uniform data collection and reporting is also being established.

Section 108 adds specific requirements for implementation of annual mandatory cultural competency training programs for IHS employees, and other contracted employees engaged in direct patient care. Cultural competency in the IHS workforce is essential to the provision of quality care and is a requirement under the accreditation standards for hospitals. I have recently issued direction for all IHS employees to complete training, which will become an annual requirement.

Section 110 requires IHS to establish a tribal consultation policy. The specific provision is unnecessary as IHS already has a tribal consultation policy in place. The requirements for consultation are contained in statutes and various Presidential Executive orders including: the Indian Self-Determination and Education Assistance Act, Indian Health Care Improvement Act, Presidential Memoranda in 1994 and 2004, and Executive Orders in 1998 and 2000. It is the policy of HHS and IHS that consultation with American Indian and Alaska Native Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes. IHS is committed to regular and meaningful tribal consultation and collaboration as an essential element for a sound and productive relationship with Tribes.

Despite all of the challenges, I am firmly committed to improving quality, safety, and access to healthcare for American Indians and Alaska Natives, in collaboration with HHS, our partners across Indian Country, and Congress. I appreciate all your efforts in helping us provide the best possible healthcare services to the people we serve to ensure a healthier future for all American Indians and Alaska Natives.

We look forward to working with the Committee on this legislation as it moves through the legislative process. Thank you for your commitment to improving quality, safety, and access to healthcare for American Indians and Alaska Natives. I am happy to answer any questions the Committee may have.

The CHAIRMAN. Thank you, Admiral.
Ms. Kitcheyan.

**STATEMENT OF HON. VICTORIA KITCHEYAN, TREASURER,
WINNEBAGO TRIBE OF NEBRASKA TRIBAL COUNCIL**

Ms. KITCHEYAN. Good afternoon, Chairman Hoeven and Vice Chairman Udall.

Thank you for the opportunity to testify today on S. 1250, the Restoring Accountability in the Indian Health Service Act.

My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska where I serve as Tribal Council Treasurer. I am also the Great Plains Area Rep to the National Indian Health Board. I will be making some national level comments on NIHB as well.

The Winnebago Tribe and national Tribal advocates support the efforts of Congress to address the ongoing challenges for health delivery at the IHS-operated facilities. Legislative efforts to address these issues should be conducted in conjunction with the tribes. Increased oversight and scrutiny are essential to improving the service unit care.

Essentially, we need to get this right. We are at a point where our people need help. Some of the quality care issues in the Great Plains and my tribe cannot be overlooked any further. It is important that we garner the voice of Indian Country and that we all have input on this legislation. The best outcome can only be derived from the tribes.

We look forward to working with Indian Country in the coming months and weeks on how we can further have legislative consultation on this bill because it is going to affect all of us. We want to make sure that is a part of this process.

I have shared in previous testimony with this Committee that the IHS hospital on my reservation has demonstrated deficiencies

back to 2007. These deficiencies were so numerous, egregious and life threatening that in 2015, we lost our CMS certification. Two years later, we are still without that certification.

Month after month this decertification is delayed due to lack of resources, key staff vacancies, and the lack of CMS-generated third party revenue is an additional strain on the service unit. In addition to the staffing challenges, this has kept the facility in dire constraint.

It is important that the leadership roles be filled with qualified, permanent providers so that we can continue to offer the services the tribes need. It is this dedicated staff that we need to be committed to making these improvements that have been identified.

It is this rolling of administrators and recycled employees from other Great Plains service units that are, in our opinion, dumped on one of the most dire service units. It is the unacceptable level of administration and this revolving door that has left area hospitals in the Great Plains continuing to suffer. The resources and continuity of leadership has been a problem.

Given this critical state, we are much appreciative of this Committee taking the action to introduce S. 1250. However, there are a few items in this legislation that I want to address and make sure it works for everyone in Indian Country.

As I mentioned before, the legislation should not be enacted without the proper consultation of all of Indian Country. This legislation is going to affect everyone, so we want everyone's voice to be a part of this. This is particularly important as a National Indian Health Board representative. We do not want to take down any other tribe in our path of turmoil. That is important to me as a rep and as a member of NIHB.

Also, there are provisions in the bill that address new programs and functions in IHS. Although these would be beneficial, we need adequate oversight and funding to make these beneficial. We want to make sure that this is not just a program that becomes an unfunded mandate.

This is very much true in the Indian Health Care Improvement Act which was implemented seven years ago and has yet to be fully funded. We do not want to make this another broken promise to Indian Country. We want this to be funded and be a real commitment to improving the health care.

The Winnebago Tribe and NIHB also support the intent to make a streamlined system for licensed health care professionals, credentialing procedures, including volunteers. However, I want to note this is not the substitute or final step in increasing available, permanent, full-time providers in IHS and throughout Indian Country.

Tribes in some areas have already come up with some very creative and innovative solutions to address this problem. We would like to replicate that model throughout Indian Country. We hope to discuss that more in the future and develop some creative solutions together.

When it comes to hiring authorities outlined in the legislation, NIHB and the Winnebago are happy to see there is some streamlining of Federal hiring authority, but we believe this section needs

more tribal input, especially when it comes to waiving Indian preference.

Tribes need to have important input on that so that it becomes a tool and not so much the norm to Indian preference. More details are outlined in the testimony.

Section 10 establishes rules regarding a tribal consultation policy. We are in complete agreement that a consultation policy should exist and that Tribes should have input into ways that will provide community input.

If this had been done earlier, I think some of our issues at the local level may not have reached the levels they have.

We strongly agree with increasing fiscal accountability measures in the bill. We hope we can modify the language, especially around third party revenue so that we can include the community input on where those monies should go. We should have access to that in the programs we know we need the most.

Finally, we are glad to see the reporting requirements but we would also like to see those done in the purchased and referred care so that we can assure the quality through that process as well.

Overall, this legislation is important and necessary. We thank this Committee for their genuine interest in being a partner to the tribes so that we can address the transparency, accountability, recruitment and management. All these continue to be a problem.

I would like to plead with you that we cannot continue to starve the system and expect a different result.

I thank you for this time. I am happy to answer any questions.
[The prepared statement of Ms. Kitcheyan follows:]

PREPARED STATEMENT OF HON. VICTORIA KITCHEYAN, TREASURER, WINNEBAGO
TRIBE OF NEBRASKA TRIBAL COUNCIL

Good afternoon Mr. Chairman and Members of the Committee:

Thank you for holding this hearing on this very important piece of legislation. My name is Victoria Kitcheyan. I am a member of the Winnebago Tribe of Nebraska and I currently serve as Treasurer of the Winnebago Tribal Council. I also serve as the Great Plains Area Representative of the National Indian Health Board and will offer national-level comments on behalf of NIHB as well. The National Indian Health Board serves all 567 federally-recognized Tribal nations when it comes to health. This means we serve both tribes who receive care directly from the Indian Health Service and those who operate their health systems through self-governance compacts and contracts.

The Federal Government has a duty, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members throughout the country. Yet, the federal government has never lived up to that trust responsibility to provide adequate health services to our nation's indigenous peoples. Historical trauma, poverty, lack of access to healthy foods, loss of culture and many other social, economic and environmental determinants of health as well as lack of a developed public health infrastructure in Indian Country all contribute to the poor state of American Indian and Alaska Native (AI/AN) health. AI/ANs suffer some of the worst health disparities of all Americans. We live 4.5 years less than other Americans. In some states, life expectancy is 20 years less, and in some counties, the disparity is even more severe. With these statistics, it is unconscionable that some IHS-operated facilities continue to deliver a poor quality of care to our people.

The Winnebago Tribe and national Tribal advocates support the efforts of Congress to address the ongoing challenges for health delivery at the IHS-operated facilities. We appreciate the commitment of the Senate Committee on Indian Affairs to find real change. Legislative efforts to address these issues should be conducted in tandem with increased oversight and scrutiny over the administration of the delivery of care at service units operated by the Indian Health Service. The legal cur-

rent framework for IHS provides much of the necessary guidelines for the operation of the agency.

While we appreciate the speed at which the Senate is considering the legislation given the critical situation going on in the Great Plains region, we need to make sure we get this right. It is true, our people need help. Some of the quality of care issues found at my Tribe and elsewhere in the Great Plains region cannot go on any longer. However, it is also important that these changes are accompanied by input from tribes across the country to ensure the best possible outcome and product. We think legislation is needed and would have appreciated an opportunity for the Winnebago Tribe and other tribes across the country to review any draft legislative language before S. 1250 was introduced. NIHB is ready and willing to lead a legislative consultation on this bill and we intend to do so in throughout the coming weeks and months. This step must happen first before anything can be enacted.

Winnebago IHS Hospital

For those of you that may not know, the Winnebago Tribe is located in rural northeast Nebraska. The Tribe is served by a thirteen (13) bed Indian Health Service operated hospital, clinic and emergency room located on our Reservation. This hospital provides services to members of the Winnebago, Omaha, Ponca and Santee Sioux Tribes. It also provides services to a number of people from other tribes who reside in the area. Collectively, the hospital has a service population of approximately 10,000 people.

As I have shared in previous testimony before this Committee, since at least 2007 the Winnebago IHS Hospital has been operating with demonstrated deficiencies which should not exist at any hospital in the United States. The Centers for Medicare and Medicaid Services (CMS) deficiencies were so numerous and so life-threatening that in July 2015 the IHS Hospital in Winnebago became what still is, to the best of our knowledge, the only federally operated hospital ever to lose its CMS certification. Other IHS facilities in the Great Plains Region have been experiencing similar quality of care issues throughout this time and are also under threat of decertification by CMS.

Nearly two years have passed since the Winnebago Hospital lost its certification and IHS has yet to submit the application to CMS for recertification. Initially, the target date to apply for recertification was scheduled for October 2015. Since then, the date for submitting the application has been repeatedly delayed. It is an extremely frustrating situation and it is unacceptable that such a bad situation should take so long to correct. While the staff at the facility have been working hard to prepare for recertification and corrective action plans have been implemented, including multiple mock surveys, staff training and necessary policy changes, the fact remains that the facility continues to lack critical resources necessary to move forward.

Senior officials at IHS have said that recertification at Winnebago is a top priority, but for some reason the practical resources to achieve this have not reached the ground level. The inability to generate necessary revenue from all third party sources has caused serious budget issues. The financial constraints in addition to staffing challenges have kept the facility in a dire situation. The Hospital Governing Body finally decided last month that the Hospital was ready for recertification. However, the application has not been submitted due to key staff vacancies including the CEO, Director of Nursing and Lab Supervisor. The fact that these vital positions are vacant is a huge indicator that the hospital is not adequately staffed to be ready for CMS review.

Many of the situations that led to the Hospital losing its certification in the first place have also played a role in the delay to submit the application for recertification. For example, the Great Plains Region has operated under an Acting Regional Director for nearly one and a half years. At Winnebago, the hospital also operated with a series of Acting CEO's until a permanent hire was made approximately 6 months ago. Both the Omaha and Winnebago Tribes have been very pleased with the progress he has made at the facility. Unfortunately, due to personal reasons, he is now resigning as the CEO and the position will be vacant once again later this month.

These important leadership roles need to be filled by permanent, qualified and dedicated employees who have a vested interest making improvements. There have been instances where the IHS has continued to hire key personnel without any input from the Tribe and/or "recycled" employees who were found to be unacceptable at other IHS hospitals in the Great Plains Region. A multi-million dollar staffing contract was awarded to a company previously used by IHS that had placed unsatisfactory employees in many of the Great Plains IHS hospitals. Finally, the federal hiring freeze implemented earlier this year caused great delays in filling critical po-

sitions. While waivers were eventually obtained for many positions, it is our understanding that some positions necessary for CMS certification remain under a freeze status. The hiring freeze is detrimental to the needs of our tribal members and others who rely on IHS for their healthcare.

Many missteps could have been avoided by getting input from the Tribes and actually acting on that input. The Governing Body for the Winnebago Hospital was basically non-functional around the time of the loss of the CMS Certification. Although the Governing Body appears to be meeting more often, the tribal representatives have since lost their seats on the Governing Body since IHS deemed that the non-IHS members (Tribal Council representatives from the Winnebago Tribe and the Omaha Tribe) have no oversight over IHS and therefore should not be on the Board. This is ridiculous and counter-intuitive. Perhaps Tribal Council members have no “authority” over IHS, but they know their own communities and are more likely to have an interest in holding management accountable if their actions are not conducive to patient care or a well operated medical facility. We have already learned that IHS officials in the Great Plains region were not using their authority to police each other, which was another reason that led to the decertification in the first place.

Although some IHS regions around the country seem to function better than others, the Great Plains Region has been problematic for years, despite several reports conducted by Congress and U.S. Government agencies. Many provisions contained within this proposed legislation are designed to correct some of the issues that plague the Winnebago Hospital and other IHS Hospitals within the region. I will now provide more specific comments on S. 1250 and how certain provisions will help the situation in Winnebago or how it might be amended to meet our specific needs.

Comments on S. 1250

First, we have some general areas of concern regarding the proposed legislation that we would like to stress. There are provisions in the bill that address new programs and functions for the IHS, which will be beneficial if they are actually funded. We want to make sure the legislation does not put forward programs that become in essence unfunded mandates. We urge this Committee to work with Appropriations to ensure that these provisions are funded so they do not end up just being lip service to tribal communities. The Indian Health Care Improvement Act was permanently enacted in 2010 and contained many provisions designed to modernize the provision of care, such as the development of new health care delivery demonstration projects and expansion the types of health professionals available within the Indian health system. Yet those provisions remained unimplemented due to lack of adequate funding. We do not want to see the same type of thing happen with this legislation. Congress cannot continue to starve the Indian health system and expect major change.

The Winnebago Tribe is working its way toward self-governance, a status many other tribes throughout the country already have. In fact, about 60 percent of the IHS budget is delivered directly to the tribes through contracts and compacts. The proposed legislation does not do an adequate job of stating which provisions of the legislation pertain to self-governance tribes and which do not. The legislation provides a “Savings Clause” that appears to ensure that the legislation does not interfere with tribal contracting or compacting. Yet the provision at 607(e) of the proposed legislation is not clear on what provision or provisions that Savings Clause language pertains. Since we hope to be a self-governance tribe in the reasonably near future we would certainly appreciate some clarity regarding the application of this provision. The Winnebago Tribe and NIHB are happy to work with you on the drafting of that provision.

The Winnebago Tribe and NIHB support the intent to make a streamlined system for licensed health care professional credentialing procedures, including volunteers, as outlined in Section 102. However, we note that these provisions should not be considered a substitute or final step for increasing available providers to the IHS and tribes throughout the country. For example, NIHB and the tribes fully support the expansion of the dental therapy model, which was first brought to the United States by tribes in Alaska in 2004. It is a highly effective way to provide reliable, safe, and quality dental care providers to underserved areas. We urge the Committee to consider models such as these to address the chronic staffing shortages in the Indian health system.

Section 105 addresses Improvement in Hiring Practices. While we certainly agree that hiring practices need drastic improvement we are not completely comfortable with the language in the proposed legislation. First, this provision indicates that the Secretary has direct hire authority, which in and of itself is not a bad idea. However, the Winnebago Tribe and NIHB want to make sure that Tribal Preference is

not ignored in the direct hire authority. This provision of the proposed legislation goes on to note that the Secretary shall notify each tribe in the service area prior to the direct hire taking place. While notice is appreciated, it would be useful if tribes could file objections to any hire, especially if the new hire is somebody who has been recycled through the system previously and has not performed well with other tribes in the Region, which has been a common practice at IHS. Lastly, this provision provides that the Secretary may seek waivers to Indian preference from each Indian tribe concerned if certain criteria are met. We understand that when there are no qualified "Indian" candidates or the Indian candidates have not performed well in the past, it may be appropriate to hire a non-Indian candidate. However, Tribes are concerned about diminishing Indian preference in the hiring process. This path should only be used in the most extreme circumstances and should be initiated by the Tribe(s) served by the facility in question.

We are pleased to see a provision addressing the Timeliness of Care in Section 107. We believe that timeliness of care has been an issue at the Winnebago Hospital and that additional standards to improve the reporting and tracking of timeliness are necessary. It should be noted that underfunding also contributes to the inadequate and timely care. There is currently a system in place that, if implemented, correctly tracks these important care initiatives. However, if a region does nothing to implement the current system or inadequate staffing impedes the ability to track these initiatives, then it becomes a major problem. We feel that additional Congressional oversight over this particular area may be necessary. Section 107 also states that regulations and standards to measure the timeliness of the provisions of health care services must be done within 180 days of the enactment of this legislation. We are concerned that 180 days may not be enough time to develop the regulations and standards if proper consultation with the tribes is used to develop said regulations and standards. Lastly, we request that any data gathered regarding the timeliness of care be provided to the tribes as well as the Secretary.

The Winnebago Tribe finds Section 108 regarding training programs in tribal culture and history to be of utmost importance. Meaningful cultural training can do nothing but help IHS employees as they learn the history and culture of the people they are serving on a daily basis. We think this training should be mandatory and it should include all IHS employees from headquarters to all staff at the service unit facilities, who have daily interaction with Native American people. It would be even more useful if the training involved and was tailored specifically for the tribes in the service area.

Section 110 establishes rules regarding a tribal consultation policy. We are in complete agreement that a consultation policy should exist and that Tribes should have input into the way services are provided to tribal communities. However, it is imperative that the consultation policy developed under this section mandate to IHS staff that consultation shall be more than simple lip service or a listening session with the tribes. It should be viewed as a true partnership and collaborative effort. Tribal input is key to IHS in providing high quality services and must be taken seriously. The issues with the Winnebago Hospital would have never have risen to the level that existed if there was true consultation and collaboration at every step in this process and they never would have received the attention it has if it were not for Tribal action.

Fiscal accountability is never a bad thing as laid out in Section 202, but the provision in subsection (b) that addresses the prioritization of patient care is somewhat troubling in its specificity. This section explains that IHS should only use certain dollars for patient care directly and limits their use to essential medical equipment; purchased/referred care; and staffing. While we certainly appreciate the need for more scrutiny, we worry that the criteria may end up being too constraining on the programs. IHS should consult with the Tribes in their service area before they make decisions on what can be done with the funds pertaining to this section. With consultation, the money can go to the most needed programs in a particular service areas.

Most of Title III of the proposed legislation deals with a variety of reports. The one report that drew our attention was the Inspector General reports on patient care in Section 304. We definitely agree that reports on the quality of care and patient harm at IHS are necessary. However, we want to draw attention to the fact that many tribal members end up receiving their care outside of the IHS system through the purchased and referred care program. For example, in South Dakota, approximately 70 percent of care referred outside of IHS facilities. It would be useful to also have information on quality of care once a patient has left the IHS facility and is care for in an outside facility. We suggest that another subsection be added to Section 304 in order to address this issue.

Overall, we think this proposed legislation is necessary and once again thank the Committee for its genuine interest in trying to alleviate problems within IHS. It is clear that management, recruitment, accountability and transparency are all still issues that need to be addressed, most of which are covered in the proposed legislation. Nearly two years has passed since the CMS certification was terminated at the Winnebago Hospital and our CEO, Director of Nursing and Lab Director positions are once again vacant. As we have stated at prior hearings, real change and the rebuilding of the hospital cannot happen without permanent qualified personnel and the funding necessary to carry out the mission.

Mr. Chairman, the Winnebago Tribe supports the passage of this legislation once the issues listed above are addressed and after thorough comment and review by Indian Country. As I stated last year at a hearing and this bears repeating, while everything in this bill is needed, legislation alone will not solve our problem. Proper training of hospital staff costs money, new equipment costs money, and recruitment under these circumstances is also going to cost money. We would consider the passage of this legislation an initial solid first step and implore you not to abandon us after this bill is passed. Correcting this situation is going to require a continuous team effort, additional resources, and consistent Congressional oversight of IHS activity.

Thank you again for allowing me to testify, I will be happy to answer any questions you may have.

The CHAIRMAN. Thank you.

Dr. CROWLEY.

**STATEMENT OF DR. JOSEPH P. CROWLEY, PRESIDENT-ELECT,
AMERICAN DENTAL ASSOCIATION**

Dr. CROWLEY. Thank you, Mr. Chairman.

As stated, my name is Joe Crowley. I am President-elect of the American Dental Association and a practicing general dentist in Cincinnati, Ohio.

The ADA supports the “medical credentialing system” provision (section 102) of the S. 1250, “Restoring Accountability in the Indian Health Service Act of 2017.”

The provision calls for the IHS to implement a centralized credentialing system to licensed health care professionals who seek to provide health care services at any IHS facility. A central credentialing system would benefit both the practitioners and the IHS.

According to former and current IHS area dental chiefs, the credentialing process easily takes eight to twelve hours of staff time at local service unit levels at a cost of about \$1,000 per application. The current credentialing process makes it difficult for the Service to timely fill dental vacancies. It serves as a disincentive to those who want to contract IHS or volunteer their services.

As an example, a private sector dentist in Mayville, North Dakota, who currently contracts with the Spirit Lake Reservation in Fort Totten, said that his IHS paperwork was much more difficult and much more extensive than the paperwork for his hospital privileging credentials.

In 2012, despite the best efforts of the South Dakota Dental Association and Delta Dental of South Dakota to place volunteers in IHS dental clinics, the time-consuming credentialing process proved too large a barrier to overcome for all but two pediatric dentists. There were 70 volunteers who started that application.

The Dental Association ultimately abandoned this project and established a partnership with the Jesuit Mission on the Rosebud Reservation just eight miles down the road from the IHS facility

where the two pediatric dentists worked. This speaks to the issue raised by the current credentialing services and it can be corrected with the language in this bill today.

As my testimony details, many of the Federal services currently operate centralized credentialing services. The IHS dental officers that the ADA spoke with suggested that the IHS would benefit from a centralized credentialing unit with the proper technology that enabled applicants to upload documents similar to the other Federal services.

The good news is that it appears IHS is making progress in centralizing the credentialing process according to the November 2016 press release from the agency. The ADA recommends that the IHS agency be encouraged to support continuing down this path with adequate funding in its project. In addition, the ADA encourages this Committee to ask the Indian Health Service to provide an update on the status of this new credentialing process.

Mr. Chairman, I would also like to point out that the ADA is currently supporting implementation of a ten-year health and wellness plan which includes oral health and is designed to reduce oral disease by 50 percent among the Navajo tribal communities. This will be done by developing a foundation of prevention, early detection and treatment of dental disease and utilizing the interprofessional models of care, while providing timely and accessible oral health care.

This model is being considered by other Indian Nations in Arizona and Washington State tribes. Centralizing the credentialing process will facilitate these efforts by getting more dentists into IHS and tribal clinics. Having more dentists available to provide care will also greatly enhance access to oral health care services as shown in the Navajo Health Plan. It builds capacity utilizing existing resources, including their Community Health Representatives and the ADA community Delta health coordinators.

Mr. Chairman, thank you for this opportunity to share with you and the members of the Committee why the ADA supports the medical credentialing system provisions of S. 1250.

I would be pleased to answer any questions.

[The prepared statement of Dr. Crowley follows:]

PREPARED STATEMENT OF DR. JOSEPH P. CROWLEY, PRESIDENT-ELECT, AMERICAN DENTAL ASSOCIATION

My name is Dr. Joseph P. Crowley, president-elect of the American Dental Association (ADA) and a practicing general dentist from Cincinnati, Ohio. The ADA represents over 161,000 dentists nationwide, including many dentists working in the federal dental services, such as the Indian Health Service (IHS), as both U.S. Public Health Service commissioned officers and civil servants.

The ADA supports the “medical credentialing system” provision (section 102) of the “Restoring Accountability in the Indian Health Service Act of 2017” (S. 1250) that calls for the IHS to implement a Service-wide centralized credentialing system to credential licensed health care professionals who seek to provide health care services at any IHS facility.

Need for Centralized Credentialing

Based on discussions with current and former IHS officials and a number of private sector dentists and state dental associations who have had experience with the credentialing process at various IHS facilities, the ADA believes a centralized credentialing system would benefit both practitioners and the IHS.

According to former and current IHS area dental chiefs, credentialing is handled at the service unit level and generally assigned to a clerical employee. The

credentialing process easily takes 8–12 hours of staff time for a full-time dentist, a part-time dentist, or a volunteer. Because of the challenges associated with this process and the cost (estimated to be about \$1,000 per applicant), IHS dental chiefs do not put a high priority on recruiting volunteers, especially if they only have a limited block of time to devote to the assignment.

A private-sector dentist from Mayville, N.D., Dr. Rob Lauf, currently contracts with the Spirit Lake Reservation in Fort Totten, N.D. He describes the credentialing process as “arduous,” noting that the IHS paperwork far exceeded the amount of paperwork required for his hospital privileging credentials. Despite this administrative burden, Dr. Lauf sees that the dental need is very apparent and he intends to continue to provide services. The most recent *credentialing* guide published by IHS is 74 pages long with one short paragraph on volunteer credentialing, which focuses solely on residencies through medical schools.

In 2012, the South Dakota Dental Association (SDDA), working with Delta Dental of South Dakota, made a serious attempt at placing volunteers in IHS dental clinics. The SDDA surveyed its membership of 400 practicing dentists and approximately 70 indicated a willingness to volunteer or contract with IHS. All of these dentists were sent the IHS credentialing packet and the instructions needed to complete them. Due in part to the fact that the packet is quite large and intimidating for the uninitiated, out of the 70 dentists who indicated interest in volunteering ultimately only two members, both pediatric dentists, became credentialed to work in an IHS facility. SDDA ultimately abandoned this project and established a partnership with the Jesuit Mission on the Rosebud Reservation, just eight miles down the road from the facility where the two pediatric dentists volunteered. In order to volunteer at the Mission, dentists must only have a current license to practice dentistry in South Dakota or, if they are from outside of the state, obtain a volunteer license issued by the South Dakota State Board of Dentistry. Of course, private charities are not subject to the same quality control constraints as those placed on federal facilities. This example is cited merely as a means of showing that many dentists are more than willing to help address the oral health care needs of the American Indian/Alaska Native population and that streamlining the credentialing process will facilitate those efforts.

In fact, the IHS dental officers that the ADA spoke with suggested that the IHS would benefit from a centralized credentialing unit with the proper technology that enabled applicants to upload documents. This would allow for the appropriate primary source verification of dental education, license verification, and National Practitioner Databank checks to be conducted in a timely manner, saving significant work at the service unit level.

Federal Agencies with Centralized Credentialing

The ADA inquired about centralized credentialing and privileging among the federal services. All three of the military services and the U.S. Coast Guard use the Centralized Credentials & Quality Assurance System (CCQAS).

According to information provided by the Coast Guard and verified by the Army, Navy and Air Force:

The Centralized Credentials & Quality Assurance System is a standard Department of Defense (DOD) system jointly undertaken, operated, and controlled by the Army, Navy, and Air Force medical departments within the overall corporate sponsorship and policies of the Office of the Assistant Secretary of Defense for Health Affairs. The Defense Health Services System is responsible for the development, deployment, and maintenance of credentialing and quality policies. CCQAS is a Web-based worldwide credentialing, privileging, risk management, and adverse actions application that supports medical personnel readiness.

This centralized system enables the military medical community to electronically manage provider credentialing and privileging, malpractice and disability claims, and adverse action investigations of diverse, multi-disciplinary health care professionals and their support personnel at all levels of the Department of Defense.

The system provides the following features:

- Maintains and tracks the credentials and privileging history of all military and civilian health care providers, including Active Duty, Reserves, and National Guard.
- Contains comprehensive provider demographic, specialty, licensing, training, education, privileges, assignment history, and provider photographs for identification purposes.

- Enables providers to complete and submit an application for clinical privileges online.
- Automates the online review and approval of a provider's application for initial and renewal of privileges.
- Expedites the transfer of provider credentialing and privileging information for temporary change of assignment or Permanent Change of Station.

As noted in the last bullet, each facility is still charged with the responsibility for actually granting privileges to a provider when assigned to that facility either temporarily or permanently.

According to Dr. Patricia Arola, Assistant Under Secretary for Health for Dentistry, within the U.S. Department of Veterans Affairs (VA), "Centralization of the privileging process has been on the wish list for years; but unfortunately, the process remains local. There is, however, a repository for credentialing information called VetPro, which allows for online entry of information by providers and credentialing staff." It appears that this particular VA process is similar to but distinct from the DOD centralized credentialing and privileging system.

IHS Making Progress toward Centralized Credentialing

The good news is that it appears that the IHS is making progress on the centralized credentialing issue and should be encouraged and supported to continue down this path with adequate funding for its project. The Office of Human Resources at the IHS is spearheading this initiative, based a November 16, 2016, press release, titled "Indian Health Service (IHS) Quality Framework, 2016-2017" at: https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/IHS_2016-2017_QualityFramework.PDF.

As you can see, the first order of business in this plan was to assign a key leader (<https://www.ihs.gov/aboutihs/keyleaders/>) as the Deputy Director for Quality Health Care. Mr. Jonathan Merrell, RN, BSN MBA has been assigned these duties in an acting role.

In the press release cited above, the IHS addresses the centralized credentialing issue in Objective 1B: Standardize Governance: Standardizing and strengthening governance processes and structures promotes reliability, consistency, and management excellence while emphasizing quality improvement as an Agency priority.

- A standard governing body structure will be developed to improve planning and oversight processes while ensuring that all Direct Service facilities are meeting external accreditation and certification Governance requirements.
- IHS will support a central repository of key IHS policies and procedures accessible to each Area Office and Service Unit to ensure consistency across the Agency and enable easy access to, and version control of, current policies and procedures. This effort will include a review of policies and procedures to reduce variation across the Agency.
- IHS will standardize the credentialing business process and implement a single credentialing software system for Direct Service facilities. IHS will automate business processes where possible and review, update, and simplify credentialing and privileging policies and procedures. Training and technical assistance will be provided to staff. The Quality Office will provide operational support and oversight to ensure system-wide high quality credentialing processes and procedures.

The ADA encourages the Committee to ask the Indian Health Service to provide an update on its implementation of the Quality Framework, including implementing the credentialing business process. It is important to ensure there are adequate funds available to complete this initiative. As the committee knows, the IHS has approximately 100 funded dental vacancies at the time of this testimony. Other disciplines, such as nursing and medical, have similar recruitment challenges. Streamlining the credentialing process could help fill those vacancies with quality health care professionals in a timely, efficient manner.

Improving Oral Health in Tribal Communities

Working closely with Navajo tribal leaders, the ADA is currently supporting implementation of a 10 Year Health and Wellness Plan, which includes oral health and is designed to reduce oral disease by 50 percent among the Navajo tribal communities. This will be done by developing a foundation of prevention, early detection and treatment of dental disease, and utilizing interprofessional models of care, while providing timely and accessible oral health services. This model is being considered by other Arizona and Washington State tribes. Centralizing the credentialing process will facilitate these efforts by getting more dentists into IHS and tribal clinics.

Having more dentists available to provide care will also greatly enhance access to oral health services as the Navajo Health Plan builds capacity utilizing existing resources, namely Community Health Representatives (CHRs). Utilizing both the *Smiles for Life* oral health curriculum and educating a number of Navajo CHRs and dental assistants with Community Dental Health Coordinator (CDHC) certification will enable greater community outreach, community education, and preventive services. The role of a CDHC is threefold: educating the community about the importance of oral health to overall health across the lifespan; providing limited preventive services, such as fluoride varnish and dental sealants; and connecting the community to oral health teams that can provide needed dental treatment. CDHCs work in inner cities, remote rural areas and Native American lands. Most grew up in these communities, allowing them, through cultural competence, to better understand the problems that limit access to dental care.

A September 2013 evaluation of 88 case studies of the CDHC program conducted by the ADA verified the real world value of the CDHC in making the dental team more efficient and effective. Screenings, dental education and certain preventive services were delivered by the CDHC and an increasing number of individuals needing dental care did not “fall through the cracks” of a complicated delivery system.

Before the end of this summer, the CDHC program will have over 100 graduates working in 21 states. This includes 16 CDHCs working in tribal facilities, including clinics serving the Chickasaw Nation Division of Health, Wewaka Indian Health, and the Muskogee Creek Nation in the Oklahoma City area. And more are being trained. For example, four additional Navajo CHRs are being trained at the Central Community College in New Mexico. These four will soon join two Navajo CDHCs serving in Fort Defiance on the Navajo Reservation. Following the lead of the Navajo Nation, the Chickasaw Nation is working on a grant to begin a CDHC program with Pontotoc Technical College.

Mr. Chairman, thank you for this opportunity to share with you and the members of the committee why the ADA supports the medical credentialing system provision of S. 1250, which calls for the IHS to implement a Service-wide centralized credentialing system.

Attachments

ARIZONA TRIBAL COMMUNITIES ORAL HEALTH PLAN OFFERING—2016

Making Oral Health a Priority

Goal: Reduce incidence of oral disease by 50 percent among the Arizona Tribal Communities by developing a foundation of prevention, early detection and treatment of dental disease, and utilizing Interprofessional models of care, while providing timely and accessible referral services.

Practical Goals Across the Lifespan

- Every individual will have access to the benefits of water fluoridation
- Every pregnant woman will have a healthy mouth
- Every child will start kindergarten cavity free
- Every individual with a chronic disease such as diabetes or hypertension will have oral health as an integral part of their disease management
- Every elder will have access to dentures or other tooth replacement options

Objectives to Achieve Practical Goals

- Establish collaboration between dental and medical services
- Build grassroots support for oral health throughout tribal leadership
- Build a collaborative relationship with organized dentistry
- Establish/enhance strong, sustainable community oral health prevention programs
- Establish/enhance electronic health record for tribal individuals that incorporates medical, dental and behavioral health data
- Build relationships with dental industry and research entities
- Promote health literacy for sustainable results of health improvement actions
- Incorporate Community Dental Health Coordinators (CDHCs) into tribal health clinics and communities
- Develop awareness and encouragement to pursue oral health careers for teens and young adults

Action Steps*Building Capacity*

- Work with Tribal Community Health Representatives to become CDHCs
- Recruit students for dental school careers
- Actively work with local dental offices to expand access for tribal oral health care
- Create “on the job” training for high school students to learn dental assisting skills
- Promote interdisciplinary approach to improve Native American health care:
 - Establish a dental home by age 1
 - Provide mouthguards for athletes
 - Establish oral health protocols for pregnant women, young children and individuals living with chronic diseases

Building Infrastructure

- Establish reliable data and surveillance to support health improvement efforts
- Coordinate research efforts building upon relevant historical data and medical surveys
- Educate physicians to enter oral health findings into shared health record and educate patients on the value of oral health to overall health
- Educate oral health professionals to promote overall prevention efforts, such as hypertension and cancer screenings, immunizations and good nutrition

Building Community

- Incorporate CDHCs into existing CHR programs
- Build upon existing efforts to integrate oral health education into WIC, Early Health Start, Head Start and elementary education programs
- Expand community prevention programs for tobacco cessation, school-based sealant programs, and oral cancer screening events
- Raise awareness of oral health value through events for tribal populations

Building Partnerships

- Contract with local dentists in order to expand oral health access without expense of additional “brick and mortar” expansion
- Participate in Local and State Oral Health Coalition meetings
- Enhance the voice of Native Americans to advocate to the Indian Health Service for oral health improvement initiatives
- Encourage the dental industry to contribute materials to support/sustain oral health activities to improve tribal oral health

The CHAIRMAN. Thank you, Doctor.
Mr. Stier.

**STATEMENT OF MAX STIER, PRESIDENT/CEO, PARTNERSHIP
FOR PUBLIC SERVICE**

Mr. STIER. Thank you very much, Mr. Chairman, Mr. Vice Chairman, and Senator Heitkamp.

It is a great pleasure to be here. You are focusing on a very important issue. I would like to put this in context, however. The problems you are seeing at IHS are not unique to IHS. They actually exist across the Federal Government.

My proposition to you would be, learn from what else is going on in the Federal Government. Don't see this as an insulated, isolated example. There is a lot of learning to be done. Senator Heitkamp has done some very important work on some broader changes.

Senator Udall, you said let us not tinker around the edges. Tinkering is not going to get you what you want. If you want to have

better quality service, you are going to have to do a lot more. You are going to have to fix the system that was designed for a different era and a different age.

Let us look at the data. It is devastating. IHS hospital rates, physician vacancy rates are at 33 percent; 1,550 health care professional vacancies exist across the system. Only 38.3 percent of the IHS employees believe that their work unit can recruit people with the right skills.

Only 7.3 percent of the employees there are actually under the age of 30. Nearly three-quarters of the employees do not believe that steps are taken to deal with poor performers. This is a real problem. You are focusing on something important but I would propose to you that there are better ways for you to fix these issues.

You have jurisdiction for IHS. I think there are some key things you can do around the areas of hiring and accountability that would be much more powerful. Let us start with accountability.

You are on a path now that the Veterans Affairs Committee has been down for more time than you have. I would propose to you that you look to see what kind of changes they have made. The provisions you have on accountability are Version 1.0 from the Veteran Affairs Committee. They are beyond that. I would take a look at the things they are doing already. Let me point out four particular opportunities to promote accountability that I think will do more.

First and foremost, you have to understand what the problem is. One of the real problems is that employees who are excellent technical experts are promoted to management because that is the only way for them to be promoted.

One solution is, have dual tracks where you can have expertise that are technical experts that get promoted through the system that they don't have to go into management in order to move up in the system.

Second, we have a probation period in the Federal Government, typically a year long. A lot of folks point at it to say it doesn't work, they want to extend it. The problem is it doesn't work. Why doesn't it work? Because managers don't use it appropriately. They don't actually decide whether an employee deserves non-probationary status.

My proposition to you would be to flip the presumption. Today, if you are a Federal employee, you have been there for a year, you automatically become non-probationary. I would say it should be the opposite. You are not actually non-probationary unless the manager who is supervising you determines that you are right for the job. Put the burden on the manager.

The same goes for the manager. If you are put into management, you have a probation period of a year. You should not stay in management unless your supervisory affirmatively decides that you are doing that job well and then you become non-probationary for that position. That is the second point.

Third, we need to do more training for managers. Right now, people are made managers but not helped in any way to actually do the difficult and different things they have to do as managers.

Fourth, I think you have to hold leadership accountable. There is a performance plan requirement for the head of the Indian

Health Service. My view is I don't know where that performance plan is. It ought to include the management functions of running the organization.

Let me move to hiring. One, we need to focus more on the entry level side on student level talent. The Federal Government does not do the most basic thing that every other private sector organization does which is to see student interns as a primary way of bringing talent in at the entry level. It doesn't happen. A lot more could be done on that.

Secondly, we have a pay system that was designed in 1949. That is not a pay system that is designed for today's world. We need more market sensitive pay. Again, look at the VA. It is not just enough to duplicate Title 38.

You need to think about what kind of pay you need to get the right talent into the jobs. It is not just the doctors; it is actually the leaders of the hospitals and the medical directors for the system, the same problems you see at the VA.

Then you are going to have to evaluate the impact of the authorities and flexibilities that already exist that oftentimes are not used. The bottom line is you have a lot of talented people. The system is failing them.

Finally, you do need more data. I propose that you really need a dashboard that has four critical elements around quality of care to health outcomes, number one; number two, what is customer service perspective; number three is the employee voice which you have which is very powerful. I think you can look at that more. Fourth obviously is fiscal prudence because there are only so many resources to get this done.

I work at the Partnership for Public Service. I should say at the front end, it is a non-partisan, non-profit organization. We would be pleased to help in any way we can. There is a lot you can do. I am glad you are focusing on it.

Thank you very much.

[The prepared statement of Mr. Stier follows:]

PREPARED STATEMENT OF MAX STIER, PRESIDENT/CEO, PARTNERSHIP FOR PUBLIC SERVICE

Chairman Hoeven, Vice Chairman Udall, members of the Senate Committee on Indian Affairs, thank you for the opportunity to appear before you today to offer the views of the Partnership for Public Service on S.1250, the *Restoring Accountability in the Indian Health Service Act of 2017*.

I am Max Stier, President and CEO of the Partnership for Public Service. The Partnership is a nonpartisan, nonprofit organization committed to revitalizing our federal government by inspiring a new generation to answer the call to public service and transforming the way our government serves the American people. Our organization meets that commitment by working with colleges and universities to promote federal careers, assisting federal agencies in engaging their workforces, developing strong career and political leadership, advocating for a more modern federal personnel system and building networks of support for our country's civil servants.

The committee deserves credit for its dogged focus on the workforce challenges facing the IHS. No single factor is more critical to the ability of the IHS to deliver care than the quality of its employees and their morale. The Partnership was pleased to submit a statement for the record last year on a previous iteration of this legislation, the *Indian Health Service Accountability Act of 2016* (S.2953), and I am pleased to be part of this important conversation once again.

In the Partnership's view, the myriad challenges that confront the IHS are the result of both a broader federal civil service system that is poorly suited to the needs of a modern health care delivery organization as well as an insular, hidebound organizational culture. In our 2014 report, *Building the Enterprise: A New Civil Service Framework*, the Partnership outlined the contours of a transformed personnel system that operates under a set of common principles while giving agencies the flexibility to adapt to their specific mission needs.¹ This transformation would require fundamental reforms to the government's hiring, pay, classification, performance management, and workplace justice systems. For the IHS, it would represent an opportunity to level the playing field with other agencies that recruit health professionals as well as the ability to compete on an equal footing with private sector providers. No less significant a set of reforms will truly position the Indian Health Service to meet the physical, mental, social and spiritual health needs of native peoples. While I recognize that such government-wide reforms are outside of the purview of this committee, I strongly hope you will work with your colleagues to take them on.

Leadership turnover, poor employee engagement and lack of data hold back the Indian Health Service

Building a workforce that is engaged, accountable and committed requires a continual focus on two factors: leadership and employee morale. Unfortunately, the Indian Health Service struggles in both these areas, which tend to feed on each other as vacancies in key roles lead to a lack of institutional focus on leadership and, in turn, reduce employee morale. Low employee morale may end up driving current and potential future leaders out of the organization. Ultimately, hiring and accountability come down to strong leadership that selects the right people for leadership roles and provides those leaders the incentives and tools they need to succeed.

The critical leadership vacancies across the IHS system are well-documented. The Government Accountability Office's January 2017 report on the quality of care at the IHS found that four area offices reported having at least three area directors within the last five years.² Also, some individual facilities

¹ "Building Enterprise: A New Civil Service Framework." *Partnership for Public Service* with Booz Allen Hamilton, April 2014, <http://ppspublicservice.org/publications/viewcontentdetails.php?id=18>.

² Government Accountability Office. "Indian Health Service: Actions Needed to Improve Oversight of Quality of

reported four or more CEOs within that same period.³ The Department of Health and Human Services Office of the Inspector General similarly found that 24 of 28 hospitals they investigated had someone acting in a leadership role.⁴ Eleven of the 28 hospitals had an acting CEO, while 10 had an acting clinical director and nine reported an acting director of nursing.⁵ One hospital reported an astounding three different acting CEOs in a six week period.⁶

It goes without saying that such situations cause significant harm to an organization, and are causing harm at the IHS. The Partnership has found that high-level vacancies in federal agencies have the effect of “slowing decision-making and ultimately diluting agencies’ ability to best serve the public interest” and put agencies in a neutral gear in which they delay important decisions and plans.⁷ Findings from GAO confirmed that this was indeed happening at the IHS, where turnover and vacancies in key leadership positions proved “detrimental to the oversight of facility operations and the supervision of personnel,” with acting leaders who were “afraid to commit to decisions” and who needed “additional supervisor training.”⁸ The HHS OIG reinforced this finding by reporting that in some cases individuals in non-supervisory roles were being assigned to acting leadership positions and that leadership vacancies and turnover led to inconsistent or absent oversight of the quality of care at the facility level.⁹ To its credit, the agency is taking actions to address its leadership vacancies by, for example, establishing a senior executive search committee process that is recruiting highly qualified executives to the organization and beginning a succession planning process across its facilities.¹⁰ However, the upshot of the findings of the HHS-OIG, GAO, and others is that a lack of sustained leadership and acting leaders without the training or tools to lead effectively are hurting the quality of care at service units across the country.

A dearth of leadership development opportunities is another real challenge facing the Indian Health Service. The tendency to fill agency leadership roles with individuals who have risen through the ranks strengthens the strong commitment of the IHS to the communities it serves but also reinforces an insular and inward-looking organizational culture. This insularity is true of many other government organizations as well. Research by the Partnership and McKinsey has demonstrated that the vast majority of senior executives and other senior leaders come from within their agency and that external recruitment is largely ad hoc.¹¹ The committee should explore ways to encourage greater investment in leadership development and efforts by the agency to seek external candidates for critical executive and senior management positions. One solution that I strongly believe would be helpful is the creation of a public-private talent exchange that would provide rich development opportunities and allow current and aspiring IHS leaders

Care.” GAO Publication No. 17-181, January 2017, p. 21, <https://www.gao.gov/assets/690/681951.pdf>.

³ Ibid., 21.

⁴ Department of Health and Human Services Office of Inspector General. “Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care.” OIG-06-14-00011, October 2016, p. 13, <https://oig.hhs.gov/oel/reports/oig-06-14-00011.pdf>.

⁵ Ibid., 13.

⁶ Ibid., 13.

⁷ “Government Disservice: Overcoming Washington Dysfunction to Improve Congressional Stewardship of the Executive Branch.” *Partnership for Public Service*, September 2015, p. 29, <https://ourpublicservice.org/publications/viewcontentdetails.php?id=589>.

⁸ Government Accountability Office, No. 17-181, p. 15.

⁹ Department of Health and Human Services Office of Inspector General, OIG-06-14-00011, p. 13.

¹⁰ *High Risk, No Reward: GAO’s High Risk List for Indian Programs: Hearing before the Committee on Indian Affairs, Senate, 115th Cong. 1* (2017).

¹¹ “Preparing the People Pipeline: A Federal Succession Planning Primer.” *Partnership for Public Service* with Booz Allen Hamilton, June 2011, <http://www.govexec.com/pdfs/060611k1.pdf>.

to build managerial skills and infuse new thinking into their agency. Congress has recently created such exchanges at the Departments of Defense and Veterans Affairs. Another option would be to explore the VA model of partnering with medical schools around the country. These partnerships would allow the IHS to get a head start on recruiting new doctors by giving them hands-on opportunities to work in IHS facilities.

Beyond the impact that leadership vacancies and lack of leadership development have on the mission of the Indian Health Service, these deficiencies hurt employee morale as well. Data from the Indian Health Service bear this out. The Partnership's *Best Places to Work in the Federal Government Rankings*¹² have found that leadership is the single biggest factor in determining how employees view their organization.¹³ In fact, leadership effectiveness has been a key driver every year since the Partnership began publishing its rankings in 2003.¹⁴ It has also been one of the lowest-rated workplace categories overall, especially when compared to the private sector.¹⁵ Regarding overall morale, IHS employees rank their agency 249 out of 305 subcomponents included in the Partnership's rankings with a score of 55.0 out of 100. The agency performs even worse in employees' views of leadership, ranking just 291 of 303 ranked agencies in the workplace category of "Effective Leadership." The IHS performs similarly poorly in the four leadership subcategories ranked by the Partnership: "Empowerment" (261 of 303), "Fairness" (281 of 303), "Senior Leaders" (272 of 303) and "Supervisors" (297 of 303).¹⁶ These rankings are borne about by employee responses to questions from the *Federal Employee Viewpoint Survey* (FEVS). For example, just 36.4 percent of employees are satisfied with the policies and practices of the agency's senior leaders, while just over half (50.5 percent) believe prohibited personnel practices *are tolerated* in their organization. Though over half of employees (57 percent) believe their supervisor is doing a good job, that number is well below the government-wide score (68.2 percent) and the private sector (82 percent).¹⁶

There are, however, a few bright spots for the agency: this past year the IHS increased its score in every category but satisfaction with pay and its overall employee satisfaction score, or index score, by 0.5 points. Further, the agency saw its largest increase, of 2.4 points, in the workplace category of "Effective Leadership – Fairness." It is also worth noting that low morale was not always the norm. From 2003 to 2007 the IHS scored above the government-wide average in overall employee satisfaction, and survey data show that Indian Health Service employees are exceptionally committed to their jobs. In the category of "Employee-Skills Mission Match," which measures the extent to which employees get satisfaction from their work, the IHS scored 80.6 out of 100 (53 of 304). These findings, combined with the fact that

¹² The Best Places to Work rankings offer the most comprehensive assessment of how federal public servants view their jobs and workplaces, providing employee perspectives on leadership, pay, innovation, work-life balance and other issues. The vast majority of the data used to develop the scores and rankings was collected by the Office of Personnel Management's Federal Employee Viewpoint Survey (FEVS) from April through June 2016.

¹³ Partnership for Public Service, "Government-Wide Analysis: Category Findings," *Best Places to Work*, 2017, <http://bestplacetowork.org/BPTW/analysis/categories.php>.

¹⁴ Partnership for Public Service, "Government-Wide Analysis: Overall Findings and Private Sector Comparison," *Best Places to Work*, 2017, <http://bestplacetowork.org/BPTW/analysis/>.

¹⁵ The "Empowerment" subcategory measures the extent to which employees believe leadership at all levels of the organization generates motivation and commitment, encourages integrity and manages people fairly; the "Fairness" subcategory measures the extent to which employees believe disputes are resolved fairly, whether employees believe arbitrary action and personal favoritism are tolerated and if employees feel comfortable reporting illegal activity; the "Senior Leaders" subcategory measures the level of respect employees have for senior leaders and perceptions about senior leaders' honesty, integrity and ability to motivate employees; the "Supervisors" category measures employee opinions about their immediate supervisor's job performance.

¹⁶ These data are based on the Partnership's analysis of OPM's FEVS data.

IHS has seen its index score increase for two consecutive years, should give the agency's leadership as well as the committee a foundation to build on going forward.

A lack of good data about its performance also hampers the Indian Health Service. It is a well-acknowledged maxim of management that an organization cannot manage what it does not measure. For the IHS, the lack of meaningful data has a very real impact on its ability to achieve its mission. For example, GAO found that while the IHS did review some clinical quality data consistently, other performance data, such as on customer satisfaction, was not "consistently obtained or reviewed by all area offices because IHS has not required that they be reviewed or reported."¹⁷ To truly and measurably improve, IHS must begin consistently collecting quality data that leaders can immediately see and react to. Especially valuable would be information on customer satisfaction, health outcomes, employee performance data, hiring process information and disciplinary outcomes that encompass the key aspects of the IHS mission.

Faster firing is not a path to sustained accountability

The Partnership supports the committee's goal of an Indian Health Service that holds employees accountable for their performance and prevents bad actors from tarnishing the reputation of the thousands of committed employees who have dedicated their professional careers to serving Native communities. Misconduct such as that described in the committee's 2010 report, "In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area" clearly has no place in government. In fact, IHS employees themselves believe there is an accountability problem in their organization – according to the 2016 FEVS, three-quarters of IHS employees believe that their work unit *does not* take steps to deal with poor performers and that pay raises *do not* depend on how well employees perform their jobs. But as the committee strives towards the goal of a more accountable Indian Health Service, I strongly urge you to consider whether the changes to due process laid out in Section 106 of S.1250 represent the right approach.¹⁸ In the Partnership's view, simply making it easier to remove employees without addressing larger management challenges will fail to create sustained improvement or accountability and will further hinder the agency's recruitment of needed talent.

The authority created in Section 106 is meant to be in addition to statutory authorities already available under Chapters 43 and 75 of Title 5, but I believe that such additional authority is unnecessary. As I noted in my statement for the record of June 17, 2016, the Indian Health Service already has the statutory and other authorities it needs to take corrective action to remove, suspend, demote or transfer an employee.¹⁹ Data from the Merit Systems Protection Board bear this out: though data for the IHS alone is not available, its parent agency, the Department of Health and Human Services, had just 2.1 percent of its decisions reversed at MSPB.²⁰ The MSPB appeals process is just not a significant barrier to holding employees accountable, and reducing the time that an employee facing an adverse action has to appeal to MSPB will not bring real accountability. Section 106 also presents a potential constitutional issue. Last May, the Department of Justice declined to enforce a nearly identical provision in the Veterans Access,

¹⁷ Government Accountability Office, No. 17-181, p. 10.

¹⁸ *In Critical Condition – The Urgent Need to Reform Indian Health Service's Aberdeen Area: Hearing before the Committee on Indian Affairs, Senate, 111th Cong. 1* (2010).

¹⁹ United States. Cong. Senate. Committee on Indian Affairs. *Improving Accountability and Quality of Care at the Indian Health Service through S.2953*. June 17, 2016. 114th Cong. 2nd sess. Washington: GPO, 2016 (statement of Max Stier, President and CEO, Partnership for Public Service).

²⁰ U.S. Merit Systems Protection Board. "Annual Report for FY 2016." January 2017, p. 24, <https://www.mspb.gov/mspbsearch/viewdocs.aspx?docnumber=1374269&version=1379643&application=ACROBAT>.

Choice, and Accountability Act of 2014 (P.L. 113-146), citing concerns that the law violated the Constitution's Appointments Clause.²¹ Passing a law that immediately faces constitutional challenges will only set back the cause of accountability at the agency further. Instead, the IHS and this committee should take steps to empower IHS managers to deal with poor performers and bad actors as well as to motivate the best and brightest.

There is much the committee can do to improve the quality of supervision and performance at the IHS, particularly by focusing on the beginning of an employee's or supervisor's tenure when the opportunity to affect employee habits and attitudes is greatest. For instance, the committee should require additional training to supervisors and managers on rewarding high performers and dealing with poor performers, and work to ensure that funding is available to make the requirement real. In many cases, agencies select for supervisory roles technical experts who may lack the people skills or training to be successful.²² Without these skills, supervisors are being set up for failure from the very beginning. Additionally, the committee should provide further support to the agency by instituting a dual-track promotional system by which both aspiring managers and technical experts can advance their careers by focusing on their strengths, and the agency can allow those individuals who want to become leaders to self-select into those roles. Finally, the committee should strengthen the probationary period at the IHS for both new employees and newly promoted supervisors and managers. The probationary period represents an important continuation of the assessment process – an opportunity for the agency to see how the employee performs on the job. More often than not the probationary period is treated as a formality. MSPB has found that managers tend to treat probationers the same as tenured employees and that more than half of supervisors would be likely to keep a probationer on regardless of performance.²³ The committee should address this by holding IHS supervisors and managers accountable for using the probationary period as Congress originally intended by making an affirmative decision to retain an employee once their probation ends. The committee should also encourage the IHS to deal with employee conduct and performance issues through Chapter 75 of Title 5 to the extent possible, as it is less administratively burdensome than procedures under Chapter 43. Given that many employee performance issues have conduct elements as well, this shift should cover the vast majority of adverse actions in the Service.

Hiring reforms are a strong start, but more can be done

The talent challenges of the Indian Health Service have been widely publicized. Remote locations, uncompetitive pay, and a lengthy and inefficient hiring process all contribute to the agency's problems recruiting, hiring and retaining mission-critical talent. The IHS contends with a vacancy rate of 33 percent for physicians in its hospitals, while across the system overall vacancy rates are 23 percent for physicians and 17 percent of nursing positions.²⁴ The agency's 1,550 medical professional vacancies represent the largest obstacle to improving the quality of care, according to GAO.²⁵ The complex and rigid hiring process does little to help. Witnesses before this committee have noted that IHS officials feel they are

²¹ "Helman v. Department of Veterans Affairs, No. 15-3086 (Fed. Cir.)." Loretta E. Lynch to Patricia Bryan, Senate Legal Counsel, May 31, 2016, Office of the Attorney General, Washington, DC.

²² U.S. Office of Personnel Management. "Supervisors in the Federal Government: A Wake-Up Call." January 2001, p. 6, <http://www.au.af.mil/au/awc/awcgate/opm/suns.pdf>.

²³ U.S. Merit Systems Protection Board. "The Probationary Period: A Critical Assessment Opportunity." August 2005, p. 7, <https://www.mspb.gov/MSPBSEARCH/viewdocs.aspx?docnumber=224555&version=224774&application=ACROBAT>.

²⁴ Department of Health and Human Services Office of Inspector General, OEI-06-14-00011, p. 11.

²⁵ Government Accountability Office. "High-Risk Series: Progress on Many High Risk Areas, While Substantial Efforts Needed on Others." GAO Publication No. 17-317, February 2017, p. 212, <http://www.gao.gov/assets/690/682765.pdf>.

held back by the current system, noting that the agency has lost many candidates who are forced to wait six or more months before the agency can hire them.²⁶ Findings of the Inspector General of the Department of Health and Human Services reinforce these concerns, noting that while time-to-hire at the IHS was just under OPM's 80-day benchmark, it could still take up to six months to hire new staff.²⁷ Employees themselves are aware of these challenges – just 38.3 percent believed that their work unit was able to recruit people with the right skills.²⁸ The result is that IHS facilities like the Blackfeet Community Hospital in Browning, Montana cannot provide the level of care that patients deserve.²⁹

With these interconnected challenges in mind, I am pleased to see the aggressiveness with which the committee is working to address IHS staffing challenges. The authorities made available by S.1250 should help the agency bring in and keep top talent. In particular, direct hire authority represents a valuable tool, and the IHS has already found it to be useful in streamlining the hiring process for medical professionals.³⁰ I urge the committee to ensure, however, that this authority is, on the one hand, used responsibly by hiring managers and, on the other, made flexible enough to meet the agency's needs. At the very least, this authority should be implemented immediately for mission-critical positions of demonstrated need that have been vacant at least six months.

The committee is also right to include in Section 101 of S.1250 language allowing the IHS to establish a pay system for its medical professionals that establishes pay parity with individuals compensated under Title 38 of the U.S. Code. But while this authority will help the IHS close the gap, it is worth noting VA itself struggles to recruit and retain medical professionals even under Title 38.³¹ The committee should also make clear that this pay authority works not just for medical professionals but to hospital CEOs and other senior healthcare administrators in the agency whose positions remain hard to fill. The committee must go further in reforming the IHS compensation system, recognizing the added difficulties that the agency faces in recruiting providers to facilities located in rural and remote locations. In the Partnership's view, this means a market-sensitive compensation system for IHS medical and healthcare administration professionals. Individuals in private sector medical leadership positions typically see compensation multiple times greater than that of federal executives with similar responsibilities. Though the IHS already has limited ability to provide special pay rates to medical professionals who fill critical needs, granting broad market-sensitive pay would eliminate the need for lengthy application processes.³² Implementing a new pay system will also require that IHS conduct a comprehensive compensation survey which allows the agency to understand the positions for which it underpays, those for which it overpays, and how it can adjust its compensation to ensure that it can be competitive in recruiting the talent it needs. While the federal government will likely never be able to match private sector compensation levels, Congress must be willing to invest in its leaders if it is to expect results.

²⁶ United States. Cong. Senate. Committee on Indian Affairs. *Reexamining the Substandard Quality of Indian Health Care in the Great Plains*. Feb. 3, 2016. 114th Cong. 2nd sess. Washington: GPO, 2016 (statement of Victoria Kitcheyan, Treasurer, Winnebago Tribal Council).

²⁷ Department of Health and Human Services Office of Inspector General, OEI-06-14-00011, p. 12.

²⁸ These data are based on the Partnership's analysis of OPM's FEVS data.

²⁹ Department of Health and Human Services Office of Inspector General. "OIG Site Visits to Indian Health Service Hospitals in the Billings, Montana Area." OEI-09-13-00280, August 2015, p. 3, <https://oig.hhs.gov/oig/reports/oei-09-13-00280.pdf>.

³⁰ Department of Health and Human Services Office of Inspector General, OEI-06-14-00011, p. 12.

³¹ The White House Office of the Press Secretary. (2017). *Press Briefing by Secretary of Veterans Affairs David Shulkin* [Press release]. Retrieved from <https://www.whitehouse.gov/the-press-office/2017/05/31/press-briefing-secretary-veterans-affairs-david-shulkin>.

³² Department of Health and Human Services Office of Inspector General, OEI-06-14-00011, p. 12.

There are other actions the committee can take to grant the IHS short-term flexibilities to recruit and retain top talent. The committee could allow the IHS to noncompetitively rehire former federal government medical professionals to any grade for which they qualify, providing an additional incentive to former IHS medical professionals to return to the agency after having gained experience outside of government. Sen. Heitkamp, a member of this committee, introduced legislation, the *CBP HiRe Act*, to improve recruitment and retention of Customs and Border Patrol officers in rural and remote locations. The bill allows the agency to “use existing hiring and retention authorities with more flexibility” and is a narrower version of legislation the Senator introduced last year that would have provided the same flexibility to all agencies.³³ The Partnership supports this legislation and believes it represents a potential model for addressing the unique hiring challenges of the IHS. Finally, I hope the committee might take another look at recommendations from the Partnership’s previous statement, including implementing an IHS exit survey, collecting data on hiring process outcomes, providing training to hiring managers on flexibilities available to their agency and better utilizing student interns as a pipeline for entry-level talent.

Recommendations

Provide Training to IHS Supervisors and Managers on Rewarding High Performers and Managing Poor Performers

As I have noted elsewhere in this statement, many supervisors and managers are poorly prepared and ill equipped for supervisory and management roles. Particularly difficult for new supervisors may be the challenge of dealing with employees who cannot or will not perform. In many cases, going through the disciplinary process may be a period of “discovery learning” for these supervisors. The IHS and this committee should help support new supervisors by mandating immediate as well as recurring training for new supervisors on leading people, managing performance, understanding whistleblower protections, and engaging their teams. By better equipping new supervisors to lead from the very beginning of their tenure, the IHS can actively address performance issues when they occur.

Establish a Dual-Track Career Path That Allows Aspiring Leaders to Self-Select Into Supervisory Roles

The rigid structure of the General Schedule system tends to force employees to take on supervisory roles because it is the only way advance their careers, regardless of whether the employee has the skills or inclination to be an effective manager. For employees with valuable technical expertise but who are not suited for or interested in supervisory duties, this is especially problematic. A dual-track career path that allows employees to become managers or advance as technical experts would give employees more options and provide agencies with a cadre of managers who have chosen to lead people. The result is more effective managers throughout the organization and more satisfied employees overall.

Strengthen the Probationary Period for New Hires and Supervisors

As noted above, agencies typically select supervisors for their technical expertise rather than their leadership abilities. The selection process, and the fact that government does not treat leadership as a discipline leaves managers without the tools or incentives to manage effectively. The committee should include as part of S.1250 language requiring managers to make an affirmative determination to continue a new employee or supervisor past their probationary period – the period during which the individual is supposed to demonstrate successful performance in their position – only if the individual has demonstrated their fitness for the role. Managers should be held accountable in their performance plans for making this determination and providing feedback to probationers throughout this time. Raising the

³³ Office of Senator Heidi Heitkamp. (2017). *CBP Heeds Heitkamp's repeated Calls to Proactively Address Federal Hiring, Recruitment & Retention Issues* [Press release]. Retrieved from <https://www.heitkamp.senate.gov/public/index.cfm/2017/1/cbp-heeds-heitkamp-s-repeated-calls-to-proactively-address-federal-hiring-recruitment-retention-issues>.

profile of the probationary period is one of the quickest and most effective ways by which the committee can ensure that poor performers do not find a permanent place in the IHS.

Hold Political Appointees Accountable

The Indian Health Service deserves credit for requiring its Director to have a performance plan connected to the organization's strategic goals and which cascades down into the plans of other employees, though the plan itself does not appear to be publically available.³⁴ The committee should request that plan and hold the Director accountable for the goals contained therein. In reviewing the plan, the committee should also ensure that it includes goals relating to building a pipeline of future leaders within the organization, creating a culture of accountability, filling mission-critical positions with high-quality talent, and ensuring that employees are engaged in their work and committed to the goals of the organization. Additionally, the performance plan of the Director should be widely available and accessible to both employees within the agency and the public. Having these goals as part of the Director's performance plan, and by connection, the plans of other senior leadership will help drive greater focus on employee engagement and leadership development.

Require IHS to Use the "Highly-Qualified" Standard When Hiring Individuals Through the Direct Hire Authority Granted By S.1250

Direct hire authority provides agencies much greater flexibility to fill mission-critical and hard-to-fill jobs. The committee should ensure that the direct hire authorized by Section 105 truly meets the agency's need by including a requirement that candidates be "highly-qualified" to be appointed directly to a career position in the IHS. Current law allows the use of direct hire authority requires only that a candidate is minimally qualified for the position. By making clear that the candidate must be highly qualified, IHS can ensure that it is appointing top talent into these critical jobs. The Partnership believes the government should seek only the most highly-qualified candidates, as opposed to individuals who meet only the minimal qualifications for the job. Further, this change would better focus the agency's use of direct hire authority on the quality of its hires, rather than simply the time it takes to fill a position.

Authorize the IHS to Noncompetitively Rehire Former Employees to Any Position for Which They Qualify

According to current law, federal employees who have held a career or career-conditional position can be reinstated non-competitively within the federal government only to a job that is at or below the grade level they last held in the federal government regardless of the experience they may have gained during their time outside of government. The result is that government unnecessarily disincentivizes talented former federal employees from returning to public service. This proposal would encourage more movement between the IHS and the private sector, particularly private sector hospitals, and encourage talented individuals to return to government service.

Better Align Pay for IHS Medical Professionals and Healthcare Administrators with the Private Sector

Executives and medical professionals at Indian Health Service facilities take on exceptionally difficult jobs in unique, sometimes challenging environments. If the IHS is to attract and retain individuals with the skills needed to meet its mission, it must be able to compensate them at a level that is at least roughly comparable to the private sector. Unfortunately, the General Schedule does not allow for the kind of flexibility that the IHS needs. While the legislation under discussion today would create pay parity with medical professionals under Title 38 of the United States Code, which provides for limited market-sensitivity, the problem of private sector comparability will remain. Ideally, Congress would revamp the federal pay system to enable all federal agencies to act on a level playing field to attract the best and

³⁴ Government Accountability Office, No. 17-181, p. 7.

brightest. As a first step, however, the committee should look for ways to more aggressively close the gap between IHS medical and healthcare administration professionals and the private sector.

Require IHS To Conduct Regular Succession Planning Exercises

One of the key findings from GAO's January 2017 report on the quality of care at the IHS is the pressing need for stronger succession planning activities across the organization. IHS reportedly had not defined succession or contingency plans for key personnel across the organization.³⁵ Such planning is especially critical because 45.3 percent of IHS medical professionals are over the age of 50 while just 30 percent are under 40.³⁶ The agency deserves credit for taking up GAO's recommendation and beginning the succession planning process by distributing succession planning instructions and descriptions of competencies for leadership positions to office and area directors. However, this should be an ongoing process. The Partnership and Booz Allen Hamilton found, in *Preparing the People Pipeline: A Federal Succession Planning Primer*, that such planning is an effective tool for dealing with both departures and retention by helping managers understand the critical skills within their organizations and retain needed talent.³⁷ The committee should require that the IHS regularly conduct succession planning exercises and ask GAO to report on the quality of those plans.

Collect and Use High-Quality Performance Data Benchmarked to the Private Sector

To effectively achieve its mission, the Indian Health Service must collect, report and, most importantly, use high-quality data that allows it to understand the needs of the individuals and communities it serves. While the Service collects some clinical quality data used by area offices in performance evaluation and decision-making, it could and should do more. Data should include the customer experience, employee engagement, healthcare quality, and human resources metrics like time-to-hire, quality of hire, and disciplinary process outcomes. Further, the Service should make this information publically available and assure stakeholders through its actions that it is acting on it to improve performance. The committee should mandate that this information is collected and reported and make it a subject of ongoing oversight. The native communities served by the IHS deserve no less.

Promote Greater Mobility between the IHS and the Private Sector

Breaking down the walls between the Indian Health Service and the outside world is a proven way to improve the agency's performance. Creating exchange programs that temporarily assign high-performing employees to private sector organizations, or other agencies with similar missions like the Department of Veterans Affairs, would allow the IHS to offer unique development opportunities for aspiring leaders, strategically fill critical vacancies, and bring innovative ideas into the organization. A well-designed exchange program would also IHS employees that the agency values their development. Assignments could last from six months to one year with options to extend and would be in addition to the talent exchange authority already available under the Intergovernmental Personnel Act. The committee should also encourage and, where necessary, authorize the Service to develop academic partnerships with local medical schools, as the VA does today.

Reform of the Indian Health Should Serve as a Catalyst for Government-Wide Changes

³⁵ Government Accountability Office, No. 17-181, p. 15.

³⁶ U.S. Office of Personnel Management, FedScope: Federal Human Resources Data, 2017, <https://www.fedscope.opm.gov/>.

³⁷ "Preparing the People Pipeline: A Federal Succession Planning Primer," *Partnership for Public Service* with Booz Allen Hamilton, June 2011, <http://www.govexec.com/pdfs/050611k11.pdf>.

The current political moment and pressing need for reform present valuable opportunities to pursue a fundamental overhaul of the way in which agencies like the Indian Health Service manage their talent. Leaders in the public and private sector, in academia and the good government stakeholder community all agree that the federal government's personnel system is in desperate need of reform. That system is nearly 70 years and has not kept up with the demands of modern government. Reforms enacted over the last few years both government-wide and within individual agencies like the Department of Defense represent an important starting point, and your efforts are building on this foundation. I urge the committee to work with your colleagues in the House and Senate to pursue broader government-wide reforms so that we can improve our civil service system not just for some agencies, but for all.

Conclusion

Chairman Hoeven, Vice Chairman Udall, members of the Committee on Indian Affairs, thank you for the opportunity to share the views of the Partnership on S.1250, the *Restoring Accountability at the Indian Health Service Act of 2017*, and the challenges facing the Indian Health Service. I greatly appreciate your committee's engagement on this important topic and hope to continue to work with you and your staffs on these important issues going forward. I am happy to answer any questions you may have.

The CHAIRMAN. Thank you for being here and for your testimony. We really appreciate it.

I will turn to the Ranking Member and see if you would like to begin the questions.

Senator UDALL. As we all heard at the last hearing, Medicaid billing accounts for a substantial part of IHS funding. That means the loss of CMS certification is both a safety concern and a funding issue.

The Committee frequently receives status updates on the IHS-CMS system improvement agreements for the three South Dakota facilities placed on probation last Congress. The Committee has heard very little about the efforts to regain accreditation at the Omaha Winnebago. Omaha Winnebago tribal leaders, like Ms. Kitcheyan, report that they have similarly received few updates.

What is the current CMS accreditation status of the Omaha Winnebago IHS facility, Admiral Buchanan?

Mr. BUCHANAN. Currently, it remains unchanged. As mentioned earlier, it has been about two years since the certification was lost.

One of the challenges we have had has been locating a senior leader for that position, a CEO position. We were able to locate a senior leader to operate the Omaha Winnebago Hospital and with input from the Winnebago Tribe and the Omaha Tribe, that person was selected, brought onboard and started implementing changes.

As I understand, he has been holding regular meetings with the tribes, both Omaha and Winnebago, to provide those regular updates.

Some of the challenges continue to be the leadership positions. Some of our key positions there still remain vacant. I recently heard that the CEO we hired will be resigning at the end of the month. That could pose a continual challenge going forward.

Senator UDALL. Do you have a timeline for getting them back up and getting accreditation?

Mr. BUCHANAN. We have been working continuously to try to get that timeline. It continues to move. Specifically, as new leaders come in, we want to apply for that certification when it is safe to do so. The next step in the process is to bring in a contractor such as Joint Commission Resources to evaluate and see where we are. That has been the next step. That is where we are.

Senator UDALL. Admiral, you are very aware that Medicaid and Medicare, if these facilities are in a status where they don't get those, that hurts the ability to their offering health care to a significant degree. It is very important to try to make sure we get them off that list and up and running, as you are well aware.

Identifying and removing bad IHS employees is certainly an issue this Committee has heard about for some time but I really want to use this hearing today to drill down and make sure we are addressing the root cause.

This question is to Mr. Stier. Mr. Stier, has your organization done any sort of analysis of how many IHS employees are reinstated through the MSPB appeal? When you mentioned leadership, you have heard we don't have leadership at one of these facilities or more. We don't have leadership today of the overall IHS in terms of a permanent person. We have the very well qualified gentleman here but he is in an acting capacity. Do you believe it is important to get full-time leadership rather than an acting person?

Mr. STIER. Senator, there is no question that it is critical to get full-time leadership at IHS. I have no doubt that Acting Director Buchanan is terrific but the reality is, when you are in an acting status, it is impossible to really do the job in the same way.

My analogy is the substitute teacher. You can be an excellent educator but the reality is that you are not perceived as having that long-term authority and it is very difficult to do the job as well as you might.

It is also true, we just heard from testimony now that they are missing a CEO in a critical place. That kind of leadership vacancy is incredibly debilitating and fundamental to all of these issues.

Figuring out how to deal with that, I would propose that a more market sensitive pay system would be one way of getting at that in a bigger way, again very much analogous to what the VA is experiencing as well.

On the issue you raised directly about the Merit Systems Protection Board, the reality is the agency wins in the vast number of times. Only 2.1 percent of the cases actually get reversed in favor of the employee. That is not where the real issue is.

Federal employees themselves, three-quarters of them at IHS, will tell you that poor performers are not dealt with. The problem is not creating rules to fire them faster, in fact, that will actually have unintended negative consequences, but the problem is trying to improve the management, the leadership. That is where you will get real improvement.

That has not been done in the way that it needs to be. Your Committee could do it.

Senator UDALL. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Senator Heitkamp.

Senator HEITKAMP. Thank you, Mr. Chairman, for letting us go ahead of you.

First, Mr. Stier, thank you so much for the plug for the work we are doing over in Homeland Security and Government Affairs. Senator Lankford, who is also a member of this Committee, and I have really made this a major initiative. We appreciate your support but

I think there are other lessons we are learning that can be applied here equally.

I really appreciate your reference to our bill. I think it can, in fact, provide that support on hiring but we also have a supervisory training bill that I think can also be extraordinarily helpful. Could you comment on that?

Mr. STIER. Yes, absolutely, I think you are entirely correct.

These problems are the same across the board. You have general jurisdiction. Obviously, it is great that this Committee is focusing on the particular agencies over which it has oversight.

The training piece is fundamental. Right now, we put great people in place without the tools they actually need to do their jobs well. The first thing that gets cut in these agencies is the training and development budgets. There really isn't the kind of investment or requirements around managers that I think is necessary to actually see improvements in productivity and outcomes for the people being served.

I think you are very much on the right track in the work you are doing. I think there ought to be, again, sort of alignment across the board with the efforts being done.

Senator HEITKAMP. Admiral Buchanan, before she left her post, Mary Wakefield, who was the Deputy Secretary for HHS, performed a lot of hours of review of the problems we have at HHS or at the Indian Health Service. Where is that work? We don't really need legislation for you guys to fix this. It is important to send a message that you guys can fix this on your own. I am appalled that the Winnebago Tribe still does not have a facility that is CMS-certified. That is not acceptable.

Where are those initiatives? Have you benchmarked them? Why haven't those initiatives been carried out to the point where we could see the Winnebago of Nebraska actually having a full service medical facility?

Mr. BUCHANAN. I heard the comments down the line related to acting. This is actually personal to me.

I am a member of the Seminole Nation of Oklahoma, having been born in an IHS hospital, with family members that work at IHS. I hear Ms. Kitcheyan, a friend of mine, experiencing the issues at Omaha Winnebago Hospital and having worked there for three weeks to get an idea of what the conditions were and the challenges at Omaha Winnebago, this is truly personal.

I respect the acting questions but I have family members that rely on the IHS system. I have family members who work in the system, so I hear your concerns and the issues you are raising.

We are working hard to make those changes. One of the things that Ms. Wakefield developed, and the former Administration, was something we implemented in November 2016. It is the Quality Framework and Implementation Plan. That is the culmination of all the activities and recommendations of experts where the goal is to provide top quality health care and get back the trust of the tribes related to those issues.

We have specifically identified five priority areas going forward: organizational capacity, accreditation, getting back the accreditation for the Omaha Winnebago Hospital, doing that specifically

with contracting to get one contractor to accredit all of our IHS hospitals across the Country. That is one avenue.

Senator HEITKAMP. I just think this Committee would benefit. Maybe there are some changes we should make to those plans, but it would benefit from an analysis of where we were at the end of that survey, where we are headed going forward, and what additional tools does Indian Health believe they need to meet quality standards.

I think it is not just about discipline. No discipline in the world is going to prevent a CEO from resigning literally weeks after the CEO took the job.

Finally, I want to speak to Ms. Kitcheyan. How has this really affected the availability of health care for your tribe?

Ms. KITCHEYAN. It has impacted the services at the service unit. Without that third-party revenue, which makes it enough, the services are weakened, the reputation is poor and the PRC, the preferred care dollars, are minimal.

We were at Level 1 for a while. I think now they are down to Level 2. Many of the services aren't available at the service unit so they are referred out. If you are only referred out, life or limb, there are many people who are sick and have chronic conditions that are not life or limb and continue to suffer. It is an essential piece of the operating revenue, this third-party revenue.

I also want to mention that we are also without our Director of Nursing and our lab supervisor, two essential pieces along with this CEO. I guess I have to acknowledge our Acting Area Director, again another acting role, in getting the job posted.

We have to celebrate our success where we can celebrate it, but that is such a small thing that we are happy it was posted in a timely manner. We are trying and they are trying as well but it is just not successful. It is very frustrating to lose these administrators in whom we put our confidence. We understand people have their lives and have to leave these positions, but we are not making any progress in these two years. I wish I could tell you differently.

Senator HEITKAMP. I think this Committee shares that frustration that we aren't making progress. We need benchmarks and then levels of accountability. Without it, I don't see this getting better.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Heitkamp.

Senator Cortez Masto.

Senator CORTEZ MASTO. Thank you, Mr. Chairman. Thank you to the panel members. I appreciate you being here.

Ms. Kitcheyan, let me just follow up because I also was concerned with what I was hearing regarding on what is going on with your community. You addressed some concerns with S. 1250, one being that Indian Country should be consulted because they are going to be impacted within its entirety.

The need for adequate funding and oversight for new programs and no under-funded mandates, I agree with you. I don't like unfunded mandates or unintended consequences.

Then, you talked about tribal best practices for retaining providers. Are there models out there? Are there things we should be

looking at as we look to retain our providers in our tribal communities that you can cite?

Ms. KITCHEYAN. I wasn't so much talking about the retention of employees, but innovative programs such as the dental health therapy program in the Alaska area that has been successful with recruiting permanent, local providers who are more like a long-term solution than short-term volunteers who are not going to be sustained or circle back.

Senator CORTEZ MASTO. Models that we should be looking to for recruitment?

Ms. KITCHEYAN. We should be looking, at the local level, at programs such as the Alaska Native Dental Health Therapy Program which has been successful for that area and models like that which can mimicked throughout Indian Country.

Senator CORTEZ MASTO. Thank you. I appreciate that.

Ms. KITCHEYAN. We are looking for sustainable change for our communities.

Senator CORTEZ MASTO. Mr. Stier, thank you for being here as well.

In your testimony, you acknowledged the Committee's focus on the workforce challenges facing IHS. You said in your statement, "The myriad of challenges that confront the IHS are the result of both a broader Federal civil service system that is poorly suited to the needs of the modern health care delivery system."

I agree that we need some fundamental reforms in our delivery system. What do you think is the biggest exterior challenge to our leadership that is causing such a high turnover rate?

Mr. STIER. I think there are so many different pieces to this but I think it would be best to think about how must the Federal Government stop being an island, an insulated and isolated institution and adopt practices that are now the norms in the private sector.

When I say that, I mean very fundamentally the pay system. It was a pay system that was designed literally in 1949 and intended for a government that was almost, in large majority, a clerical workforce. Now it is a professional workforce.

When you think about the challenges of hiring what is already a short supply set of professionals in areas that are very difficult to recruit for in rural and remote areas, I think it is really important to make sure IHS has the same tools that the best in class in the private sector has.

That means finding market sensitive pay, in particular, not just for the physicians. Again, I think of the comparison to the Veterans Affairs problems, and they are very much the same thing. They have the same kinds of issues, especially in remote and rural areas.

I think one issue they face is it is very hard to recruit CEOs, hospital directors, people who are phenomenal administrators that are fundamental to the success of those institutions.

If you ask me what the largest factor is right now, it is a system that doesn't offer the same kinds of tools to the government that the best in class in the private sector has. If you have those, then IHS will beat anyone out there.

What is amazing when you look at the data, what the employees have to say is, you have a workforce that is fundamentally charged up about its mission; they care about what they are doing. You

hear that from Director Buchanan. He cares about what he wants. That is something private sector employees would die for, that kind of intensity of mission commitment.

What they don't have is the right tools. That is one thing you can give.

Senator CORTEZ MASTO. Thank you. I appreciate that.

I have one final question. Because I am new to the Committee, I am going to focus this on Admiral Buchanan. I am curious how you would handle this.

I was the Attorney General in Nevada for eight years. As part of that work, I represented the State agencies. Anytime there was legislation passed, we helped them to interpret it and address unfunded mandates, unintended consequences, and also, constitutionality provisions.

I understand, after reading through everything, there is a concern with Section 106 in S. 1250. That particular section has been held unconstitutional by the U.S. Court of Appeals for the Federal Circuit in *Helman v. Department of Veterans Affairs*.

If that provision is still in the bill as we pass it, how would you address the constitutionality provision in Section 106 that has been held unconstitutional by the court?

Mr. BUCHANAN. That is a great question.

At the Indian Health Service, we defer to the Department of Justice for court issues and litigation. We would typically defer to them.

Senator CORTEZ MASTO. To legal counsel, similar to what I addressed. Thank you for that.

Mr. Chairman, as a new member, I don't know how this would normally be handled, but I would love an opportunity to address that provision if it has truly been held unconstitutional by the courts, how that normally would be handled in the Committee, and that process.

Thank you to the panel members. I appreciate the comments made today.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Daines.

**STATEMENT OF HON. STEVE DAINES,
U.S. SENATOR FROM MONTANA**

Senator DAINES. Thank you, Mr. Chairman and Ranking Member Udall.

I think it is pretty clear from what we have heard today, as well as what I hear as I jump in my Ford pickup and drive all across Montana and Indian Country, that the Indian Health Service isn't working.

However, across the Country, we see large, complex health systems that are deploying the principles of improvement science to improve the quality of care and health outcomes. One mechanism to do so is through the Collaborative Improvement and Innovation Networks, also known as CoIIN, whereby these multidisciplinary teams of Federal, State and local leaders work together to tackle a common problem.

IHS has certainly been a common problem for Montana's Native American communities. I cannot tell you how many hours, if you

are a member of the United States Senate and you come from Indian Country, you spend time engaging and sitting down with tribes and you get an earful. As soon as your left ear is full, your right ear gets full in terms of the challenges we face right now in IHS.

Admiral Buchanan, I believe you are familiar with the CoIIN model. I understand IHS has been participating in the HHS Health Resources and Services Administration's CoIIN design to prevent infant mortality, an important place to start. How has the participation of IHS in that CoIIN improved infant mortality rates in Indian Country?

Mr. BUCHANAN. IHS has been using elements of the CoIIN model through NOAs and IPAs for a very long time. The Indian Health Service has partnered with HRSA in partnerships related to the infant mortality CoIIN with the goal of preventing and reducing American Indian and Alaska Native infant mortalities.

We have implemented the recommended strategies that are culturally appropriate with the pre-natal and post-natal education activities. I can provide additional details for the record if you like.

Senator DAINES. Admiral, can you think of any other specific trends you are seeing in Indian health where a CoIIN might be able to address it?

Mr. BUCHANAN. There are some other activities we have been doing. One that comes to mind right off the bat is the Special Diabetes Program for Indians where we provided funding to NCAI, I believe, of \$1 million or so where they work with a TRAIL program to implement something similar to the CoIIN model you are referencing.

Senator DAINES. Thank you, Admiral.

Ms. Kitcheyan, among the reforms in the system included in the Restoring Accountability in the Indian Health Service Act, I know you found the expansion of training for IHS personnel in tribal cultural and history to be "of utmost importance" just as it is to the Montana tribal leaders with whom I consulted on this legislation.

Could you share with this Committee why you believe that is important?

Ms. KITCHHEYAN. It is important that the IHS personnel, whether it be the providers or the administrators, have the proper cultural sensitivity training when they engage with the tribal community.

One of the things I want to impress upon this Committee is that it is not going to be a one size fits all model. We need to design these cultural sensitivity programs that are distinct to the Nation that this provider or administrator will be working in.

That is one of the challenges with solutions for Indian Country. It is like this pan-Indian idea that they want to roll out to every tribe. We find it does not fit for every tribe. We have to have respect for that distinct Nation and their cultural norms, especially with the elders and some of the lady relatives and things that are appropriate and inappropriate in our communities. I will just leave you with that.

Senator DAINES. Would you say then it would also be beneficial to train new medical personnel on the unique history? I am using the words unique history and culture of each tribal community in which they serve prior to beginning the work at an IHS facility?

Ms. KITCHEYAN. Yes. Thank you. I think that is an amazing suggestion. It is only fair to the provider as well, in order them to feel like they are fully prepared to engage with the tribal community and patient.

Senator DAINES. It seems like a tool in an on-boarding process. You get off to a much better start if you have some those issues trained ahead of time.

Ms. KITCHEYAN. Right, and that might help with the retention so that the provider feels they know where they are going and they would, I feel, be further embraced by the community if they had that respect and effort into learning about the people.

Senator DAINES. I am out of time but it is good to hear. I would be interested in exploring that concept in working with the tribal leaders back in Montana, as well as with my colleagues here in the Committee, as well as with IHS.

Thank you.

Ms. KITCHEYAN. Thank you.

The CHAIRMAN. Dr. Crowley, in S. 1250, we are trying to come up with a simplified, uniform credentialing process so that dentists who are willing to volunteer can go out and provide services on the reservation. What recommendations do you have for us?

The Dental Association and dentists have approached me and they are willing to do this. I think it is a remarkable opportunity and there is an incredible need out there. How do we make sure that we set up a system that gets them credentialed and gets them out there helping in Indian Country?

Dr. CROWLEY. Thank you, Senator. I thought you were going to let me off the hook.

The CHAIRMAN. No, sir.

[Laughter.]

Dr. CROWLEY. I think the model is there. The other Federal services have a credentialing service that is national that goes to simplification, using online means and they can get all the data they need with licensing, the national databank, issues and any other education issues they need. It can be done in a simple and fast way through online credentialing.

The CHAIRMAN. Who administers that?

Dr. CROWLEY. Maybe the Admiral would know but it is the Federal service, the Army, Navy, Coast Guard, I think the Veterans Service. I think they use that service now as they credential. It is a much more condensed, abbreviated, quicker pathway to get the information they need to accredit someone they want to bring onto their service.

The CHAIRMAN. IHS could plug into that system?

Dr. CROWLEY. The Admiral may be able to answer whether there is a plug-in to that but I certainly think there is a model there.

The CHAIRMAN. You would be willing to work with us and IHS to try to plug-in to that type of model?

Dr. CROWLEY. Most certainly. If I can speak to a higher level of what you have said, the millennials in dentistry are almost half of our dentists now. Our dentist millennials are just like the other millennials. They take social responsibility seriously. They want to reach out; they want to do good.

To have the availability to be able to quickly go someplace, coupled with the fact that the dental students today graduate with more debt than any professional in the Country, and the fact they have loan payment systems, it certainly is an eye opener for these young people to combine their social consciousness with the ability to get a job that they can go help people.

We also know the Indian Nations have the highest amount of dental disease as any of our population. The care needs to be there. We have to get the model there to help them prevent this disease. You cannot treat your way out of it.

I think our system where we are working with our CDHCs, we are going in with the Navajos and bringing young people to the table to help educate so they can go back to their populations and be a culturally competent person from the get-go on how we are treating prevention of oral disease and access to work with others and collaborate with our other health care professionals to bring oral care to the level it needs to be with the Indian population.

Getting the dentists there is critical. This credentialing would simplify that tremendously. I think you would see very good results because of that.

The CHAIRMAN. I really appreciate of the Dental Association and individual dentists. Their willingness to do this is just an incredible opportunity. It is something we need to put in place as soon as we can.

I would ask Admiral for your commitment to work with the Dental Association to effectuate that type of credentialing process so that we can get these dentists out there doing the good work they are willing to do.

Mr. BUCHANAN. That is a great question and I am happy to work with the Committee, with Mr. Crowley and Mr. Stier on the issues they have raised.

I wanted to provide a quick update on the credentialing process. We recently awarded a contract for a national credentialing system. We are excited about that. We are rolling that out to four pilot sites across IHS through July. All of our facilities will be on that credentialing system and all of our areas will have that by the end of the year.

We are excited that it will streamline and standardize the process. As a former CEO and former area director, I know what it takes to go through the credentialing process for a provider. It is a huge binder and lots of checks, making sure the provider has the training, credentials, and checking databases. That is just for one provider. That goes on for a long time.

Those documents get rolled up to the area office. My chief medical officer and I will review those. We will signoff. It is a cumbersome process. Putting it in an electronic format, as discussed, is a goal that we are implementing now. We definitely will be happy to work with the Committee.

The CHAIRMAN. How long will it take to get that in place and working?

Mr. BUCHANAN. We have awarded it and have pilots going out right now. We have updated our policies. Of course, with government agencies, you have to create policy and guidance on how to

operate the credentialing system. That is in place and it is going through clearance right now.

Dr. CROWLEY. Senator, if I may. I promise that the American Dental Association will work with the Admiral and IHS to move this forward. We will get out the message to the dentists of America that this opportunity exists for them to help in this process.

The CHAIRMAN. I very much appreciate that, Doctor. Do you have a time frame to have it activated?

Mr. BUCHANAN. We do. By the end of July, we will have it going. It is actually in process right now.

The CHAIRMAN. The end of July?

Mr. BUCHANAN. Yes.

The CHAIRMAN. Good. I thank you both.

Ms. Kitcheyan.

Ms. KITCHEYAN. I am sorry, I have to make a comment.

Although I appreciate the partnership that is being garnered right now, Indian Country does not need more short-term providers. That is not a long-term solution. With all due respect to the panel, I just have to voice that.

The CHAIRMAN. It is not mutually exclusive of long-term solutions. It would be in addition to that.

Ms. KITCHEYAN. There are some creative solutions happening within Indian Country that I would like the Committee to consider. It is just that we don't need more short-term, revolving doors in Indian Country in terms of chronic oral health. We already have that problem on the other side of the aisle. I just want to make that comment so it is clear that Indian Country wants sustainable solutions, not short-term volunteers.

The CHAIRMAN. Absolutely. Thank you.

At this point, I am going to turn over the gavel to Senator Murkowski to preside. Senator Udall also had some more questions. I am turning it over to you.

Senator MURKOWSKI. [Presiding]. Thank you.

I have what is not really a question. I apologize that I was not able to hear the full testimony.

Ms. Kitcheyan, you mentioned some of the innovative solutions that are out there. In Alaska, we led on the middle level provider, the dental health therapist, and the DHATS Program that I think for many years was viewed as far too experimental, that we would see poor health outcomes, and that it was less than acceptable care.

The reality was that getting dentists full-time out to our villages was just not going to happen. We did have a great many dentists who were very generous with their time who would literally volunteer to come out for a month or six weeks in the summer.

However, that meant for a family in a village to wait a full year when your child needed dental care and when you needed dental care. Then when the dentist did come, they literally worked around the clock to provide for the needs.

What we have been able to do with the DHATS Program, I think has been viewed as a model, as remarkable and as a response that was generated by the extraordinary need. What has been very heartwarming to me is to see how over the years, the Dental Asso-

ciation has come to accept, I think is a fair word, that the level of service that has been provided has been important.

We now have preventative care being given in our villages when we had nothing before. It is being done by local people who, when you are in the grocery store and you see an eight-year old, say, how is that flossing coming? That is kind of a reminder instead of waiting and hoping you will have a dentist who actually comes to your village that year.

Being innovative is important. Longer term solutions are important. I think in Alaska we have clearly seen the proven success of mid-level providers.

The Chairman did not give me a list but I am told that Senator Tester has a question.

**STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA**

Senator TESTER. Boy, do I ever. Thank you, Madam Chair.

Admiral Buchanan, what is the biggest challenge IHS has? You have been onboard since when, January. What is the biggest challenge it has, in your opinion?

Mr. BUCHANAN. Recruiting and retention of qualified providers in rural and remote areas.

Senator TESTER. The budget is not a problem?

Mr. BUCHANAN. We are very effective with the resources that we have.

Senator TESTER. You understand that we pay more money for health care for prisoners and our prison system than we do for folks in Indian Country?

Mr. BUCHANAN. I have seen those reports.

Senator TESTER. So you are saying we are spending too much money on prisoners?

Mr. BUCHANAN. I did not say that.

Senator TESTER. I will tell you that I think IHS has a huge problem. That problem is you are dealing with rural areas of this Country where, quite frankly, it is hard to get people because it is tough work, number one, and very challenging work, number two.

I think it is very difficult to keep people when the budget, before ACA, what was the term they used, "If you weren't going to die, you ran out of time." I think that is a huge problem.

The question becomes, you are low on staff, right, just like the private sector, just like the VA, and cannot get enough doctors or nurses. What are you doing about that? How long does it take you to hire somebody in the VA?

Mr. BUCHANAN. It depends.

Senator TESTER. Not the VA, IHS.

Mr. BUCHANAN. I understand. I want to comment a little bit to Senator Murkowski's comments related to the Alaska issues related to DHATS and some other providers.

Last week, I had the opportunity to visit Alaska. I was invited by some of the chiefs to see some of the innovative activities going on. I would be remiss if I did not mention Allakaket Village, Rampart, Marshall, and Bethel, Alaska where they are implementing the DHAT Program and providing the training with some truly in-

novative ways in Alaska in truly challenging conditions. Hats off to them.

We are looking at those as opportunities to move those types of activities forward specifically with developing work groups related to those mid-level activities. That is something we are actually doing and will be implementing very soon in the near future.

Of course, recruitment and retention is a huge challenge. The time that it takes to get a physician onboard can depend. We have implemented the Global Recruitment Initiative where you can announce in one location for a physician and that announcement can go across IHS to a field where that physician wants to go.

To answer your question, we have been able to get a physician on as quickly as 60 days.

Senator TESTER. Sixty days if they were within the VA. What if they are not within the VA?

Mr. BUCHANAN. That is within IHS.

Senator TESTER. I mean within IHS. What if they are not within IHS?

Mr. BUCHANAN. That is actually them coming in off the street into the Indian Health Service.

Senator TESTER. You can get them hired in 60 days? That is not bad.

Have you guys implemented any best practices since you have been head of the IHS?

Mr. BUCHANAN. Specifically related to recruitment and retention?

Senator TESTER. Specifically recruited to patient care, because I think that also impacts recruitment and retention.

Mr. BUCHANAN. Quality is at the focus of everything we do. The quality framework is something we have been implementing. I mentioned one of the items, the credentialing software program that we have rolled out. Patient wait times is another activity where we have identified a standard that is going through our process to formalize. We will have those by July.

We have been implementing telemedicine that recently rolled out in the Great Plains starting with Pine Ridge and Rosebud. Eagle Butte is also on the list and scheduled to roll out today. We have done several things.

Senator TESTER. That is great. What is your wait time standard?

Mr. BUCHANAN. Wait time standard, I have yet to see the document. It is working its way through the process.

Senator TESTER. We would love to have that as soon as you get it.

Lastly, this is for Dr. Crowley and Mr. Stier, very quickly because I am out of time.

Could you give me your top recommendations on how we can recruit better folks to the IHS, whether dentists, MDs or whatever?

Dr. CROWLEY. From my perspective, for dentistry, it is to make it easy for the dentists to get there and actually hire them and bring them on board to do the work.

Senator TESTER. In a timely manner, you are talking about?

Dr. CROWLEY. Yes.

Mr. STIER. My recommendation would be to focus at the top. Make sure that you actually give IHS the tools to recruit the CEOs and the hospital directors they need. They can then do the recruit-

ing for the physicians and other staff that they need. If you do not have the people at the top, nothing else underneath is going to work the way you want it to.

Senator TESTER. Very good.

I want to thank you all for your work. I can tell you that IHS has been a failure, quite frankly. We have had a couple different Administrations; this is the third one, since I have been in the Senate.

One of the best things that transpired for Native Americans is Medicaid expansion because it freed up some money for IHS and helped move the ball forward for people who were not making enough money to be able to afford health insurance.

As we approach taking up a health care bill a week from Monday, as I see a budget that is about \$300 million short, I might be off on that, I think we have some tough decisions to make here. I do not know if we can make them and actually accomplish the trust responsibilities we have for our Native Americans across this Country.

Rear Admiral, I think everyone on this Committee is more than happy to work with you, but you cannot get blood out of a turnip.

Thank you.

Senator MURKOWSKI. Thank you, Senator Tester.

I think Senator Udall and I are both looking at one another as the appropriators on the Interior Appropriations that has the oversight of IHS. I think we want to continue to try to do right by these budgets. You mentioned it is tough but we have an obligation here.

Senator Thune.

STATEMENT OF HON. JOHN THUNE, U.S. SENATOR FROM SOUTH DAKOTA

Senator THUNE. Thank you, Madam Chair.

I thank you and Senator Udall for your indulgence and letting me briefly join the Committee. This is an issue in which, as you know, I have a great interest. It has a profound impact on our State of South Dakota. Thank you for giving me a chance to ask a couple of questions.

I just want to echo what Senator Tester said and say it as plainly as possible. That is that the Indian Health Service just continues to underperform. The consequences continue to negatively impact the quality of care, with sometimes devastating consequences.

What we see is taxpayer dollars get wasted and patients are put at risk. We have significant problems at the facilities in South Dakota. Even after two IHS facilities had entered systems improvement agreements with CMS, they continue to find serious deficiencies at both facilities.

These systemic problems are what prompted Senators Barrasso, Hoeven and I to introduce the Restoring Accountability in the IHS Act, one of the issues we are here to discuss today.

It is long past time to address the problems with IHS. They have been identified time and time and time again. This bill is aimed at giving the Indian Health Service and the tribes the tools they need to provide quality care for patients.

Our tribes deserve better than the status quo. This hearing, I think, is an important first step in getting these reforms passed

through Congress and hopefully to the President's desk for his signature.

I want to ask, if I might, Director Buchanan, a question that has to do deal with what is going on in South Dakota as I referenced earlier. I appreciate the IHS's efforts to address these systemic issues but it seems to me that what my colleagues and I are told by IHS often does not match what is happening on the ground.

You mentioned in your testimony that "In November 2016, IHS launched the Quality Framework and Implementation Plan to strengthen the quality of care and organizational capacity." Yet in April, 12 months after the Rosebud and Pine Ridge IHS facilities entered into their systemic improvement agreement with CMS, unannounced CMS site visits found both facilities out of compliance for failures within the governing body and the quality assessment and performance improvement programs. Even more concerning is feedback from my staff and what I hear from Pine Ridge and Rosebud tribal members that the quality of care has not improved and, in some cases, has gotten worse.

My question is, how can we trust IHS in addressing these issues when CMS site visits and tribal members consistently say otherwise?

Mr. BUCHANAN. That is a great point. I acknowledge the concerns that you bring up. We are implementing the quality framework going forward specifically related to organizational capacity which is one of our priorities.

The other priority is transparency and accountability, communications with the tribe, which I believe we have increased even more so, and accreditation, trying to maintain that going forward. We have been doing several things to make those changes to be more long term going forward.

Implementing the quality framework, putting area quality assurance officers at the area level, at the service unit levels, is another activity we have done. We have doubled our efforts by bringing folks from other areas to assist.

As to Ms. Kitcheyan's point, we do not want short-term fixes. We want them to be sustained over a long period of time.

Senator THUNE. One of the things you state in your testimony is "IHS is committed to regular, meaningful tribal consultation and collaboration for a sound and productive relationship with the tribes." That is your quote.

We continually hear that there is a lack of consultation. It is a complaint I deal with all the time, as does my staff. What steps are you taking, in the midst of this mess that we have in South Dakota, to consult with and hear from the tribes when it comes to some of the issues we have raised about quality?

Mr. BUCHANAN. We have created a template. One of the things that comes to mind is the request for budgets, financial documents, and those sorts of things. As the area director when I was in the Great Plains, I provided those documents, what I thought, at least twice to all the tribal leaders in the Great Plains. There was obviously a breakdown in communication.

Specifically related to the budget issue, we have created a template that we were utilizing for not only the Great Plains but

throughout IHS. It is a template of those financial documents so that we can standardize those and be streamlined.

Some of the other things we are doing is we have had all tribes calls where if an issue is brought up and there are questions, whether related to the budget, we provide budget 101 to increase those communications and transparencies.

When an issue was raised regarding the budget, the \$300 million decrease in the budget, we reached out to all the tribes and had a call to explain the \$300 million reduction and also where that information can be found on websites across the agency.

Senator THUNE. Madam Chair, I want to be respectful with the Committee's time so I have other questions I would like to submit for the record.

I just want to say that I hope this Committee can move quickly on this legislation being discussed today. I think there are some steps in here that will help enormously with some of the issues I identified, certainly with respect to the Great Plains tribal issues but hopefully all across the Country.

Thank you for the time.

Senator MURKOWSKI. Thank you, Senator Thune.

Senator Udall.

Senator UDALL. Thank you. I have just a couple of quick questions.

Ms. Kitcheyan, last year when you testified before this Committee you told us, "Employees need to be held accountable for their actions. No longer can IHS continue to protect, cover up, shuffle, transfer or perpetuate incompetency." That is your quote.

Is it your opinion that the employee accountability problem at IHS stems from fired employees gaming the appeals process and being reinstated or in the alternative, do you believe it comes from a failure of IHS to formally identify and take action against bad employees?

Ms. KITCHHEYAN. I believe it is the failure to take action against bad employees. For so long, there was this system, I know we have used the term "cronyism" where they protected one another. Bad nurses protected other bad nurses.

It had become so egregious that there was just a culture of that amongst my service unit. It is that cronyism that led to some of the deficiencies in patient care because things had become so acceptable because you could just cover it up.

I would say it is directly tied to the relationships they had amongst each other that it never reached area or headquarters.

Senator UDALL. Thank you for that answer.

At our last hearing, I mentioned the Democratic members of this Committee sent a letter to President Trump urging him to exempt Indian programs from a February hiring freeze. Mr. Buchanan, I then asked you if IHS was being impacted by the subsequent "reduction in force" planning ordered by the President. You stated it was not.

However, in her testimony today, Ms. Kitcheyan states, "While hiring freeze waivers were eventually obtained for many IHS positions, it is our understanding that some positions necessary for CMS certification remain under freeze status."

Mr. Buchanan, what is the current hiring status of the IHS? This is really a yes or no answer. Are all critical medical vacancies being actively and expeditiously filled?

Mr. BUCHANAN. Yes, sir.

Senator UDALL. Thank you very much.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you.

We do have a second panel we would like to go to. If there are no further questions, we thank each of you for your testimony here this afternoon and invite the second panel to come before the Committee. We appreciate the patience of each of you in spending time with us.

This afternoon we will hear from Heidi Frechette, Deputy Assistant Secretary, Office of Native American Programs, U.S. Department of Housing and Urban Development here in Washington; Dr. Keith Harris, Director of Clinical Operations, Homeless Programs Office, U.S. Department of Veterans Affairs here in Washington; The Honorable Liana Onnen, Area Vice President, Southern Plains Region, National Congress of American Indians also here in Washington; and our long traveler, my friend, Mr. Mark Charlie, President/CEO, AVCP Regional Housing Authority located in Bethel, Alaska. I think you get the prize for traveling the farthest. We appreciate your making the trip to be here. The panel is rounded out by Sami Jo Difuntorum, Chairwoman, National American Indian Housing Council here in Washington, D.C.

Ms. Frechette, would you begin your testimony. We would ask that you please limit your testimony to no more than five minutes. Your full statement will be incorporated as part of the record.

STATEMENT OF HEIDI FRECHETTE, DEPUTY ASSISTANT SECRETARY, OFFICE OF NATIVE AMERICAN PROGRAMS, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Ms. FRECHETTE. [Greeting in native tongue.] Hello and thank you.

My name is Heidi Frechette. I am the Deputy Assistant Secretary for Native American Programs at the Department of Housing and Urban Development.

Thank you, Chairman Hoeven and Senator Murkowski as well as Vice Chairman Udall, and members of the Committee, for this opportunity to discuss Senate Bill 1275, the BUILD Act, and Senate Bill 1333, The Tribal HUD-VASH Act of 2017.

I also wish to say thank you to the Committee staff for coordinating the hearing and their ongoing engagement with HUD on many Native American issues.

I am honored and humbled to testify with this esteemed panel of tribal leaders, tribal advocates and the Department of Veterans Affairs. As a career SES at HUD, I administer the largest national Indian housing programs and work closely with tribal leaders, tribally-designated housing authorizes known as TDHEs and tribal housing departments who are doing amazing and innovative work in their communities.

Since I began my tenure in June 2016, I have visited Native communities in most of your States to discuss the issues and chal-

lenges tribes face and to hear directly from the tribal leaders on what HUD can do to strengthen Indian housing programs.

Today, one out of every four Native Americans lives in poverty, including more than one-third of all Native American children. Given these grave statistics, HUD looks forward to working with Congress on the reauthorization of the Native American Housing Assistance and Self-Determination Act known as NAHASDA, which authorizes the single largest source of Federal funding for housing in Indian Country.

Tribes have made great strides under NAHASDA and a recently published Indian Housing Needs Study concluded NAHASDA works. Under NAHASDA, tribes have produced more housing units per year and have produced better housing, housing tailored for local conditions, customs and climates.

NAHASDA supports the government-to-government relationship between the Federal Government and tribal governments. It recognizes tribal sovereignty by providing flexibility and local control so that each tribe can decide how to best address the unique housing and community needs.

NAHASDA funds are often used as seed money to leverage funding for new construction and rehabilitation. Last week, I had the honor of visiting the San Felipe Pueblo in New Mexico. The TDHE used their \$500,000 annual IHB block grant, HUD's Title VI Loan Guarantee Program and HUD's Section 184 Program to attract an additional \$5 million in funding to construct a new housing subdivision.

There are examples like this from tribes across the Country. Tribes are leveraging NAHASDA dollars and utilizing other programs such as low income housing tax credits to address their housing needs.

The BUILD Act, in addition to reauthorizing NAHASDA, also seeks to streamline the environmental review process, authorize technical assistance funding for a broader range of TA providers and reauthorize the HUD Section 184 Program, which is a home loan program and is the largest mortgage program for Native American families. HUD looks forward to working with the Committee on this bill.

Senate Bill 1333, the Tribal HUD-VASH Act of 2017, permanently authorizes the current pilot program that HUD is conducting in conjunction with the VA which has made great strides in housing Native veterans in Indian Country. The Tribal HUD-VASH pilot was authorized to reach eligible veterans who were unable to access the general HUD-VASH Program because they were Native and lived on Indian lands.

As of June 1, the Tribal HUD-VASH Demonstration Program has housed 103 veterans in tribal areas. Tribal HUD-VASH has real tangible impacts on veterans' lives. One veteran in the program struggled with substance abuse for many years. Through Tribal HUD-VASH, she accessed safe and affordable housing along with support services to help her combat her addiction.

This alone is amazing. However, equally amazing is to see how her neighboring veterans check in on her and help protect her sobriety by preventing contact from people who come around and try

to trigger a relapse. She is now employed and is maintaining her sobriety.

At Standing Rock, North Dakota, veterans are being housed in Title VI-financed units and the Black Feet Tribe of Montana is finishing construction of 50 new units, 20 of which will be new units, new project-based Tribal HUD-VASH units.

We can see the difference Tribal HUD-VASH is making in the lives of individual veterans. HUD is committed to serving this population. We look forward to working with Congress, VA and IHS to ensure that they are well served.

In closing, HUD's Indian housing programs do more than just build homes. They bring hope to communities. Last week, I visited a tribe and was invited into a new home of a mother and her four children.

Often on my visits to tribal communities, I am shown vacant units so that we do not disturb families in their homes. I was surprised this mother was so insistent that we visit her house. When we arrived, we were welcomed by the grandmother because the mother was at work. The grandmother was accompanied by her eight-year old granddaughter who was out of school for the summer.

It was so moving to see how happy and excited this young girl was as she moved out of overcrowded conditions. She insisted on giving me a tour of her new home. She was particularly proud to show me her new bedroom which she pointed out she did not have to share with her three little brothers. That was very important to her.

Senator MURKOWSKI. Ms. Frechette, if you can wrap up, you are well over your time. I am sorry because it is a very compelling story.

Ms. FRECHETTE. I will hurry.

As I left, I thanked the grandmother for hosting us and she gave me a hug and thanked me for the hope and opportunities the HUD programs provide. That is the gist of why we do what we do. I was encouraged by the difference the tribe made, the TDHE made and is making in the lives of people utilizing HUD programs.

Thank you. It was an honor to appear before you. I am happy to answer any questions you may have.

[The prepared statement of Ms. Frechette follows:]

PREPARED STATEMENT OF HEIDI FRECHETTE, DEPUTY ASSISTANT SECRETARY, OFFICE OF NATIVE AMERICAN PROGRAMS, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Thank you Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, for this opportunity to discuss Senate bill 1275, "Bringing Useful Initiatives for Indian Land Development Act" (BUIILD Act), and Senate bill 1333, "Tribal HUD-VASH Act of 2017", providing rental assistance to Indian veterans who are experiencing or at-risk of homelessness through the tribal Department of Housing and Urban Development—Department of Veterans Affairs Supportive Housing Program (Tribal HUD-VASH). I also wish to acknowledge and thank the Committee's staff, not only for coordinating this hearing, but also for their ongoing engagement with HUD staff on the many issues that impact the Native American communities across our nation.

As the Deputy Assistant Secretary for Native American Programs, I have had the opportunity to visit Native communities to learn first-hand about the issues and challenges the tribes face, and to hear directly from tribal leaders what we need to do to strengthen and improve HUD's policies and programs for Native Americans.

Far too many Native American communities struggle with severely overcrowded housing, affordable housing shortages, substandard living conditions, and significant barriers to economic opportunity.

Today, one out of every four Native Americans lives in poverty—including more than one-third of all Native American children. Far too many families live in unacceptable circumstances and face a future that lacks educational and economic opportunity. In the last 14 years (2003–2016), the number of low-income families in the Indian Housing Block Grant (IHBG) formula areas grew by 44 percent and now exceeds 322,000 families. The number of overcrowded households, or households without adequate kitchens or plumbing, grew by 23 percent to over 111,000 families. Finally, the number of families with severe housing costs grew by 58 percent to over 66,000 families.

To put these numbers in greater perspective, American Indian and Alaska Native people living in tribal areas in 2006–2010 had a poverty rate and an unemployment rate that were approximately twice as high as those rates for non-Indians nationally. American Indian and Alaska Native people in large tribal areas were more than 8 times as likely to live in housing that was overcrowded, and more than 6 times as likely to live in housing that did not have adequate plumbing facilities than the national average.

HUD looks forward to working with Congress on reauthorization of the Native American Housing Assistance and Self-Determination Act (NAHASDA), which authorizes the single largest source of Federal funding for housing in Indian Country. Tribes have made great strides under this legislation. The recently published *Housing Needs of American Indians and Alaska Natives in Tribal Areas*, the product of a congressionally mandated, multi-year study of housing needs and conditions in Indian Country concluded, “. . . tribes have demonstrated the capacity to construct and rehabilitate housing for low-income families at substantial levels under the NAHASDA framework.” Since 1998, under NAHASDA, tribes have not only produced more housing units per year, but they have produced better housing—housing that is tailored for local conditions, customs, and climates. Tribes also use the flexible block grant in many different and innovative ways to address unique local needs, such as assisting college students with housing, counseling prospective homeowners, providing self-sufficiency training to residents, and maintaining critical community infrastructure.

NAHASDA supports the government-to-government relationship between the Federal Government and tribal governments, established by long-standing treaties, court decisions, statutes, Executive Orders and the United States Constitution. NAHASDA recognizes the importance of tribal sovereignty and is designed to provide flexibility and local control, so that each tribe can decide how best to address its unique housing needs and economic priorities.

Since 2014, HUD has led a workgroup of several Federal agencies to develop a coordinated environmental review process for housing and housing-related infrastructure in Indian Country, as directed by the report of the Senate Appropriations Committee. HUD issued a Final Report on the workgroup’s activities in December 2015. The Final Report and its recommendations would not have been possible without the invaluable input of numerous tribal leaders and Indian communities. The workgroup interviewed tribes and tribally designated housing entities (TDHEs) about their existing environmental review processes. Tribes and TDHEs participated in a series of briefings and listening sessions around the country to explain this effort and discuss their concerns and suggestions. Additionally, two formal tribal consultations were held to discuss findings, seek feedback, and garner additional information regarding processes and barriers. HUD is very grateful to those who generously gave, and continue to give, their time and attention to this effort.

The Final Report made several recommendations, including measures that could be taken to coordinate agencies’ environmental review processes within existing frameworks and processes. The workgroup continues to meet to implement the recommendations of the Final Report. The workgroup is finalizing a Memorandum of Understanding to encourage the use of National Environmental Policy Act efficiency tools, and is drafting an implementation plan that puts forth action items derived from the recommendations of the final report and tribal consultation. The goal of the workgroup is to facilitate a more efficient environmental review process by being responsive to the Final Report recommendations, and to the continued input of tribal leaders.

The BUIILD Act would expand tribes’ ability to assume responsibility for environmental review, decisionmaking, and action to include all federal agency funded actions associated with a NAHASDA section 202 funded project. This would facilitate a more efficient environmental review process since tribes are already authorized to complete the review process on behalf of HUD, which is typically the largest

source of funding for these projects. The environmental review would include the HUD review requirements, plus any additional laws and authorities that are required for the other funding agencies.

Additionally the BUIILD Act provides that Indian Housing Block Grant (IHBG) funds may be used to meet matching or cost participation requirements of other Federal and non-Federal programs; as well as extend the maximum period that trust or restricted Indian lands can be leased for residential purposes from 50 years to 99 years. We look forward to working with Congress to develop these ideas.

HUD recognizes the importance of assisting tribes and their housing entities to increase their capacity and technical expertise. HUD is committed to exploring ways to use its technical assistance to help tribes enhance their development efforts and to better leverage the assistance they receive through the dissemination of successful tribal strategies that meet the urgent housing needs of tribal communities. The BUIILD Act would authorize technical assistance funding to a broader range of TA providers than is currently authorized by NAHASDA.

The BUIILD Act provides continued authorization of the Section 184 Indian Home Loan Guarantee Program. HUD continues to be the largest single source of financing for housing in tribal communities. The Section 184 program is the primary vehicle to access mortgage capital in Indian communities. As of December 31, 2016, the program has guaranteed a cumulative total of 36,324 loans with a principal balance of more than \$6 billion. In January 2017, as part of the congressionally mandated Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs, HUD published, *Mortgage Lending on Tribal Land: A Report from the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs*. The report finds that the Section 184 program successfully eliminates the functional market barrier to private lending presented by tribal trust land.

The Section 184 program is the primary vehicle to access mortgage capital in Indian communities. The program helps tribes promote the development of sustainable reservation communities by making homeownership a realistic option for tribal members. It provides access to market-rate, private mortgage capital, and is not subject to income restrictions. The Section 184 program does not have minimum requirements for credit scores, and allows for alternative forms of credit and non-traditional income to address specific issues within the Native American communities. The program gives Native Americans from across the income spectrum the choice of living in their native community. In addition to individual Indians, tribes and tribally designated housing entities (TDHE) are eligible borrowers. This benefit of the program makes it possible for tribes and TDHEs to address housing shortages by developing and financing rental housing or by promoting homeownership opportunities for tribal members through lease purchase programs.

As of June 1, 2017, the Tribal HUD-VASH demonstration program has housed 103 veterans in tribal areas who were homeless or at-risk of becoming homeless. Approximately 201 Native American veterans are in case management with VA and may soon receive housing assistance under this program. Tribal HUD-VASH is an offshoot of the standard HUD-VASH program, which has been successful in many communities across the country but unable to reach eligible Native American veterans living on tribal lands, largely because tribes and TDHEs were not eligible to administer the program. HUD is committed to serving this population and looks forward to working with Congress to ensure they are well-served.

HUD has been working tirelessly with VA to coordinate services and case management with housing. The program is housing families and helping veterans struggling with substance abuse and other mental health issues. One of the first veterans who was housed and received supportive services was a female veteran with a young daughter living in a trailer in severely overcrowded conditions. She and her daughter moved into their new home and for the first time in her life her daughter had her own room and a quiet place to do her homework.

Another very moving story is about a veteran who had struggled with substance abuse for many years. Through Tribal HUD-VASH she was able to access safe affordable housing and support services to help her combat her addiction. The other veterans living nearby looked out for her and protected her sobriety by helping prevent contact from people who might trigger a relapse. She now is employed and is maintaining her sobriety.

Some of the challenges HUD and VA have faced in implementation are identifying adequate housing stock and locating veterans who are eligible for and need access to the HUD-VASH program. Given the overall shortage of housing units in Indian Country and the limited number of private rental units, many tribes have found it difficult to find units for their veterans and are using their own NAHASDA housing stock to house the veterans. While this approach provides a home for a Veteran who has experienced homelessness, it does not create a net increase in the number of

affordable housing options available to tribal members and means that the unit is not available as an opportunity for another household on the tribe's waiting list. Attempts to house veterans in private rental units near tribal lands are mixed. Some veterans, predominately younger veterans, are willing to move off tribal lands to obtain housing. Many, especially elderly veterans, are not willing to leave their community to obtain housing.

Some tribes are using project-based rental subsidies to develop new units; however, many are reluctant to leverage the funding provided by the program for new units since the program continues to be a "demonstration."

Finding eligible veterans who are experiencing or at-risk of homelessness in Indian Country can be difficult because they are often in overcrowded and transient situations. In Indian Country, there are rarely emergency shelters for people who are experiencing homelessness which can be used as a way to identify homeless veterans. There are also typically few people experiencing unsheltered homelessness in Indian Country, as community members take in veterans experiencing homelessness, oftentimes creating overcrowded situations, and those veterans often have to "couch surf" from one family member's home to another.

To fully leverage Senate bill 1333, HUD seeks to strengthen its partnership with the Indian Health Service (IHS), and continue to work with VA to better identify veterans experiencing homelessness in Indian Country. IHS serves eligible American Indian/Alaska Native veterans in IHS operated health care facilities and programs. Through an agreement between IHS and VA's Veterans Health Administration, VA reimburses IHS for the direct health care services of these veterans. An enhanced partnership could help identify eligible veterans by linking veterans who are being served by IHS health facilities with the Tribal HUD-VASH program. Another potential outcome of an IHS, HUD, and VA partnership is to explore the possibility of using IHS's telemedicine network to deliver VA case management to more remote locations.

In conclusion, HUD's Indian Housing programs, including IHBG, Section 184, and the Tribal HUD-VASH program are all successful examples of federal programs that provide local choice, under streamlined governmental requirements, and leverage private market investment while respecting tribal self-governance.

Thank you again for this opportunity to appear before you today. I would be happy to answer any questions you may have.

Senator MURKOWSKI. Dr. Harris.

STATEMENT OF DR. KEITH HARRIS, DIRECTOR OF CLINICAL OPERATIONS, HOMELESS PROGRAMS OFFICE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. HARRIS. Thank you, Madam Chair Murkowski, Vice Chair Udall and members of the Committee.

I want to thank you for the opportunity to discuss the Tribal HUD-VASH Act of 2017 and our experience at VA of implementing this demonstration program.

I would like to begin by stating emphatically it remains a key priority for VA to end veteran homelessness, especially as it applies to our homeless and at risk Native Americans living in their tribal communities.

I think my comments will be most useful if I focus on VA's experience in implementing the demonstration program, some lessons learned there, as well as how they might apply to the new bill.

The current status, as you just heard in testimony, there are approximately 200 veterans in their demonstration program now, 103 of them as of June 1, are housed. The remainder, about two-thirds, are essentially holding a voucher as we would say in the standard program and the remaining one-third entered into case management and were referred to the tribal housing authority.

I want to speak to VA hiring and case management. I know that is an interest, especially in Alaska, of the Committee and I assume of my fellow panel members.

Of the 25 active sites, 21 have a case manager onboard either through VA hiring or contract. Two others have been selected and are in the on-boarding process and/or moving to their location. That leaves two vacancies. One is in Montana and the other, as you know, Senator Murkowski, is in Bethel, Alaska.

In both of those remaining cases, they have been very difficult to fill because of the remote nature of the location. I am pleased to report a couple of things. One is that both medical centers have agreed to search for broader disciplines than social work only. They are looking at licensed marriage and family therapists, for instance, and clinical mental health counselors.

Both medical centers have also, at our urging, agreed to introduce recruitment incentives into the recruitment process. I am very pleased to say I actually just today authorized funding from our office for both recruitment incentives and permanent change of station to Bethel. We are hopeful that by broadening the disciplines and increasing the incentives, we can get those positions filled.

All medical centers are also working on providing temporary case management in the case of vacancies so that we can move veterans forward in the program even in those areas.

I wanted to touch on a couple of lessons we have learned. First is, partnership is necessary and critical in this program. We have an excellent collaborative relationship with our partners at HUD; within VA, with the Office of Government and Tribal Relations; and certainly, with all of the tribes we have worked with.

This has been particularly important in developing new policies. We built this program from the ground up. There are differences in this model and some of the rules with tribal entities especially regarding substance use. There is a lot of work and a lot of negotiation around that. Partnership has been excellent.

On the flip side, despite a lot of work, I think on both sides, we were unable to achieve a partnership with IHS to enter an agency agreement. We worked for several months on that. I am pleased to see language in the bill bringing IHS back to the table. We are excited to work with them and hope to achieve further partnership with them as this program expands.

I will touch on other challenges just briefly. People are well aware of this already. Housing stock is a very difficult challenge, especially on reservations. Finding eligible veterans is a challenge both at a macro and micro level. It is difficult to quantify need. The typical way is the Federal Government does this through its standard PIT count, point in time count, and it doesn't necessarily work or apply on Federal lands.

At a micro level, some of the tribes and some of the medical centers have had trouble finding enough eligible veterans for this program. I know that VA hiring, especially in remote areas, is particularly challenging.

I just want share really quickly, I reviewed feedback from all the medical centers running this program. It really was striking to me the number of them that noted the value and importance of permanent housing and the case management tied to that.

We have seen many stories of people gaining employment, education or training, family reunification and stabilization of mental health and substance use symptoms. I think it is a testament to

the housing, first, the model this program was based on and I think it is great evidence for continuing and expanding it in the future.

Thank you very much for the opportunity today. I look forward to any questions.

[The prepared statement of Dr. Harris follows:]

PREPARED STATEMENT OF DR. KEITH HARRIS, DIRECTOR OF CLINICAL OPERATIONS,
HOMELESS PROGRAMS OFFICE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Chairman Hoeven, Vice Chairman Udall, and distinguished Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) efforts to end homelessness among Veterans and specifically Native American Veterans, including legislation regarding the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program. Unfortunately, VA did not receive the draft bill regarding this program in sufficient time to fully coordinate views on the bill. We will follow up with the Committee as quickly as possible to provide comments on the draft bill.

Ending homelessness among all Veterans, including Native American Veterans, is a VA priority. The HUD-VASH Program is a collaborative program between HUD and VA which combines HUD housing choice vouchers with VA supportive services to help Veterans experiencing homelessness and their families find and sustain permanent housing. Through public housing authorities, HUD provides rental assistance vouchers for privately owned housing to Veterans eligible for VA healthcare services who are experiencing homelessness. VA case managers connect these Veterans with support services such as health care, mental health treatment, and substance use counseling to help them in their recovery process and with their ability to maintain housing in the community. Among the VA programs addressing Veteran homelessness, HUD-VASH enrolls the largest number and largest percentage of Veterans who have experienced long-term or repeated homelessness. Since 2008, HUD-VASH has admitted over 180,000 homeless Veterans to case management.

Historically, legal rules have prevented Tribes or Tribally Designated Housing Entities (TDHE) from participating in the HUD-VASH program. In December 2014, Congress authorized funding for a Tribal HUD-VASH demonstration program, which targets housing and supportive services to Native American Veterans who are homeless or at risk of homelessness and who are living on or near a reservation or other Indian areas. Under the first-ever Tribal HUD-VASH Program, 26 tribes share \$5.9 million in funding for rental assistance. Case management and supportive services are primarily provided by VA for participating Native American Veterans.

Tribal HUD-VASH is modeled on the standard HUD-VASH program, which combines HUD rental assistance for homeless Veterans with VA case management and clinical services. In the program's first year, HUD and VA are working to implement the program and have begun to lease the 500 housing subsidies allocated for the demonstration program and to provide supportive services. Some of the rental assistance will be used as project based unit subsidies, supporting development of affordable housing stock on tribal lands. Consistent with other project based housing, some of these units are in development or otherwise not yet active.

Implementation of Tribal HUD-VASH

Tribal HUD-VASH is a program that requires strong collaborative and coordinated efforts from the involved partners, including VA, HUD, the tribes and tribal housing authorities, as well as the tribal Veterans Service Officers and other community partners. In implementing this program, VA and tribal entities have developed policies and procedures related to assessment, screening, referral, and entry into the program, and have worked together to identify and engage eligible Veterans. Community partnerships are needed to ensure that additional resources are available for supports that VA is not able to provide, such as services for the Veteran's family members.

When a potentially eligible Veteran is identified, VA conducts the initial screening to determine if the Veteran meets basic eligibility criteria, including determination of homelessness or at risk of homelessness status, eligibility for VA health care, and the clinical need for case management services. As in the standard HUD-VASH program, eligible Veterans must agree to participate in VA case management to receive Tribal HUD-VASH assistance as one of the eligibility criteria, particularly as this program provides permanent supportive housing, not housing only. The tribally des-

ignated housing entity (TDHE) makes its own eligibility determination after VA referral. TDHE eligibility includes meeting Native American criteria, income threshold, and state lifetime sex offender prohibitions.

Goals of Tribal HUD-VASH include improved physical and/or mental health, employment, education, and/or goals the Veteran chooses for himself/herself. Substance use can have a significant impact on Veterans' ability to achieve and sustain housing stability and related goals, addressing substance use is a significant focus of the services provided to Veterans within the Tribal HUD-VASH program. Through Veteran-centered services, HUD-VASH case managers support Veterans to achieve their goals regarding substance use and recovery, and Veterans are provided access to VA behavioral health care services and substance use treatment.

Tribes and TDHEs deliver tenant- or project-based rental assistance to eligible Native American Veterans who have been screened for eligibility by VA and the Tribe or TDHE. VA prioritizes eligible Native American Veterans with the greatest need for case management. VA must document the assessment and screening process in the Veteran's medical record and in VA's Homeless Operations Management and Evaluation System (HOMES). The tribe or TDHE must maintain written documentation of all referrals and housing eligibility screening in the Veteran's file, as well as electronically report participant data as required in the Federal Register implementation notice, Vol. 80, No. 203. VA may provide case management services directly or via contract with a Tribal health care provider for service delivery. A Tribe or TDHE may partner with VA to provide office space for the VA case manager, or VA, in coordination with the Tribe, or TDHE may partner with IHS to provide space for VA case management at an IHS facility. Services may include substance use treatment, mental health care, health care, job training, and education about tenancy rights and responsibilities.

Similar to the standard HUD-VASH program, Native Americans are housed under Tribal HUD-VASH based on a Housing First approach. This means that Veterans are provided housing assistance, along with case management and supportive services to foster long-term stability to prevent a return to homelessness. Housing First provides immediate access to housing without prerequisites, such as sobriety or the demonstrated absence of current substance use. This approach targets those who are homeless and have complex clinical needs. There are two main components to Housing First: permanent housing and wrap around services to support continued tenancy. Housing First uses a treatment philosophy that is consumer-directed and Veteran-centric.

Housing First is a research-based approach based on the premise that supportive services are more effective when the daily stress of being homeless is relieved. The key principles of Housing First as it is applied under HUD-VASH policy are: respect, warmth, and compassion for all Veterans; Veteran choice and self-determination; a recovery-oriented approach; and utilization of Harm Reduction strategies to assist Veterans to understand and reduce the impact any substance use may be having on their housing stability and the achievement of their goals.

Informed by the evidence that housing stability enhances the ability of Veterans to seek and engage in appropriate health and behavioral health care services including substance use treatment, Housing First approaches do not require sobriety as a precondition for obtaining or sustaining tenancy, and such criteria are not required within leases. With a focus on Veteran-driven services, mandatory testing for substance use is not implemented, but assisting Veterans to achieve and sustain recovery is a significant focus of the case management and other supportive services delivered, and Veterans are linked to appropriate treatment and behavioral health care services as needed. VA and tribal grantees work together to establish eligibility, case management, outreach strategies and next steps. All partners work to develop processes that obtain and sustain housing for eligible Veterans. Every partner provides points of contact for all involved agencies. Additionally, VA and tribal grantees work with community agencies such as tribal Veterans' services/offices, tribal law enforcement, health agencies, drug and alcohol service providers, and others to let them know about this potential resource for Native American Veterans who are homeless or at risk of homelessness.

Eligible Native American Veterans and their families pay no more than 30 percent of their monthly-adjusted income, as outlined in the Tribal HUD-VASH implementation notice. Tribes or TDHEs pay the difference between the rent and the Veteran's rent contribution with the Tribal HUD-VASH rental assistance. Tribes or TDHEs may also negotiate the inclusion of utilities in payment contracts with housing owners. Funds may cover any additional costs related to housing Native American Veterans under this program.

To date, Tribal HUD-VASH has 103 Veterans housed, with another 98 Veterans currently enrolled and in the process of becoming housed. Many of these Veterans

are married or have children residing with them. In addition, several Veterans have engaged in employment opportunities, or have enrolled in education or training programs, now that they are housed.

With regard to other bills on the agenda, S. 1250, the Restoring Accountability in the Indian Health Service Act of 2017, we defer to the Department of Health and Human Services, Indian Health Service, for views and comments. We note for that same bill certain portions of the text reflects the language in 38 U.S.C. § 713(e), the constitutionality of which was successfully challenged in *Helman v. Department of Veterans Affairs*, case 2015-3085 (Fed. Cir. May 9, 2017). We defer to the Department of Justice for further comment on that issue. We defer to the Department of Housing and Urban Development with respect to S. 1275, the Bringing Useful Initiatives for Indian Land Development Act of 2017 or BUIILD Act of 2017.

VA remains steadfast in our commitment to end homelessness among all Veterans, no matter their circumstance or background, with recognition of the special efforts needed to reach especially vulnerable Native American Veteran populations. We are fortunate to have robust partnerships with HUD, other Federal agencies, and tribal organizations in that effort. Thank you and I look forward to your questions.

Senator MURKOWSKI. Thank you, Dr. Harris.
Ms. Onnen, welcome.

**STATEMENT OF HON. LIANA ONNEN, VICE PRESIDENT,
SOUTHERN PLAINS REGION, NATIONAL CONGRESS OF
AMERICAN INDIANS (NCAI)**

Ms. ONNEN. Good afternoon, Madam Chairwoman, Mr. Vice Chair and members of the Committee.

My name is Liana Onnen. I am an Area Vice President for the National Congress of American Indians, Chairwoman of the Prairie Band Potawatomi Nation, and a former housing director for my tribe.

I want to thank you for holding this important hearing and allowing me to testify specifically on two important pieces of legislation that will address housing issues throughout Indian Country.

The first bill focuses on reauthorization of the Native American Housing Assistance and Self-Determination Act which has not been reauthorized since 2013. The second addresses the important issue of providing housing opportunities for our Native veterans.

The housing needs in Indian Country are great. I would even say that the lack of housing is at a crisis point. I know this because in Indian Country, we are well aware of the lack of basic housing in our communities.

We are aware of the overcrowding that often means multiple families are living under one roof in a three-bedroom house. We know that in many of our communities, we lack the basic infrastructure to provide for housing, even when we can afford to build the houses.

At NCAI, we have long advocated for increased attention to housing programs. We have long supported reauthorization of NAHASDA but we are also aware that to truly address the housing needs in tribal communities, we also need to look at innovative ways to not only address the basic needs of our tribal citizens, but also to provide homes for teachers, public safety professionals and health care providers. It is not possible for us to recruit and retain these vital services to our communities if we lack basic housing.

The recently released Housing Needs Assessment highlighted the housing needs we are addressing today. That report, based on a small sampling of individual households, tribes, tribally-designated

housing entities, and Native Hawaiians focused on three factors: one, demographics, social and economic conditions; two, housing conditions and needs; and three, housing policies and programs.

That study is beneficial to illustrate the need in Indian Country, but it was only a small sampling, so we strongly recommend that Congress request a more comprehensive study of the housing needs in tribal communities. Without accurate data about the true need, we will continue to be under funded.

You and your colleagues in Congress rely on data to show need and more importantly, to show results when scarce Federal funding is provided to Federal programs. The NAHASDA funding has been stagnant for nearly a decade, while the housing need only continues to grow.

NCAI supports the reauthorization of NAHASDA as well as the comprehensive review of other programs and innovative ways to address the housing needs in tribal communities. We stand ready to assist you in engaging tribal leaders across Indian Country to bring solutions to housing needs.

NCAI's membership has strongly supported reauthorization of NAHASDA and passed a resolution to that effect at our 2013 mid-year conference in Reno. That resolution is entitled, Support for the Immediate Reauthorization of the Native American Housing Assistance and Self-Determination Act.

NCAI resolutions remain the standing policy of NCAI until withdrawn or modified by subsequent resolution. Therefore, we continue to strongly advocate for reauthorization of NAHASDA during this Congress.

NCAI also has a resolution passed during the same mid-year conference that supports reauthorization of the Native Hawaiian programs as part of the overall NAHASDA reauthorization. Support reauthorization of the Title VIII part of the overall reauthorization of NAHASDA programs is the name of that resolution.

NCAI's membership has also strongly spoken on the need to ensure that any overall reauthorization also includes the Native Hawaiian programs. This is important to our membership because the housing needs of our Native Hawaiian brothers and sisters are just as critical as those throughout Indian Country.

There are other provisions contained in the bill that NCAI will seek additional tribal input on. NCAI is encouraged that the bill contains provisions to streamline NEPA requirements by affirming a lead agency to assist tribes and remove bureaucratic hurdles for environmental reviews. NCAI is consulting with tribal leaders this week to seek their views on this provision.

In addition, we are seeking additional tribal input on the 99-year leasehold interest in trust or restricted land for housing purposes. We are encouraging this Committee to consult with tribes so that we can ensure this provision would not create unintended hardship for tribes at the end of these leasing terms.

In closing, I would again like to thank you for allowing NCAI to be here to discuss the housing needs in Indian Country. We stand ready to assist you as this legislation moves forward for consideration by this Committee and this Congress.

I am happy to answer any questions you may have.

[The prepared statement of Ms. Onnen follows:]

PREPARED STATEMENT OF HON. LIANA ONNEN, VICE PRESIDENT, SOUTHERN PLAINS
REGION, NATIONAL CONGRESS OF AMERICAN INDIANS (NCAI)

Good Afternoon. On behalf of the National Congress of American Indians (NCAI), I would like to thank the Chairman Hoeven, Vice-Chairman Udall and other distinguished members of the Committee for the opportunity to provide testimony about our views on S. 1275, and HUD-VASH. NCAI is the oldest and largest national organization representing American Indian and Alaska Native tribal governments in the United States. We are steadfastly dedicated to protecting the rights of tribal governments and the achievement of self-determination and self-sufficiency. NCAI looks forward to working with this Committee to ensure that the recommendations from the Committee's hearing process today take into account the unique needs of Indian Country.

NCAI has been working diligently with tribal governments and other national tribal organizations to find solutions to protect and improve the infrastructure, health and welfare of Indian Country. Reauthorization of housing programs for tribal governments and citizens is a key component of meeting the infrastructure needs of tribal communities.

The accessibility and condition of housing and other related physical infrastructure needed in American Indian, Alaska Native and Native Hawaiian communities continues to lag far behind that in all other segments of the U.S. population. Providing quality and safe housing within tribal communities for members and essential employees is crucial for the health and welfare of those communities. Without a vibrant housing sector, tribal governments cannot recruit or retain essential employees such as doctors and nurses, law enforcement personnel and teachers who are vital to ensuring the health, safety and education of their members and a thriving community. Moreover, given the shortage of supply and problem of undersized homes for Indian households, many families are forced to live in overcrowded conditions that negatively impact the lives of Native families, children and elders virtually all areas of their lives.

S. 1275: Bringing Useful Initiatives for Indian Land Development Act of 2017

NCAI agrees with and is willing to work with the Committee on the reauthorization of NAHASDA. NCAI's comments regarding S. 1275, *Bringing Useful Initiatives for Indian Land Development Act of 2017 (Build Act of 2017)* are outlined below by Section.

Section 2: Environmental Review

Tribes have requested a streamlined approach to NEPA requirements that are already authorized in statute, and request identification of a lead agency when there are multiple federal agencies in one project. It has been difficult to get the federal agencies to remove the barriers that keep their work in silos and to agree to accept the review and determination of another agency. HUD issued a notice entitled PIH-201622 Environmental Review Requirements for Public Housing Agencies that aims to implement a lead agency for environmental review to address the inter-agency coordination.

NCAI is encouraged that this section affirms the lead agency provision and allows the governmental review requirements to be satisfied by the tribe or its tribal housing authority. NCAI will review this provision as drafted with tribes at our mid-year conference this week and we will be glad to share the comments we receive with the Committee.

Section 4: 99-Year Leasehold Interest in Trust or Restricted land for Housing Purposes

The legislation authorizes all tribal trust or restricted lands to be leased for up to 99 years for residential purposes and NCAI urges further consultation with tribal leaders on this issue. Before 1955, except in rare and localized circumstances (for example, Salamanca and the congressional villages on the Seneca Nation's Allegany Reservation), surface leasing of Indian lands had been limited to 5- or 10-year periods, which are appropriate for agricultural leases, but not for commercial, residential, industrial and other uses promising major economic returns. In 1955, Congress passed a statute (now codified as 25 U.S.C. 415) allowing all tribes and individual Indians to lease trust and restricted lands for up to 25 years, with the possibility of an additional renewal term of 25 years while retaining shorter limits for agricultural leases. Amendments to the 1955 Act have allowed longer lease terms for business purposes, usually up to 99 years, for over two dozen specified tribes.

We urge further consultation with tribal leaders on the concept of 99 year leasing for residential purposes, particularly where large tracts of land could be leased for

non-Indian residential leasing. Even if a 99 year lease may be authorized, the Tribe should retain the right to a term of less than 99 years.

Section 6: Loan Guarantees for Indian Housing

NCAI supports the reauthorization of Section 184, and it is vital for Congress to continue this program which increases tribal homeownership. However, the Committee needs to be aware of the small percentages of acquiring home loans on Indian reservation land.

Native Community Development Financial Institutions, or CDFIs, are critical to closing the homeownership gap in tribal communities. A recently released study *Access to Capital and Credit in Native Communities* concluded that Native people residing in tribal communities “who wish to buy a home. . . have much better options now than they did [in 2001]: they have access to a [Native CDFI] that can help them realize their ambitions.”

Loan guarantees enable Native CDFIs to leverage the financing necessary to provide low-interest mortgage loans to Native people who otherwise would not have any other affordable options. Native CDFIs also provide mortgage loan recipients with credit counseling, home ownership preparedness training, and the ongoing support they need to stay in the homes that they purchase.

Section 7: Leveraging

NCAI supports the clarification that all NAHASDA funds meet the full faith and credit for leveraging funding from other federal programs and is essential to the leveraging needs in Indian Country.

Native Hawaiian Housing Programs

As much as the need for housing is a priority for Indian Country, NCAI is concerned with the S. 1275, the Build Act, because this proposed legislation leaves out the Native Hawaiian Housing Block Grant and Native Hawaiian Guarantee Home Loan Programs within the NAHASDA reauthorization title. The exclusion of the Native Hawaiian housing programs sets a harmful precedent for federal programs serving American Indians, Alaska Natives, and Native Hawaiians. NCAI stands with our Native Hawaiian brothers and sisters and requests the committee to include Native Hawaiians in the NAHASDA Reauthorization. Please refer to NCAI's resolution #REN-13-017, Support Reauthorization of Title VIII Part of the Overall Reauthorization of NAHASDA Programs.

Housing Needs Assessment

Earlier this year, the U.S. Department of Housing and Urban Development (HUD) released a study entitled, *“Housing Needs of American Indians and Alaska Natives in Tribal Areas: A Report From the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs.”* This report provided the results of a multi-year study based on interviews of individual households, tribes and Tribally Designated Housing Entities (TDHE), and Native Hawaiians. The report focused on three factors related to housing needs: (1) demographic, social and economic conditions; (2) housing conditions and needs; and (3) housing policies and programs.

The study confirmed what we already know about the needs and barriers to adequate housing in Indian Country. The main housing needs are tied to: structural deficiencies (i.e. plumbing, kitchen, heating and electrical); inadequate housing conditions; overcrowding; and the need for Congress to provide funding that will enable, and not hinder, tribes from meeting the needs for their communities. According to the study, 33,000 new housing units are needed to alleviate housing overcrowding and an additional 35,000 housing units are needed to replace existing housing units in severe condition. The estimate to construct new and replace existing housing totals over \$33 billion (based on a HUD calculation of the average construction costs of a three-bedroom house).

NCAI encourages Congress to work with tribal governments to find solutions to ensure adequate funding and oversight that enables tribes and federal agencies to have the data and other resources needed to truly determine the need for housing throughout Indian Country. We are confident that once there is consistent housing needs data, it will provide much needed information that shows the relative housing needs and tribal government accountability. This report is the only current study that identifies the data, information and needs of housing in Indian Country. However, the study was limited in scope, and the comprehensive needs in Indian Country have yet to be determined. This needs data will enable this Committee and Indian Country to advocate for the appropriations and policy considerations necessary to bring adequate housing to Indian Country.

S. _____ HUD/VA Veterans Affairs Supporting Housing, and for other purposes

NCAI and its members strongly support the Tribal HUD-Veterans Affairs Supportive Housing Program (HUD-VASH) program and expansion of HUD-VASH on tribal lands. American Indians serve in their country's armed forces in greater numbers per capita than any other racial and ethnic group, and they have served with distinction in every major conflict for over 200 years. Homelessness among Native Veterans is a serious issue throughout Indian Country. However, the current HUD-VASH program does not include its impact on tribal lands. In 2015, the HUD-VASH demonstration program was created to address at-risk and homeless Veterans on tribal lands. For the first time, tribes and tribal Veterans organization were eligible to apply for HUD-VASH funding. Funding for the HUD-VASH program increased from \$5.9 million to its current funding level of \$7 million for enacted FY 2017.

The HUD-VASH program is a successful program nationwide. However, without providing funding for tribes, it is virtually impossible for tribes to utilize this program. Tribes request the same opportunity given to all of America's local municipal governments. According to a 2016 HUD Annual Report on Homelessness that estimated the number of homeless Veterans, "the remaining five percent were of Native Americans, Pacific Islander, or Asian descent." Please refer to NCAI resolution # ECWS-14-001, Support for Indian Veterans Housing Rental Assistance Demonstration Program in the Native American Housing and Self-Determination on Act Reauthorization.

Conclusion

NCAI thanks the Committee for its commitment to the important goals of tribal self-determination through flexible and effective housing policy for American Indians, Alaska Natives, Native Hawaiians and Native Veterans. We look forward to working with the Committee to take the necessary steps to support tribes as they improve the housing conditions in their communities and to effectively respond to the changing economic environment.

Senator MURKOWSKI. Thank you, Ms. Onnen.
Mr. Charlie, welcome to the Committee.

STATEMENT OF MARK CHARLIE, PRESIDENT/CEO, ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS (AVCP) REGIONAL HOUSING

Mr. CHARLIE. Good afternoon, Chairman and other members of the Committee. Thank you for the opportunity to appear.

In respect of time, I offer my full written testimony to the Committee for the record.

My name is Mark Charlie. I am a Yupik Eskimo and an enrolled member of the Native Village of Tununak. I have the privilege and honor of serving as the President and CEO of the Association of Village Council Presidents Regional Housing Authority.

AVCP RHA is the regional housing authority for the AVCP region in Southwest Alaska and the Tribally Designated Housing Entity for 51 tribes out of 56 in our region. We are also one of the three PTHEs participating in the Tribal HUD-VASH Program.

As you know, housing conditions in Native communities remain far worse than those of non-Native communities. Housing conditions in Native communities are five times more likely to have plumbing deficiencies, six times more likely to have heating deficiencies, and seven times more likely to be overcrowded.

Substandard and overcrowded housing conditions imperils Native communities and exposes Native families to health, social, and economic conditions that impede their ability to become permanently self sufficient. A recent HUD study estimates that 68 new homes

are needed in tribal communities and that figure does not include estimates for much of Alaska.

Although our housing needs remain substantial, NAHASDA has had a profoundly positive impact in Native communities. Tribes have used block grant funding to build, acquire, and renovate more than 123 homes and to operate and maintain 43,000 homes built before NAHASDA as well as potential thousands of additional homes built since NAHASDA.

Today, IHGB remains the single most critical tool for developing safe, affordable housing in Native communities. Thank you, Chairman Hoeven, for introducing the BUILD Act which represents a streamlined effort to reauthorize the Indian Block Grant. Passage of the BUILD Act is a critical step toward ensuring that the good work being done by tribal housing programs will continue.

Unfortunately, reauthorizing IHGB is not enough. As noted in HUD's recent report, flat funding and inflation have seriously eroded the purchasing power of the IHGB Program. Without additional appropriations, development in Native communities will decline. This is, in part, due to higher development costs, but also because tribes must use a large portion of the IHGB to support the housing we have built.

Without reasonable funding adjustment, development activity will continue to decline and Native families will fall further behind their non-Native counterparts.

Allow me to turn to the Tribal HUD-VASH Demonstration Program.

We in Alaska admit to being frustrated by the program's slow implementation. However, we see the program's potential since one region in our State has begun implementing the program.

In one instance, a program participant Native veteran had a serious medical issue that required immediate attention and was taken to a hospital emergency room. He was admitted and treated and that veteran has recovered.

An innovative aspect of the Tribal HUD-VASH Demonstration Program is that it allows tribes to serve both Native veterans and their families. This approach respects traditional family structures and empowers tribes to reunite veterans with their families, to find permanent housing for a Native veteran and his family of five including three young children.

The veteran's wife had been battling a serious illness. Sadly, she died soon after her family moved into their new home. Before she passed away, she expressed happiness and relief that her family had found a safe place to live.

External barriers have made achieving the program's potential difficult. Two Tribal HUD-VASH recipients in Alaska continue to struggle with implementation. In our experience, the primary barriers to VA credentialing requirements exceed those of similar positions in many communities for case managers making it difficult to recruit case managers.

We believe VA and HUD have the authority to reconsider the VA's credentialing requirements. If not, we would appreciate congressional efforts to give the agencies that flexibility.

We have reviewed the recently circulated Tribal HUD-VASH bill and believe it will have a positive impact on tribal communities. It

would enhance program stability and give tribes the opportunity to engage in direct consultation with VA leadership about barriers to program implementation.

On behalf of The Association of Village Council Presidents, The Association of Alaska Housing Authorities, and tribes across the United States, thank you for your efforts to improve housing conditions in tribal communities and for the privilege of speaking with you today.

[The prepared statement of Mr. Charlie follows:]

PREPARED STATEMENT OF MARK CHARLIE, PRESIDENT/CEO, ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS (AVCP) REGIONAL HOUSING

Good afternoon Chairman Hoeven, Vice-Chairman Udall, and distinguished members of the Senate Committee on Indian Affairs. Thank you for the opportunity to appear today as the Committee examines two bills intended to strengthen American Indian and Alaska Native communities and improve housing conditions for Native families.

My name is Mark Charlie. I am a Yupik Eskimo and an enrolled member of Native Village of Tununak. I serve as the President and CEO of the Association of Village Council Presidents Regional Housing Authority (AVCP RHA). AVCP RHA is the regional housing authority for the AVCP region in Southwest Alaska and the Tribally Designated Housing Entity for 51 tribes. The AVCP region, approximately the size of the state of Illinois, has 48 remote communities. Access to our region is by air year round and by barge from May to October. Use of a barge is mainly for delivery of building materials and petroleum (heating fuel and gasoline).

The AVCP region is home to many thousands of Alaska Native people. Many of our families lack safe and decent housing or housing that is affordable. Unfortunately, this problem is not isolated to the AVCP region but is experienced in the remainder of Alaska and throughout Indian country.

S. 1275 (The Build Act) and NAHASDA

Housing Needs in Native Communities

In January 2017, HUD published the results of a comprehensive national study on the housing needs of American Indians and Alaska Natives living in tribal communities. The study confirmed that the housing problems experienced by Native peoples in tribal areas are extremely severe and considerably worse than the housing conditions of non-Native populations.

For example, the study found that physical deficiencies in plumbing, kitchen, heating, electrical, and maintenance issues were found in 23 percent of households in tribal areas but only five percent of U.S. households overall. Compared to the general population, homes in Native communities are five times more likely to have plumbing deficiencies, six times more likely to have heating deficiencies, and seven times more likely to be overcrowded. The study estimated that between 42,000 and 85,000 Native Americans are “doubled up,” meaning that they live with family or friends because they have no place else to stay and would otherwise reside in a homeless shelter or on the streets.

HUD’s report, *Housing Needs of American Indians and Alaska Natives in Tribal Areas*, estimates that 68,000 units of new affordable housing are needed to replace substandard or overcrowded units in tribal communities nationwide. Further, the Report estimates that an additional 30,000 homes in tribal communities are candidates for rehabilitation. It must be noted that these figures do not capture the housing needs of all Indian areas served by tribal housing providers, including significant portions of the Alaska Native population. While we applaud HUD’s diligent efforts to quantify and describe the housing needs of Alaska Native and American Indian people, the Association of Alaska Housing Authorities estimates that the methodology used by the study team has caused housing needs in Alaska to be underrepresented by thousands of units.

The availability of safe, affordable housing is crucial for the survival of Native cultures. Tribal communities that lack decent housing often cannot recruit the health care providers, law enforcement officers, and teachers needed to ensure the health, safety, and education of their tribal members. Substandard housing also negatively impacts health and wellness outcomes for the families who live in them. The World Health Organization has identified respiratory and cardiovascular disease stemming

from poor indoor air quality and the spread of communicable disease due to poor living conditions as key health risks caused by substandard housing.

In rural Alaska, respiratory diseases are responsible for two-thirds of child hospitalizations. Recently, a study evaluated the effect of home ventilation improvements on 68 homes in eight villages in Southwest Alaska, having a combined population of 211 children. When outcomes were monitored one year later, hospitalizations had decreased from ten cases to zero, health clinic visits had decreased from 36 to 12, and school absences had decreased from 18 to three.

There remains a significant disparity in housing conditions for Alaska Native and American Indian people compared to non-Native populations in the United States. This inequity imperils Native communities and exposes Native families to health, social, and economic conditions that impede their ability to achieve permanent self-sufficiency. For these reasons, federal investment in housing programs for low-income Alaska Native and American Indian families remains of critical importance.

The Native American Housing Assistance and Self-Determination Act (NAHASDA)

Prior to NAHASDA, housing assistance for Alaska Natives and American Indians was provided by various programs under the Housing Act of 1937 and other legislation. While these programs provided a broad range of assistance, they were administratively cumbersome and inefficient when used in tribal communities. They required separate applications and program administration, and eligibility requirements differed from one program to the next. The programs were an extension of urban-oriented housing programs and failed to recognize the unique social, cultural, and economic needs of Alaska Native and American Indian communities.

In 1994, HUD articulated its intent to strengthen the unique government-to-government relationship between the United States and federally recognized Native American tribes and Alaska Native villages. This created momentum toward the development of NAHASDA, which was introduced in the U.S. House of Representatives by Congressman Rick Lazio. In his remarks, Congressman Lazio explained:

Tribal governments and housing authorities should also have the ability and responsibility to strategically plan their own communities' development, focusing on the long-term health of the community and the results of their work, not over burdened by excessive regulation. Providing the maximum amount of flexibility in the use of housing dollars, within strict accountability standards, is not only a further affirmation of the self-determination of tribes, it allows for innovation and local problem-solving capabilities that are crucial to the success of any community-based strategy.

Congress enacted NAHASDA in 1996, establishing an Indian Housing Block Grant (IHBG) program specifically for the benefit of Alaska Native and American Indian communities. NAHASDA represents an affirmation of the unique relationship between the Federal government and Indian tribes. Acknowledging the Federal government's trust obligation to promote the wellbeing of Native peoples, it for the first time addressed the distinct affordable housing needs of low-income Alaska Natives and American Indians. NAHASDA authorizes tribes to address their specific housing needs using the strategies that are most effective in their own tribal communities, rather than strategies mandated by federal officials working in offices thousands of miles away.

Although our housing needs remain substantial, NAHASDA has had a profoundly positive impact in American Indian and Alaska Native communities. Recipients have used IHBG funding to build, acquire, or rehabilitate more than 123,000 homes. We have developed new housing; modernized, weatherized, and rehabilitated old homes; provided rental assistance; created home loan programs; delivered housing and financial literacy counseling; offered down payment assistance; prevented crime; and revitalized blighted communities. In addition, tribes continue to operate, maintain, and renovate about 43,000 homes developed under the 1937 Housing Act and the tens of thousands of additional homes that we have built since the passage of NAHASDA. HUD's recent report on Native American housing needs confirms that NAHASDA has enabled tribal housing providers to match or exceed the rate of housing production under previous HUD programs.

The Indian Housing Block Grant remains the single most significant source of funding for affordable housing in Alaska Native and American Indian areas. The program helps to stabilize Native communities and makes it easier to grow their economies. Although HUD monitors grantees to ensure compliance with applicable statutes and regulations, the flexibility inherent in NAHASDA also allows tribes to design, develop, and operate the affordable housing programs that best address their local needs.

Support for NAHASDA is strong throughout Indian Country. According to the Government Accountability Office, 89 percent of tribal housing providers hold positive views toward the effectiveness of NAHASDA.

IHBG Case Study—Hooper Bay, Alaska

The village of Hooper Bay is located in remote western Alaska. In 2006, the village was ravaged by a fire, which destroyed 15 acres of the old section of town, including 13 residential homes, six units of teacher housing, the grocery store, the school, the water and sewer treatment plant, warehouses, food caches, and vital equipment such as boats, outboard motors, and snow machines. As the TDHE for Hooper Bay, AVCP RHA began to identify solutions to rebuild. One potential solution was the use of Low Income Housing Tax Credits (LIHTC), but at the time AVCP RHA did not have experience developing or operating LIHTC properties.

We reached out to Cook Inlet Housing Authority, a tribal housing provider that had the necessary experience. Together, our two organizations secured an allocation of Low Income Housing Tax Credits, sold the credits to an investor to generate equity for the project, and built a 19-unit apartment building for a community in the midst of a housing crisis.

The Hooper Bay partnership between AVCP Regional Housing Authority and Cook Inlet Housing demonstrates the importance of leveraging both money and capacity. Our investment of IHBG funds, which were just 13 percent of the total project cost, made it possible to secure other sources, including tax credit equity, while our willingness to collaborate produced timely results and a mutually beneficial relationship that continues to this day.

HUD Section 184 Loan Guarantee Program

The Section 184 Loan Guarantee Program was created by the Housing and Community Development Act of 1992 to address the lack of mortgage lending and homeownership in Native communities. The program offers a loan guarantee to private lenders, who then make mortgage loans to American Indian and Alaska Native families, tribes, and Tribally Designated Housing Entities. As of March 2016, the Section 184 program has guaranteed over 33,000 loans, representing over \$5.4 billion dollars in increased capital into Native American Communities.

Several characteristics of the Section 184 loan guarantee make it a particularly powerful leveraging tool. For example, new construction can be financed with a “single close” loan that provides permanent guaranteed financing before construction begins. This eliminates the need to procure separate construction financing, which typically carries a high interest rate. Additionally, the required down payment (2.25 percent) is achievable for both families and smaller tribal entities that may not have the financial capacity to make a large down payment. Because there are no income limitations for the 184 program, tribes are also able to serve a broader range of families and build healthier, more economically diverse tribal communities.

Positive Impact of the BUILD Act

On behalf of AVCP RHA and the Association of Alaska Housing Authorities, thank you, Chairman Hoeven, for introducing S. 1275, the BUILD Act. The BUILD Act represents a streamlined effort to reauthorize the single most critical tool for developing safe, affordable housing in Alaska Native and American Indian communities—the Indian Housing Block Grant.

When the IHBG operates under an expired authorization the unintended result is that potential investors in Native housing developments become anxious. Frequently, their investments are predicated on the assumption that IHBG funding will be available in the long-term, often to subsidize property operations in future years. Extended periods of expired authorization send the message that Congress is not an enthusiastic investor in the IHBG program, despite its historical success. This uncertainty worries some potential housing investors and makes them reluctant to invest in Alaska Native and American Indian communities. Passage of the BUILD Act will resolve this issue. Further, we deeply appreciate the extended period of authorization for the IHBG in the BUILD Act, which run through 2025.

AVCP RHA is also pleased that the BUILD Act will reauthorize the HUD Section 184 program for the same extended period. Reauthorization of the Section 184 program sends a clear message that Congress is committed to meeting its trust obligations to Alaska Native and American Indian tribes, and will continue to encourage private investors to deploy capital to Native communities.

IHBG Funding

Reauthorizing the Indian Housing Block Grant program is critical. However, the potential impact of NAHASDA has been undercut by flat funding over nearly twenty years. HUD’s recent report on Native American housing needs noted, “Congress has

provided a fairly consistent level of funding for the [IHBG] in nominal terms, but this flow has been seriously eroded by inflation.”

Without additional appropriations to inflation-proof the IHBG program, the amount of new affordable housing developed in Alaska Native and American Indian communities is likely to decline in future years. This is in part attributable to higher development costs, but it is also because tribes must now use a more significant portion of their grants to support the housing they previously developed. Because NAHASDA severely limits the rents recipients can charge under the IHBG program, many tribes must use more of their annual housing block grant to fund the operations of existing housing. In other words, IHBG recipients are increasingly focused on just keeping the lights on.

Without a reasonable adjustment to IHBG funding, development activity under the IHBG program will continue to slow and families in Native American communities will fall farther behind their non-Native counterparts. On behalf of AVCP RHA and the Association of Alaska Housing Authorities, I implore the members of this Committee to educate Senate appropriators regarding the critical importance of adequately funding the Indian Housing Block Grant program.

Tribal HUD–VASH Demonstration Program

In January 2015, HUD and the VA announced a demonstration program to offer rental assistance and supportive services to Native American veterans who experience or are at risk of experiencing homelessness. One year later, in January 2016, HUD and the VA awarded \$5.9 million to 26 tribes, effectively launching the Tribal HUD–VASH demonstration program.

Tribal HUD–VASH Successes and Program Potential

The demonstration program has faced challenges during initial implementation, which are described below. However, the Tribal HUD–VASH has tremendous potential. With a few sensible adjustments, the program has the ability to permanently change the lives of Alaska Native and American Indian veterans and their families, lifting them from homelessness or near homelessness and offering them permanent access to safe, stable housing.

Three Alaska tribes were selected to participate in the Tribal HUD–VASH demonstration program:

- The Association of Village Council Presidents Regional Housing Authority is headquartered in Bethel, Alaska, and serves 51 tribes in 48 remote communities spread over an area of Western Alaska the size of the state of Illinois.
- Tlingit and Haida Regional Housing Authority (THRHA), headquartered in Juneau, Alaska, serves Alaska Native people living in twelve Southeast Alaska tribal communities and Juneau. Similar to AVCP RHA, the communities THRHA serves are inaccessible from the road system and spread over a vast geographic area.
- Cook Inlet Housing Authority is headquartered in Anchorage, Alaska. In addition to serving Alaska Native and American Indian people in Alaska’s largest urban center, Cook Inlet Housing provides housing assistance in tribal communities scattered throughout Southcentral Alaska.

In Alaska, one of the three tribes selected to participate in the Tribal HUD–VASH program has begun placing veterans in stable housing. Cook Inlet Housing Authority, based in Anchorage, has benefitted from access to a qualified and credentialed workforce, as described below, and its Tribal HUD–VASH program has begun to realize the outcomes Congress intended when it authorized the Tribal HUD–VASH demonstration.

To date, Cook Inlet Housing has issued all twenty of its tribal HUD–VASH vouchers to Alaska Native veterans. They have been able to secure housing for nine veteran families totaling 23 individuals, and they anticipate that the remaining 11 Native veteran households will be housed this summer and early fall.

Cook Inlet Housing has found that the impact of the Tribal HUD–VASH program goes beyond simply sheltering Alaska Native and American Indian veterans. For example, it has already helped to stabilize the health of Native veterans. Cook Inlet Housing was able to find housing for “James,” a 75-year-old veteran who had been homeless for many years. Once James was housed, his VA case manager was able to arrange personal care services that help James meet his basic needs, including eating, bathing, and dressing. In another instance, the Tribal HUD VASH case manager realized during an appointment that “Susan,” a female veteran, had a serious medical issue that required immediate attention. The case manager took Susan to a hospital emergency room, where she was admitted and treated. Susan has since recovered.

One of the most innovative aspects of the Tribal HUD–VASH demonstration program is that program eligibility is sensibly expanded. Whereas the traditional VASH program limits eligibility to chronically homeless veterans, the Tribal HUD–VASH demonstration program allows tribes to serve Native veterans who are homeless or at risk of homelessness, as well as their families. This approach respects traditional Alaska Native and American Indian family structures and empowers tribes to reunite veterans who lack stable housing with their families. This program flexibility has led to several noteworthy success stories in Alaska’s Cook Inlet region:

- Cook Inlet Housing received an inquiry from “Steven,” a veteran whose family spanned three generations, including a grandmother, Steven and his wife, and their five children. Their eight-person family was living with another three-person family in a small two-bedroom home. Cook Inlet Housing was able to qualify Steven and his family under the Tribal HUD–VASH program, and they have since relocated to a larger four-bedroom duplex.
- “Mark,” an Alaska Native veteran, was referred to Cook Inlet Housing’s Tribal HUD–VASH program after being homeless for some time. He was determined to be eligible, which allowed him to reconnect with his family, including his young child. Mark’s family has been reunified and is now the recipient of a Tribal HUD–VASH voucher for a two-bedroom home.
- Cook Inlet Housing was able to find housing for a Native Veteran and his family of five, which includes three young children. The veteran’s wife, “Karen,” had been battling a serious illness, and sadly, she died soon after her family moved in to their new home. Before she passed away, Karen told the Tribal HUD–VASH case manager that she was happy her family had found a safe place to live and that it gave her peace of mind in the end.

As these stories demonstrate, the Tribal HUD–VASH program has the potential to truly and permanently change the lives of homeless and at-risk Native veterans and their families. However, external barriers have made achieving the program’s potential difficult for many tribes.

Tribal HUD–VASH Program Barriers

Two of the three Tribal HUD–VASH demonstration program participants in Alaska continue to struggle with program implementation. My organization, AVCP Regional Housing Authority, has been unable to deploy our vouchers, and in Southeast Alaska, Tlingit and Haida Regional Housing Authority has also been unable to deploy its vouchers. Even Cook Inlet Housing Authority, based in Anchorage, experienced a lengthy delay before eventual deployment.

The primary barrier to the timely deployment of Tribal HUD–VASH vouchers in Alaska has been the process of filling the required case management positions under VA specifications. When the VA hires a case manager, it does so under Office of Personnel Management classification 0185 (Social Worker). That classification requires a “master’s degree in social work.” In Alaska, however, most non-institutional case management is performed by clinical associates—people with knowledge of community resources and the training to work with the focus population but who do not necessarily have a graduate degree in a clinical mental health professional field. Put simply, the VA’s required case management credentials exceed those required for comparable positions in Alaska, and they have made it extremely difficult to recruit qualified case managers for the Tribal HUD–VASH demonstration program.

This issue became apparent to Alaska’s Tribal HUD–VASH recipients in the early months of 2016, after the VA notified us that it would not provide case management services directly. Instead, the VA required the three Alaska recipients to secure independently contracted case management services.

After months of exhaustive efforts, none of the three Alaska Tribal HUD–VASH recipients were able to identify any organization willing to provide case management services under the VA’s contract specifications. One of the primary reasons potential contractors cited for declining to participate in the program was the VA’s credential requirements for case managers. One large, extremely capable tribal healthcare organization considered the VA’s educational and licensure requirements to be unnecessary, unduly restrictive, and out of alignment with professional standards in Alaska.

In July 2016, the VA recognized that the three Alaska Tribal HUD–VASH recipients had exhausted all reasonable efforts to secure third-party case management services under the VA’s contract specifications and informed the recipients that it would fill the case management positions internally within the VA. However, like the recipients themselves, the VA found it difficult to recruit case managers with the VA’s preferred credentials. In September 2016, the Alaska VA was able to leverage staff time from other VA programs to begin providing part-time case manage-

ment services in the Cook Inlet Region, and in November 2016, the VA was finally able to hire a full-time case manager position for Cook Inlet Housing's tribal HUD-VASH program.

In Southeast Alaska, THRHA located a counselor who it believed would be a suitable case manager. The individual held a master's degree in secondary education, was a licensed professional and chemical dependency counselor, and had received a statewide Counselor of the Year Award. Because the candidate's master's degree was not in "social work," the VA informed THRHA that he could not be hired.

Another candidate for the THRHA case manager position subsequently began the VA's vetting process this spring. However, the VA's recruitment, credentialing, boarding, and offer process can be cumbersome, and the candidate has not yet been hired. THRHA and the Alaska VA are hopeful that the VA will be able to make a final offer to the candidate by mid-June. Once a hire is made and a case manager begins work, THRHA can finally begin connecting homeless Alaska Native Veterans with the case management services that will help prepare them to transition into permanent housing.

Sadly, in the AVCP region of Southwestern Alaska, little progress has been made toward the hiring of a VA case manager. We credit the VA with recently adding Licensed Professional Mental Health Counselors and Licensed Marriage and Family Therapists to the list of licensed professionals it will deem to meet their credential requirements. However, we are not optimistic that this step will be sufficient to secure the case management services that our homeless veterans so desperately need in order to access the Tribal HUD-VASH demonstration program.

We believe that there is more that the VA and HUD can do to address this significant impediment to implementation. The simplest solution would be for the VA to proactively reconsider its credential requirements and more appropriately align them with the professional standards for "clinical associates," para-professionals who frequently provide case management services in many communities.

Alternatively, Congress could explicitly require the VA to waive or specify reasonable alternative requirements for its case management credentials. When Congress authorized the Tribal HUD-VASH demonstration via P.L. 113-235, it required that the program be modeled after the general HUD-VASH program, but "with necessary and appropriate adjustments for Native American grant recipients and veterans." Congress further required that HUD, in coordination with the VA, "ensure the effective delivery of supportive services to Native American veterans that are homeless or at-risk of homelessness. . ." When Tribal VASH recipients, because of their remoteness, economic conditions or other factors, do not have access to personnel meeting the VA's case manager credentials, the VA should be compelled to adjust those credentials to align them with the standard qualifications of other positions, such as clinical associates, that capably perform case management functions in similar communities.

Draft Tribal HUD-VASH Bill

I appreciate the opportunity to review and offer comment regarding the recently circulated draft Tribal HUD-VASH bill. We in Alaska believe the draft bill would, if passed, have a positive impact on tribal communities by strengthening the Tribal HUD VASH Program.

The draft bill would enhance program stability by setting aside a small portion of the funding provided for the general HUD-VASH Program on a permanent basis. Veteran families that have been successfully housed under the Tribal HUD-VASH demonstration would be at less risk of losing their assistance and once again struggling to find safe, affordable housing. Additionally, the added sense of program permanency could make it easier to attract qualified case managers, who may be less concerned that their position will evaporate at the conclusion of the Tribal HUD-VASH demonstration.

The draft bill also requires consultation between HUD, the VA, the Tribal HUD-VASH recipients, and other appropriate tribal organizations on program design. The three Alaska recipients, as well as the Association of Alaska Housing Authorities, would welcome the opportunity to share our observations and recommendations with high-level leadership from the VA, in particular. While we have expressed our thoughts and concerns to the Alaska VA Healthcare System, it can sometimes be difficult for local VA officials to communicate our local perspective to VA leadership at the national level. We believe that the opportunity to engage in direct tribal consultation with the VA will prove beneficial to all stakeholders.

Finally, we appreciate that the draft bill includes provisions that give administrative flexibility to HUD and the VA. These provisions empower HUD and the VA to make necessary and appropriate modifications to the program after engaging in consultation with recipients and tribal organizations. Additionally, HUD is provided au-

thorization to waive or specify alternative requirements for any provision of law when doing so is necessary for the effective delivery and administration of rental assistance under the Tribal HUD–VASH program. Provisions of this nature leave open the possibility that HUD and VA will help address future issues that impact program implementation without the need for a legislative fix.

Conclusion

Housing conditions in Alaska Native and American Indian communities remain far worse than the conditions experienced by America's non-Native populations. This persistent inequity imperils Native communities and exposes Native families to health, social, and economic conditions that present a barrier to the attainment permanent self-sufficiency.

The Indian Housing Block Grant program has successfully empowered tribes to address their housing conditions using strategies developed and implemented at the local level. S. 1275, the BUILD Act, would reauthorize the IHBG, a critical step toward ensuring that the good work being done by tribal housing providers will continue. However, simply reauthorizing the IHBG is not enough. Without a reasonable funding adjustment, development activity under the IHBG program will continue to slow and families in Native American communities will fall farther behind their non-Native counterparts.

In Alaska, we admit to being frustrated by the unacceptably slow implementation of the Tribal HUD–VASH program. However, we are also beginning to see the program's impacts in one region of our state, and the outcomes have been impressive. We believe that the primary barrier to program implementation in many Native communities has been the VA's credential requirements for case managers, which exceed those required for comparable positions in many communities and make it extremely difficult to recruit qualified case management personnel.

It appears that the current legislative authorization for the Tribal HUD–VASH demonstration program allows the VA and HUD to reconsider the VA's credential requirements for case managers and more appropriately align them with the professional standards for "clinical associates," which frequently provide case management services in many communities. Alternatively, Congress could explicitly require the VA to waive or specify reasonable alternative requirements for its case management credentials.

Finally, we in Alaska believe the draft Tribal HUD–VASH bill would, if passed, have a positive impact on tribal communities by strengthening the Tribal HUD VASH Program. It would enhance program stability and provide the opportunity for recipients to engage in direct tribal consultation with the VA about current barriers to program implementation.

On behalf of The Association of Village Council Presidents, The Association of Alaska Housing Authorities, and tribes across the United States, thank you for your efforts to improve housing conditions in tribal communities and for the privilege of speaking with you today.

Senator MURKOWSKI. Thank you. Again, thank you for coming so far to provide your testimony today.

Ms. Difuntorum. I hope I am pronouncing that correctly.

Ms. DIFUNTORUM. That is about as close as it gets.

STATEMENT OF SAMI JO DIFUNTORUM, CHAIRWOMAN, NATIONAL AMERICAN INDIAN HOUSING COUNCIL

Ms. DIFUNTORUM. Good afternoon.

My name is Sami Jo Difuntorum. I am the Chairwoman of the National American Indian Housing Council. I am a member of the Kwekaeke Band of Shasta Indians of California, and I am the Housing Director for the Confederated Tribes of Siletz Indians in the beautiful State of Oregon.

I appreciate the opportunity to testify before you today. I would like to thank Chairman Hoeven, Ranking Member Udall and members of the Committee for having this hearing today and for staying engaged on tribal housing issues.

The NAIHC is comprised of 267 voting members that represent nearly 471 tribes and tribally-designated housing entities across

the United States. We were established 43 years ago and our core functions are advocacy and capacity building to our training and technical assistance program.

In addition to the comments I will make today, I have submitted a formal written statement for the record. Today, I want to focus on the two bills I have been asked to speak about and discuss a tribal housing issue we have identified with the new Administration.

First, with respect to S. 1275, the BUILD Act, I would like to thank Senator Hoeven for introducing the bill and for focusing on NAHASDA reauthorization. I would also like to thank Committee staff. We have had several reauthorization bills introduced in the last couple of sessions to no avail. I was encouraged to hear people on the Committee commit to working together to get this done this year. I hope that happens.

To be clear, NAIHC supported the past reauthorization efforts that included Title VIII and will continue to advocate for Title VIII reauthorization. I am encouraged that members of the Committee pledged to one another to find a solution to reauthorize or authorize Title VIII. Whether it is in NAHASDA or not, I do not know, but I am encouraged with the commitment of the people on the Committee to do that.

There are a number of things that we really like in the bill. We strongly support reauthorization of both the Indian Housing Block Grant and the 184 Loan Guarantee Program, the backbone of tribal housing programs across the Country. The Indian Housing Block Grant Program is the third largest source of Federal funds on Indian reservations and the primary source for Indian housing development.

We also support the longer, seven-year authorization. As you can tell by how long it has taken to not get it authorized so far, it would be nice not to have this pressure every five years.

The environmental review process, as in the past, we supported provisions to streamline environment reviews. The BUILD Act has a provision that goes in the right direction. We think it could be a little bit better. We are committed to helping work on refining that a little bit.

Section 703, as I mentioned before, capacity building, is one of the core functions of NAIHC. We are mainly concerned that the BUILD Act proposes to change Section 703 Training and Technical Assistance provisions.

As part of negotiations in 2000, tribal leadership understood the need for quality training and technical assistance in housing programs. Tribal leaders also understood that for T/TA to be effective, it should be delivered by an organization that represents and understands housing issues and the complexity of housing development on tribal lands.

The provisions of the BUILD Act would strip away the requirements that the T/TA be provided by an organization knowledgeable in tribal housing. We don't think that is in Indian Country's best interest. Tribes have not asked for this change and, frankly, we don't support it.

There are a number of provisions that the BUILD Act leaves out that we would like to see enacted. If you get to the point that you

are looking at mark up, obviously, we would like to see Title VIII enacted, Title VIII authorized in some way, shape or form. We would like to see elevation of the ONAP that position to an assistant secretary position. That was in S. 710 introduced in the last Congress by then-Chairman Barrasso.

We think it is important to elevate Indian Country to where it needs to be within HUD and some relief from the 30 percent rule. It is not part of the BUILD Act so I am not going belabor the discussion here, but that is something we have worked very hard on for a number of years to try and get some change and relief. We hope, going forward, that is a discussion we can take up with all of you.

We support the efforts of all members of the Committee and Congress to reach these goals and we stand ready to work with each of you to secure their inclusion and passage of the BUILD Act.

I am already out of time. I thought I was talking fast.

The CHAIRMAN. [Presiding]. You are doing just fine.

Ms. DIFUNTORUM. Thank you.

With respect to the HUD-VASH bill, NAIHC generally supports efforts to improve housing conditions and opportunities for Native veterans. We believe the HUD-VASH Program is a step in the right direction.

We support making HUD-VASH a permanent program and we also support the provision within the larger HUD-VASH Program for a five percent minimum set aside for Indian Country. Every time we have a conference, I ask people in the room how many of you have veterans on your reservation. Every single person in the room raises their hand. All tribes have vets and we have homeless vets.

We think expansion of this program is really important. I think it is doing a lot of good in Indian Country.

Funding is the last issue on which I want to touch. I realize this is not an appropriations hearing or an appropriations committee, but I would be remiss in my duty as chairwoman if I did not bring this up.

The President's budget request proposes to reduce the Indian Housing Block Grant by \$54 million from the 2017 enacted level. That is 30 percent. That would be devastating to tribes. It zeroes out the Native Hawaiian Block Grant entirely.

I know a lot of people on this Committee are also on appropriations committees, so I want you to think about this when you start doing appropriations work.

It completely eliminates the Community Development Block Grant. The Indian Community Development Block Grant is a component of the larger CDBG. If that goes away, ICDBG goes away. That is one of our primary mechanisms and funding streams for developing infrastructure on tribal land. I hope those of you who are part of appropriations will take a close look at that.

Earlier this year, a HUD Needs Assessment Study showed tribal rates of substandard housing and overcrowded homes well in excess of the national average. This is not new. This isn't news.

The report indicates that 68,000 new units are needed in Indian Country. I would suggest that is probably a low estimate. We have a lot of hidden homeless not on the radar a lot of the time.

We recognize the budget constraints the Federal Government is in. However, that does not diminish the trust and treaty responsibilities the United States has towards tribes. Tribal programs have been operating with severe unmet needs for decades. Tribal programs are certainly not the cause of this Country's fiscal issues and cuts to these programs should certainly not be a part of any solution.

I would like to thank the Committee again for its attention to tribal housing. Thank you, Chairman Hoeven, for introducing the BUILD Act. I look forward to answering any questions you have before I have to leave for the airport.

Thank you.

[The prepared statement of Ms. Difuntorum follows:]

PREPARED STATEMENT OF SAMI JO DIFUNTORUM, CHAIRWOMAN, NATIONAL AMERICAN INDIAN HOUSING COUNCIL

Good Afternoon. My name is Sami Jo Difuntorum, and I am the Chairwoman of the National American Indian Housing Council. I am a member of the Kwekake Band of Shasta Indians of California, and I am currently the Executive Director of the Siletz Tribal Housing Department in Oregon. I would like to thank Chairman Hoeven, Ranking Member Udall and committee members for having this hearing today and for staying engaged on tribal housing issues.

The NAIHC is comprised of 255 voting members that represent nearly 470 tribes and tribally-designated housing entities across the United States. The NAIHC was established 43 years ago to advocate on behalf of tribal housing programs and now also provides vital training and technical assistance to increase the managerial and administrative capacity of tribal housing programs.

Background on the National American Indian Housing Council

The NAIHC was founded in 1974 and for over four decades has provided invaluable Training and Technical Assistance (T&TA) to all tribes and tribal housing entities; provided information to Congress regarding the issues and challenges that tribes face in their housing, infrastructure, and community development efforts; and worked with key federal agencies to ensure their effectiveness in native communities. Overall, NAIHC's primary mission is to support tribal housing entities in their efforts to provide safe, decent, affordable, and culturally appropriate housing for Native people.

The membership of NAIHC is comprised of 255 members representing 478¹ tribes and tribal housing organizations. NAIHC's membership includes tribes and groups throughout the United States, including Alaska and Hawaii. Every member of this Committee serves constituents that are members of NAIHC. Our members are deeply appreciative of the consistent leadership this Committee provides in Congress related to issues affecting tribal communities.

Profile of Indian Country

There are 567 federally-recognized Indian tribes in the United States. Despite progress over the last few decades, many tribal communities continue to suffer from some of the highest unemployment and poverty rates in the United States. Historically, Native Americans in the United States have experienced higher rates of substandard housing and overcrowded homes than other demographics.

The U.S. Census Bureau reported in the 2015 American Community Survey that American Indians and Alaska Natives were almost twice as likely to live in poverty as the rest of the population—26.6 percent compared with 14.7 percent. The median income for an American Indian Alaska Native household is 31 percent less than the national average (\$38,530 versus \$55,775).

In addition, overcrowding, substandard housing, and homelessness are far more common in Native American communities. In January of this year, the Department

¹ There are 567 federally recognized Indian tribes and Alaska Native villages in the United States, all of which are eligible for membership in NAIHC. Other NAIHC members include state-recognized tribes eligible for housing assistance under the 1937 Housing Act and that were subsequently grandfathered in under the Native American Housing Assistance and Self-Determination Act of 1996, and the Department of Hawaiian Home Lands, the state agency that administers the Native Hawaiian Housing Block Grant program.

of Housing and Urban Development (HUD) published an updated housing needs assessment. According to the assessment, 5.6 percent of homes on Native American lands lacked complete plumbing and 6.6 percent lacked complete kitchens. These are nearly four times than the national average, which saw rates of 1.3 percent and 1.7 percent, respectively. The assessment found that 12 percent of tribal homes lacked sufficient heating.

The assessment also highlighted the issue of overcrowded homes in Indian Country, finding that 15.9 percent of tribal homes were overcrowded, compared to only 2.2 percent of homes nationally. The assessment concluded that to alleviate the substandard and overcrowded homes in Indian Country, 68,000 new units need to be built.

Since NAHASDA was enacted, tribes have built over 37,000 new units according to HUD. However, as the IHBG appropriations have remained level for a number of years, inflation has diminished the purchasing power of those dollars, and new unit construction has diminished as tribes focus their efforts on unit rehabilitation. While averaging over 2,400 new unit construction between FY2007 and 2010, new unit construction has dropped in recent years with only 2,000 new units between 2011 and 2014, and HUD estimating less than 1,000 new units in future years as tribes maintain existing housing stock.

S. 1275, the Bringing Useful Initiatives for Indian Land Development Act of 2017

First and foremost, the NAIHC would like to thank Senator Hoeven for introducing S. 1275 and for focusing on NAHASDA reauthorization. This is the fourth year now that the program has been left unauthorized, and our membership continues to grow more concerned as discussions in Washington, DC focus on cutting spending and eliminating unauthorized programs.

While NAHASDA may be currently unauthorized, the United States' trust and treaty responsibilities towards Native peoples remain and will not go away. The members of this Committee know these commitments well and NAIHC is very appreciative of all your efforts in supporting tribal programs and tribal self-determination.

There are a number of provisions in S. 1275 that NAIHC supports, and the following section-by-section outlines area we support and those with which we have concerns.

Section 3 and 6: Reauthorizations of the IHBG and 184 Loan Guarantee Programs

NAIHC strongly supports the re-authorization of both the Indian Housing Block Grant and the 184 Loan Guarantee program. We also support the longer term of authorization of 7 years, as it recognizes the complexity in reauthorizing these types of programs.

Section 2: Environment Reviews

As in the past, NAIHC supports provisions to streamline environmental reviews. Completing multiple reviews adds additional time and cost to housing projects that are already complex enough due to the number of parties involved in tribal projects. Section 2 of the BUIILD Act would eliminate some of those costs and delays. While NAIHC believes the language could be further simplified, we understand the provisions in the BUIILD Act were crafted to address practical concerns expressed by HUD. We would be happy to offer further technical assistance to ensure the provisions are effective.

Section 5: Training and Technical Assistance

The NAIHC remains concerned that the BUIILD Act proposes changes to the NAHASDA section 703 Training and Technical Assistance (T/TA) provisions. As part of the original negotiations leading up to NAHASDA's enactment, tribal leadership understood the need for a national organization to provide quality technical assistance and training opportunities to tribal housing programs. Tribal leaders also understood that for the T/TA to be effective it should be delivered by an organization that specifically understands tribal housing issues and the complexity of housing development on tribal lands.

Furthermore, tribal leadership negotiated the provision with the understanding that the funds would come out of the Indian Housing Block Grant, which would otherwise go directly to tribal housing programs. Without a mandate from tribal leaders to change these provisions, NAIHC cannot support a change that would open up funds from the Indian Housing Block Grant to organizations that do not have a strong background or specific expertise in tribal housing, which the BUIILD Act does not currently require.

If a consensus of tribal leaders indicates that the current language of section 703 is no longer useful in fulfilling the T/TA needs of tribal housing programs, NAIHC would support such a change. But until that happens, we would ask members of this Committee to leave section 703 of NAHASDA unaltered.

Section 7: Leveraging

NAIHC supports the provision that clarifies that NAHASDA funds can be used to meet matching or cost-sharing requirements of other federal or non-federal programs. This provision is common in other tribal self-determination programs, and provides tribes greater flexibility and leveraging opportunities.

Other NAHASDA provisions

S. 1275 represents a departure from past NAHASDA reauthorization efforts in that it leaves out many provisions found in past bills in an effort to secure passage. However, it is unclear at this time to NAIHC that the changes found in the BUIILD Act provide a clearer path to enactment.

In particular, the BUIILD Act does not include a reauthorization for Title VIII programs for Native Hawaiians. Past versions of NAHASDA reauthorization bills included reauthorization of these programs. Notably in the 114th Congress, both H.R. 360, which passed out of the House of Representatives, and S. 710, introduced by Senator Barrasso and reported unanimously out of this Committee, contained language reauthorizing Title VIII.

In December of last year, NAIHC provided a letter to Congress that indicated it could support a bill that only reauthorized the Indian Housing Block Grant. However, that approach contemplated a two-prong approach where a second more substantive and thorough tribal housing bill (likely including Title VIII programs) would also be developed and moved forward. NAIHC is concerned that we have not seen movement on the second prong of that approach, and are worried the lack of such progress will diminish broader Congressional support of the BUIILD Act itself.

To be clear, NAIHC supports reauthorization of IHBG, reauthorization of Title VIII Native Hawaiian housing assistance programs, and a host of other tribal housing related provisions. We support the efforts of all members of this Committee and Congress to reach those goals, and stand ready to work with each of you to secure their inclusion and passage in the BUIILD Act or other legislative vehicle.

S. _____, the HUD-VASH bill

NAIHC has not been able to fully analyze S. _____ but generally supports efforts to improve housing conditions and opportunities for Native American veterans. In addition to making the HUD-VASH program permanent, the draft bill appears to provide the Secretaries of HUD and the VA the necessary flexibility to improve implementation of HUD-VASH on tribal lands.

Two of the primary concerns that NAIHC has heard regarding HUD-VASH implementation are the lack of case managers the VA can identify willing to work in tribal areas, and the restrictions placed on certain tribal housing units by HUD that make them ineligible for VASH vouchers. The flexibility provided to the agencies by the bill could allow the VA and HUD to address these concerns. However, the restrictions on certain tribal housing units being eligible for VASH vouchers could be addressed more directly in the bill, as we believe HUD has too narrowly restricted which tribal housing units should be eligible. Many communities have housing shortages, and limiting the housing stock that can be used in the tribal HUD-VASH program forces some of the participating tribes to house their tribal veterans in nearby urban areas, rather than the tribal community as intended by the program.

While that concludes NAIHC's statement on the bills placed on today's hearing agenda, the NAIHC believes it must raise the issue of several troubling developments made by the new Administration.

Concerns with the Administration's FY 2017 Omnibus Signing Statement

On May 5, when President Trump signed into law the FY 2017 omnibus spending bill, the President issued a signing statement that characterized the "Native American Housing Block Grants" as quote "a program that allocated benefits on the basis of race."

All of the members of this Committee know full well that tribal programs are not based on race, but on the political relationship that have existed between Native peoples and the United States for over two hundred years.

The relationship is grounded in the United States Constitution and treaties, Congressional statutes and numerous Supreme Court decisions. So we ask that members of Congress work with the new Administration to ensure it knows the history and importance of tribal programs.

There are numerous Supreme Court cases that can be cited upholding this principle of federal Indian Law and countless legal articles that chronicle this background. NAIHC is happy to provide documentation to the Committee if necessary, but believes the question is well settled and did not see the need to include such information here.

Concerns with the Administration's FY 2018 Budget Proposal

While the signing statement could be dismissed as not fully understanding the background of federal Indian law, the Administration's FY 2018 funding proposals is much more concerning. In short, NAIHC believes that the budget, if enacted, would devastate tribal housing programs across the country.

The budget provides substantial cuts or completely eliminates the Community Development Block Grant at HUD, the CDFI Fund at Treasury, and Rural Development programs at the USDA.

The proposed budget would also cut the Indian Housing Block Grant to \$600 million, which is essentially the same level of funding tribal housing programs received in 1996. However adjusting for inflation, the proposal represents a cut of about one-third compared to 1996 funding levels.

The HUD tribal housing needs assessment released in January showed that tribes have rates of substandard housing and overcrowded homes well in excess of the national average. The report indicated that 68,000 new units are needed in Indian Country. As the ability of tribes to develop new housing units has diminished in the last few years due to inflation, the problem cannot be compounded by the severe program funding cuts proposed in the Administration's FY 2018 budget.

NAIHC asks that members of this Committee, particularly those who also sit on the Appropriations Committee, support adequate funding of the Indian Housing Block Grant and other tribal housing programs. Funding the IHBG at \$900 million would provide tribes relatively the same purchasing power it had in 1996 and NAIHC requests no less than \$700 million for FY 2018. Congress should also reject the proposed cuts to the other programs listed above, as they provide tribes additional resources for their housing programs. Funding tribal housing programs not only fulfills Congressional trust and treaty responsibilities, but does so in a way that spurs economic development, creates jobs and builds credit in tribal communities.

The CHAIRMAN. Thank you for your outstanding testimony. I thought yours was excellent and I am sorry I missed some of the others. I do thank all of you very much for being here.

Madam Chairwoman, in previous Indian Affairs Committee hearings, we had one entitled, Accessing Capital in Indian Country. Witnesses from NAIHC provided testimony recommending that NAHASDA dollars, the BUILD dollars, should be allowed for leveraging investment opportunities in Indian Country, combining and leveraging those investments.

We have included some of those leveraging authorities. I am just wondering if you think that would be helpful in terms of the housing challenges?

Ms. DIFUNTORUM. Chairman Hoeven, the short answer is yes. I do think that would be helpful. I also think being able to use Indian Housing Block Grant dollars for matching funds, which is a provision in the BUILD Act, would help us to leverage as well.

The CHAIRMAN. You mentioned the appropriations process. I am on appropriations and yes, we have a lot of work to do there. We will be hard at work.

Also, do you think the HUD-VASH bill addresses some of the problems the National American Indian Housing Council has heard from the tribes, the feedback they are getting? Are we getting to some of their priorities and concerns?

Ms. DIFUNTORUM. I do think so. There are two concerns I consistently hear from our membership. One is the education level required for the counselors in remote areas. It is very difficult to get

people with Master's degrees as counselors. I think Alaska had suggested maybe remote counseling and lowering the requirement to Bachelor degrees. I think that is helpful.

The other that surfaced recently, I have only heard from one of our members, is that they cannot use the HUD-VASH in what we call formula current assistance stock which is our 37 Act units. I have not been able to delve into that and it is not addressed in the BUILD Act. Ms. Frechette might be able to speak to that.

The CHAIRMAN. I am going to turn to her next and ask that.

I also want to ask about the remote counseling. Is anyone doing that? If so, how is it working? How can we try to implement something like that? You express a very real challenge. Maybe the tele-counseling is something that can be done. Are you doing it and, if so, how do you think it is working? What can we do to try to make it work?

Ms. FRECHETTE. I will invite Keith to comment on this also because he is in charge of the case management.

This is an opportunity that we see in the Indian Health Service to become a strong partner with VA and HUD, to look at ways to use their telemedicine system. This is something we have talked about for a while. We would be able to access folks in rural and remote areas.

The CHAIRMAN. Has anyone done it?

Ms. FRECHETTE. We have with telemedicine but I don't know about case management.

The CHAIRMAN. No, I mean counseling, particularly in regard to veterans in remote areas and so forth?

Dr. HARRIS. Not in the tribal programs specifically. We have done it more generally in HUD-VASH. Telemedicine and tele-mental health are both big pushes.

The CHAIRMAN. You have not done it in the tribal community?

Dr. HARRIS. Not in the tribal community. It is one of the things we wanted to try.

The CHAIRMAN. Do you have the ability to do it in any tribal community?

Dr. HARRIS. It requires infrastructure. That is one of the things we are hoping to get from IHS in an interagency agreement. We hope to restart those conversations but certainly we could.

The CHAIRMAN. You could maybe link with VA and IHS to try to do it?

Dr. HARRIS. Yes.

The CHAIRMAN. It seems like that would be a really good idea, would it not?

Dr. HARRIS. That is the goal.

The CHAIRMAN. It would pose some challenges also because it is challenging work, right? You would have to figure out how to do it so it is sensitive and effective and you get some kind of feedback as to whether you are accomplishing something.

Dr. HARRIS. That is right.

The CHAIRMAN. It is such a challenge in these remote areas. It is not easily solvable either in terms of time and resources, getting people in place, and going where you need to go. It seems to me this is something we need to really pursue.

Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman.

This is a question for all witnesses. I will start on my left and go down the line.

If this bill marked up in Committee, the BUILD Act, would any of you object to an amendment that included Native Hawaiians?

Ms. FRECHETTE. Thank you for your question. I am career staff at HUD, so I don't comment on what vehicles are appropriate and stuff like that.

Senator SCHATZ. Dr. Harris?

Dr. HARRIS. The same answer, unfortunately. Sorry, sir.

Ms. ONNEN. I am within CAI, and you missed part of my testimony, but we would support that.

Senator SCHATZ. Thank you.

Mr. CHARLIE. We would support that.

Ms. DIFUNTORUM. We support authorization of Title VIII. If it happens through Committee, we would support that.

Senator SCHATZ. Thank you.

The next question is for NCAI and Ms. Onnen.

For decades, as you know, Native communities have stood together fighting off divide and conquer. Could you give us a little bit of historical context for why this bill is a departure from the way we have done business both on the Committee with NCAI and Native communities generally?

Ms. ONNEN. I think what I could comment on is our concern at NCAI about the legal precedent this would set. We have always worked in partnership with the Native Hawaiian community. It has a special political and trust relationship with the United States and it has been reaffirmed through Congress through over 150 statutes, as well as the message it sends.

I think the concern is the message it sends by condoning separate treatment of Native communities by this Committee. I think that is our concern at NCAI.

Senator SCHATZ. Thank you very much.

Ms. Difuntorum, am I getting your name right?

Ms. DIFUNTORUM. Yes, thank you.

Senator SCHATZ. I have good staff.

You have Native Hawaiian members, right?

Ms. DIFUNTORUM. Members?

Senator SCHATZ. Of your housing council?

Ms. DIFUNTORUM. Let me answer that. The Department of Hawaiian Homelands is the voting member and we also have an associate member which is a different level. That is the way our by-laws read. The short answer is yes, but it is a bit more complicated than that.

Senator SCHATZ. Could you quickly elucidate what the impact would be for the Department of Hawaiian Homelands' Hawaiian housing generally if this bill were to be enacted without taking care of Native Hawaiians? What would be the impact of passing NAHASDA without including Hawaiians?

Ms. DIFUNTORUM. I don't know that means; there would not be funding or the Native Hawaiian Housing Block Grant Program. That is the piece that would be devastated. On a political level, I think it is a very different question for Hawaiians in general. I am sure you know the answer to that. It is in everyone's best interest

to include them in reauthorization. Does that answer your question?

Senator SCHATZ. Yes, thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Vice Chairman Udall.

Senator UDALL. Thank you, Mr. Chairman.

President Trump's recent signing statement called into doubt the legality of Federal housing programs for Native Americans, Alaska Natives and Native Hawaiians. He also questioned the constitutionality of Native Hawaiian and Alaska Native education programs.

For Mr. Charlie, as an Alaska Native leader, are you concerned about the President's statement questioning the legality of programs benefitting Alaska Natives and Native Hawaiians?

Mr. CHARLIE. Yes, I am.

Senator UDALL. Are you similarly concerned that it supports the idea that Alaska Natives and Native Hawaiians have weaker claims to the Federal trust responsibility than American Indians?

Mr. CHARLIE. The way I understand your question, yes, I think it weakens that responsibility, that understanding, that relationship.

Senator UDALL. You believe it weakens the trust responsibility to those tribes?

Mr. CHARLIE. Yes.

Senator UDALL. Ms. Onnen, you represent the oldest, largest and most representative tribal organization in the Country. I understand that NCAI has a resolution supporting the reauthorization of the Native Hawaiian Housing Block Grant Program as a part of the overall reauthorization of NAHASDA, is that correct?

Ms. ONNEN. That is correct.

Senator UDALL. Why did your organization take such a strong position and why hasn't it changed its position?

Ms. ONNEN. I think the answer to that question is very similar to the answer that I just gave. We are concerned about the message that it may send by condoning separate treatment of different Native communities within the United States.

It begins, in essence, to create potential classes of Native Americans. I think that is a concern at NCAI. The membership has stood behind the Native Hawaiians and the reauthorization of that piece. We have discussed this a couple times at our conventions and that stance has not yet changed. The resolution on file from 2013 stands and that is where we stand right now.

Senator UDALL. Thank you.

Ms. Difuntorum, you represent the housing interests of more than 277 tribally-designated housing entities providing housing services to approximately 450 tribes, Alaska Natives and Native Hawaiians.

Your organization has a resolution supporting the reauthorization of the Native Hawaiian Housing Block Grant Program as part of the overall reauthorization of NAHASDA. Do you stand by this resolution?

Ms. DIFUNTORUM. Yes.

Senator UDALL. Thank you.

ABCP is a member of your organization. So are the Department of Hawaiian Homelands and the Hawaiian Homestead Community Development Corporation. Does it concern you that S. 1275 seeks to divide the interests of your membership?

Ms. DIFUNTORUM. Was that a question for me? I am sorry.

Senator UDALL. Yes, that was.

Ms. DIFUNTORUM. I am sorry, would you repeat the question? I thought you were talking to Mark Charlie.

Senator UDALL. No. ABCP is a member of your organization. So are the Department of Hawaiian Homelands and the Hawaiian Homestead Community Development Corporation. Does it concern you that S. 1275 seeks to divide the interests of your membership?

Ms. DIFUNTORUM. I wouldn't characterize it quite like that.

Senator UDALL. How would you characterize it?

Ms. DIFUNTORUM. I would say, again, Committee staff has worked very hard for several sessions of Congress to get a reauthorization bill, including Title VIII. We support authorization of Title VIII even though they have never been authorized under a NAHASDA reauthorization, right? Everybody knows that.

We support the Hawaiian program. Chairman Hoeven spoke to this at the very beginning in his opening remarks that there has not been any success in getting any authorization done. Unfortunately, Title VIII has been a big barrier. That does not mean that we do not support authorization of that program. We do and if there is a way to do NAHASDA and have Title VIII included, absolutely, we support that.

I do not know if that answers your question but that is our position. We support including Title VIII if we can get reauthorization done in its entirety with Title VIII intact, absolutely we would support that.

Senator UDALL. Let me ask it just a little bit differently. Would you support passage of a NAHASDA reauthorization bill that does not include Native Hawaiian housing programs?

Ms. DIFUNTORUM. Okay, that is a different question. What I am going to say is I do not think that is a fair question to ask me. The Department of Hawaiian Homelands is a member of the Housing Council. We also have a lot of other members and I would really have to consult with the Board of Directors and our membership before I would be willing to go there.

Senator UDALL. Thank you.

I am well over time here, Mr. Chairman.

The CHAIRMAN. That is fine. I did not have any other questions but I think Chairwoman Difuntorum, you are getting at what we are trying to do. That is to pass the BUILD Act, pass NAHASDA, and reauthorize the Indian Housing Program. We have been stuck for the last two Congresses so it is just to figure out how we can move forward.

I appreciate your responses because I think what you are making clear and what I am trying to make clear is we are looking for solutions and trying to find ways to get things done. I would it would not be characterized as splitting the group in any way. That is not it.

If we decide as a Committee to include it and we remain stuck, we cannot move it through the Congress. Then we are in the same situation we have been for the last two Congresses.

Further, I would add it is not that the Native Hawaiians are just not included in BUILD, at the same time we made an offer to provide their funding through the appropriations process. I would not want that to get left out. I am a little concerned that those questions kind of left that out. That is why I think you answered it in the right way. Look, we are trying to find a solution that gets it accomplished.

NAHASDA is about \$650 million in reauthorization for housing programs. My understanding is about \$2 million goes to Native Hawaiians. That is why we were talking about trying to maybe do something through appropriations so we could advance the ball. Simply put, the effort is not to leave anyone behind. The effort is trying to find a way to advance but it may take some creativity.

I am open, as I said at the outset. That is the only concern I have with the question as put to you by the Ranking Member. It was kind of like this splits the BUILD. No, it is trying to find a creative way to get reauthorization done. Maybe there is another way to do it, maybe there isn't, but aren't we here to try to see if there is some possibilities that we could come up with? We are just working on trying to find a way to get something done. Anyway, I appreciate your answers.

Yes, Chairwoman, you had a comment?

Ms. DIFUNTORUM. I do have a comment.

At the beginning of the hearing, you also made comments on the record and several of your colleagues on the Committee have also commented that they were committed to working on a solution to see Title VIII authorized.

I don't know what that is going to look like but I do hope that isn't lost in the shuffle. We would like to have Title VIII included. At the end of the day, people can ask me my opinion about it, I don't get to vote on it. I am not actually a legislator. I don't have a magic pen to sign things into law.

This is the work you all are going to have to do. I was really encouraged by the comments and what sounded like a commitment from people on the Committee to try and get this done with Title VIII intact. I want to leave it at that.

The CHAIRMAN. Thank you.

Ranking Member, are there other questions you might have?

Senator UDALL. Yes. Mr. Chairman, let me first say that I very much appreciate your very sincere effort to reach a resolution. Those questions were not asked in any way to reflect on your effort. They were asked to try to clarify, as best we can, the positions of the people before us.

As you know, Senator Schatz has objections. I very much appreciate your trying to work with him and we are trying to work, in a bipartisan way, through these issues. Unfortunately, when you appear before us with issues like this, I think it is important that we try to glean as far as possible what your positions are. We understand the positions the first two witnesses are in.

The CHAIRMAN. I appreciate that and I think we are all trying to find a path forward.

Senator UDALL. Mr. Chairman, I have just a couple of questions on HUD-VASH but if you are really pressed, we can submit these for the record.

The CHAIRMAN. No, go ahead.

Senator UDALL. This Committee agrees that we want to ensure that the Tribal HUD-VASH Demonstration Program is achieving maximum efficiency. That means that an all hands on deck effort from the Administration and Congress. We need to work collaboratively to take care of our veterans.

Dr. Harris, could you highlight any other services the VA is providing for Native veterans?

Dr. HARRIS. I oversee operations in the Homeless Program Office. I would much prefer to take that back to VA and provide written response if that is okay with you?

Senator UDALL. Yes, please do.

Dr. HARRIS. Thank you.

Senator UDALL. Thank you very much.

I have a follow up for the panel for our tribal witnesses today. How do you feel these additional VA services are working in Indian Country? Is there more the Department could do to engage with Indian Country? For example, I have heard that the VA's Home Loan Guarantee Program does not reach a lot of reservations. Do you feel that is the case?

Dr. HARRIS. I can say a little bit about that. I have heard the same feedback, that the ideal candidate for the home guarantee loan, for instance, is more of a middle-class level Native American which is not the case, unfortunately, in too many cases. There is more that could be done there. I would defer to other panel members.

Mr. CHARLIE. In response to that question, I learned about the Native Veteran Home Loan Program. One of the things it states is it has to be in trust land. In Alaska, we have very few or no trust lands. The question becomes how do we apply to the Native Home Loan Program in our region where we do not have trust land?

Senator UDALL. Thank you very much.

Let me thank all the panelists today for your testimony and your patience. It has taken a while to get to you and we very much appreciate the time and effort.

I would say again to my Chairman, it has been such a pleasure working with him. He is one of the most bipartisan Senators I know in the United States Senate. I know he is making an incredibly sincere effort to try to reach resolution on some of these contentious issues. I really look forward to working with him and making sure that we can get something done.

Thank you very much.

The CHAIRMAN. Thank you. Hopefully, we will get there.

Thanks to all of the witnesses. We appreciate so much your being here today. I want to remind you that your full written testimony will made a part of the official record.

At this point, if there are no more questions, members may submit follow-up questions for the record. The hearing record will be open for two weeks.

Again, thanks so much for being here. We appreciate it.

We are adjourned.

[Whereupon, at 5:35 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PAs

On behalf of the more than 115,000 nationally-certified PAs (physician assistants) represented by the American Academy of PAs (AAPA), we appreciate the Senate Indian Affairs Committee's work to ensure high quality healthcare is available to Native Americans through Indian Health Services.

AAPA appreciates efforts by the committee to improve the quality of care offered to American Indians and Native Alaskans at Indian Health Service (IHS) facilities and to ensure that IHS can recruit and retain needed medical providers. Currently, over 250 PAs are working to meet the healthcare needs of American Indians and Alaska Natives at Indian Health Services facilities. PAs practice medicine on healthcare teams with physicians and other providers. Within IHS, PAs work in emergency and family practice settings, as well as specialty clinics and programs, such as orthopedics, diabetes care, surgery, geriatric, pediatric, women's health, hospitalist and community health.

AAPA respects the effort made by Senators Barrasso, Thune, and Chairman Hoeven to improve recruitment and retention for needed healthcare providers at IHS in S. 1250, the Restoring Accountability in the Indian Health Service Act of 2017. However, we would like to work with the authors and the committee to ensure this legislation reaches its full potential to help IHS attract and retain needed healthcare providers, including PAs.

As introduced, S. 1250 seeks to improve the ability of IHS to recruit and retain providers by requiring the agency to establish pay scales where health providers are paid "to the maximum extent practicable" comparable to what such providers would make under the pay scales that apply to health providers at facilities operated by the Department of Veterans' Affairs (VA). While the VA generally takes into consideration wages for providers in local geographic markets, the VA has a flawed process in relation to PAs that does not consistently take into consideration local market compensation. Under the flawed compensation system at the VA, it is not uncommon for PAs in the VA to be compensated by as much as \$30,000 less than other providers performing the exact same job. This flawed approach to compensation within the VA has resulted in VA facilities having difficulty recruiting PAs and provides PAs practicing at the VA a significant financial incentive to take positions with private employers. Recent reports by the VA Office of Inspector General consistently recognized the importance of PAs as part of VHA's healthcare team and identify PAs as one of the five critical occupations with the "largest staffing shortages." Because of problems the flawed formula has caused the VA in recruiting and retaining needed providers, Senators Tester and Moran have introduced S. 426 that would ensure PA salaries at the VA take into consideration private pay rates in local markets. AAPA feels strongly that it is important to make sure any legislation intended to help IHS recruit and retain providers does not replicate inequities that exist at the VA.

AAPA is committed to working to improve access to care at IHS facilities, and we look forward to working with the Committee on this critical issue.

PREPARED STATEMENT OF THE HAWAII CONGRESSIONAL DELEGATION

Chairman Hoeven and Vice Chairman Udall, please accept this written testimony in opposition to S. 1275, the Bringing Useful Initiatives for Indian Development (BUIILD) Act of 2017. While we have and continue to support reauthorizing the Native American Housing Assistance and Self-Determination Act (NAHASDA) programs, we strongly oppose this bill in its current form because it fails to include Native Hawaiian Housing Block Grants (NHHBG) and Section 184A Native Hawaiian Home Loan Guarantee programs, as set forth in Title VIII of NAHASDA.

The housing needs faced by our Native communities are among the worst in our country. In recognition of the Federal Government's trust responsibility to Native

Americans, including Alaska Natives, Congress passed the Native American Housing Assistance and Self-Determination Act in 1996. In 2000, the American Homeownership and Economic Opportunity Act of 2000¹ inserted Title VIII in NAHASDA and created the NHHBG and Section 184A programs to provide resources for affordable housing programs for Native Hawaiians, pursuant to the Hawaiian Homes Commission Act of 1920 (HHCA).²

HHCA recognizes the Federal Government's "unique trust responsibility to promote the welfare of the aboriginal, indigenous people of the State [of Hawaii]."³ This law created the Hawaiian Home Land Trust, which includes more than 200,000 acres of land managed by the Department of Hawaiian Home Lands (DHHL). The purpose of the HHCA is to improve the lives of Native Hawaiians, who continue to be more economically disadvantaged and lag behind in education and health, compared to other Hawaii residents. The trust lands create a land base where beneficiaries are able to reestablish connections to their native lands and cultural traditions that are vital in maintaining their identity and foundation.

While many Native Hawaiian families benefit from the HHCA, there are a large number of low-income families who are unable to take advantage of these lands because obtaining and managing a property is not within their financial means. To put this into perspective, DHHL recently reported that there were more than 27,000 applicant families on the waitlist to reside on Hawaiian homesteads and the latest U.S. Census numbers indicate that approximately 16.8 percent of Native Hawaiians live in poverty in the State of Hawaii.⁴ The NHHBG and Section 184A programs are crucial in bridging the gap between low-income Native Hawaiian families and their ability to live on homestead lands.

Congress has recognized the special relationship between the U.S. government and Native Hawaiians, and a responsibility to continue promoting programs that counter these sobering figures. NAHASDA's Title VIII programs provide vital tools that promote safe and affordable housing for Native Hawaiians. Healthy, sustainable homeownership is also fostered through the provision of funds for direct loans, housing counseling, self-help housing, and home rehabilitation programs. These resources focus on developing strong communities that serve as foundations for Native Hawaiian families to improve their collective quality of life.

In 2015, the U.S. House of Representatives passed legislation to reauthorize NAHASDA with overwhelming bipartisan support. Also in 2015, this committee favorably reported a Senate version to reauthorize NAHASDA. Both versions included improvements to allow for NAHASDA programs to have a greater ability to self-determine—as is stated in the title of the law we are discussing—how to efficiently meet local housing needs. To abandon this bipartisan progress and Title VIII entirely—as the BUILD Act does—would be a grave mistake and disservice to our Native communities. This is simply not the way forward.

It is incumbent upon Congress to continue to acknowledge our responsibility to protect and improve the lives of Native Americans, Alaska Natives, and Native Hawaiians, which the BUILD Act, in its present form, does not do. As such, we urge members of this committee to oppose the BUILD Act and to continue to work to improve on the progress made on NAHASDA reauthorization in the last several years.

We look forward to working with this Committee on how we can continue to work toward meeting the dire housing needs of all our Native people.

PREPARED STATEMENT OF ANEVA J. YAZZIE, CEO, NAVAJO HOUSING AUTHORITY

On behalf of the Navajo Housing Authority (NHA) and our NHA Board of Commissioners (BOC), I am grateful and appreciate the opportunity to provide this written statement to the United States Senate Committee on Indian Affairs for review of the following legislative bills: S. 1250, a bill to amend the Indian Health Care Improvement Act; S. 1275, the "Bringing Useful Initiatives for Indian Land Development," (BUILD Act of 2017); and a bill relating to the HUD/VA Veterans Affairs Supporting Housing (HUD-VASH) program. It is NHA's goal to work with Congress in addressing our mutual interests in advancing effective policies to build economic

¹Public Law 106-569

²The Hawaiian Homes Commission Act was passed by Congress and signed into law by President Warren Harding on July 9, 1921.

³Hawaiian Homes Commission Act of 1920, § 201.5

⁴U.S. Census Bureau, 2015 American Community Survey 1-Year Estimates, Selected Population Profile in the United States, Hawaii http://files.hawaii.gov/dbedt/census/acs/ACS2015/ACS2015_1_Year/Select_Pop_Profiles/major_race_aoc.pdf

and community development opportunities through addressing healthcare, housing and comprehensively support our Native Veterans.

Background on NHA

The Navajo Housing Authority is the Tribally Designated Housing Entity (TDHE) for the Navajo Nation. NHA is the largest Indian housing authority and is nearly the eighth largest public housing authority in the United States. NHA is comparable in size to the public housing agency for the City of Atlanta. The Navajo Nation is the largest Indian tribe in the United States, with a total enrollment of approximately 320,000 tribal members, a land base of 26,897 square miles (larger than West Virginia) that extends into the states of Arizona, New Mexico, and Utah.

Comprised of 365 employees headquartered in Window Rock, Arizona and 15 field offices across the reservation, NHA manages 9,200 rental and homeownership units including 43 administrative facilities, and oversees an additional 1,800 units from sub-recipients. The 15 field offices deliver housing services to tribal members that reside within 110 Chapters (local regional government units) and the surrounding communities.

Success of the NHA 5-Year Expenditure Plan

In 2012, following a three-year HUD-imposed moratorium on development, NHA had accumulated approximately \$470 million in unspent Indian Housing Block Grant (IHBG) funds. NHA developed and implemented an aggressive five-year expenditure plan to timely and responsibly expend a large accumulated balance.

Over the past four years, NHA has proven that it has the sustained capacity to effectively and responsibly expend its allocated IHBG funds; over \$600 million in the past four years (an average of \$143 million per year). Since the beginning of 2012, the NHA delivered housing services to over 10,592 households, built 538 new housing units, modernized 878 older housing units, funded the development of 7 bed group homes and emergency shelters, and oversaw the acquisition and transition of 29 housing units for persons with disabilities. NHA is in its final year of the expenditure plan and is on target for a consecutive 5th year in meeting its spending goal by the end of Fiscal 2017.

S. 1250 Indian Health Care Improvement Act

Indian Healthcare Service (IHS) programs, administered by the Department of Health and Human Services, are the single largest investment into tribal communities at \$3.5 billion annually. From this amount, \$446 million is used to fund sanitation facility infrastructure. As NHA and many tribal housing programs have previously mentioned, those sanitation funds are impeded by appropriations language that restricts IHS funds from being comingled with the funds received through the Native American Housing Assistance and Self-Determination Act (NAHASDA). In short, this limits a tribe's ability to maximize the federal investment.

The Administration and Congress have vowed to spur growth into the economy by funding infrastructure, however a key challenge to providing housing in tribal communities is the lack of infrastructure, especially in rural areas. Development costs in rural areas are higher and can easily double the price tag or even make housing development impossible in many places. On Navajo, there is often no sanitation infrastructure and using NAHASDA funds alone for development, although authorized for infrastructure, significantly eats into housing funds which is unnecessary. Tribes should be allowed to leverage federal funding sources (NAHASDA and IHS sanitation funds) for developing the necessary sanitation infrastructure. NHA respectfully requests this Committee to seriously consider language that would statutorily allow the co-mingling of IHS sanitation funds so that the federal investment into infrastructure could be maximized.

S. 1275 the "Bringing Useful Initiatives for Indian Land Development," or BUILD Act of 2017

The Build Act has 6 sections that re-authorizes and amends the Native American Housing Assistance and Self-Determination. On December 16, 2016, the NHA BOC passed Resolution NHA-4677-2016, this resolution authorizes the support of key provisions for any NAHASDA Reauthorization bill.

Section 2: Consolidated Environmental Review (ER), this section authorizes a tribe who co-mingles federal funds from different agencies will discharge the tribe from other applicable environmental review requirements of the other applicable agencies under Federal law if the largest source of federal funding is from HUD. NHA supports this provision.

Section 3: Reauthorizes NAHASDA from 2018 through 2025. NHA supports this provision.

Section 4: Extension of Leasehold interest for housing from 50 years to 99 years. NHA takes no position on this provision.

Section 5: Reauthorizes Training and Technical assistance from 2018 through 2025. NHA supports this provision.

Section 6: Reauthorizes the Indian Loan Guarantee program (commonly known as the 184 loan program) from 2018 through 2025, with a limitation on funding at \$12.2 Million. NHA supports the reauthorization of the 184 Loan Program but does not support a limitation on funding.

Section 7: Authorizing Leveraging: Allows for all grants funds under NAHASDA to be used for purposes of meeting matching or cost participation requirements under any other Federal or non-Federal programs. NHA supports this provision.

NAHASDA outlined dual roles for Indian housing, to build safe homes and sustainable communities while spurring economic development. Under the IHBG, funding must first cover the continuing support of the remaining housing stock that was funded under the 1937 Housing Act. NAHASDA includes other eligible activities such as new construction, acquisition and rehabilitation, thus in addition to the above sections in the Build Act, NHA supports additional provisions in the Re-authorization of NAHASDA which are outlined in Resolution NHA-4677-2016. These additional provisions were identified to stream-line the administrative workload of housing authorities and to reduce the duplication of rules and regulations between federal agencies. Tribes need these provisions so that they can focus on the important task of building houses instead of working tirelessly to meet burdensome administrative rules.

HUD/VA-Veterans Affairs Supportive Housing

NHA Success with HUD-VASH Program

Tribal HUD-VASH recipients are having success placing tribal veterans into local supportive housing but we need the program to be permanently authorized or else we risk leaving those homeless Native Veterans without affordable housing options that include critical supportive services.

HUD approved 20 HUD-VASH vouchers for NHA in the amount of \$268,835 on January 6, 2016. NHA has prioritized and incorporated the 20 VASH vouchers for homeless Navajo Veterans and to date we have issued nine vouchers (four have found housing) in Arizona and New Mexico. These homeless Navajo Veterans were reviewed by case-managers and determined eligible for the program and were immediately issued a voucher. Further NHA took efforts a step further and instituted its own Veterans Housing Assistance Policy. This policy goes above and beyond Federal legislative authority and has helped over 120 veterans become homeowners and has extended \$8.8 million in veteran debt forgiveness and assisted 17 widowers/mothers of service men and women through NHA's veterans housing assistance program.

Project Coordination

NHA partners with Veterans of the Armed Services residing on the Navajo Nation and are eligible to receive housing assistance services through the Department of Navajo Veterans Affairs (DNVA). The DNVA partners with Federal, state and local services, but the amount of case management that is needed to service our veteran population is large and added federal resources are needed. Navajo has one case manager for the HUD-VASH program to handle cases that cover the entire Navajo reservation (Navajo extends into three states: Arizona, New Mexico and Utah). Moreover, the remote location of the reservation is not conducive to providing adequate case-management unless that case-management can be provided in their community as opposed to off the reservation. NHA believes a solution is to provide for more case-managers to meet the needs in the Navajo community.

Place-based Vouchers

The biggest problem with using the tenant based rental assistance vouchers on the Navajo Nation is the lack of private or non-profit housing for renters. Therefore, the HUD-VASH program should allow rental assistance vouchers to be used for housing currently included in the housing stock of the tribal housing program. NHA's only option for using our HUD-VASH rental vouchers is to use Section 8 approved properties off the reservation. This solution will not help veterans who are needing supportive services who wish to stay on the reservation close to their family who are helping in their recovery. Thus, creating a place based voucher system that stays on the reservation, where most tribal veterans reside is the best option to alleviate our TDHE's lack of public and non-profit housing.

Conclusion

It is the goal of NHA to help build safe sustainable homes for the Navajo People while strengthening the socio-economic fabric of the Navajo Nation. The re-authorization of NAHASDA, development of sanitation infrastructure and expansion of HUD-VASH coordination and program is critical in maintaining the growth of NHA and sustaining the progress of the Navajo People. We hope our testimony can assist this Committee in expanding each of these programs for the benefit of NHA and all Tribal TDHE's. Thank you for this opportunity.

PREPARED STATEMENT OF THE UNITED STATES MERIT SYSTEMS PROTECTION BOARD (MSPB)

Chairman Hoeven, Vice Chairman Udall and distinguished Members of the United States Senate Committee on Indian Affairs ("Committee"). Thank you for the invitation to present a written statement on behalf of the United States Merit Systems Protection Board (MSPB) in connection with the Committee's legislative hearing to receive testimony on S. 1250, the "Restoring Accountability in the Indian Health Service Act of 2017" and other legislation which was held on June 13, 2017.

As an initial matter, I would like to note that under statute, MSPB is prohibited from providing advisory opinions on any hypothetical or future personnel action within the executive branch of the federal government. 5 U.S.C. § 1204(h) ("The Board shall not issue advisory opinions."). Accordingly, this statement should not be construed as an indication of how I, any other presidentially appointed, Senate-confirmed Member of the Merit Systems Protection Board ("Board"), an MSPB administrative judge, or an administrative law judge acting on behalf of the MSPB would rule in any pending or future matter before the agency. Moreover, at this time, MSPB is not taking a policy position on this legislation. Accordingly, I would respectfully request that the Committee consider the substance of my statement to be technical in nature.

The Potential Impact of S. 1250 on MSPB's Adjudicatory Function

MSPB's views on S. 1250 derive from its statutory responsibility to adjudicate appeals filed by federal employees in connection with certain adverse employment actions. Generally, after a federal agency imposes an adverse personnel action upon a federal employee, such as removal or demotion, and the federal employee chooses to exercise his or her statutory right to file an appeal with MSPB, MSPB will begin the adjudication process. In the case of a federal employee who is removed from his or her position, that individual is no longer employed by the Federal Government, and is not receiving pay at the time he or she files an appeal with MSPB or at any point during the subsequent MSPB adjudication process.

Once an appeal is filed, an MSPB administrative judge¹ in one of MSPB's regional or field offices will first determine whether MSPB has jurisdiction to adjudicate the appeal. If MSPB has jurisdiction, the administrative judge may conduct a hearing on the merits and then issue an initial decision addressing the federal agency's case and the appellant's defenses and claims. Thereafter, either the appellant or the named federal agency may file a petition for review of the MSPB administrative judge's initial decision to the 3-Member Board. The Board Members constitute an administrative appellate body that reviews the administrative judge's decision and issues a final decision of the MSPB. Both the Board Members and MSPB administrative judges adjudicate appeals in accordance with statutory law, federal regulations, precedent from United States federal courts, including the Supreme Court of the United States and the United States Court of Appeals for the Federal Circuit, and MSPB precedent.

S. 1250 contains similar language to Section 707 of the Veterans Access, Choice, and Accountability Act of 2014, which was enacted into law and became effective in August 2014. (Public Law No. 113-146; 38 U.S.C. § 713). In pertinent part, S. 1250 would allow the Secretary of Health and Human Services ("Secretary"), acting through the Director of the Service, to remove, demote, or transfer employees, including Senior Executive Service employees, of the Indian Health Service ("Service") if the Secretary determines the performance or misconduct of the employee warrants such a personnel action. If the Secretary removes or demotes such an employee, the Secretary may:

- Remove the employee from the civil service altogether;

¹ MSPB administrative judges are federal employees under the General Schedule System employed by MSPB. They are not "administrative law judges" appointed under 5 U.S.C. § 3105 nor federal judges.

- Regarding SES employees, transfer the employee from the SES to a position in the General Schedule at any grade of the General Schedule for which the employee is qualified and that the Secretary determines is appropriate; and
- Regarding managers and supervisors, reduce the grade of these employees to any other grade for which the employee is qualified and the Secretary determines is appropriate.

With respect to the above-referenced personnel actions, S. 1250 provides that “the procedures under chapters 43 and 75 of title 5, United States Code, shall not apply.”² Instead, S. 1250 provides that “before an employee may be subject to a personnel action, he or she must be provided with: (1) written notice of the proposed personnel action not less than 10 days before the personnel action is taken; and (2) an “opportunity and reasonable time” to answer orally or in writing.

Expedited MSPB Appeal Rights Under S. 1250

Employees who are either removed or demoted by the Secretary may appeal that personnel action to MSPB “under section 7701 of title 5.” Any appeal must be filed with MSPB “not later than seven days after the date of the personnel action”³ and the MSPB will be required to refer the appeal to an administrative law judge⁴ for adjudication. An administrative law judge would be required to issue a decision “not later than 21 days after the date of the appeal,” and that decision “shall be final” and not subject to further review, either by the Board or a United States federal court. In the event that an administrative law judge does not issue a final decision within 21 days, the decision of the Secretary to remove or demote the employee becomes final and the employee has no further right to appeal.

Possible Constitutional Defects of S. 1250

In May 2015, MSPB released a study⁵ entitled: *What is Due Process in Federal Civil Service Employment?* The report provides an overview of current civil service laws for adverse actions and, perhaps more importantly, the history and considerations behind the formation of those laws. It also explains why, according to the Supreme Court of the United States, the Constitution requires that any system which provides that a public employee may only be removed for specified causes must also include an opportunity for the employee—prior to his or her termination—to be made aware of the charges the employer will make, present a defense to those charges, and appeal the removal decision to an impartial adjudicator. We encourage Members of the Committee and their staff who have interest in these issues to read this report.⁶

² Under 5 U.S.C. § 7513(b)(1)-(4) and (d), a federal employee against whom certain adverse actions are proposed is generally entitled to: (1) at least 30 days advance written notice stating the specific reasons for the federal agency’s proposed action; (2) not less than 7 days to respond to the proposed adverse action; (3) be represented by an attorney or other representative before the federal agency; (4) a written decision and the specific reasons therefor by the federal agency; and (5) file an appeal to MSPB under 5 U.S.C. § 7701.

Under 5 U.S.C. § 4303(b)(1), a federal employee who is subject to removal or a reduction in grade for unacceptable performance is generally entitled to: 1) at least 30 days advance written notice of the federal agency’s proposed action identifying certain information; 2) be represented by an attorney or other representative before the federal agency; 3) a reasonable time to answer orally and in writing to the proposed adverse action; 4) a written decision by the federal agency specifying the instances of unacceptable performance which has been concurred in by an employee who is in a higher position that proposes the removal or reduction in grade; and 5) appeal to MSPB under 5 U.S.C. § 7701. Moreover, under 5 U.S.C. § 4302(b)(5), before a federal agency can take a personnel action based on performance, the employee whose performance is in question shall be provided an opportunity to improve his or her unacceptable performance.

³ Generally, under current law, an appeal must be filed at MSPB no later than 30 days after the effective date, if any, of the action being appealed, or 30 days after the date of the appellant’s receipt of the agency’s decision, whichever is later. 5 C.F.R. § 1201.22(b).

⁴ MSPB does not directly employ any administrative law judges, but can retain the services of administrative law judges via contract. Thus, if S. 1250 were to become law without amendment, and MSPB was required to retain the services of administrative law judges to adjudicate appeals covered by this legislation instead of using MSPB administrative judges, MSPB would likely incur significant operating costs.

⁵ In addition to adjudicating appeals filed by federal employees, MSPB is required under statute to:

⁶ This report can be found at: <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=1166935&version=1171499&application=ACROBAT>

Conduct, from time to time, special studies relating to the civil service and to the other merit systems in the executive branch, and report to the President and to Congress as to whether the public interest in a civil service free of prohibited personnel practices is being adequately protected. 5 U.S.C. § 1204(a)(3).

In the landmark decision of *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985) the Supreme Court held that while Congress (through statutes) or the president (through executive orders) may decide whether to grant protections to employees, they lack the authority to decide whether they will grant due process rights once those protections are granted. Stated differently, when Congress establishes the circumstances under which employees may be removed from positions (such as for misconduct or malfeasance), employees have a property interest in those positions. *Loudermill*, 470 U.S. at 538–39.⁷ Specifically, the *Loudermill* Court stated:

Property cannot be defined by the procedures provided for its deprivation any more than can life or liberty. The right to due process is conferred, not by legislative grace, but by constitutional guarantee. While the legislature may elect not to confer a property interest in public employment, it may not constitutionally authorize the deprivation of such an interest, once conferred, without the appropriate procedural safeguards.

Id. at 541.

The Court explained that the “root requirement” of the Due Process Clause is that “an individual be given an opportunity for a hearing before he is deprived of any significant property interest,” and that “this principle requires some kind of a hearing prior to the discharge of an employee who has a constitutionally protected property interest in his employment.” *Id.* at 542.

According to the Court, one reason for this due process right is the possibility that “[e]ven where the facts are clear, the appropriateness or necessity of the discharge may not be; in such cases, the only meaningful opportunity to invoke the discretion of the decisionmaker is likely to be before the termination takes effect.” *Id.* at 542. The Court further held that “the right to a hearing does not depend on a demonstration of certain success.” *Id.* at 544.

I further note that the requirements of the Constitution have shaped the rules under which federal agencies may take adverse actions against federal employees, as explained by the Supreme Court, U.S. Courts of Appeal, and U.S. District Courts. Accordingly, should Congress consider modifications to these rules, many of which have been in place for more than one hundred years, MSPB respectfully submits that the discussion be an informed one, and that all Constitutional requirements be considered.

As stated above, S. 1250 provides ten days’ notice to an employee prior to a personnel action, a “reasonable time” to respond, and the right to an expedited appeal at MSPB. Whether these rights—taken as a whole—satisfy constitutional due process requirements would depend on the various factors and the circumstances of a given appeal, and it would be inappropriate for me to address that issue at this point.

Finally, and significantly, I note that a panel of judges on the United States Court of Appeals for the Federal Circuit—MSPB’s primary reviewing court—recently issued a decision that casts serious doubt on the constitutionality of at least one provision of S. 1250. In *Helman v. Dep’t of Veterans Affairs*, 856 F.3d 920, 929 (Fed. Cir. May 9, 2017), a panel of the Federal Circuit ruled that the provision of Section 707 of the Veterans Access, Choice, and Accountability Act of 2014 that allowed MSPB administrative judges to issue final decisions on behalf of the MSPB—without allowing review of those decisions by MSPB Board members—was unconstitutional. Specifically, the court found that this provision of Section 707 (as codified at 5 U.S.C. § 713(e)(2)) violated the Appointments Clause of Article II of the United States Constitution:

Thus, we conclude that the authority to render a final decision, affirming or overturning the Secretary of the DVA’s removal decision, is a significant duty that can only be performed by officers of the United States. Through [38 U.S.C.] § 713, Congress purports to vest this significant authority in [MSPB] administrative judges who are hired as employees. This is unconstitutional under the Appointments Clause. Accordingly, we declare invalid those portions of § 713. *See, Helman* at 929 (Fed. Cir. May 9, 2017)

The Court also struck down the provision of Section 707 (38 U.S.C. § 713(e)(3)) that provided that the Secretary’s decision became final in the event that an MSPB AJ was unable to issue a decision within the 21 day period provided for in that section. *Helman*, 856 F.3d at 929 n.4. We recommend that the Committee consider the

⁷The *Loudermill* case involved a state employee, not a federal employee. Nevertheless, while the Federal Government is covered by the Fifth Amendment and the states by the Fourteenth Amendment, the effect is the same. *See Lachance v. Erickson*, 522 U.S. 262, 266 (1998); *Stone v. Federal Deposit Insurance Corp.*, 179 F.3d 1368, 1375–76 (Fed. Cir. 1999).

Federal Circuit's decision in *Helman* before approving S. 1250 to the extent that it prohibits MSPB Board members from reviewing the decisions of MSPB administrative judges and provides that decisions shall be final in the event that any MSPB administrative judge does not meet any arbitrary deadline to decide an appeal.

Permitting Appeals to MSPB "Under 5 U.S.C. § 7701"

S. 1250 would permit covered employees to appeal to MSPB "under 5 U.S.C. § 7701." Section 7701 of title 5, United States Code, provides in pertinent part that "the decision of an agency shall be sustained. . . only if the agency's decision. . . is supported by a preponderance of the evidence." 5 U.S.C. § 7701(c)(1)(B). The term "preponderance of the evidence" is defined as "the degree of relevant evidence that a reasonable person, considering the record as a whole, would accept as sufficient to find that a contested fact is more likely to be true than untrue." 5 C.F.R. § 1201.4(q).

Additionally, 5 U.S.C. § 7701(c)(2)(B) provides that "an agency's decision may not be sustained. . . if the employee or applicant for employment shows that the decision was based on any prohibited personnel practice described in section 2302(b) [of title 5, United States Code]." Among the "prohibited personnel practices" described in section 2302(b) are illegal discrimination, 5 U.S.C. § 2302(b)(1)(A)-(E), coercion of political activity or reprisal for refusal to engage in political activity, 5 U.S.C. § 2302(b)(3), and reprisal for lawful "whistleblowing," 5 U.S.C. § 2302(b)(8). Thus, if such issues are raised by appellants as defenses in any appeal filed pursuant to the language contained in S. 1250, an administrative law judge acting on behalf of the MSPB will be required under law to consider those defenses prior to issuing a final decision.

Restriction on the Issuance of Stays of Personnel Actions

S. 1250 provides that the "Merit Systems Protection Board or any administrative law judge may not stay any personnel action." While I take no policy position on this language, I note that it appears to be in direct conflict with 5 U.S.C. § 1214(b)(1)(a)(i) and (ii), which allows the Office of Special Counsel to seek, and the MSPB to grant, a stay of any personnel action "if the Special Counsel [and the MSPB] determines that there are reasonable grounds to believe that the personnel action was taken as a result of a prohibited personnel practice," including illegal retaliation for lawful whistleblowing. I would recommend that the Committee make clear whether it wishes to prohibit OSC from seeking—and the MSPB from granting, in appropriate circumstances—stays of personnel actions that may be the result of prohibited personnel practices with respect to the agency and employees covered by this legislation.

This concludes my written statement. I am happy to address any questions for the record that Members of the Committee may have.

PREPARED STATEMENT OF HON. W. RON ALLEN, CHAIRMAN, SELF-GOVERNANCE COMMUNICATION & EDUCATION TRIBAL CONSORTIUM; TRIBAL CHAIRMAN/CEO, JAMESTOWN S'KLALLAM TRIBE

On behalf of the Self-Governance Communication & Education Tribal Consortium (SGCETC), I am pleased to provide the following written testimony regarding Senate Bill 1250 (S. 1250), *Restoring Accountability in the Indian Health Service Act of 2017*. SGCETC appreciates the time, attention and effort this Committee and others have devoted to improving the quality and access to health care for all American Indians and Alaska Natives (AI/ANs). While we agree that legislation offers new opportunities for IHS, Self-Governance Tribes cannot support the legislation as introduced.

Today, 352 Federally-recognized Tribes and Tribal Organizations exercise Self-Governance authority to operate and manage health programs previously managed by the Indian Health Service (IHS), while many more continue to evaluate their opportunities. As Tribes assume greater authority over the delivery of health care in their communities, legislation like S. 1250 is increasingly important to us as we seek to gain more autonomy in the management and delivery of health care programs in partnership with the IHS. This collaboration has proven successful and has improved the Indian health system that existed prior to the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA).

Over the last decade, this Committee, in partnership with Tribes, has passed several pieces of legislation that provided opportunities to modernize IHS, support self-determination, and permanently reauthorize the Indian Health Care Improvement Act (IHCIA). Similarly, shared efforts and continued partnerships will be required to successfully correct the health care quality challenges that IHS faces.

We would be remiss without first reiterating that the agency is chronically underfunded, and receives a fixed amount of appropriations each year to provide health care for 2.2 million AI/AN people, a per capita spending level that is the lowest of any healthcare system. AI/AN have the right to have quality health care services, but without proper resources put behind these intentions, it is unlikely to be fully successful. We appreciate Congress expanding health programs in the Indian Health Care Improvement Act to increase access to health care services in Tribal communities, but more is needed to both appropriately fund these initiatives and further incorporate new and innovative ways to modernize IHS health delivery. Without funding to address the information technology gap, to treat critically diagnosed patients with specialized care, and improve the facilities to maintain accreditation and accommodate the diverse cultural health needs of native people, IHS will remain an outdated system that is locked in a “time capsule” and unable to achieve its mission of “raising the health status of AI/AN to the highest possible level.”

We offer the following recommendations for the Committee to consider and hope that additional Tribal input will improve the legislation to make meaningful progress toward modernization of the IHS.

General Recommendations

This legislation offers many solutions to some of IHS’ leading challenges, including provider recruitment and retention and filling shortages, improving quality care and increasing Tribal engagement and culture in the system. While we have some specific comments below to provide additional insight and to identify potential unintended consequences of certain provisions, we also recommend that specific legislation be considered to advance the Federal policy that has proven to improve quality, increase access to care for Tribal citizens and reduce the federal bureaucracy—Self-Governance.

Self-Governance is the most successful partnership between the Federal and Tribal governments to ever exist. S. 1250 does articulate protections for Tribes to assume programs, services, functions, and activities at any time. However, it does not encourage or create additional opportunities for Tribes to assume these responsibilities. We hope that in future legislation, the Committee will consider legislation to expand Self-Governance and assure Tribal rights to assume management of their health care.

Additionally, Self-Governance Tribes note that the legislation does not authorize additional appropriations to support the new initiatives. We strongly believe that overlooking the funding necessary to properly implement the proposed programs will likely result in diminished returns on the Committee’s efforts. In fact, even though IHCA was permanently reauthorized seven years ago, more than 20 provisions remain unfunded and therefore unimplemented. As this legislation moves forward, we recommend and offer any support to Senators who can seek additional appropriations for IHS to improve the quality and access to care for all AI/ANs.

Creating Parity between IHS and Veterans Health Administration

Many of the programs which stand to remain unimplemented are those that seek to address IHS’ provider shortage and vacancies. Self-Governance Tribes were heartened by the efforts this legislation makes to bring parity between the Veterans Health Administration (VHA) and IHS in provider compensation and personnel policy, to expand the IHS Loan Repayment Program, and to create demonstration projects to employ successful recruitment and retention strategies. However, some of the proposals do not recognize the challenges that exist in Indian Country. For instance, the housing voucher program included in Section 101 is limited to three years and does not acknowledge that the real challenge in Tribal communities is that there is a housing shortage. Recognizing that appropriations for IHS-constructed provider housing are far below need, granting IHS authority and flexibility to explore innovative means for addressing housing shortages would be extremely helpful. At a minimum, we ask that the Committee considers extending the termination date for this program as well as authorizing appropriations so that IHS and Tribes can properly support such a voucher program.

Similar to VHA, this legislation also provides IHS additional flexibility to take personnel actions or to remove employees when necessary. Self-Governance Tribes agree that additional authority to manage employee performance is essential to improving quality of care over time. These practices also more closely mirror private industry standards for personnel management.

Addressing Provider and Administrator Vacancies

This legislation responds to long-standing Tribal requests to modify IHS authorities to increase qualified providers and health administrators through expansion of the IHS Loan Repayment Program in Section 104. Self-Governance Tribes support

the increased flexibility in eligibility for the Loan Repayment Program, as it is an important tool for recruitment and retention. We recommend that this section be expanded further to provide the IHS with flexibility to repay student loans for shortages of providers in geographic areas with chronic vacancies as long as the provider agrees to serve at least 4 years in that location.

Though we appreciate the efforts to better include Tribal leadership in important hiring decisions, we are concerned that the legislation may have inadvertently included too many positions for Tribal notification. The legislation includes the “position of a manager at an Area office or Service unit” under the Tribal notification requirement in Section 105(a). Self-Governance Tribes are concerned that this could be interpreted quite broadly and that a “too” general interpretation of this language could include an overwhelming number of positions at the local and area levels—creating significant administrative burdens for IHS Human Resources staff. This may lead to unintended consequences, including further delays in the hiring process for critical day-to-day program management and vacancy rate increases. The highest-level managers should have Tribal support; however, program level management decisions should be left to the Senior Executive Service (SES) positions and service unit Chief Executive Officers (CEOs) so as not to interfere with their autonomy, accountability and ability to fill vacancies at the earliest opportunity.

With regard to the waiver of Indian Preference in hiring in Section 105(b), we are unclear of the intention to allow waivers in order to consider former employees that have been removed from employment or demoted for performance or misconduct. This would seem to be at odds with our collective goals to provide quality health care services.

S. 1250 offers a few solutions to improve the Service’s ability to hire employees, including centralization of medical credentialing and direct hire authority. Self-Governance Tribes know all too well that an efficient hiring process will increase quality and access to care. We fully support shared credentialing throughout the IHS-operated facilities as proposed in Section 102, allowing IHS to efficiently deploy and assign providers to facilities as needed. A centralized medical credentialing process has been initiated by the IHS through Tribal Consultation under a Quality Framework, and is currently being implemented. We support full implementation of the Framework, and while IHS has created a small staff to implement the Framework by reallocating existing resources, implementation would be expedited and enhanced by appropriately funding this effort through additional appropriations. We further recommend that the Committee protect current and future Self-Governance Tribes’ rights to choose to operate their own credentialing systems or leverage the efficiency of a centralized credentialing system and quality standards administered by IHS.

Another opportunity the bill offers IHS is the Staffing Demonstration Project included in Section 109. Self-Governance Tribes know the value that demonstration projects can create in Indian Country. Demonstration projects often establish best practices and scalability of a program. However, the proposed project seems over-limiting in that it only includes Federally-operated sites with significant third-party resources. Staffing shortages are a challenge for all rural health care systems. Self-Governance Tribes recommend that access should be broad enough to include Tribes who are managing their health services and wish to exercise their right to participate. The provisions should address cases when Tribes wish to exercise their Self-Governance authority during the demonstration project. Self-Governance Tribes also recommend that an option be available to Tribal Health Programs to extend the liability protections for health professional volunteers under Section 103.

The legislation does not address one common recommendation Tribes previously made to this Committee to improve recruitment and retention of providers. The loan repayment program has proven to be the IHS’s best recruitment and retention tool to ensure an adequate health workforce to serve in the many remote IHS locations. Self-Governance Tribes recommend that the Committee included a provision that would provide IHS loan repayment program the same tax free status enjoyed by those who receive National Health Service Corps (NHSC) loan repayments. Under the IHS and NHSC programs, health care professionals provide needed care and services to underserved populations. However, the IHS uses a large portion of its resources to pay the taxes that are assessed on its loan recipients. Currently, the Service is spending 29.7 percent of its Health Professions’ account for taxes. Making the IHS loan repayments tax free would save the agency \$7.21 million, funding an additional 232 awards. Changing the tax status of the IHS loans to make them tax free would enable the agency to fill two-thirds or more of the loan repayment requests without increasing the IHS Health Professions’ account.

Improving Timeliness of Care

Self-Governance Tribes recognize that access to care can be partially measured by evaluating patient wait times. We appreciate the efforts by the proposed legislation in Section 107 to require measurement and accountability for patient wait times. The Improving Patient Care (IPC) initiative, which began in 2008, provides a good foundation for measuring wait times as well as other measures, and we would recommend the IHS implement IPC in all of its facilities. However, additional time may be necessary to develop the rule. One hundred and eighty days would likely not allow for the proper development of a policy and required Tribal consultation. We would recommend additional time to develop a new set of standards. Further we hope the Committee will consider requiring Consultation prior to implementation and that data collected be available to impacted Tribes on a regular basis.

Establishing a Formal Tribal Consultation Policy

In the Department of Health and Human Services, IHS has set the gold standard for government-to-government consultation. The IHS policy has undergone many revisions and continues to be updated as the relationship between Tribes and IHS changes. Tribes have been an active partner with the IHS in the development and subsequent changes of the IHS Tribal Consultation Policy. If a negotiated rule is required as described in Section 110, it may unnecessarily limit future Tribal engagement or restrict the flexibility the agency requires to serve the best interest of Tribes. Generally, Self-Governance Tribes agree there is always room to improve implementation of the IHS Tribal Consultation Policy, but we are unsure that development of a rule will create the enforcement and results the Committee is seeking.

Fiscal Accountability

While Self-Governance Tribes are supportive of the Committee's effort to ensure that valuable resources are committed to improving patient care, we believe this is a provision that needs additional consideration before passage. The current language in Section 202 is significantly more restrictive than current regulations and could inadvertently impact both the ability of the IHS to meet its obligations to provide care, as well as current and future Self-Governance opportunities.

Specifically, narrowing the use of unobligated funds may negatively impact the ability of IHS and Tribes to meet accreditation standards and requirements in the future such as technology requirements, which may include additional spending categories other than those included in this Section. The language also does not take into account specific appropriations for Facilities and Contract Support Costs, which are limited to those appropriations accounts, and much of this funding is intentionally available until expended. These provisions would also seem to limit IHS' ability to pay funds to a Tribe under a Title I or Title V contract that were collected associated with a Program, Service, Function or Activity that is being assumed for operation by a Tribe. These provisions could also complicate IHS service delivery when there are delays in the appropriations process. Finally, the Section should be clarified to apply only to the IHS directly-operated program.

With regard to the reporting requirements of Section 202, it appears as though the fiscal year reporting required under this section would also include Title I and Title V contracts and funding agreements. Under current law, IHS would not have the ability to obtain information to accurately report the requested information, because the fiscal data is reported by Tribes under their required audits.

In closing, SGCEC would like to thank the Committee for the opportunity to submit testimony and feedback. We look forward to working with you to improve the quality and access to care at IHS.

PREPARED STATEMENT OF THE NAVAJO HOUSING AUTHORITY BOARD OF COMMISSIONERS

Honorable Chairman Hoeven and Vice Chairman Udall, and members of the committee, thank you for the opportunity to provide written comments on a crucial legislative proposal aimed at improving the state of housing in Indian Country. The Navajo Housing Authority (NHA) Board of Commissioners, the President of the Navajo Nation, and the Navajo Nation Speaker recognize your commitment to Indian Country. We greatly appreciate your efforts to improve housing in Indian Country. We are grateful for the opportunity to provide this written statement to the United States Senate Committee on Indian Affairs for review of the following legislative bills: S. 1250, a bill to amend the Indian Health Care Improvement Act; S. 1275, the "Bringing Useful Initiatives for Indian Land Development," (BUILD Act of 2017); and a bill relating to the HUD/VA Veterans Affairs Supporting Housing

(HUD–VASH) program. It is NHA’s and the Navajo Nation’s goal to work with Congress in addressing our mutual interests in advancing effective policies to build economic and community development by addressing healthcare and housing.

Background on NHA

The Navajo Housing Authority is the Tribally Designated Housing Entity (TDHE) for the Navajo Nation. NHA is the largest Indian housing authority and is nearly the eighth largest public housing authority in the United States. NHA is comparable in size to the public housing agency for the City of Atlanta. The Navajo Nation is the largest Indian tribe in the United States, with a total enrollment of approximately 320,000 tribal members, a land base of 26,897 square miles (larger than West Virginia) that extends into the states of Arizona, New Mexico, and Utah.

Comprised of 365 employees headquartered in Window Rock, Arizona and 15 field offices across the reservation, NHA manages 9,200 rental and homeownership units including 43 administrative facilities, and oversees an additional 1,800 units from sub-recipients. The 15 field offices deliver housing services to tribal members that reside within 110 Chapters (local regional government units) and the surrounding communities.

S. 1250 Indian Health Care Improvement Act

Indian Healthcare Service (IHS) programs, administered by the Department of Health and Human Services, are the single largest investment into tribal communities at \$3.5 billion annually. From this amount, \$446 million is used to fund sanitation facility infrastructure. As NHA and many tribal housing programs have previously mentioned, those sanitation funds are impeded by appropriations language that restricts IHS funds from being comingled with the funds received through the Native American Housing Assistance and Self-Determination Act (NAHASDA). In short, this limits a tribe’s ability to maximize the federal investment.

The Administration and Congress have vowed to spur growth into the economy by funding infrastructure, however a key challenge to providing housing in tribal communities is the lack of infrastructure, especially in rural areas. Development costs in rural areas are higher and can easily double the price tag or even make housing development impossible in many places. On Navajo, there is often no sanitation infrastructure and using NAHASDA funds alone for development, although authorized for infrastructure, significantly eats into housing funds which is unnecessary. Tribes should be allowed to leverage federal funding sources (NAHASDA and IHS sanitation funds) for developing the necessary sanitation infrastructure. NHA respectfully requests this Committee to seriously consider language that would statutorily allow the co-mingling of IHS sanitation funds so that the federal investment into infrastructure could be maximized.

S. 1275 the “Bringing Useful Initiatives for Indian Land Development,” or BUILD Act of 2017

NAHASDA was passed in 1996 with the Congressional intent to empower tribes to build homes for low-income families in Indian Country. We hope this intent continues in the BUILD Act, while also eliminating any duplicative requirements to streamline the building of homes.

The Build Act has 6 sections that re-authorizes and amends the Native American Housing Assistance and Self-Determination.

Section 2: Consolidated Environmental Review (ER), this section authorizes a tribe who comingles federal funds from different agencies will discharge the tribe from other applicable environmental review requirements of the other applicable agencies under Federal law if the largest source of federal funding is from HUD. NHA and Navajo Nation support this provision.

Section 3: Reauthorizes NAHASDA from 2018 through 2025. NHA and Navajo Nation support this provision.

Section 4: Extension of Leasehold interest for housing from 50 years to 99 years. NHA takes no position on this provision.

Section 5: Reauthorizes Training and Technical assistance from 2018 through 2025. NHA and Navajo Nation support this provision.

Section 6: Reauthorizes the Indian Loan Guarantee program (commonly known as the 184 loan program) from 2018 through 2025, with a limitation on funding at \$12.2 Million. NHA and the Navajo Nation support the reauthorization of the 184 Loan Program but do not support a limitation on funding.

Section 7: Authorizing Leveraging: Allows for all grants funds under NAHASDA to be used for purposes of meeting matching or cost participation requirements under any other Federal or non-Federal programs. NHA and the Navajo Nation support this provision.

NAHASDA outlined dual roles for Indian housing, to build safe homes and sustainable communities while spurring economic development. Under the Indian Housing Block Grant (IHBG), funding must first cover the continuing support of the remaining housing stock that was funded under the 1937 Housing Act. NAHASDA includes other eligible activities such as new construction, acquisition and rehabilitation, thus in addition to the above sections in the Build Act, NHA supports additional provisions in the Re-authorization of NAHASDA. These additional provisions will stream-line the administrative workload of tribal housing entities and reduce the duplication of rules and regulations between federal agencies. This will help TDHE's focus on building new homes efficiently and effectively.

NAHASDA expired on September 30, 2013. Since its expiration, the act's funds have been reauthorized on a yearly basis. This has caused uncertainty for Tribally Designated Housing Entities (TDHE) to meet the construction timelines, which furthers the delay of building any new homes. Reauthorizing NAHASDA through the BUILD Act will eliminate any uncertainty for funding housing projects in Indian Country.

S. 1333 HUD/VA-Veterans Affairs Supportive Housing

NHA Success with HUD-VASH Program

Tribal HUD-VASH recipients are having success placing tribal veterans into local supportive housing but we need the program to be permanently authorized or else we risk leaving those homeless Native Veterans without affordable housing options that include critical supportive services.

HUD approved 20 HUD-VASH vouchers for NHA in the amount of \$268,835 on January 6, 2016. NHA has prioritized and incorporated the 20 VASH vouchers for homeless Navajo Veterans and to date we have issued nine vouchers (four have found housing) in Arizona and New Mexico. These homeless Navajo Veterans were reviewed by case-managers and determined eligible for the program and were immediately issued a voucher. Furthermore, NHA took efforts and instituted its own Veterans Housing Assistance Policy. This policy goes above and beyond Federal legislative authority and has helped over 120 veterans become homeowners and has extended \$8.8 million in veteran debt forgiveness and assisted 17 widowers/mothers of service men and women through NHA's veterans housing assistance program.

Project Coordination

NHA partners with Veterans of the Armed Services residing on the Navajo Nation and are eligible to receive housing assistance services through the Department of Navajo Veterans Affairs (DNVA). The DNVA partners with Federal, state and local services, but the amount of case management that is needed to service our veteran population is large and additional federal resources are needed. Navajo has one case manager for the HUD-VASH program to handle cases that cover the entire Navajo reservation (Navajo extends into three states: Arizona, New Mexico and Utah). Moreover, the remote location of the reservation is not conducive to providing adequate case-management unless that casemanagement can be provided in their community as opposed to off the reservation. NHA believes a solution is to provide for more case-managers to meet the needs in the Navajo community.

Place-based Vouchers

The biggest problem with using the tenant based rental assistance vouchers on the Navajo Nation is the lack of private or non-profit housing for renters. Therefore, the HUD-VASH program should allow rental assistance vouchers to be used for housing currently included in the housing stock of the tribal housing program. NHA's only option for using our HUD-VASH rental vouchers is to use Section 8 approved properties off the reservation. This solution will not help veterans who are needing supportive services who wish to stay on the reservation close to their family who are helping in their recovery. Thus, creating a place based voucher system that stays on the reservation, where most tribal veterans reside is the best option to alleviate our TDHE's lack of public and non-profit housing.

Conclusion

It is the goal of NHA and the Navajo Nation to help build safe sustainable homes for the Navajo People. The re-authorization of NAHASDA through the BUILD Act, the development of sanitation infrastructure through Restoring Accountability in the Indian Health Service Act, and expansion of HUDVASH coordination and program is critical in maintaining the growth of the Navajo Nation and sustaining the progress of the Navajo People. We hope our testimony can assist this Committee in expanding each of these programs for the benefit of the Navajo Nation and all Tribal TDHE's. Thank you for this opportunity.

JOINT PREPARED STATEMENT OF HON. RUSSELL BEGAYE, PRESIDENT, NAVAJO NATION
AND JONATHAN HALE, CHAIRMAN, HEALTH, EDUCATION & HUMAN SERVICES,
NAVAJO NATION COUNCIL

As President of the Navajo Nation and Chairman of the 23rd Navajo Nation Council Health, Education, and Human Services Committee, we are submitting the following written testimony to the Senate Committee on Indian Affairs (SCIA) in response to the June 13, 2017 legislative hearing on the Senate Bill 1250 “Restoring Accountability in the Indian Health Service Act of 2017.” We support the overall legislative goals of this bill to improve the quality, access, and delivery of health care services through the Indian Health Service (IHS). However, we remain concerned about several provisions, which are outlined in this testimony. Finally, we have concerns regarding the funding of this bill and support a commensurate increase in appropriations to support increased operations.

The Navajo Nation is the largest land based Indian tribe in the United States spanning over 27,000 square miles across three states: Arizona, New Mexico, and Utah. We have over 300,000 enrolled tribal members, with nearly 180,000 members living on the Navajo Nation. The Navajo Nation easily comprises the largest IHS footprint in Indian Country. Therefore, any changes to the IHS system will have an overwhelmingly significant effect on our Navajo people.

The health care system on Navajo Nation includes five Indian Health Service direct service units, five tribal health organizations, and the Navajo Department of Health. The Navajo Area Indian Health Service (NAIHS) is the primary health care provider that serves two federally recognized Indian tribes—the Navajo Nation and the San Juan Southern Paiute Tribe. NAIHS is responsible for providing health care services to nearly 246,776 users through inpatient, outpatient, purchase referred care for specialized services, contract providers, and an urban Indian health program. The NAIHS system includes five hospitals, six health centers, fifteen health stations and twentytwo dental clinics. In 2016, as a result of limited funding, the IHS per capita expenditure rate for patient health services was just \$3,688, compared to \$9,523 per person nationally.¹ In order to more fully serve the quarter of a million individuals within the Navajo Area, IHS must be fully funded to appropriately deliver critical services. Therefore, any proposed changes should be accompanied by increased funding to fully implement new programs and functions, and to reduce the strain on the insufficiently funded IHS system.

Employee Compensation

The Navajo Nation supports section 101 with the intent to create parity of employee compensation between the Veterans Administration and Indian Health Service. We also support the creation of a Housing Voucher program for critical health professionals. However, the proposed voucher program is limited to three years, which does not address the long-term shortage of adequate housing on the Navajo Nation and may inadvertently create a temporary workforce. In order to invest in long-term workforce solutions, we suggest establishing a permanent program to create more permanent employment opportunities to attract quality health care professionals into the IHS system.

Centralized Credentialing

We understand that IHS is piloting a similar credentialing system. We believe examining the results of the IHS pilot system and further tribal consultation will better inform all IHS stakeholders of the possible benefits and concerns associated with such a system. As stated earlier, we cannot support the creation and implementation of the proposed credentialing system if adequate funds are not appropriated.

Loan Repayment Program

The Navajo Nation supports Section 104 to increase eligibility for the Loan Repayment Program for health administration-related degrees, an important tool for the recruitment and retention of qualified health care professionals. Health administration-related degrees should be considered under the IHS Scholarship program as well. However, it is imperative that Congress appropriates new funding to cover these programs, as IHS is already severely underfunded.

Direct Hiring Authority

The Navajo Nation has grave concerns regarding Section 105, which provides the Secretary of HHS with direct hiring authority. We do not support waiving Indian Preference in hiring within IHS, as we believe there are qualified AI/AN candidates for all IHS positions, including Navajo tribal members.

¹ IHS 2016 Profile. <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>

Employee Removal

The Navajo Nation understands the need to refine current human resources practices to remove ineffective employees. However, in *Helman v. Department of Veterans Affairs* (Fed. Cir.), the proposed process has been deemed questionable by the United States Court of Appeals for the Federal Circuit.² Therefore, we are opposed to this method, which may result in costly litigation further burdening the IHS budget intended for health care.

Standards to Improve Timeliness of Care

The Navajo Nation supports Section 107, which requires IHS to establish standards to improve the timeliness of care in order to provide faster care for patients. Wait times at NAIHS facilities are notoriously high.

For example, the Gallup Indian Medical Center (GIMC) provides dental exams three days per week. GIMC policy only allows for one patient per household per day to receive a dental exam. As a result, families are forced to make multiple trips to the facility so that various family members can receive critical dental services. Currently, GIMC only treats four dental patients per day, which has resulted in families arriving well before the opening hours of the facility in hopes of receiving care. Patients must then endure wait times greater than one hour. Due to the outstanding need of dental services within this service region, and the limited resources at GIMC, many patients are turned away daily, leaving them without necessary oral health services.

We support the proposed data collection and establishment of timeliness of care standards to improve this challenge; however, we encourage Congress to appropriate additional funds to support this effort.

Tribal Culture and History Training Programs

We fully support the development and implementation of tribal culture and history training programs for all employees in a particular service area. Currently, Navajo employment practices mandate such training on the Navajo Nation. The Office of Navajo Labor Relations enforces Section 604 of the Navajo Preference in Employment Act, which mandates that:

An employer-sponsored cross-cultural program shall be an essential part of the affirmative action plans required under the Act. Such program shall primarily focus on the education of non-Navajo employees, including management and supervisory personnel, regarding the cultural and religious traditions or beliefs of Navajos and their relationship to the development of employment policies which accommodate such traditions and beliefs. The cross-cultural program shall be developed and implemented through a process which involves the substantial and continuing participation of an employer's Navajo employees, or representative Navajo employees.³

Again, we encourage Congress to appropriate funding for this activity, which complements current requirements on the Nation.

Staffing Demonstration Project

The Navajo Nation understands and supports the overall goals of addressing workforce shortages through the development of staffing demonstration projects for federally managed health care facilities. However, the requirement for tribal contribution for construction funds will prevent Tribes from accessing this potential resource. Therefore, we believe that this requirement should not be a factor for selection. Additionally, we suggest that tribally operated health care facilities be considered for participation, such as the 2 tribally contracted and 3 compacted facilities on the Navajo Nation. The inclusion of these facilities fully supports the aims of the Indian Self Determination Act (P.L. 93-638).

Tribal Consultation

Direct, meaningful Tribal consultation is a crucial part of the relationship between Tribal Nations and the Federal Government. In current practice, IHS drives the consultation efforts. While the proposed legislation is designed to improve consultation, we are concerned that a negotiated rulemaking committee may hinder or restrict future Tribal consultation. As proposed, potential negotiated rulemaking could likely result in a time-consuming and costly process. Alternatively, we recommend that the current IHS consultation policy be reexamined for improvements

²*Helman v. Department of Veterans Affairs*, <http://www.ca9.uscourts.gov/sites/default/files/opinionsorders/15-3086.Opinion.5-5-2017.1.PDF>

³ 15 N.N.C. 604(B)(11)

and be recommitted to engaging in meaningful consultation. Additionally, we suggest that a greater emphasis be placed on Tribal concerns as they arise, and this must result in meaningful and timely consultation.

Proposed Reports

The Navajo Nation supports the directive for the additional reporting contained within sections 302–304. To be most effective, reports should be developed in collaboration with Tribes. Reports should then be presented to affected Tribes for comment before the final version is officially released.

CMS Survey

The Navajo Nation supports the call for a CMS compliance survey. Again, to be most effective, the proposed survey should be developed in collaboration with Tribes. Reports should be presented for Tribal input before the final version is officially released.

Conclusion

In conclusion, we would like to thank the Senate Committee on Indian Affairs for the opportunity to submit testimony and feedback. As it is the goal of the Navajo Nation to ensure delivery of quality health care for our Navajo people, we appreciate Senators Barrasso, Thune, and Hoeven's efforts to improve health services within the IHS. It is critical that we find successful, lasting solutions to the current challenges facing Indian health care system, including the recruitment and retention of employees and unacceptable standards of care. We hope this testimony can assist the Committee in improving the quality, access, and delivery of health care services through the Indian Health Service (IHS). Thank you.

PREPARED STATEMENT OF UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) we write to provide the Senate Committee on Indian Affairs with the following testimony for the record of its June 13, 2017 legislative hearing on S.R. 1250, the Restoring Accountability to Indian Health Service Act of 2017.

USET SPF is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine.¹ Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638.

While we appreciate efforts to address the healthcare disparities identified within the Great Plains Area of the Indian Health Service (IHS), we feel a broad, one-size-fits-all approach to addressing these problems is unwarranted. Not all IHS Areas are experiencing these same types of failures, and there are lessons to be learned from the best practices they employ. In addition, despite Tribal concerns with similar legislation last Congress, this bill was introduced without broad Tribal consultation. Any attempts to reform IHS, through Congressional action or otherwise, must be accomplished through extensive Tribal consultation. Finally, we maintain that until Congress fully funds the IHS, the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations. Although USET SPF supports reforms that will improve the quality of service delivered by the IHS, we continue to underscore the obligation of Congress to meet its trust responsibility by providing full funding to IHS and support additional innovative legislative solutions to improve the Indian Health System.

¹ USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Uphold the Trust Responsibility to Tribal Nations

The United States has a trust responsibility to Tribal Nations that has been reaffirmed time and time again. The most recent reaffirmation came through the permanent reauthorization of the Indian Health Care Improvement Act when, “Congress declare[d] that it is the policy of this nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” This trust responsibility obligates the federal government to provide quality healthcare to Tribal Nations. Providing quality healthcare can only be accomplished when these programs are fully funded. We further recommend the inclusion of language directing the IHS to request a budget that is reflective of its full demonstrated financial obligation, as this is the only way to determine the amount of resources required to deliver comprehensive and quality care.

As long as IHS remains dramatically underfunded, the root causes of the failures in the Great Plains and IHS will not be addressed. In FY 2015, the IHS medical expenditure per patient was \$3,136 while the Veteran’s Administration, the only other federal provider of direct health care services, spent \$8,760 per patient—a 36 percent difference. Disparities in financing for health care such as these lead to disparities in health outcomes. Congress must authorize full funding for the IHS in order to make meaningful progress on the chronic challenges faced by IHS. We remain hopeful that Congress will take necessary actions to fulfill its federal trust responsibility and obligation to provide quality health care to Tribal Nations, by providing adequate funding to the IHS.

Authorize Advanced Appropriations

On top of chronic underfunding, IHS and Tribal Nations face the problem of discretionary funding that is almost always delayed. Stability in program funding is a critical element in the effective management and delivery of health services. Since FY 1998, there has only been one year (FY 2006) in which appropriated funds for the IHS were released prior to the beginning of the new fiscal year. The FY 2016 omnibus bill was not enacted until 79 days into the Fiscal Year, on December 18, 2015. Delays in funding only amplify challenges in providing adequate salaries and hiring of qualified professionals, particularly in areas with high Health Professional Shortage Areas where many Tribal Nations are located.

Budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts all depend on annual appropriated funds. As Congress seeks to improve IHS’ ability to attract and retain quality employees, as well as promote an environment conducive to effective health care administration and management, we urge the inclusion of language that would extend advance appropriations to the IHS.

Clarification for Tribal Health Programs

When it comes to Tribal Nations operating facilities pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638, the current language is ambiguous. We recognize that many provisions contain a “rule of construction” clause that appears to be intended to ensure that the new obligations placed on the IHS in these areas would not interfere with Tribal health programs’ ability to enter into or maintain contracts or compacts under the Indian Self-Determination and Education Assistance Act. We believe that such a rule of construction is helpful, but are concerned that the precise language used does not achieve its goal. Instead, these provisions should be revised to simply state they do not apply to Tribally-operated health programs. Tribal Nations should have a clear sense of which provisions apply to our Tribally-operated programs and which do not.

Section-by-Section Comments

Below, USET SPF offers section-by-section comments and concerns. Again, S. 1250 should not move forward without additional, thorough Tribal Consultation on a national basis.

Section 101—Incentives for Recruitment and Retention

In order to address the ongoing challenges with the recruitment and retention of IHS staff, the legislation would allow HHS to provide housing vouchers or reimburse the costs for those relocating to an area experiencing a high level of need for employment. Though this provision provides the Secretary discretion to determine whether a location is experiencing a high level of need, USET SPF suggests including language for positions that are “difficult to fill in the absence of an incentive.” This addition would allow IHS more flexibility when determining when to offer relocation compensation.

USET SPF agrees that there is a need for recruitment and retention programs. However, the establishment of these programs should not come at the cost of health

care services. USET SPF recommends that additional appropriations be authorized for the proposed recruitment and retention programs.

Additionally, it is unclear why the bill includes a sunset date on the housing voucher program. It is unlikely that IHS staff housing needs will be fully addressed in only a 3-year period. USET SPF suggests that the sunset date be stricken.

Section 102—Medical Credentialing System

USET SPF has deep concerns about the centralization of any Area Office functions, including credentialing. Nashville Area Tribal Nations have consistently advocated for Area Office presence and for services to be administered at the Area level. Collectively, we have worked hard to establish the strong and high functioning Area Office we have today. Taking away functions from Area offices causes significant backlogs in services, and disrupts an established and trusted relationship between the Area Office and Tribal Nations. We believe credentialing should be kept at the Area level, utilizing established best practices.

Section 103—Liability Protections for Health Professional Volunteers at IHS

While USET SPF understands that providing an incentive for healthcare professionals to volunteer at IHS facilities by protecting them from liability would aid in delivering quality healthcare to Indian Country, we believe this provision needs further technical evaluation to ensure patients and healthcare providers are adequately protected. In addition, USET SPF recommends adding language to ensure similar protections are available at Tribally-operated facilities.

Section 104—Clarification Regarding Eligibility for IHS Loan Repayment Program

USET SPF encourages efforts that would expand the Indian Health Service Loan Repayment Program to include degrees in business administration, health administration, hospital administration, or public health professions as eligible for awards. We recommend including language that would expand these degrees as eligible under the IHS Scholarship Program as well. Allowing for comprehensive eligibility under these programs would increase the number of AI/AN individuals seeking business and health administration degrees, as well as increase the pool of qualified health professionals within Indian Country.

Section 105—Improvements in Hiring Practices

When it comes to improvements in hiring, three provisions are included in S. 1250. On the first of these, Direct Hire Authority, language should be included that would require the Secretary to consult with the Tribal Nations served by the Area office where the position will be filled prior to any secretarial action.

On the second provision, we appreciate the inclusion of Tribal Notification of individuals who have been appointed, hired, promoted, transferred or reassigned within IHS. However, language should also be included that would provide notification to Area Tribal Nations on removals based on performance or misconduct. This would supplement the effort of this legislation in increasing transparency and allow Tribal Nations to have greater knowledge and confidence in healthcare professionals providing services to their citizens.

On Waivers of Indian Preference, USET SPF firmly believes that the providers best suited to care for our communities are ones that come from the communities themselves. Therefore, we cannot support the inclusion of this provision, which would set a dangerous precedent throughout other federal agencies that serve Tribal communities. The aims of this provision can be achieved by modifying hiring practices within the current legal framework. There is room for improvements in hiring practices to ensure that positions are being filled in a timely manner with qualified candidates. We recommend directing the Secretary to update and streamline Indian preference hiring practices to ensure that qualified non-Indian applicants will be considered in cases where no qualified Indian applicants are available, at the sole discretion of the Tribal Nations served.

Section 106—Removal or Demotion of IHS Employees Based on Performance or Misconduct

While USET SPF understands the purposes of including language that would expand the Secretary's authority to remove or demote IHS employees based on performance or misconduct, we believe Tribal governments must also be notified when IHS employees within their Service Area become subject to a personnel action such as removal, transfer or demotion. In under Sec. 606 (d) "Notice to Congress", we recommend including "Tribal Governments located in the affected service area" to the

list of entities the Secretary would be required to provide notification to 30 days after the Secretary takes a personnel action on an IHS employee.

Section 107—Standards to Improve Timeliness of Care

It is imperative that any timeliness of care standards are developed in consultation with Tribal Nations. We note that IHS is currently implementing a timeliness standard in accordance with its Improving Patient Care (IPC) Initiatives. We urge consultation with the 170 IHS and Tribally-operated sites that have chosen to participate in the IPC Initiative, as well as aligning with these standards with IPC to ensure that the standards and reporting are not overly burdensome for Tribal health programs.

In addition, we request that any data collected under the provision be provided to Tribal Nations as well as the Secretary.

Section 108—Tribal Culture and History

We support the inclusion of Section 108 that would require annual and mandatory cultural competency trainings for IHS employees, including contractors. However, because each Tribal Nation is unique, language should be included that would require IHS to compile these trainings through consultation with the Tribal Nations they serve, on a regional basis.

Section 110—Rule Establishing Tribal Consultation Policy

While IHS is currently operating under an existing Tribal Consultation Policy, it may be appropriate for Tribal Nations to reexamine and reevaluate its efficacy. Tribal consultation is a cornerstone of the relationship between federally recognized Tribal Nations and the federal government. We do, however, have concerns about the functionality of a negotiated rulemaking and its potential to divert attention and resources away from patient care. USET SPF encourages the use of a Tribal/Federal workgroup to examine, evaluate and update the existing policy and approve through the Public Comment procedures versus official negotiated rulemaking.

Section 202—Fiscal Accountability

USET SPF has concerns with this section and its effect on base funding. This section requires further technical evaluation and explanation, including from IHS, in order to assess its true impact.

Section 302-304—Reports by the Secretary of HHS, Comptroller General, Inspector General

USET SPF recommends including language that would require greater collaboration and consultation with Tribal Nations. We feel the reports laid out in this section should be conducted in collaboration with Tribal Nations and provided to those Tribal Nations for consultation prior to their release to Congress or the public.

Section 305—Transparency in CMS Surveys

As above, USET SPF recommends adding language that would require collaboration and consultation with Tribal Nations during the formulation of these compliance surveys. We also believe the results of these surveys should be provided to Tribal Nations prior to their public release.

Conclusion

USET SPF acknowledges the efforts of the Committee and others within Congress in seeking to address the long-standing challenges within IHS. However, we believe that S.1250 fails to recognize the deep disparities in funding faced by IHS and how these disparities contribute to failures at the Area level. We maintain that until Congress fully funds the IHS, the Indian Health System will never be able to fully overcome its challenges and fulfill its trust obligations. Finally, a number of provisions within S. 1250 seem to be responding to Area-specific concerns. While we stand with our brothers and sisters who are experiencing these failures, we ask that the Committee strongly consider the national (rather than regional) implications of S. 1250, and work with Tribal Nations to ensure its impact is positive in all IHS Areas. We thank the Committee for the opportunity to provide comments on this bill and look forward to further consultation on S. 1250, as well as an ongoing dialogue to address the complex challenges of health care delivery in Indian Country.

PREPARED STATEMENT OF THE DEPARTMENT OF HAWAIIAN HOME LANDS

Chairman Hoeven, Vice-Chairman Udall, Senator Schatz and Members of the Senate Committee on Indian Affairs, we thank you for the opportunity to submit written testimony for the Committee's June 13th, 2017 hearing on S. 1275.

We want to express our deep appreciation to Chairman Hoeven and the members of this Committee for your continuing leadership in seeking to address the housing needs of Native American communities.

Your efforts are a vital part of a long history of congressional initiatives—beginning in 1920, when the United States Congress recognized the dire circumstances in which native Hawaiians were living and enacted legislation to authorize the designation of approximately 203,500 acres of some of the worst available lands in the Hawaiian Islands for homesteading. These lands were intended to provide permanent, safe and secure home lands for the indigenous people of what was later to become the 50th state of America's union of states.

The Hawaiian Homes Commission Act of 1920 did not, however, provide for an appropriation of funds to develop those designated lands, and from that time to the present day, the Hawaiian Homes Commission and the Department of Hawaiian Home Lands have struggled mightily to secure the financial resources needed to clear forested lands and difficult terrain for the development of housing; to assure that roads, clean water resources and sources of power, including access to coal-produced power as well as solar- and wind-produced energy, can be supplied to those housing areas; and to provide for the rehabilitation of the native peoples of these islands while celebrating their traditional knowledge, language and culture.

Title VIII of the Native American Housing and Self Determination Act (NAHASDA) was the response of the Congress to address the critical housing needs of Native Hawaiians. Title VIII moneys have provided opportunities for many families over the years:

- The single father of four who lost his job and could not qualify for a conventional loan to convert his rental to home ownership. With the help of Title VIII funds paying for case management services and homeowner financing, a year later he is employed and providing for his four children as a homeowner
- The autistic young man living in rural Molokai that now owns his own home using NAHASDA mortgage financing and a Section 8 home ownership voucher. In 15 years the home will be his, permanently affordable.
- The elderly grandmother in Maui on a fixed income who received a ready-to-build lot with roads, water, electrical, (etc.) financed by NAHASDA. Her son and grandsons, all employed in the construction industry, plan to help build the home.

Today, while significant progress has been made in carrying out the Congress' 1920 statutory directive, challenges remain and the goals of 1920 Act have yet to be fully realized, as documented by the recently-released 2017 report of the U.S. Department of Housing and Urban Development (HUD) on housing needs in Native America.

According to the May 2017 *Housing Needs of Native Hawaiians: A Report From the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs* HUD study (the study), Native Hawaiians comprise approximately 10 percent of the Native American population of the United States. Of this number, approximately 27,000 Native Hawaiian households are on DHHL's waitlists.

While Native Hawaiians living in Hawaii continue to have lower incomes, need higher rates of assistance, and experience higher poverty rates than other residents of Hawaii, it is not because they are not working. In fact, Native Hawaiians participate in the civilian labor force (either working or looking for work) at higher rates than do other residents of Hawaii, however, the jobs that are available are low wage service industry jobs that do not pay enough to keep up with the sky-high cost of living in Hawaii.

The study highlights that within the Native Hawaiian population, the Native Hawaiian households on DHHL's waiting list (DHHL applicant households) are more economically disadvantaged than are (1) Native Hawaiian households overall, (2) residents of Hawaii households, and (3) Native Hawaiian households already located on the home lands (DHHL lessees). Compared to those groups, DHHL applicant households also experience substantially higher rates of overcrowding and significantly higher rates of substandard housing.

Specifically:

- DHHL applicant households have the lowest median income of the four groups: \$48,000 compared with more than \$60,000 for the three comparison groups;
- One in five of DHHL applicant households receive public cash assistance compared to 7 percent of Native Hawaiians and DHHL lessees and 3 percent for residents of Hawaii;

- Nearly 40 percent of DHHL applicant households are overcrowded compared to 15 percent of Native Hawaiian households and 8 percent of resident of Hawaii households; and
- 10 percent of DHHL applicant households lack complete plumbing compared with one percent for all other comparison groups.

The study identifies one key area affecting all resident households living in Hawaii: housing affordability.

Cost burden rates for residents of the State of Hawaii of 40 percent surpass the national rate of 36 percent. Again, Native Hawaiian residents experience a higher rate than the state as a whole with Native Hawaiian rates at 42 percent. Consistent with the earlier trends, DHHL applicant household rates are the worst off—experiencing cost burden rates of 46 percent.

However, for residents of the home lands (DHHL lessees), the cost burden is very different. DHHL lessees experience a substantially lower rate of cost burden (21 percent) in the Hawaiian home lands communities that were sampled. This is due in part to the financial benefits of living on the home lands, including substantially-reduced housing cost burdens.

For a family and a community, lower housing costs and a permanent home eases the pressures on parents to seek and hold multiple jobs to support their families, provides the opportunity for new households to form, and enhances the well-being of an entire native people.

NAHASDA funding has enabled DHHL to address and target those Native Hawaiian households most in-need: those waiting to reside on the home lands. During the fiscal year ending June 30, 2016, 150 families participated in homebuyer and financial literacy education workshops and received case management services to help prepare them for homeownership as roads, water, drainage, electrical, and other infrastructure investments were being made to the home lands with NAHASDA resources to prepare housing lots for building.

During the fiscal year ending June 30, 2017, 98 ready-to-build lots were awarded to families on Oahu, Maui, and Kauai. Working with selfhelp providers, contractors selected by the families, their own family and friends, and home-builders certified by DHHL, these families are now building their own homes that address their needs at a level they can afford. Another 211 lots are ready to be awarded in fiscal year 2018, available to families now because of NAHASDA.

With NAHASDA monies, DHHL has had the financial ability to address those usually left behind. In Hoolimalima, a rental project on the home lands that converted to homeownership in the state fiscal year ending June 30, 2017, nearly 50 percent of the families were able to successfully purchase their homes because of financing offered by DHHL using NAHASDA resources. Without NAHASDA, the dream of homeownership may never have become a reality for these families.

Over the years, we have come to know much more about the similar challenges that our brothers and sisters in Indian country face—our lands are also held in trust—making it difficult to secure loan guarantees and mortgage financing in the absence of Federal incentives that recognize and seek to address the unique circumstances of trust lands.

We also share with our relatives and friends in the Alaska Native community the barriers of the distance of our lands from urban areas, creating extremely high construction costs for housing.

For Native Hawaiians, perhaps most heart-breaking, is to see their beloved Hawaii Nei be priced out of their reach as land prices and construction expenses soar and new housing is built not for residents but for off-shore investors seeking a vacation home or a luxury residence. The Hawaiian home lands may be the most important, if not only, opportunity for Native Hawaiian families to stay in Hawaii in a permanently affordable home on land that will never be sold.

We endeavor to address the housing needs of a hard-working Native population whose families often have incomes below the poverty level; who are forced to live in overcrowded conditions simply because the housing costs off the home lands are too-expensive; who must work two or more jobs just to pay for basic expenses: food, transportation, shelter, and utilities. Through financial literacy programs, self-help housing projects, and by providing a greater range of housing options we are seeking to reduce the burden of housing costs, as well as reducing overcrowded households and homelessness for working Native Hawaiian families by placing an increasing number of families on the home lands.

We recognize that the resources needed to achieve this goal are substantial. For the state fiscal year 2018, DHHL requested over \$148 million from the Hawaii state legislature to address development costs associated with the development of new lots and the necessary capital for loans for just one fiscal year. Of the requested

amount, the State provided \$34 million or 23 percent of the amount requested. The \$2 million in NAHASDA funds appropriated by the Congress represents a little over 1 percent of the amount needed. Clearly, we recognize that public resources alone cannot meet the need.

Accordingly, we have reached out to partners in the private and commercial markets who have assisted us in the means of leveraging our resources to attract lenders and developers who understand that with the development of homes and communities, comes the potential for greater economic development for all—as neighborhoods, community centers, schools, health care facilities, police and fire protection services, grocery supplies, service industries and stores locate in newly-developed areas on, near and around housing developments on the home lands.

Housing programs under the authority of Title VIII of NAHASDA, including the Native Hawaiian Housing Block Grant, and the section 184(A) Native Hawaiian Home Loan Guarantee programs, have made the dream of home-ownership possible for thousands of native Hawaiians who, for generations, have long thought that access to decent, affordable housing would never be part of their future.

We well understand that today, there are those who harbor constitutional concerns about the provision of housing to America's native people. We believe that those concerns have been answered by the Congress in its enactment of over 160 laws, signed by the President of the United States, and designed to address the conditions of Native Hawaiians, as well as the enactment of hundreds of Federal laws addressing conditions in Indian country and Alaska Native communities.

Like other Native Americans, we seek only to improve the lives of our people—loyal Native Americans who have served our country in defense of our nation in proportionally greater numbers—we are veterans and families of veterans, and we are citizens of the United States. Like many Americans, our people simply want to be able to live in the land of their forefathers, and provide a good life for their children and grandchildren.

We firmly believe that if we work together, we can together forge a legislative path forward which will address the housing needs of all Native Americans—always keeping in the forefront of our minds the knowledge that throughout its history, our great nation has endeavored to assure the highest quality of life for all of its people, including America's first indigenous citizens.

PREPARED STATEMENT OF MIKE HODSON, CHAIRMAN, BOARD OF COMMISSIONERS,
HOMESTEAD HOUSING AUTHORITY

Aloha Chairman Hoeven, Vice Chairman Udall and members of the SCLA,

Mahalo for the opportunity to submit testimony on the BUILD Act of 2017. I am the Chairman of the Board of Commissioners of the Homestead Housing Authority, a nonprofit CDC focused on affordable housing development, services, as well as job creation strategies on our Hawaiian Home Lands. As you know, our land trust was established by the Congress in 1921 with the enactment of the Hawaiian Homes Commission Act.

Our housing authority is a member of the National American Indian Housing Council (NAIHC), and a member of the Council for Native Hawaiian Advancement (CNHA). We were formally incorporated in 2009 by native Hawaiian leaders that are members of their respective island based homestead associations that govern themselves in dozens of trust land areas. Each of our homestead associations, like tribal governments, deliver programs and projects on our trust lands, and in 2009, we decided to combine our efforts through the designation of a housing authority solely focused on affordable housing and jobs for our people across homestead association areas.

My comments on the BUILD Act of 2017, are first and foremost, to correct the omission of NAHASDA Title VIII originally enacted by Congress in 2000, to the BUILD Act. As a recognized native people, and almost 100 years of the existence of our land trust, we must be included and have parity in the BUILD Act with the two other Native groups, American Indians and Alaska Natives.

My second comment is that the actual name of the BUILD Act of 2017 is very exciting, because it focuses on "Building useful initiatives for Indian land development". We definitely need this here on our trust lands. The bill seems to be the reauthorization of NAHASDA, with some positive amendments, like the matching funds to help leverage these powerful resources. We support this, and recommend that this also be included in Title VIII.

My third comment is that our homestead leaders from across the state, convened on March 30, 2017. We had a day long discussion, with one of the top issues being NAHASDA Title VIII. Our leaders have all resided on our trust lands for decades, and are not only experts in our communities, but have become outstanding leaders in taking on economic development and housing projects. We believe that after 17 years of NAHASDA funds being directed to our state agency, the Department of Hawaiian Home Lands (DHHL), we must step forward to fulfill the intent of the HHCA, and Title VIII of NAHASDA. We must take on the responsibility to deliver services as homestead leaders, and relieve the state agency to refocus on its job, which is land distribution under the HHCA. DHHL has stated publicly that they are not a "housing agency", and we agree. As such, we request that NAHASDA Title VIII be included in the BUILD Act, and that the Homestead Housing Authority be named as the TDHE, in keeping with the way NAHASDA for over 200 tribal housing authorities are treated.

This is the most significant action our Congress can do to bring solutions that will last. DHHL will be able to focus on the issuance of homestead allotments, and our Homestead Housing Authority will be able to focus on families to build homes on those lands. We know that this is a bold move, and we also know that boldness is exactly what is needed to position DHHL and our people to succeed.

Thank you.

PREPARED STATEMENT OF THE OFFICE OF HAWAIIAN AFFAIRS (OHA)

Aloha e Chairman Hoeven and Vice Chairman Udall:

The Office of Hawaiian Affairs (OHA) is grateful for the opportunity to provide written testimony on S. 1275, the Bringing Useful Initiatives for Indian Land Development Act of 2017, or BUILD Act. The Office of Hawaiian Affairs is a quasi-independent, semi-autonomous agency of the State of Hawaii established through our State's constitution. Hawai'i state law recognizes OHA "as the principle public agency in this State responsible for the performance, development, and coordination of programs and activities relating to native Hawaiians." OHA is also directed by state law to review policies and practices that impact the indigenous people of Hawai'i. As a native serving organization, OHA supports initiatives that allow native communities opportunities to grow and strengthen. As such, we support reauthorization of the Native American Housing Assistance and Self-Determination Act (NAHASDA).

However, we write to share our concerns with the Committee regarding the exclusion of Title VIII of NAHASDA, the Native Hawaiian Housing Block Grant (NHHBG) and the 184A Native Hawaiian Home Loan Guarantee program, from the BUILD Act. As a vehicle for reauthorizing native housing programs supported by the federal government, the BUILD Act provides an opportunity to support all native communities. The decision to exclude one is, in the end, a detriment to all. The Office of Hawaiian Affairs strongly urges the Committee to restore Title VIII in full, thereby reaffirming Congress's longstanding commitment to its obligations to indigenous people.

Though OHA is not the agency directly responsible for administering the Hawaiian Homes Commission Act (a responsibility which belongs to our sister agency, the Department of Hawaiian Home Lands) many of our beneficiaries are also Hawaiian Homes beneficiaries who

are either residing on or waiting for a lease of Hawaiian Home Lands. There are roughly 9,000 families living on what we refer to as homestead lands, and there are another 27,800 on the waitlist. Based on these numbers alone, which do not encompass the total number of Hawaiian Homes beneficiaries, we note that the BUILD Act is choosing to ignore roughly 37,000 individuals and their families.

A brief history of the Native Hawaiian housing programs may here be warranted. In 1920, Hawai'i's delegate to Congress, Prince Jonah Kūhiō Kalaniana'ōle, put forth a bill aimed at addressing the devastating impact Western contact had inflicted on the Hawaiian people. At the time of first contact in 1778, estimates put the Hawaiian population at as high as 1,000,000 people. By 1920, estimates had the native population at between 20,000 to 30,000 people. Prince Kūhiō, recognizing that his people were dying, made a fairly straightforward proposal: allow native Hawaiians the opportunity to reestablish themselves by providing access to residential, agricultural, and pastoral land formerly held by the Native Hawaiian-established Kingdom of Hawai'i. When Congress contemplated the HHCA, they discussed which lands to set aside, and settled on the proposal of restoring some part of these crown lands, which were held in trust for the Hawaiian people. In 1921, the proposed Hawaiian Homes Commission Act (HHCA) became law. The HHCA set aside 203,500 acres in Hawai'i for 99 year leases to Hawaiian Homes beneficiaries, or native Hawaiians with a blood quantum of 50 percent or more. The passage of the HHCA, and its consideration by Congress over nearly a century, demonstrates Congress's view that the welfare of these indigenous people is in part a federal responsibility.

Since its creation, Congress has continuously acted on the Hawaiian Homes Commission Act. When Hawai'i was admitted into the Union as a State in 1959, a condition of admission was that the State of Hawai'i adopt the HHCA as part of its constitution and continue to administer the law. The United States retained the responsibility of providing consent to any changes made to the HHCA by the Hawai'i State Legislature that could alter the class of beneficiaries or certain trust funds. As the Hawai'i State Legislature made changes to the HHCA, Congress continued to provide consent to those amendments. In 1996, after decades of expressing consent to changes made by the Hawai'i State Legislature, Congress passed the Hawaiian Home Lands Recovery Act (HHLRA). The HHLRA set the parameters for certain settlements owed to the State of Hawai'i by the United States as well as how amendments made to the HHCA by the Hawai'i State Legislature would be handled. In 2000, Congress amended NAHASDA to create a Title VIII, comprised of both the Native Hawaiian Housing Block Grant, to assist the State of Hawai'i in meeting the needs of HHCA beneficiaries, and the 184A Native Hawaiian Home Loan Guarantee program, which provided access to capital that had previously been difficult for lessees to obtain.

That the NHHBG and 184A program were included in NAHASDA is no accident. They represent Congressional action to support the Native Hawaiian community which, like American Indians and Alaska Natives, continues to lag behind our non-indigenous peers in terms of socioeconomic indicators. According to the 2010 Census, Native Hawaiians make up nearly one-quarter of Hawai'i's population. Almost 11 percent of Native Hawaiians in Hawai'i live below the poverty level, compared to 7 percent statewide. Housing costs in Hawai'i are the highest in the nation, with the median price for a single-family home on O'ahu, the state's most populous island, hovering at \$720,000 in 2016. In comparison, according to the Census Bureau, the median cost of a home nationwide is roughly \$300,000. Hawai'i's homeless population is also on

the rise, and some estimates argue that the Native Hawaiian community makes up a significant percentage of the state's homeless individuals and families.

These facts bear out in the housing needs of the Hawaiian population. According to the Department of Housing and Urban Development, relying on the 2010 Census: "27.2 percent of native Hawaiian (or other Pacific Islander) households in the State of Hawai'i are overcrowded, compared to 8.5 percent of all households in Hawai'i." Further:

"Sixty-eight percent of low-income native Hawaiian households experience some kind of housing problem such as affordability, overcrowding, structural quality, availability, or some combination of these problems. For very low-income native Hawaiian households (not exceeding 50 percent of area median income), the needs are more severe, with 75 percent of households in this category facing some kind of housing problem."

The Native Hawaiian Housing Block Grant (NHHBG) was created to address these issues. First, the program provides funding for housing development. The HHCA clearly delineated which lands would be set aside as Hawaiian Home Lands, and in a story similar to that lived by Alaska Natives and American Indians, they were generally remote, arid, and difficult to develop. Most lands must be cleared of forest and leveled. Roads and other infrastructure must be built before the actual process of putting up homes can begin. Providing the Department of Hawaiian Home Lands with funding to support the development of housing has helped hundreds of Hawaiian Home beneficiaries. Beyond this, NHHBG money has also gone to housing counseling programs that have assisted over 1,000 Hawaiians who may not have otherwise qualified for a mortgage or other financing to purchase their homes.

The 184A Native Hawaiian Housing Loan Guarantee Program has assisted numerous beneficiaries in accessing needed capital for purchasing, refinancing, and rehabilitating homes. Again, in a story familiar to our American Indian and Alaska Native brethren, native Hawaiians living on Hawaiian Home Lands have traditionally had difficulty accessing capital. Because Hawaiian Home Lands are leased tracts that cannot be encumbered or otherwise used as collateral, traditional lenders were reluctant to provide loans to Hawaiian Home beneficiaries. The 184A program offers lenders a guarantee in the case of default, providing those Hawaiians most in need with access to more traditional mortgages.

The NHHBG and 184A programs are thoughtful programs created by Congress to assist the State of Hawai'i in carrying out the responsibilities of administering a program that Congress created. They have provided Hawaiian Home beneficiaries, whether currently residing on Home Lands or waiting for a lease, with the opportunity to realize one of the greatest American dreams - home ownership. This is an especially poignant hope for Native Hawaiians, who have too often been priced out of the housing market and forced to leave our ancestral home. NHHBG funds have created new Hawaiian Home communities, supported innovative ways to secure homes including self-help housing, and provided the kind of housing counseling that prevents foreclosure and debt. Through the 184A program, numerous lessees have been able to secure loans they have traditionally struggled with due to the nature of Hawaiian Home Lands; rehabilitate severely dilapidated homes; and find some security through refinancing.

The need for these programs is clear. Yet, we often hear from opponents that they may not be appropriate because they are "race based" programs. This is an odious and erroneous argument that OHA would like to address. The Native Hawaiian community is the indigenous community of the Hawaiian archipelago, which now makes up the State of Hawai'i. Our ancestors were those inhabiting the islands when British explorer Captain James Cook first "discovered" what he named the Sandwich Islands. By the time Captain Cook arrived in Hawai'i, the *kānaka maoli*, one of several names for our community, had resided in Hawai'i for a millennia. Our creation stories convey that these islands are the elder siblings of our people, and that Hawaiians and Hawai'i have been together from the beginning.

Our ancestral governance structure varied from island to island but shared similar traits: chiefs, or *ali'i*, ruled separate land divisions from *moku*, or entire islands, to *ahupua'a*, districts on each island which ran from mountain to sea. The *maka'āinana*, commoners and citizenry, worked the land and sea in a communal structure. This changed in 1810, when after a lengthy struggle, Kamehameha the Great, whose birth we recently honored in the halls of the U.S. Capitol, at the State Capitol in Hawai'i, and at his birth place on Hawai'i Island, united the Hawaiian Islands into one kingdom. While the kingdom allowed citizenship to all people, our monarchs were all descendants of Kamehameha I. Our governance structures changed in type but maintained political influence and authority over the Hawaiian community.

Hawai'i remained a kingdom until 1893, when our last sovereign monarch, Queen Lili'uokalani, was overthrown by a provisional government with strong ties to the United States. In 1898, the Republic of Hawai'i was annexed by the United States. Despite this, however, the Hawaiian people continued to express and demonstrate communal ties and political organization. We formed our own party, to stand in contrast to the Democrats and Republicans elected to our Territorial Legislature. We sent Hawaiian delegates, first Robert Wilcox, a Native Hawaiian descended from our chiefs, then Prince Kūhiō, to represent the Territory of Hawai'i in Congress.

Some other flashpoint examples in recent Hawaiian history demonstrate that we have maintained our collective cultural ties; working to stop the bombing of Kaho'olawe, an effort led by Native Hawaiians to protect a sacred island; with the assistance of other Pacific peoples creating the Polynesian Voyaging Society, which demonstrated that Hawaiians could and did navigate the Pacific Ocean without the use of modern, European technology; the restoration of the Hawaiian language, which had nearly died out; the 1978 Hawai'i Constitutional Convention which led to the creation of the Office of Hawaiian Affairs. We continue to exist as a distinct community, as we have since time immemorial.

Congress has repeatedly recognized and affirmed not only the United States' relationship to the Native Hawaiian community but how that relationship is akin to the relationship the United States has with Alaska Natives and American Indians. In short, Native Hawaiians are an indigenous community with which the United States has a unique, special trust relationship. The Native Hawaiian housing programs outlined in this testimony are modeled after the Indian Housing Block Grant and the 184 Indian Home Loan Guarantee program because, not in spite, of this fact.

As this Committee is structured to consider policies that affect Alaska Native, American Indian, and Native Hawaiian communities, we would like to restate our original premise for the

Committee's consideration. Native Hawaiians, like Alaska Natives and American Indians, enjoy the same rights to self-determination as native communities. As native communities, we demonstrate similar successes, but also suffer similar setbacks. A misguided policy by Congress to exclude Native Hawaiians in a bill that could instead lift all native communities is a precedent that should be avoided. We urge this Committee to include the Title VIII Native Hawaiian housing programs in the BUILD Act or any other legislation aimed at reauthorizing NAHASDA.

Again, we thank the Committee for the opportunity to submit this testimony regarding the BUILD Act. We thank Chairman Hoeven for his commitment to strengthening native communities by the continued authorization of the Native American housing programs included in his bill. We hope that we have demonstrated to the Chairman and this Committee the importance of the Native Hawaiian housing programs that are currently excluded from this bill, and ask the Committee to reject any measure that excludes or divides our nation's indigenous people.

PREPARED STATEMENT OF ROBIN PUANANI DANNER, CHAIRMAN, SOVEREIGN COUNCILS OF THE HAWAIIAN HOMELAND ASSEMBLY (SCHHA)

Aloha Chairman, Vice Chairman, Members of the Senate Committee on Indian Affairs:

About the SCHHA & Homestead Associations

My name is Robin Puanani Danner, and I am the elected chairman of the Sovereign Councils of the Hawaiian Homelands Assembly (SCHHA). Founded in 1987, the SCHHA is the oldest and largest coalition of native Hawaiian self-governing homestead associations defined by and recognized in the 1921 Hawaiian Homes Commission Act (HHCA), enacted by Congress.

For nearly 100 years since enactment of the HHCA, native Hawaiians have organized themselves in land-based areas of trust lands located on every island in the state, which we refer to as 'homesteads' or 'Hawaiian home lands'. Today, these organizations are commonly known as homestead associations with democratically elected leaders by HHCA eligible native Hawaiian beneficiaries. The SCHHA coalition unites more than 35 of these trust land areas across our state, bringing together the collective knowledge and leadership of HHCA native Hawaiians, to focus on the implementation of the HHCA.

The federal government defines homestead associations in the Code of Federal Regulations as follows:

A beneficiary controlled organization that represents and serves the interests of its homestead community; has as a stated primary purpose the representation of, and provision of services to, its homestead community; and filed with the Secretary a statement, signed by the governing body, of governing procedures and a description of the territory it represents.

While the SCHHA and all of the homestead associations in our coalition work directly with our state government and relevant state agencies, including the State of Hawaii, Office of Hawaiian Affairs (OHA) and the State of Hawaii, Department of Hawaiian Home Lands (DHHL), we have a direct trust relationship with the federal government as established by the Congress under the HHCA. Similar to federally recognized tribal governments, our self-governing associations engage directly with our federal government, most notably, the federal Department of Interior, the USDA, the FCC and HUD, to promote the well-being of our trust lands and its people.

We also engage with the national Native Hawaiian advocacy organization, the Council for Native Hawaiian Advancement (CNHA) most comparable to the National Congress of American Indians (NCAI) and the Alaska Federation of Natives (AFN) to fully participate in national policy issues to advance the tenets of the HHCA and the well-being of all Native peoples.

HHCA Policy Era & Land Trust Administration

The HHCA was enacted during the policy era of the United States, wherein many Indian Land Allotment Acts and trust land areas were established by the federal government for American Indians and Alaska Natives. Congress established the HHCA to address the same issues for the Native people of Hawaii now in the 50th state, as it had done for the 49th state of Alaska and the 48 contiguous states. The HHCA is most similar to 1906 enacted allotment policies for American Indians and Alaska Natives of that era.

In 1959, our trust lands under the HHCA were directed by the Congress through the Hawaii Statehood Act, to be administered by the State of Hawaii, with federal oversight. As a result, the State of Hawaii has been delegated administrative functions to implement the HHCA with oversight by the federal Department of Interior, and as Native peoples in Hawaii, we engage with both our State and Federal governments on issues involving the HHCA, to fulfill its purpose and intent.

In 1995, the Congress enacted the Hawaiian Home Land Recovery Act, which settled lands lost from use in our land trust for a specified period of time, but it also reaffirmed the role of the federal government in its direct trust relationship to HHCA eligible native Hawaiians, and further defined responsible parties within the federal Department of Interior to lead the overall federal government trust relationship.

In 1996, the Congress enacted the Native American Housing Assistance and Self Determination Act (NAHASDA), and four years later in 2000, the Congress added title VIII to properly include HHCA eligible native Hawaiians and our trust lands to be on par with American Indians and Alaska Natives.

The *Bringing Useful Initiatives for Indian Land Development (BUILD) Act of 2017* focuses on NAHASDA, addressing reauthorization, streamlined environmental assessment processes, technical assistance resources and leveraging authority.

S. 1275 BUILD Act Comments & Recommendations

We mahalo Senator Hoeven for the introduction of S. 1275 to primarily reauthorize NAHASDA. We offer the following comments:

1. **Include Title VIII.** We comment that Title VIII of NAHASDA, specifically for the trust lands established for HHCA eligible native Hawaiians by Congress in 1921, which were included in NAHASDA in 2000, should be included in S. 1275.

The omission of Title VIII would debilitate the efforts of our federal government, state government, self-governing homestead associations and the Homestead Housing Authority to address severe homelessness, and lack of affordable housing in Hawaii and more specifically, on the HHCA trust lands. In addition, the omission of Title VIII undermines the ability to fulfill the purposes of the HHCA, enacted nearly 100 years ago.

Trust lands are unique, as is the long-established trust relationship with American Indians, Alaska Natives and Native Hawaiians, as we know the members of the committee are aware from your own experiences in your home states where both exist.

It is imperative that Title VIII be included in the BUILD Act of 2017.

2. **Self Determination.** We comment on improvements requested to Title VIII through the BUILD Act of 2017, to better reflect the Self Determination goals of NAHASDA, that truly bring useful initiatives for land development on our trust lands. After more than 15 years of experience with NAHASDA, there are 3 major improvements that we offer to improve on meeting the self-determination goals intended by the Congress and indeed the words 'self-determination' in the title acronym of the NAHASDA law.

- a. **On or Near** - Add to the eligibility of the HUD 184a loan guarantee program under Title VIII, the words "on or near" trust lands, to enable robust engagement by HHCA eligible native Hawaiians in the open housing marketplace with mortgage lenders and developers, regardless of whether a unit is located on trust lands, or nearby on fee simple lands.

This simple improvement to NAHASDA Title VIII, will energize the real estate market to address the lack of housing inventory on trust lands by creating purchase transactions and opportunities off trust lands.

And finally, this improvement brings parity to the trust lands in Hawaii, with trust lands in Indian Country and Alaska where the 'on or near' language has been implemented.

- b. **Consultation** – Add a basic requirement that any grant recipient of Title VIII NAHASDA funds, is mandated to conduct consultation with homestead associations and HHCA eligible native Hawaiians before HUD can approve annual Housing Plans using NAHASDA funding.

This improvement will ensure that NAHASDA Title-VIII funds benefit from the direct knowledge and expertise of locally governed homestead associations in every region of our land trust, each of which are unique, just as individual tribal areas are unique.

- c. **Grant Recipient** – Replace the State of Hawaii as the NAHASDA Title VIII grant recipient, with the locally controlled and governed Homestead Housing Authority, to bring parity with the more than 200 Tribal and Native nonprofit Housing Authorities across the country. Hawaii is the only location in the country where NAHASDA funds are directed to a state government, instead of a housing authority governed by the Native people themselves.

This improvement is timely, given the incredible capacity developed over the last 2 decades by homestead associations to implement trust-land based economic and affordable housing projects. In 2009, homestead association elected leaders from across the state, convened to incorporate a dedicated homestead community development corporation nonprofit to be wholly dedicated to job creation and affordable housing.

Today, similar to hundreds of tribal and Indian housing authorities receiving NAHASDA funding, the Homestead Housing Authority is governed by a 5-person Board of Commissioners, with homestead leaders serving from the island of Kauai, Maui, Oahu, Molokai and Hawaii Island. The housing authority owns and operates marketplace projects, a certified kitchen and café, salons and retail spaces, an enterprise center, and operates business incubator programs. It has also developed affordable housing on two islands, and is in the process of a 54-unit rental project on the island of Oahu.

This improvement to Title VIII is also timely, given the challenges experienced by the currently named grant recipient, the state government agency, to adequately, efficiently and economically, spend down NAHASDA Title VIII funding to address the homeless and affordable housing needs of HHCA eligible native Hawaiians.

The time has come for the trust lands and the HHCA eligible native Hawaiians Congress intended to impact nearly 100 years ago with the enactment of the HHCA, and 17 years ago with the enactment of Title VIII NAHASDA, to take on the responsibility and activities that embody the goals of self-determination.

The SCHHA fully supports the transition of the recipient of Title VIII NAHASDA funds to be on par with over 200 tribal housing authorities, from a state government

agency to the Homestead Housing Authority. This perhaps, is the most impactful aspect that the BUILD Act of 2017 could accomplish on our trust lands to bring useful land development to our homelands.

3. **Leveraging.** We support section 7 of the BUILD Act that authorizes NAHASDA funds to be applied as match funding with other federal or non-federal programs and projects, and request that this excellent language be included in Title VIII.
4. **Trailblazing & Technical Assistance Resources.** Technical assistance and training is such an important aspect of any programming, we appreciate that the BUILD Act contains a section on this. We commit that best practices established particularly for trust land areas, should require any providers of such services to have a specific mission and expertise in Native lands, Native peoples, and indeed, the best providers are organizations that are governed by Natives themselves with an acute understanding of federal and national Indian policies. Capacity in a subject matter such as housing or the use of tax credits for example, can many times be irrelevant, if there is no expertise in Indian history, Indian lands, Indian approaches to challenges, and the practical application of Indian law.

Federal Program for Native Peoples

Some engaged in national conversations on Indian and Native public policy have opined that Indian Housing, including Native Hawaiian housing programs may be "race-based". Honorable members, your committee is well versed on the standing of Native peoples in this country, and the plenary powers of the U.S. Congress to address the needs of America's Indigenous peoples.

American Indians indigenous to the 48 states, Alaska Natives indigenous to the 49th state, and indeed Native Hawaiians indigenous to the 50th state, are without question, America's Indigenous peoples. Speaking for the SCHHA, our trust lands and people, defined under the 1921 HICA, the 1959 Hawaii Admissions Act, the 1995 HILRA and of course the 2000 NAHASDA Title VIII, the U.S. Congress has repeatedly reaffirmed its trust relationship with us, enacting federal policy and programs based on the unique political relationship with us, and other indigenous populations that predate our U.S. constitution, and not as a race of people. As members of the committee know, this is fundamental civics.

Honorable members, thank you for the opportunity to submit testimony on S. 1275, the BUILD Act of 2017. Please do not hesitate to contact me at 808-652-0140 or at schha.associations@gmail.com to provide any additional information.

PREPARED STATEMENT OF HON. TROY "SCOTT" WESTON, PRESIDENT, OGLALA SIOUX
TRIBE

Thank you for holding your June 13, 2017 hearing on S. 1250, the Restoring Accountability in the Indian Health Service Act. On behalf of the Oglala Sioux Tribe ("Tribe"), I appreciate the opportunity to comment on this important piece of legislation. As we have previously testified before this Committee, the substandard quality of care at Indian Health Service (IHS) facilities is a dire threat to the lives of our tribal members and an unacceptable abandonment of the United States' treaty and trust responsibilities.¹ The Tribe fully supports increased IHS accountability and transparency, and we urge the Committee to move forward with this legislation while ensuring that tribes are fully consulted and that the legislation itself prioritizes tribal consultation in key decision-making.

Treaty and Trust Obligations to Provide Health Care

In the Fort Laramie Treaty of 1868, the United States promised to provide certain benefits and annuities to the Great Sioux Nation in exchange for the right to occupy vast areas of our territory. Among the most sacred of the promises made was the promise to provide health care services. The United States has a trust obligation to provide for the health and well-being of all Indian tribes, but it is our position that it also has a specific treaty obligation to the Oglala Sioux Tribe.

¹ Please see the Oglala Sioux Tribe's Written Testimony and Supplemental Testimony submitted to the Senate Committee on Indian Affairs for its February 3, 2016, hearing entitled, "Reexamining the Substandard Quality of Indian Health Care in the Great Plains" for details about the substandard quality of care and problematic access to care on the Pine Ridge Indian Reservation and in the Great Plains Area.

The United States has tasked the IHS with carrying out the federal duty to provide health care services to our Tribe and others, but the IHS is failing at this task. Our Pine Ridge Hospital is not a functioning facility capable of meeting even the basic health care needs of our people, and the Centers for Medicare & Medicaid Services (CMS) has repeatedly found the facility deficient. The Sioux San Hospital near our reservation had its emergency room shut down last year. Meanwhile, our citizens face infant mortality, obesity, diabetes, and heart disease in staggering proportions; and the average life expectancy on our Reservation is only 50. This is unacceptable.

What is more, these problems are not new. In 2003, the U.S. Commission on Civil Rights shined a light on Indian Country's unmet health needs and many of the problems facing IHS, such as difficulty recruiting and training employees.² In 2010, this Committee held a hearing exploring the urgent need to reform IHS in the Great Plains Area, prompted by years of complaints of mismanagement and substandard care. The hearing followed up on a formal investigation of the IHS Area, which resulted in a report by then-Committee Chair Byron Dorgan confirming and documenting the deplorable condition of the Area's health care services to Indians.³ Nearly two years have passed since the Winnebago Hospital in our Great Plains Area lost its certification—the first of our Area hospitals to do so. Nevertheless, years pass while our tribal members continue to suffer from shamefully inadequate IHS services, gross mismanagement, and a nearly complete lack of transparency.

We thank the Committee for its attention to the grave situation our Tribe and others face. It is time for the United States to fulfill this important treaty and trust obligation.

Employee Recruitment, Retention, Training, Accountability and Termination

We strongly support S. 1250's provisions to address IHS staffing challenges. As we have previously testified, insufficient staffing is a serious problem impacting both access to and quality of care for the Great Plains Area. The bill's loan repayment program and its authorization of competitive pay scales are critical to recruiting qualified professionals to our region. We also appreciate the bill's attempt to address the need for housing assistance by providing relocation assistance and housing vouchers. However, on our Reservation, housing vouchers alone are insufficient to address this significant recruitment challenge because we lack adequate housing infrastructure near our hospital and clinic facilities. Our entire Reservation is presently in a housing crisis, and we desperately need assistance developing housing infrastructure for hospital and clinic staff.

Our Tribe also supports the bill's efforts to increase the quality and accountability of IHS staff. We support the medical credentialing system the bill would authorize and its standards

² A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country, U.S. Commission on Civil Rights (July 2003).

³ In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area, Report of Chairman Byron L. Dorgan to the Committee on Indian Affairs, 111th Cong. (Dec. 28, 2010).

to improve timeliness of care. The bill would also expand requirements for tribal culture and history training. This is a step that is desperately needed, and we encourage Congress to ensure that there are penalties for non-participation in the annual training and that training materials are developed in consultation with the particular tribes served. We also request that this provision be expanded to apply to all IHS employees, not just ones with regular patient contact. The knowledge and cultural sensitivity of employees at all levels of the IHS affects the agency's relationship with our Tribe and the way it fulfills, or fails to fulfil, its treaty and trust obligations.

We also welcome the Inspector General report required by Section 304, which would monitor quality of care. We have repeatedly testified on the shockingly substandard quality of care in the Great Plains Area. Section 304 would provide much-needed data regarding the quality of care and require an audit of IHS reporting systems. Our Tribe also supports other reports required by the bill, including GAO and HHS reports regarding housing and staffing needs.

Generally, we support S. 1250's intention to improve hiring practices and speed up demotions and terminations when necessary. In particular, we have previously testified that poor management practices and the "recycling" or shuffling of problem employees persists in the Great Plains Area, as does the use of administrative leave in lieu of more appropriate sanctions. However, we believe S. 1250 needs to require tribal consultation regarding key employment decisions. Section 105 provides that the Secretary of Health and Human Services (HHS) would be required to notify Tribes of the appointment, hiring, promotion, transfer, or reassignment of a Senior Executive position or manager at an Area Office or Service Unit. Similarly, Section 106 would allow the Secretary to remove or transfer an employee based on performance or misconduct, but the Secretary would only be required to notify Congress, not the Tribes. These employment decisions greatly affect the quality of our care, and we must have a voice in the decision-making process. Additionally, IHS employees should be held accountable not only to the agency but also to the Tribe and our members.

Section 109 of the bill provides a staffing demonstration project, which we do not support in its current form. As frequently happens, our Tribe's grave statistics and disparities fuel the creation of a demonstration project and then we are excluded from participation because we lack resources or infrastructure. The staffing demonstration project in the current bill, for instance, requires that a Tribe have contributed substantial funds to construct a health facility and be located in a Medicaid expansion state. Tribes like ours that are in the poorest and most vulnerable positions would not benefit from such a demonstration. The Great Plains is in crisis as we speak, and all necessary resources should be going to addressing this crisis. Further, the explanation for staffing shortages at our hospitals and clinics are not complicated—qualified professionals do not want to live in remote areas without adequate infrastructure, housing, schools, and roads. Further, they do not want to receive inadequate pay, have a lack the resources they need to do their jobs, and be subject to dysfunctional

managerial environments. Likewise, the solutions are not complicated and the unmet needs have been documented time and again. We urge Congress to ensure that resources are going to the areas of greatest need in order to tackle our health care crisis head on.

Fiscal Accountability

The Oglala Sioux Tribe welcomes the increased fiscal accountability that S. 1250 seeks to implement. Section 202 of the bill would provide for additional oversight of IHS money management and require the preparation of spending and status reports that would be provided to Congress and Tribes. This oversight and transparency is desperately needed. In the Great Plains Area, we have been struggling to get information regarding Area finances. Very little funding seems to reach the facility level to provide direct patient care. But, as we have previously testified, we lack the information necessary to determine whether this is the result of poor management at the Area Office level. We believe Section 202 would go a long way towards increasing transparency.

Section 202 also limits how IHS can spend unobligated funds at the end of the fiscal year. We support such limits, but the bill should require that decisions about how to spend unobligated funds are to be made in consultation with the Tribes in the Service Unit.

Tribal Consultation

Section 110 requires the Secretary to update IHS's Tribal consultation policy through a negotiated rulemaking. We are pleased to see this dedication to Tribal consultation, as it is critical that Tribes have meaningful input into IHS decision-making processes. We urge the Committee, however, to ensure that S. 1250 specifically requires consultation in key employment decisions, decisions regarding unobligated funds, and the development of training materials.

Conclusion

Thank you for your attention to the health care crisis in the Great Plains Area. Working together, I am confident that we can make needed reforms to the IHS to ensure that our tribal members receive the quality care that they deserve and were promised through treaty.

PREPARED STATEMENT OF HON. BRIAN CLADOOSBY, CHAIRMAN, SWINOMISH INDIAN TRIBAL COMMUNITY

On behalf of the Swinomish Indian Tribal Community ("Tribe"), thank you for convening the June 13, 2017, hearing on S.1250, the Restoring Accountability in the Indian Health Service Act. The legislation would amend the Indian Health Care Improvement Act in several ways and would increase transparency and accountability at the Indian Health Service (IHS), streamline the hiring of medical staff, provide incentives for doctors and nurses to stay on the job, and protect whistle-blowers who report violations of health and safety rules. Of course, all of these are laudable goals designed to address the many disparities in medical and dental health in Indian Country.

During the hearing, one of the non-tribal witnesses provided testimony on Section 102 of the legislation. That section would standardize and streamline credentialing at IHS facilities. The Tribe would like to provide additional context to ensure that the Committee understands that while streamlining credentialing is important, volunteers are not a long term solution to health care needs in Indian country.

The Swinomish Tribe and I have a particular passion for improving oral health and oral health care in Indian Country. Oral disease is the most widespread chronic

disease, despite being highly preventable and manageable. Oral health is essential to overall health and well-being at every stage of life. Like any other infection or disease, oral disease must be managed. What is needed to best do this is a workforce of skilled and culturally-competent oral health providers who have a long-term and consistent presence in tribal communities.

Dental professionals have recognized the unmet need for oral health providers in Indian Country, and have proposed volunteer or other short term providers as a solution. We appreciate the commitment of volunteers in Indian Country. But this is not an effective way to manage any infection or disease, and it has not been successful in tribal communities. Instead of looking to volunteers providing surgical or other short-term solutions, tribes want to replicate long-term strategies that follow a more medical model for oral disease management and utilize more members of the dental team.

In short, we need to think about oral disease and health care differently, and that is just what we have done at Swinomish. We looked north to Alaska, where for ten years Dental Health Aide Therapists have been an integral party of the dental team, providing long-term, consistent and culturally-competent care to remote Alaska Native populations. The Swinomish Tribe established its own program for integrating Dental Therapists into our Dental Clinic team, where all dental providers are licensed and regulated under Swinomish Tribal law. The State of Washington recently passed legislation explicitly recognizing as practitioners Dental Health Aide Therapists who are licensed under Tribal law and practicing in tribal communities.

For more than a year the Dental Therapist at our Swinomish Dental Clinic has been successfully working as a member of our oral health team. Just like the mid-level providers in our medical clinic, expanding the dental team with Dental Health Aide Therapists and more efficiently utilizing all members of the dental team has shown strong results in Alaska and here at Swinomish for improving oral health.

Swinomish takes an evidence-based approach to health care. Researchers from the University of Washington presented a paper at the National Oral Health Conference this year that shows that over a 10 year period, children and adults living in villages in Alaska with Dental Health Aide Therapists had fewer extractions and more access to preventive care than villages without Dental Health Aide Therapists. There has been a nearly 300 percent decrease in extractions of the first four front teeth for children under age three in villages with Dental Health Aide Therapists. That is nearly 300 percent more happy and healthy smiles—and that is real progress.

This demonstrated success is the result of consistent, high quality, community based oral health care provided by culturally competent staff. It was just this success that prompted the Swinomish Tribe to license and hire Dental Therapists as part of its team.

We urge the Committee in its work on this important legislation to be cognizant of the need to provide sustained health care for Indian country, including oral health. Volunteers are welcome and standardizing credentialing will make it more efficient to deploy them. Volunteers, however, will never be a long term solution to Indian country's unmet health care needs.

PREPARED STATEMENT OF GUNDERSEN HEALTH SYSTEM

On behalf of Gundersen Health System we are writing to provide testimony in response to the committee hearing held June 13th to express support for Senate Bill 1250, (and companion bill H.R. 2662), the *Restoring Accountability in the Indian Health Service Act*. Specifically, we are supportive of Section 102, relating to medical credentialing systems, and Section 103 applying liability protections for professional volunteers.

Gundersen Health System is an integrated health system located in nineteen counties throughout western Wisconsin, southeastern Minnesota and northeastern Iowa. Our system includes a primary hospital in La Crosse, four critical access hospitals and over 50 clinics throughout the region. With over 7,000 employees, we are the largest employer in the area. As a Healthgrades Top 50 hospital in overall care, many clinical specialty services, and patient experience, we are committed to supporting public policy that helps to enrich every life through improved community health, outstanding experience of care, and decreased cost burden.

Gundersen Health System is firmly committed to providing services to improve the health and wellbeing of communities both near and far. Gundersen is proud to have established the Global Partners program that has provided needed healthcare services to critical areas both in U.S. and throughout the world. Since 2008 Gundersen Health System has collaborated with the Pine Ridge Service Unit of the

Indian Health Service in South Dakota to provide healthcare services to residents on the reservation. Throughout this partnership, Gundersen Global Partners has continuously sent volunteer physicians, nurses, and staff for week-long periods at IHS clinics on the reservation, providing clinical, diagnostic, and even surgical services. The volunteers at Gundersen have logged thousands of hours of complimentary services for members of the Oglala Sioux Tribe, and is proud to continue in this partnership.

However, administrative barriers have prevented teams from volunteering on a consistent basis. Procedures for credentialing of healthcare providers for the Indian Health Service have become challenging to meeting the needs of individuals and families at Pine Ridge. We are very pleased Section 102 establishes a uniform process for medical credentialing, including the consultation with existing services that would meet the guidelines of the Indian Health Services, and efficiently credential volunteer professionals. Removing unnecessary duplication, especially for volunteer healthcare providers and nurses would provide much needed relief and improve our existing partnership.

In addition, we are supportive of liability protections provided in Section 103 of the legislation. We appreciate this provision that recognizes the volunteer efforts of our providers by deeming them public health service professionals while serving Indian Health Service individuals and families.

On behalf of Gundersen Health System, and our Global Partners Program, we greatly appreciate the opportunity to provide comments on S. 1250, *Restoring Accountability in the Indian Health Service Act*. This bill would help address administrative barriers and improve our ability to provide services for those in need. We thank the Committee for holding this hearing and ask the Committee to advance the legislation forward.

Please feel free to contact us with any questions or if you would like to learn more about Global Partners Program and partnership with the Pine Ridge Reservation.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO
DR. KEITH HARRIS

Question 1. The Blackfeet reservation is approximately 180 miles one way from the nearest VA facility. How is the VA ensuring homeless veterans of the Blackfeet reservation or any extremely rural tribe are receiving the required direct services under the program?

Answer. The Department of Veterans Affairs (VA) is ensuring that Veterans enrolled in the Tribal Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program are receiving the required direct services under the program. VA case managers are located in or near communities served by the tribe. Case managers coordinate and provide VA care, including psychosocial services, including mental health and substance use disorder care, and also connect Veterans to needed services that are available locally. VA also has technology capabilities enabling case managers to provide services remotely, augmenting the face to face services described above.

VA case managers are also working collaboratively to ensure that the supportive services and resources are available to Veterans. Most HUD-VASH programs have sought licensed clinical social workers, who provide a wide range of clinical services directly to the Veteran, from skill building to substance use disorder treatment to psychotherapy, if needed and appropriate. On or near many reservations, VA has community-based outpatient clinics (CBOC) that can provide primary care, mental health, and substance use disorder assistance. VA also connects Veterans to local service providers for assistance that VA cannot provide, such as assistance with employment, food or other support. The Indian Health Service (IHS) within the Department of Health and Human Services, or a tribally operated health program, may also offer primary care and specialty services that can be provided locally. In circumstances in which VA medical center specialty care is needed, the VA case manager can assist in securing transportation for associated appointments. VA case managers also have connections with groups such as the Elks Club, Military Outreach USA, or Home Depot, who can provide furniture and other household items.

Specific to the Blackfeet Nation, VA has a temporary case manager in place until a permanent case manager is hired. The case manager travels to the Blackfeet Nation monthly and is available to travel more frequently as needed. The current case manager ensures that Veterans are connected with the CBOC in Cut Bank, Montana, which provides primary care, mental health, and substance use disorders services. The case manager also ensures the Veterans are connected with the local IHS facility. Additionally, "Manpower," a local community center, is located nearby and

offers a range of co-located social services, including employment services. The Manpower community center also provides an opportunity for the case manager to educate key stakeholders on VA services, how to coordinate referrals, and promote service utilization between VA and the service providers.

Question 2. How does the VA identify or locate eligible veterans in areas with vast geographical challenges such as the Blackfeet Tribe of Montana, who are one of the 10 largest tribes in the United States, and sit on a reservation of approximately one-and-a-half million acres in the remote northwestern part of Montana?

Answer. VA has found success in identifying or locating eligible Veterans by ensuring that the tribal government is part of the solution. The tribal government and the tribal designated housing entity (TDHE), along with the case manager, are collaboratively working on recruitment for eligible Veteran participants. The tribe has a central role in referring Veterans, as they are most familiar with which Veteran members are homeless or at-risk of homelessness. As one example, to enhance the identification of eligible Veterans, the VA Portland Health Care System (HCS) Director and the VA Office of Tribal Government Relations Specialist met with the Warm Springs tribal government, and developed a collaborative approach that has resulted in a significant increase in referrals.

VA case managers are working with the VA Public Relations staff and tribes to engage the tribes and other local media (such as: <https://cheyennearapahotribal.tribune.wordpress.com/2017/05/11/a-veterans-guide-to-the-hud-vash-tribal-program-oklahoma-city-ok-va-health-care-system/> or <http://www.kfyrtv.com/content/news/Iraq-veteran-receives-new-home-thanks-to-HUD-VA-housing-grant-387033601.html>) in marketing the program. The tribal government and TDHEs also directly refer Veterans to the VA case manager.

VA case managers participate in various events hosted by the tribe and/or Tribal Veterans Service Officer. VA holds Homeless Veteran Stand Downs in tribal communities to meet and speak with Veterans who are homeless or at risk of homelessness.

The HUD-VASH program office holds calls with the Tribal HUD-VASH case managers twice each month, at which innovative practices and successful engagement strategies are shared. As part of the joint training led by HUD and VA with the tribes and VA case managers, there have been modules focused on marketing and engagement strategies. Tribal entities and case managers worked together in these sessions to develop outreach and marketing strategies.

Question 3. What has VA done to address these specific challenges since you wrote me that response letter?

Answer. VA has been working on the noted challenges including:

- recruiting qualified applicants who are able to work independently and have the required clinical skills
- lack of available housing for case managers working on or near the reservations
- lack of available office space for case managers
- safety and work related challenges
- transportation challenges
- locating eligible Veterans
- educating TDHEs on the implementation of the principles of Housing First, the required model of care for Tribal HUD-VASH
- concerns expressed by tribes regarding program longevity

In March, there were seven locations that did not have a VA case manager hired. Today, there are five locations, but of those, two have case managers expected to begin in August, and one is a recent vacancy after the case manager accepted another position. Additionally, the VA Montana Health Care System (HCS) has a temporary case manager assigned until a permanent case manager is hired.

At this time, there are only two positions that remain difficult to fill, Blackfeet Nation in Montana and the Association of Village Council Presidents (AVCP) in Alaska. They both were approved for fiscal incentives, such as retention and relocation expenses. These positions have ongoing open announcements posted on USA Jobs. The case manager position for the Blackfeet Nation had two applicants, who interviewed on July 18, 2017, and a provisional offer was recently made to one of the candidates. While there is no housing available in Browning, case managers may live in Cut Bank or potentially in smaller communities or farmland areas close to the tribe. The AVCP position has several applicants and interviewing will be completed during the week of August 14, 2017. VA medical centers may elect to expand the range of disciplines to include Licensed Marriage and Family Therapists, Li-

censed Professional Counselors, Registered Nurses, Licensed Mental Health Counselors, and Licensed Master Social Workers in addition to the standard Licensed Clinical Social Workers, particularly in those remote or frontier locations where other services may be more limited.

VA facilities have been working to ensure the implementation of Tribal HUD-VASH. Office space continues to be a challenge, but VA case managers are teleworking as needed. Additionally, they meet with Veterans in community locations and at the TDHE. Some case managers are working in space provided by the tribe. Case managers may travel to VA CBOC locations for meetings, for Veteran assistance, and to ensure Veterans' documentation is submitted electronically. Black Hills VA HCS purchased cell phone boosters for their staff to ensure cell coverage throughout the reservation, and they also obtained four-wheel drive vehicles to account for terrain and weather. This information has been shared with other sites. VA is actively collaborating with tribes and tribal Veteran Service Organizations on outreach, the referral process, and marketing strategies to ensure that tribal members are aware of and informed about the Tribal HUD-VASH program. Notably, twenty tribes are now housing Veterans and two tribes have Veterans in case management who are actively seeking housing. While the limited stock of viable rental housing continues to be a concern, tribes are demonstrating creativity and flexibility to ensure that housing is available for the program. For example, tribes are housing Veterans in communities within their service area but off of the reservation, are electing to forgo funding for currently unoccupied Formula Current Assisted Stock (FCAS) under the Indian Housing Block Grant (IHBG) program, so that the Tribal HUD-VASH assistance can be used on that housing unit instead, and developing housing with tax credit programs. Tribes have also investigated potentially using Federal Emergency Management Agency trailers. The recent renewal funding provided by Congress in the budget for fiscal year 2017 demonstrates Federal commitment to the program, supporting tribes' continuing investment in the Tribal HUD-VASH program.

Question 4. Why has it generally been so difficult to hire case managers to provide wrap-around services to homeless Native American veterans that are receiving Tribal HUD-VASH vouchers?

Answer. Case manager recruitment has been challenging in some locations, primarily due to the rural/frontier location of the tribe, affordable housing challenges for some staff considering a move to a location (such as in South Dakota with the Bakken oil and gas field), and in a few cases, tribal governance changes such as with Leech Lake, which elected a new tribal government; VA was asked by the tribe's interim government to stand down hiring until the new government determined their interest in program participation. Delays in the hiring process have also been a contributing factor.

The two positions that have been particularly challenging to fill are with the Alaska VA HCS associated with the AVCP TDHE, and the VA Montana HCS associated with the Blackfeet Nation. VA approved financial incentives to facilitate recruitment and retention, including fiscal relocation support for case managers for AVCP with the Alaska VA HCS and Blackfeet Nation with the VA Montana HCS. The VA medical centers also have options for broadening the pool of potential applicants. The Alaska VA HCS has opened recruitment to Licensed Marriage and Family Therapists and Licensed Master Social Workers, in addition to Licensed Clinical Social Workers. At this time, the Montana VA HCS has tentatively offered a position to a candidate, and the Alaska VA HCS is conducting interviews with applicants.

As indicated earlier, VA has expanded the pool of clinical professions for case manager positions to help recruit qualified candidates. This expansion considers the degree of independent practice expected of the case manager. VA expects the clinical case manager to be able to provide clinically sound mental health and substance use services directly to Veterans, particularly when there are regional challenges to obtaining those services elsewhere. Case managers in this program treat Veterans with high mental health and substance use acuity. VA medical centers are responsible for ensuring that the scope of practice for each employee is appropriate for the population being served, which may require a particular education level, a specific number of years of experience, and/or a clinical license.

Question 5. What are the other challenges that you have seen in implementing the Tribal HUD-VASH program, particularly to the extremely rural tribes such as the Blackfeet Tribe of Montana? What would you do to fix them?

Answer. The greatest challenge VA has experienced with implementing the Tribal HUD-VASH program is the limited amount of housing stock. In Montana, more Veterans could be admitted to the Blackfeet Nation's Tribal HUD-VASH program, but the case manager is waiting for housing to be built and pass the housing quality

standards inspections that must be completed before the units can be available. Some tribes are developing or rehabilitating housing, which similarly creates delay in placement.

Zuni, Hopi, Tohono O'odham, Spokane, Osage and others allow Tribal HUD-VASH Veterans to live outside of the reservation due to the shortage of housing stock in their tribal communities. While the Tribal HUD-VASH program was specifically designed to serve American Indian and Alaska Native Veterans in their tribal communities, those sites that have been able to most expeditiously implement the program are those utilizing housing off of the reservation. The exception is Yakama, which repurposed existing housing units from a different, previously terminated project. Tribes also report that the primary barrier is a lack of appropriately sized, decent, sanitary housing stock.

Some tribes have had difficulty locating Veterans appropriate for the program. In response, a number of tribes have opened their tribal preference to allow any Native American Veteran who is a member of any tribe, living in their tribal area, to utilize the program; which has enhanced utilization of their grant resources.

In areas where the tribe is fully committed to the program and a VA case manager is on staff, referrals have been steady and Veterans are being housed and are receiving services. Extensive marketing activities to recruit additional Veterans are also in place in these areas. There are Tribal HUD-VASH locations that have sufficient Veterans to completely utilize their grant: Oneida of Wisconsin, Cook Inlet, and Tohono O'odham. Additionally, Navajo, Zuni, Osage, Muscogee (Creek), Rosebud Sioux, and Lumbee are more than half-way to filling the units their grants support. Please see Attachment 1 for additional information.

Question 6. How will you ensure that tribes and tribal entities are properly consulted about the implementation of the program? What will that consultation look like?

Answer. VA and TDHEs have identified points of contact (POC) that meet and collaboratively discuss the program. VA case managers are encouraged to collaborate extensively with the tribes and TDHEs that they support. In some locations, the tribe has provided space for the case manager to work, which facilitates communication and relationship building, while demonstrating the partnership involved with program implementation.

During initial implementation of the program, VA POCs interacted extensively with the tribe in program execution. There was an initial meeting to discuss implementation and the tribes were engaged in case manager recruitment. Specifically, tribes were consulted about ways to obtain a case manager. VA offered to develop a contract for case management or allow the tribe to request VA obtain a full time VA employee as the case manager. VA contracted with one tribe for case management. Some tribes were actively engaged in the hiring process and participated in the selection of the VA case manager. VA is committed to ensuring eligible tribal members or Native American candidates are selected, where possible, to further support collaboration and consultation. Currently, seven of the twenty case managers VA has hired have Native American ancestry, and of those, four are members of the tribe with whom they collaborate. One of the case managers that we expect to start work in August 2017 is also Native American and, while not a member of that tribe, is a descendant of the tribe.

The earlier question regarding how the case managers are able to recruit eligible Veterans provides an example of consultative conversations with the tribes. VA worked with HUD to provide technical assistance and training for both the case managers and TDHEs, connecting them as a team to work on implementation. VA needs the tribal government and TDHE to not only help the case managers with marketing and referrals, but to also provide their wisdom and experience to help locate and engage Veterans through other local resources. VA continually looks for ways to engage, collaborate and consult with tribes on the program.

Question 7. How does VA currently work with IHS? Can inter-agency collaboration over Tribal HUD-VASH be easily worked into existing agreements?

Answer. VA currently collaborates with IHS in several regards, one of which is the 2010 Memorandum of Understanding between VA and IHS and pursuant to the VHA-IHS Reimbursement Agreement, under which VHA reimburses IHS for direct care services provided to eligible American Indian/Alaska Native Veterans at IHS facilities. Expanding our relationship with IHS would be beneficial to the Tribal HUD-VASH program and the Veterans and tribes that it serves. VA has an excellent working relationship with HUD and is confident that collaboration involving VA, IHS, and HUD would be beneficial and provide an opportunity for VA and IHS to assess the scope, capacity, and ability to collaborate at the specific Tribal HUD-

VASH locations. VA recommends that IHS be consulted to determine the ability to collaborate regarding Tribal HUD-VASH within existing agreements.

Question 8. Once this bill requires them to help support Tribal HUD-VASH, how do you envision VA working with IHS to better provide supportive services to Native American veterans receiving Section 8 vouchers?

Answer. As IHS has existing relationships with tribes, VA is confident that there is excellent potential for IHS and VA to collaborate. IHS has significant knowledge and experience understanding the cultural differences of each tribe, and would be a meaningful, collaborative partner for this program. VA had discussions with IHS that preceded the administration change that did not yield final conclusions. We believe that new discussions, with current leadership in both agencies, about how VA and IHS can collaborate and identify ways to work together in serving Veterans in Tribal HUD-VASH are needed. As appropriate, HUD should also be a part of these discussions.

Attachment 1

Tribal HUD-VASH HOMES Report for 7-17-2017												
VAMC	PHA	Tribal Title	Active Allocation	Under CMI	Entered Not Referred	Referred Not Vouchered	Vouchered Not Moved In	Moved In Under CMI	HVLS3	Exit		
(1V05) (505) Fayetteville, NC	NC387	Lumbee	20	15	0	2	5	8	40.00%	3		
(3V12) (695) Milwaukee, WI	WI555	Oneida of Wisconsin	20	21	0	0	13	8	40.00%	1		
(3V23) (437) Fargo, ND	ND013	White Earth	20	0	0	0	0	0	0.00%	0		
(3V23) (437) Fargo, ND	ND007	Turtle Mountain Chippewa	20	1	0	1	0	0	0.00%	0		
(3V23) (568) Black Hills HCS, SD	SD006	Standing Rock Sioux	20	8	0	2	1	5	25.00%	1		
(3V23) (568) Black Hills HCS, SD	SD001	Oglala Sioux (Pine Ridge)	20	6	0	0	0	6	30.00%	0		
(3V23) (568) Black Hills HCS, SD	SD002	Rosabud Sioux	5	11	0	6	1	4	80.00%	0		
(3V23) (656) St. Cloud, MN	MN012	Leech Lake	20	0	0	0	0	0	0.00%	0		
(4V19) (436) Montana HCS	MT008	Blackfeet	20	4	0	3	0	1	5.00%	0		
(4V19) (623) Muskogee, OK	OK049	Choctaw	20	1	1	0	0	0	0.00%	0		
(4V19) (623) Muskogee, OK	OK926	Cherokee	20	11	0	3	4	4	20.00%	6		
(4V19) (623) Muskogee, OK	OK959	Muskogee (Creek)	20	15	0	1	1	13	60.00%	0		
(4V19) (623) Muskogee, OK	OK961	Osage	20	13	0	1	2	10	45.00%	1		
(4V19) (635) OMAHOMA CITY, OK	OK928	Cheyenne-Arapaho	20	8	1	2	2	3	15.00%	1		
(5V20) (463) Anchorage, AK	AK004	Tlingit and Haida	20	0	0	0	0	0	0.00%	0		
(5V20) (463) Anchorage, AK	AK009	AVCP	11	0	0	0	0	0	0.00%	0		
(5V20) (463) Anchorage, AK	AK012	Cook Inlet	20	21	0	0	7	14	65.00%	2		
(5V20) (608) Portland, OR	OR013	Warm Springs	20	10	2	3	1	4	20.00%	0		
(5V20) (608) Spokane, WA	WA037	Spokane	20	4	0	0	2	2	10.00%	0		
(5V20) (608) Spokane, WA	WA013	Colville	20	6	0	1	2	3	15.00%	3		
(5V20) (608) Walla Walla, WA	WA022	Yakima	20	9	0	0	0	9	45.00%	1		
(5V22) (501) New Mexico HCS	NM019	Zuni	10	8	2	3	2	1	10.00%	1		
(5V22) (644) Phoenix, AZ	AZ011	San Carlos Apache	15	5	0	0	0	5	33.33%	1		
(5V22) (648) Northern Arizona HCS	AZ012	Navajo	20	15	0	3	7	5	25.00%	10		
(5V22) (649) Northern Arizona HCS	AZ027	Hopi	15	7	0	4	2	1	6.67%	3		
(5V22) (678) Southern Arizona HCS	AZ026	Tohono O'odham	20	23	0	0	3	20	95.00%	2		
All Tribal HUD-VASH			476	222	6	35	55	176	25.63%	36		

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JON TESTER TO
HEIDI FRECHETTE

Question 1. The Blackfeet reservation is approximately 180 miles one way from the nearest VA facility. How is the VA ensuring homeless veterans of the Blackfeet reservation or any extremely rural tribe, are receiving the required direct services under the program?

Answer. This question is best answered by VA. HUD has forwarded this question to VA and VA will respond under separate cover.

Question 2. What are the other challenges (aside from long distance to the nearest VA facility) that you have seen in implementing the Tribal HUD-VASH program, particularly to the extremely rural tribes such as the Blackfeet Tribe of Montana? What would you do to fix them?

Answer. The Tribal HUD-VASH pilot program was created to provide access to the HUD-VASH benefit for veterans who are Native American and homeless or at-risk of homelessness and living in or near Indian Country. When the Tribal HUD-VASH pilot program was designed and implemented, HUD essentially created a new program, administered by Indian Housing Block Grant recipients and operating primarily in a rural setting. This was accomplished by working closely with the tribes and VA to address challenges unique to rural and remote tribal communities. The two main challenges HUD and tribes have encountered in implementing and administering the pilot program are the lack of housing stock, and the length of time it can take to identify eligible veterans.

Lack of Housing Stock

One of the main challenges with implementing HUD-VASH in Indian Country is the lack of available housing stock in the tribal communities. Many Tribal HUD-VASH grantees house veterans in the community or in nearby locations; however, other Tribal HUD-VASH grantee tribes simply do not have available housing stock, or have veterans who do not want to move outside of their community to receive housing.

When the Tribal HUD-VASH pilot program was being considered, it was contemplated that where there was not adequate housing stock, tribes would leverage funding for new units. However, only a handful of tribes are adding new units with their Tribal HUD-VASH funding. One reason for tribes' reluctance to develop new units is that the program was established as a pilot program. Tribes are concerned that if they leverage HUD-VASH funding for new units, and then the program is discontinued, they would not be able to support the new units.

As tribes face housing shortages, HUD has encouraged tribes to leverage the HUD-VASH rental subsidy to buy, rehab, or construct new units. HUD continues to disseminate best practices, troubleshoot impediments to progress, and provide training and technical assistance on bi-weekly calls, webinars, and as-needed to specific tribes in close coordination with HUD's partners at the Department of Veterans Affairs.

Tribes are also working with each other to house veterans, and are seeking opportunities to house veterans in nearby communities.

Identifying Eligible Veterans

HUD has found that in some communities, identifying homeless veterans is taking longer than expected. Tribal communities are typically ineligible for many of HUD's homeless programs, are outside the homeless continuum of care operating areas, and often do not have homeless shelters, all of which can be a source for identifying veterans experiencing homelessness. Homelessness is typically less visible in tribal communities. Veterans experiencing homelessness live mainly with family or extended family in overcrowded housing, or "couch surf" among friends and relatives. Therefore, it can be difficult to locate and identify veterans who are homeless or at-risk of homelessness. Further, it takes time for the VA case manager to become known in the community, which is especially important since he or she will be going into people's homes to locate and work with eligible veterans.

HUD is working closely with tribes and VA to build a network of partners to assist in identifying veterans eligible for the HUD-VASH program, including working with tribal Veterans Departments, and encouraging known tribal veterans to help identify and recruit their fellow veterans who may be eligible. Potential beneficiaries may be more likely to seek out the program if a fellow tribal veteran serves as an intermediary between them and the VA case manager. HUD continues to share best practices with tribes on effective marketing and recruitment methods that other tribes have found successful. And finally, HUD and VA continue to find ways to engage the Indian Health Service to help identify Native veterans, because the IHS serves this population at its facilities in Indian Country.

Question 3. How will you ensure that tribes and tribal entities are properly consulted about the implementation of the program? What will that consultation look like?

The demonstration program was designed based on comments received from tribes in both regional and national consultation sessions, and through an open public comment period. HUD has a website dedicated to the program, has provided a series

of trainings, has sent “Dear Tribal Leader” letters to tribes with program information and to solicit feedback, and has issued program guidance and a list of “Frequently Asked Questions” that are responsive to tribal input to keep tribes abreast of the program and to solicit additional input.

Currently, HUD staff directly coordinates with Tribal HUD–VASH points of contact (both the tribal contacts and the VA case managers) on no less than a bi-weekly basis. Tribes and TDHEs participated in HUD’s and VA’s face-to-face regional technical assistance trainings, which were open to questions and discussion amongst the participants, trainers and HUD and VA subject matter experts. HUD’s Area Offices of Native American Programs communicate this feedback to HUD Headquarters through written reports and meetings. HUD carefully considers this input from tribes and has adjusted its trainings, program guidance and implementation strategy based on tribal comments.

HUD will continue with its existing level of tribal consultation by keeping tribes abreast of program changes, having a robust webpage with recorded trainings, and actively soliciting feedback from tribes on ways to improve and refine the program.

