U.S. COMMISSION ON CIVIL RIGHTS

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TELEPHONIC COMMISSION BRIEFING

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FRIDAY, JULY 17, 2020

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The Commission convened via teleconference at 10:00 a.m. EDT, Catherine Lhamon, Chair, presiding.

PRESENT:

CATHERINE E. LHAMON, Chair

DEBO P. ADEGBILE, Commissioner

STEPHEN GILCHRIST, Commissioner

GAIL HERIOT, Commissioner

PETER N. KIRSANOW, Commissioner

DAVID KLADNEY, Commissioner

MICHAEL YAKI, Commissioner

STAFF PRESENT:

MAURO MORALES, Staff Director

MAUREEN RUDOLPH, General Counsel

PAMELA DUNSTON, Chief, ASCD

A G E N D A

P R O C E E D I N G S

(10:01 a.m.)

CHAIR LHAMON: This briefing of the U.S. Commission on Civil Rights comes to order at 10:00 a.m. Eastern Time on Friday, July 17, 2020, and takes place online.

I'm Chair Catherine Lhamon. Commissioners virtually present at this briefing in addition to me are Commissioner Adegbile, Commissioner Gilchrist, Commissioner Heriot, Commissioner Kirsanow, Commissioner Kladney and Commissioner Yaki. A quorum of the Commissioners is present.

I note for the record that the staff director and the court reporter also are present.

I welcome everyone to our briefing titled COVID-19 in Indian Country, The Impact of Federal Broken Promises on Native Americans.

In 2018, the Commission issued a report titled Broken Promises, Continuing Federal Funding Shortfall for Native Americans, which addressed the inadequacy of federal funding for Native American programs despite the United States' trust responsibility to promote tribal self-government, support the general well-being of Native American people, tribes and villages and to protect their land

and resources.

My Commission colleagues and I voted to update that report to examine the COVID-19 pandemic impact on Native American civil rights, particularly in the areas of healthcare, housing and infrastructure, such as access to water and broadband, specifically examining whether the United States government is meeting its longstanding trust obligation to Native American people in the current crisis.

As we begin today's virtual briefing on these topics, which I note is the Commission's first ever virtual briefing, and I thank you all for participating in it as we manage in this COVID-19 time, we take up our investigation just one week after the United States Supreme Court reaffirmed the core importance of federal satisfaction of treaty obligations to Native Americans.

In McGirt v. Oklahoma, Justice Gorsuch wrote for the Court that, "we hold the government to its word," ruling that the federal government must continue to live up to treaty obligations.

That simple holding, that a treaty commitment made must be honored unless nullified by compacting parties undergirds our evaluation today and

more significantly reaffirms the ongoing federal obligation to make good on commitments to support capacity for sustenance in Indian Country.

As we reported in 2018, Native American people continue to face every day challenges due, for example, to poor physical, mental and behavioral health conditions, poor housing conditions, high rates of poverty and unemployment and other challenges that the shortfall of federal assistance has exacerbated.

Of particular importance to the COVID-19 context, our report documented life threatening health and health access disparities among Native Americans that predated the current pandemic and reflected the galling reality that the Native American housing crisis had deteriorated from what was already a low point in 2003 when the Commission had last reported on it.

We concluded in 2018 that instead of meeting documented needs for Native Americans, with systematically planned and sufficient funding, the nation's federal response has been haphazard and generally often wildly insufficient.

The Commission majority called on Congress in 2018 to pass a spending package to fully address unmet needs targeting the most critical needs for

immediate investment and specifically to address funding necessary for core infrastructure needs, such as electricity, water and telecommunications in Indian Country.

We called for steady, equitable, non-discretionary funding directly to tribal nations to support healthcare, housing and economic development of Native tribes in --

Our task in today's investigation is to evaluate the degree to which the United States has changed that course now in the COVID-19 pandemic. How well and how sufficiently does the United States meet its treaty obligations to Native Americans and what are the conditions of life and death in COVID-19 in Indian Country? What is working well and what more needs to be done?

Today we will hear testimony from experts on how the pandemic has impacted Native American communities with respect to healthcare, housing and infrastructure components such as water and broadband access and whether the federal government is meeting its obligations to Native American people in this current crisis.

I thank all who join us now to focus on this critical topic. Your views help us to fulfill

our mission to the nation's eyes and ears on civil rights.

I will turn us now to begin our briefing with a few housekeeping items. First, I share deep thanks to Commission staff who researched and brought today's briefing into being, including the expert team we had who worked on logistics for which this virtual environment presents a whole host of additional challenges. And I thank Staff Director Morales for his leadership.

I caution all speakers, including our Commissioners, to refrain from speaking over each other for ease of transcription. Additionally, I will need to cue our staff behind the scenes for the appropriate video and audio support. So please wait to speak until I have called on you.

For any member of the public who would like to submit materials for our review, our public record will remain open until July 24, 2020. Materials, including if individuals would like to submit anonymously, can be submitted by email to brokenpromises@usccr.gov or by mail to the U.S. Commission on Civil Rights, Office of Civil Rights Evaluation, Attention: Public Comments, 1331 Pennsylvania Avenue Northwest, Suite 1150, Washington,

D.C. 20425.

During the briefing, each panelist will have seven minutes to speak. After the panel presentation, Commissioners will have the opportunity to ask questions within the allotted period of time, and I will recognize Commissioners who wish to speak.

I will strictly enforce the time allotments given to each panelist to present his or her statement. So you may assume we have read your statement so you do not need to use your time to read them to us as your opening remarks. And please focus your remarks on the topic of our briefing.

I ask my fellow Commissioners to be cognizant of the interest of each Commissioner to ask questions. Please be brief in asking your questions so we can move quickly and efficiently through today's schedule.

So we will now proceed with our panel of speakers. The order in which they will speak is Geoffrey Blackwell, Chief Strategy Officer and General Counsel, AMERIND Risk, Chief William Smith, Chair, National Indian Health Board, Chief Lynn Malerba, Secretary, USET Sovereignty Protection Fund, Jonathan Nez, President, Navajo Nation, Fawn Sharp, President, National Congress of American Indians, and Francys

Crevier, Executive Director, National Council of Urban Indian Health.

We will begin with Mr. Blackwell. Please proceed.

PANEL - GEOFFREY BLACKWELL, CHIEF STRATEGY OFFICER
AMERIND RISK MANAGEMENT CORPORATION

MR. BLACKWELL: Good morning, Chair Lhamon, and Commissioners. (Native language spoken.) Greetings. Thank you for the opportunity to testify today about the state of broadband on tribal lands and the consequences of the lack of connectivity for our people during the outbreak of COVID-19.

By every measure that is important, Indian Country lags far behind the nation as a whole in terms of high speed internet. This is simply unacceptable. Tribal nations are as vibrant as ever and their people contribute greatly to local and regional economies in all regions of the country, yet they are consigned to second class citizenship when it comes to the most critical infrastructure of the 21st Century, broadband.

Historically, bringing broadband to Indian Country has been a very expensive, complex and largely unsuccessful endeavor, requiring negotiation with private providers that have little or no interest in

expanding their networks across tribal lands.

Broadband must be available, accessible and affordable to meet its promise in Indian Country. The solutions to the tribal broadband problem are fairly straightforward.

We need the fair and accurate use of the actual definition of tribal lands and the correction of woefully inaccurate broadband data on tribal lands.

We need dedicated resources with specifically designed purposes to get at the underlying lack of predicate infrastructures and governmental subsidy and licensing efforts to genuinely involve and position the correct parties who will actually confront the challenges.

My written testimony has detailed a number of historical failings in this regard and details the need for a new tribal broadband fund at the Federal Communications Commission.

However, for the remainder of my time I would like to focus on an immediate and instant need. There is a 2.5 gigahertz tribal priority window at the FCC addressing that major need, the need for access to wireless spectrum licensing. And this window has the potential to fundamentally change the tribal broadband dynamic by putting broadband

deployment where it belongs, in the hands of tribal nations in the form of tribally owned spectrum licenses.

These licenses were originally allocated in the Kennedy administration for the use of educational institutions for over the air TV. It is the famed educational broadband service spectrum.

The tribal priority window opened on February 3 and is currently scheduled to close on August 3. The window provides federally recognized tribes and certain tribal entities with the opportunity to be first in line to apply for broadband spectrum licenses over their tribal lands.

In addition, the license available during the window are available free of charge. However, spectrum that is not allocated during this window will be auctioned to the highest bidder.

Holding the spectrum license allows tribal nations to exercise their spectrum sovereignty and control their cyber destiny. With these 2.5 gigahertz licenses, tribal nations can, for example, build their own wireless networks or negotiate the sublease with an existing wireless carrier to build networks and serve their communities.

Because licenses can be leased and

subleased, they can also turn licenses into a revenue stream. This is a once in a generation opportunity.

The COVID-19 pandemic, however, threatens yet again to make an opportunity for the 21st Century connectivity to tribal lands an impossibility for many tribal nations.

With tribal headquarters shuttered, tribal boards closed and tribal governments attempting to remotely deal with so many competing major priorities, the scarce resources available are focused on public health and safety and the chance to meet the FCC's filing deadline is slipping away for many tribes.

Even before the pandemic, tribal governments and their entities faced challenges in obtaining information and preparing an application for the tribal window, but the pandemic multiplied those challenges.

Expecting tribal governments to focus on this unique opportunity in the midst of a global pandemic is simply unrealistic.

There is an easy solution here, however. The FCC need only heed the many requests to members of Congress, the intertribal government associations and tribal leaders from across Indian Country to extend the window.

On their own, the FCC has extended numerous other regulatory deadlines because of COVID-19 but has remained steadfast in its refusal to extend the tribal priority window.

If this once in a generation opportunity for tribes to exercise their spectrum sovereignty is to become more than illusory, the FCC must extend the deadline. This is also a very simple regulatory lift for the Federal Communications Commission, one that will have a profound and lasting impact on Indian Country.

In the context of this licensing effort, the FCC must also address the exclusion of tribal lands outside of what the agency defines as rural for the purposes of the tribal priority window. The FCC unilaterally defines tribal lands for the purposes of that window, leaving tribes with population centers of 50,000 or more at square one and unable to obtain a 2.5 gigahertz license.

The FCC must address the petitions filed before it on this issue and rectify this injustice.

The future of the 2.5 gigahertz tribal priority window affords as one -- excuse me. The future that the 2.5 gigahertz tribal priority window affords is one in which tribes build and control their

own broadband networks.

It is a future in which tribes have viable options for telehealth, distance learning and telework, particularly in a national emergency such as the one that we are in the middle of. And it is also a future in which tribes are the architects of their own communications destiny. This future will be built one license at a time.

Thank you very much, Chairman and Commissioners. I look forward to your questions.

(Native term used.)

CHAIR LHAMON: Thank you. Next we will hear from Chief Smith. Chief Smith, please proceed.

PANEL - CHIEF SMITH, CHAIRMAN

NATIONAL INDIAN HEALTH BOARD

CHIEF SMITH: Yes, thank you. On behalf of the National Indian Health Board and the 574 federally recognized tribes we serve, thank you for inviting us to participate in this very important session, to examine the impact of COVID-19 on tribal nations and communities.

As we sit together, we bear witness to the challenging times. These are also times of profound opportunity to make right hundreds of years of injustice, which is the child of colonization.

Today our nation is confronted by a dual epic of Black Lives Matter movement and then the COVID-19 pandemic.

The heaviest burden is borne by those who have the least resources, and Indian Country is right in the center. But in order to understand what has happened to us, you must first insist on honest reckoning of U.S. history for what we see today is the offspring of colonization.

How has COVID-19 impacted the Indian Country? The indigenous experience with COVID-19 confirms that colonization continues to function according to design. The federal government by and large confers authority and resources distributed to states and truly fails to meet the federal trust responsibility to tribes. Please see our written statement for our deepest message.

An underfunding of the Indian Health Service is the core problem. The Indian Health Service is the only federal healthcare system created by the result of the treaty obligation. It is also the most constant underfunded federal healthcare system, only around 48 percent of the need.

The U.S. spends about $9,409 per year on healthcare per person but just $3,779 per Indian per

year. That's 40 percent less.

Some of the ways these shortfalls show up in our systems are chronic and widespread health professional staff shortage, 25 percent of the tribal provider's positions are vacant, rationing of care.

A few years ago, 88,000 referrals for specialty care were denied due to the lack of funds. Indian Health Service Hospitals are grossly outdated and in disrepair. How do we follow CDC's COVID guidelines if we don't have running water?

Around 6 percent of our households lack access to running water. By comparison half of 1 percent of White households lack running water.

In Alaska there are over 33,000 rural Alaskan homes across 30 Alaskan Native villages that lack running water. In the places, we use honey buckets because we do not have flushing toilets. We even have honey buckets in some of our clinics.

Alaska is not alone. Roughly 30 percent of the Navajo homes lack access to public water supplies.

The Indian Health Service has outdated health information technology infrastructure, making COVID-19 disease surveillance nearly impossible.

The lack of broadband is nearly one-half

of the Native homes, making telehealth impossible as well in fact most tribal nation's public health infrastructure has never been funded.

Many tribes lack the basic disease prevention emergency preparation and response capabilities. All these factors create the perfect storm for a COVID-19 disaster on tribal communities.

As of this week, IHS has reported over 25,000 positive COVID cases. If tribes were states, the top five infected rated nationwide would be tribes. In order they are White Mountain Apache, Pueblo Azia, Pueblo of San Felipe, Navajo Nation and the Kewa Pueblo.

The CDC stated that Indian Country has experienced the second highest death rate in the nation and the highest hospitalization rate.

American Indians and Alaska Natives have the worst incentive for top chronic conditions identified by the CDC for COVID-19 severe disease risk. Among them are type-2 diabetes, obesity, heart disease, chronic immune disease.

And social distancing is critical to contain the spread of the disease, yet our people often lack adequate housing and have multiple generations of families living in homes, making social

distance impossible and placing vulnerable elders at greater risk.

Last, we lack access to testing, personal protective equipment, hand sanitizer, ventilators and so much more.

The day the first relief package was signed into law the National Indian Health Board submitted a letter to Secretary Azar asking him to utilize existing funding methods through the IHS to minimize delay in getting funding to the tribes. This did not happen.

Instead significant funds went through other agencies, which both lack experience and relationships with tribes. As a result, the tribes run into systematic barriers that delayed receiving the funds and delaying our ability to get help.

To remedy these systematic barriers and give tribes a fighting chance to fight COVID, the federal government needs to honor the treaties, listen to the tribes and act accordingly, implement the Indian's Self-Determine Act to every agency in the federal government, provide immediately $1 billion investment into tribal water and sewer sanitation systems, provide emergency funding directly to the tribes for COVID intervention, authorize permanent

full funding of the Special Diabetes Program for Indians, enact technical fixes for the federal Medicaid laws, address mental and behavioral health barriers to meet health challenges made worse by COVID-19 pandemic, stop using competitive grants mechanism and parabolic funding model with tribes, establish Indian Health Service as an entitlement program that is fully funded. Get out of our way. We got this.

In conclusion, evidence that has impacted the COVID endurance, American Indians and Alaska Natives have the highest rate of COVID hospitalization and the second highest death rate in the United States.

We, First Americans, lack healthcare opportunities. The U.S. must recast the approach to the tribal nations and break new grounds that truly honor the trust of treaty obligation. The first step is to make massive and substantive investment in building tribal communication systems and health systems in response to COVID-19.

We can do better. We must. This pandemic is far from over and the opportunities to find new ways forward is greeting us. Mindful of the past fixes on the commonization model, together we can authorize

a difference and have a just, healthy future.

(Native term used.) That's Eyak for thank you very much. My time is up.

CHAIR LHAMON: Yes. Thank you, Chief Smith. Next we will hear from Chief Malerba. Go ahead, Chief Malerba.

PANEL - CHIEF LYNN MALERBA, SECRETARY

USET SOVEREIGNTY PROTECTION FUND

CHIEF MALERBA: Chairwoman Lhamon and members of the Commission, kutapatôtamawush (thank you) for holding this hearing and the opportunity to provide testimony.

Nuteewes Sôqsqά Mutάwi Mutahάsh.

My name is Chief Mutawi Mutahash Malerba of the Mohegan Tribe, Secretary for USET Sovereignty Protection Fund. I also serve on numerous federal advisory committees, including Chairman of the IHS Tribal Self-Governance Advisory Committee.

The federal government's historic and ongoing neglect of its obligations to tribal nations is being brought into sharper focus by the COVID-19 public health emergency. Decades of broken promises, under-funding and inaction have left Indian Country severely under-resourced and at extreme risk during this crisis.

Our existing systems of service delivery and infrastructure are experiencing greater stress than those of other units of government as we seek to maintain essential services and depend on our commitments while responding to COVID-19.

Indian Country continues to face disproportionately high rates of COVID-19 infection even as rates are declining for other populations. At the same time, Indian Health system is facing steep declines in revenue, growing expenses and is not well equipped to treat the disease.

Our region, the national area of IHS, is one of the hardest hit. As of July 7, the national area has the third highest positive rate cases at over 11 percent.

One member tribal nation, the Mississippi band of Choctaw Indians, has one of the highest rates of infections in the entire nation at 960 per 10,000.

In addition, many of the business entities we have established to provide government services to our citizens are currently closed or facing major declines in revenue. This harms our tribal government operations as we rely on these non-federal resources to maintain the services that the federal government should be funding in full.

Complicating this in Indian Country is being treated as just another grantee, forced to track, monitor and apply for U.S. streams of federal funding to address the pandemic.

While this is burdensome under normal circumstances, it is nearly impossible under the reduced capacity caused by COVID-19. It runs counter to the sacred terms of our diplomatic relationship.

Since March, USET SPF and our partners have worked to ensure Indian Country is included in stimulus and relief legislation. We note that the CARES Act represents the largest transfer of resources to Indian Country in a single piece of legislation and over $10 billion. However, this is just 0.5 percent of the approximately $2 trillion in total funding.

With the majority of these resources allocated to set asides in non-tribal funding, many of these provisions are difficult to implement for tribal governments while others reach some but not all in Indian Country. Currently, many other priorities specific to Indian Country remain on the sidelines unaddressed.

As legislation is implemented, Congress is not doing enough to exercise its oversight authority. The distribution of resources intended for Indian

Country has not been consistent, expeditious or equitable.

Each department is disbursing these critical funds using different and sometimes complicated methodologies, including competitive grants, which is causing delays and barriers to these urgently needed resources.

For example, the Department of Treasury is failing to properly administer the tribal set-aside in the Coronavirus Relief Fund. Despite extensive tribal advocacy and guidance, the Department has undercut our interest and the trust obligation at every turn, from refusing to use tribally provided data to routing funds to for-profit corporations to failing to address a data breach to neglecting to provide necessary guidance. Treasury is mismanaging the CRF.

The administration is also pressing forward with hostile acts against Indian Country. On March 27, as all units of government engaged in early COVID response and mitigation, the Department of Interior informed the Mashpee Wampanoag Tribe that its homelands would be taken out of trust, ordering the dis-establishment of a Reservation for the first time since the termination era.

We continue to assert that the deep

chronic failures being further exposed by the COVID crisis require bold systemic changes in federal Indian policy and funding. They will allow Indian Country to realize its great potential and create lasting positive change for tribal nations and our people.

First the time has come for the federal government to acknowledge our nationhood and honor its promises by elevating our interests to the level of the President's cabinet.

Just as foreign nations engage with the United States via the State Department, tribal nations should have a Department of Tribal Affairs. It is critical that the administration propose and Congress demand budgets, containing full funding for all federal agencies and programs.

Given our history and unique relationship, this funding can no longer be subject to the instability of discretionary funding but must be made a mandatory and separate part of the federal budget.

Additionally, grant funding treats us as nonprofits rather than governments. ISDEAA contracting and compacting must be an available option across the federal system.

The OMB processes to develop budgets and policies impacting us require reform. We believe a

strong tribal affairs office should be created at OMB. Similarly, consultation should be reformed across the federal government to provide a meaningful standard for engaging tribal nations in decision making.

In the long-term, we must return to tribal nation consent for federal action as a recognition of sovereign equality.

Next the federal government must provide the restoration of tribal homelands, which are fundamental to our existence as sovereigns and our ability to restore healthy self-sufficient tribal economies. Our federal partners must recognize and promote our inherent sovereignty, including a full recognition of our powers to protect our communities during the COVID-19 crisis as well as tribal criminal jurisdiction by fixing the Supreme Court decision in Oliphant.

Lastly, similar to the U.S. investment in the rebuilding of the post-World War II Europe, via the Marshall Plan, the federal government should commit the same investment to rebuild tribal nations given that our current circumstances are directly attributable to the acts and policies of the United States.

In closing, we appreciate the Commission's

willingness to re-examine and update Broken Promises through the lens of COVID-19. The circumstances tribal nations face during this public health emergency are directly attributable to the federal government's centuries of dishonor in its relationship with us.

Since the release of Broken Promises, USET SPF has been calling for swift action to address its findings and recommendations. We urge all branches of the federal government to ensure that we never again have the same conversation about these shameful failures.

At a time when Americans are urgently demanding our country reconcile with its past, it should begin by atoning for its original sins against this land's first peoples. Thank you. I look forward to your questions.

CHAIR LHAMON: Thank you, Chief Malerba. And we will now hear from President Nez. President Nez, you can proceed. President Nez, if you are speaking, you are on mute.

PANEL - JONATHAN NEZ, PRESIDENT, NAVAJO NATION

PRESIDENT NEZ: Thank you. Technology. (Native language spoken) and good morning, members of the Commission and Madam Chair.

My name is Jonathan Nez. I am the President of the Navajo Nation. And thank you for the opportunity to provide testimony addressing the impacts of the COVID-19 pandemic on the Navajo Nation.

I can sum up the answers to the Commission's questions by sharing the testimony here about Mabel Charley, who is a community health worker with the Navajo Department of Health in Kayenta, Arizona.

Mabel does a wide variety of work. She provides education on COVID-19 prevention to community members. She conducts wellness checks on those who tested positive or who may have been exposed to COVID-19. And she delivers supplies including food, PPEs and isolation kits to Navajo community members who are COVID-positive or at high risk of severe symptoms if exposed.

Recently, Mabel and a colleague delivered supplies to a Navajo family in a rural community called Dennehotso, Arizona. Six members of the family tested positive for COVID-19, one member from each generation living under the same roof.

Of the six, a father, his daughter and the daughter's six-year-old child were infected. The father had been taken to a Phoenix hospital for

treatment, a hospital that is five hours away. When Mabel delivered the family supplies, they received a call that their father, grandfather, passed away.

Mabel, recalling the heartbreaking home visit, says, and I quote, my colleague and I had to take a break for 10 to 15 minutes and regroup after the visit. Until that moment, I was in denial about my younger brother's death a couple of months ago. And we just laid my nephew to rest two weeks ago. And both were 46-years-old and passed away from COVID-19.

We are all from the same community, she says, but I have a job to do. I pray for strength and spiritual growth every day because what we are doing is so important.

You know, this is one of many stories that are happening in Indian Country, Commission. Here on the Navajo Nation, as many of you all know, 27 plus square miles of land extends into three states, New Mexico, Arizona and Utah.

And we do have political subdivisions, 110 chapters or communities on the Navajo Nation, you know. And Mabel was assisting in food and supply distributions as well with our team where we visited all 110 communities during this pandemic.

As early as January 26, the Navajo Nation

began informing our residents of the deadly novel coronavirus. On March 13, 2020, we issued the first of several executive orders to close government offices and recommended the closing of schools on the Navajo Nation.

Many of these public health orders that were issued by the Navajo Nation were based on health care experts and epidemiologists on the Navajo Nation.

And what we did here on Navajo that was different is we took those recommendations, and we put those into these orders. I know not many people would like to be told what to do by their government, but we had to use our own sovereign ability to help our people because of the failure of the federal government to assist us with our share of relief.

We know the story of the CARES Act fund. A little bit over three weeks ago we finally received the remaining amount throughout the country to the tribes. And if that's not discrimination then what is?

You know, we are telling our people wash your hands, wear a mask, social distancing and stay at home. We incorporated these into our orders. And that has helped flatten the curve. That has helped reduce the COVID positive rate here on the Navajo

Nation.

And I just wish that other governments outside the Nation would accept those public health experts' recommendations.

We see high spikes of COVID positive cases all around the Navajo Nation, and it's very concerning. And there is no heed or no thought of the health and well-being for Native Americans here in the Southwest from other governments.

You will hear testimony, and we did submit our written testimonies about the health disparities. I welcome the questions. You know, we have high rates of diabetes, high rates of cancer, cardiovascular disease that put our people into this vulnerable population category. And we all know the stories of food deserts in our communities.

And it's all because of the failure of the federal government in making sure that these promises that were made by our ancestors and those founding fathers of the United States government that it makes it hard for any type of community and economic development in tribal communities.

You know, you just recently saw the President do an executive order to allow his cabinet members to waive or set aside some federal regulations

and policies, but tribes were never mentioned in the executive order.

We need to change federal laws and policy. If you can build a wall on the U.S. Mexico border and waive laws to get equipment there, then by all means they can waive certain laws and regulations in tribal communities so that we can spend much and all of this relief dollars that finally came into the tribal communities.

And lastly, I know I ran out of time --

CHAIR LHAMON: Sorry, Mr. President, I do need to --

PRESIDENT NEZ: What I do want to say is thank you for this opportunity. Our presentation is before each and every one of the Commissioners today. God bless you. Thank you so much.

CHAIR LHAMON: Thank you, President Nez. We will now hear from President Sharp. President Sharp, I think you're on mute still.

PRESIDENT SHARP: That works.

CHAIR LHAMON: Yes, thank you.

PANEL - FAWN SHARP, PRESIDENT
NATIONAL CONGRESS OF AMERICAN INDIANS

PRESIDENT SHARP: (Native term used.) Good morning. Thank you, Chairman Lhamon and members

of the Commission. On behalf of the National Congress of American Indians, I thank you for holding this hearing today.

I am Fawn Sharp, President of the Quinault Indian Nation and President of NCAI, which is the oldest and largest organization serving the broad interests of tribal nations and communities.

Today Indian Country is facing a crisis and a national emergency that while intensified by the COVID-19 pandemic has its roots in the federal government's neglect of its trust and treaty obligations to tribal nations and citizens.

This existing crisis created disparities that led to American Indian and Alaskan Natives vulnerability to the COVID-19 pandemic and resulted in our communities having the highest rate per capita COVID-19 infection rate in the United States.

We are so very grateful to the Commission in having recognized the extraordinary impacts to tribal communities and its undertaking an update to your 2018 Broken Promises report.

My written testimony documents the extensive impacts of COVID-19 on tribal communities, our health, economies, education, infrastructure. And it addresses the impact of congressional and executive

branch action and inaction.

Today I will focus my testimony on updating recommendations to the Broken Promises report to address Indian Country's need to respond and recover from the present pandemic and to address our federal trustee's chronic neglect, which has impaired the lives and livelihood of American Indians and Alaska Natives all across this country.

First I will address revised recommendations. As documented in my testimony, Indian Country needs assistance to address the financial and administrative barriers that impede our ability and our response to COVID-19.

Based on identified needs, we recommend the following three revisions to the Broken Promises recommendation. First, funding, Congress must provide increased emergency and annual appropriations for IHS and tribal governments, including for infrastructure to address the immediate and long-term impact of the pandemic.

Second, provide advance appropriations for all IHS and BIA programs. And third, increase funding and permanently reauthorize programs like the Special Diabetes Program for Indians, which is critical to treating the underlying conditions and the increase of

COVID-19's lethality.

Third, technical fixes, Congress must enact technical fixes to the following to improve tribal access, Medicaid and Medicare, the Strategic National Stockpile, the Public Health Emergency Fund and the Federal Employee Health Benefits for tribal controlled grant schools.

And third, remove non-statutory program restrictions and matching requirements for tribal programs, which hinder tribal access during the economic crisis.

And finally invest in telecommunications. To address the deep digital divide, Congress should establish a Federal Communications Commission Tribal Broadband Fund, ensure all tribal nations and lands are eligible for FCC proceedings of tribal interests, extend FCC tribal proceedings by 180 days during the pandemic and grant unassigned spectrum over tribal lands to tribal nations.

Next, I will address new recommendations in three categories. First, consultation enforcement and oversight. During the pandemic, distribution of tribal funds have been delayed due to sluggish inter-departmental cooperation, limited communication with applicants, creation of non-statutory barriers and a

lack of transparency and the creation of methodologies for distribution of funds.

To address this, future legislation should mandate tribal consultation, provide consultation enforcement mechanisms, facilitate interdepartmental transfer of funds from CDC to IHS and ensure Congressional oversight of a department's implementation of its delegated responsibilities for COVID and non-COVID legislation.

I would next like to address our recovery plan. Indian Country is in a growing crisis that requires a public health and economic Marshall Plan for our recovery that addresses the chronic conditions that led to the pandemic's devastation within our communities.

For example, for decades Indian Country has sought assistance for dual taxation by state and local governments, which causes the loss of tribal government revenues. This loss occurs at the expense of tribal government services and prevents the creation of any rainy day funds to prepare for emergencies.

Dual taxation is one of many problems. To address these structural issues, we need a national, congressional and executive branch plan that focuses

on the conditions that created and intensified the pandemic. Accordingly, Congress should designate a body with developing a Marshall Plan for Indian Country socio-economic development out of the conditions that resulted from the breach of the federal fiduciary and trust responsibility over many decades.

Federal branch infrastructure. Additionally, it is imperative that the federal tribal infrastructure be developed. During the prior administration, the White House Council on Native American Affairs was established to improve coordination of federal programs for tribal nations.

In April 2020, the Council was re-established but has not had a principal level meeting with federal departments and tribal leaders. To serve its purpose, the Council should be within the White House and have the authority to ensure coordination across departments and have ongoing engagement with tribal nations.

Additionally, each federal department should have an office expressly dedicated to fulfilling the Department's government-to-government engagement and fiduciary responsibility to Indian Country.

An Office of Tribal Affairs is critically needed within Treasury to address tribal economic development, tax and capital needs, integrate tribal nations with Treasury policy-making and facilitate tribal consultation.

Additionally, existing tribal serving offices and departments should be strengthened with increased funding and enhanced authority.

Lastly, the pandemic has illustrated that tribal nations are the first and often the only responders during emergencies in their jurisdiction. Unlike states, tribal nations are experiencing insurmountable challenges in accessing the billions of FEMA dollars set aside to support COVID-19 response efforts.

These challenges are directly linked to the lack of tribal Homeland Security and emergency infrastructure and staff and Indian Country needs.

I thank you for the opportunity to testify. And I look forward to your questions.

(Native language spoken.)

CHAIR LHAMON: Thank you, President Sharp. We will now hear from Ms. Crevier. Ms. Crevier, please proceed. Ms. Crevier, you are on mute, if you

could come off mute.

PANEL - FRANCYS CREVIER, EXECUTIVE DIRECTOR
NATIONAL COUNCIL OF URBAN INDIAN HEALTH

MS. CREVIER: I can't believe I did that one. Good morning and thank you, Chair, for inviting me to join this necessary discussion revisiting the Broken Promises report with various esteemed leaders on this panel.

My name is Francys Crevier. I am an Algonquin and serve as the Executive Director of the National Council of Urban Indian Health where we advocate for health care for Native Americans in partnership with a lot of the panelists here today.

The provision of health care to tribes is a federal obligation that also extends to over 70 percent who reside in cities across the country.

Today we will examine whether the federal government is meeting its obligations to all Native people in response to the pandemic that has tragically taken too many lives already. The short answer is no.

Our country is reeling from the recent killings of George Floyd and countless others at the hands of police, reckoning with the legacy of racial injustice while simultaneously confronting the unequal impact of COVID-19 on people of color. This moment in

time is both dangerous and full of great promise.

Because of the deeply disturbing and sobering events of the last months, outraged Americans are thinking about the collective power that they have in this moment to possibly make things better for future generations.

Right now we are at crossroads with the opportunity for massive legislative and administrative change and the time to act is now.

Reports on the impact of COVID-19 on communities of color is staggering but not unexpected. The reason for health disparities is not biological. It is the result of deeply rooted and pervasive acts of racist structures that built this country.

As the report found, the failure of the government to address the well-being of Indian Country for the past two centuries has created a system where we are bound to fail. And that has proven no different during this pandemic.

It is imperative to officially recognize systemic racism as a central factor of health inequities, not race. Urban Indian organizations were formally recognized by Congress in 1976 to fulfill the government's healthcare-related trust responsibility to Indians who live off of Reservations and stated the

responsibility arises from treaties and laws that recognize its responsibility as an exchange for the accession of millions of acres of Indian land that does not end at the borders of an Indian Reservation.

As COVID-19 hit urban areas across the country, our urban Indian healthcare heroes have been serving on the front lines of this pandemic from day one. Disease, like this obligation, does not stop at the border of the Reservation. The impacts of COVID-19 on Native communities across this country demonstrate that.

The forced relocation of our people has had detrimental effects that has persisted across generations, including homelessness, unemployment, suicide, diabetes, poverty and poor outcomes, just to name a few.

All of IHS has historically struggled with chronic neglect and underfunding from the federal government which is one of the systemic factors that created the disparities that we have today. Many Natives don't have health insurance, and they rely on our UIOs for their healthcare.

Throughout the pandemic, due to the failures of the government to provide supplies, some of the UIOs have been forced to temporarily close

their doors because Indian health was not prioritized.

Not only do we need supplies but funding to renovate facilities to keep up with this pandemic, additional staff, flexible funding and more. Despite the government's failures, our facilities have done everything they can to keep their doors open for the patients who rely on them with or without the pandemic.

Cutting back behavioral health services in conjunction with many homeless shelters closing has exacerbated the dire consequences of the government's failure during this crisis.

While IHS allocated money for telehealth to help ensure Native people can access health care from home without putting themselves or others at risk, these funds have yet to reach any urban programs. That is a failure.

Yet when the federal government provided zero dollars for our program, one program purchased old cell phones to distribute to their patients. That cell phone, something that we may take for granted, is serving as a literal lifeline for the patients who need these vital services. Access to broadband services, even in urban areas, is necessary for continuity of care.

Our congressional partners have been invaluable in their response to address Indian Country's needs to COVID-19 but more must be done to enable federal, tribal and urban facilities to combat this pandemic that is costing Native lives every single day.

We have yet to receive any information from the government about a plan for contact tracing. What can be done to better protect Native people in the healthcare systems that care for them? We need more PPE for our frontline heroes who are treated as second class citizens despite the risks they are taking every day.

We need the federal government, not just IHS, to talk to us. During this time, other agencies have heavily relied on IHS to work with Indian Country instead of talking to us themselves.

All agencies have an obligation not just IHS. We need FEMA to work with our programs to get them the supplies they need before more people die. We need CDC to understand that while we may live on a Reservation or in a rural and urban area the federal obligation is the same. For communities at high risk, we must be doing more testing there.

We need to ensure that we receive testing

and a vaccine. We need CDC to also re-evaluate their data guidelines to not be classified as "other" as the government continues to erase our people.

We would also like to emphasize that urban Indians should be included in legislative and administrative change for all healthcare programs for American Indians and Alaska Natives. When we're not explicitly mentioned in programmatic language, they are explicitly excluded, implicitly excluded, from participating in such programs.

Finally, I would like to emphasize that this system was obviously created to fail, and it is working as planned. Put yourselves in our shoes when recommending solutions. I am sure you are all afraid of you or your loved ones receiving this deadly virus right now.

Would you want to send your parent or child to a health facility that is only 30 percent funded or would you want to go to one that is 100 percent funded? If given the choice, would you choose to go to a facility that receives $11,000 per patient, less than $4,000 per patient or in the case of UIOs around $600 per patient to provide your family with healthcare?

This is not hard. Treat us the way you

want you and your families to be treated. Fully fund the system. The time is now. Black and Brown lives matter and thank you again for holding this virtual meeting today.

CHAIR LHAMON: Thank you, Ms. Crevier. At this point, we will accept questions from Commissioners. As a reminder, please do not speak until I recognize you, Commissioners. To ask a question and panelists to respond to the question, please raise your hand so I can see it or notify my assistant if you have a question or would like to respond to a question. I'm going to swing through my views on Zoom to see if there are hands raised among my fellow Commissioners.

I see Commissioner Yaki raising his hand. Go ahead, Commissioner Yaki. And you're on mute at the moment.

COMMISSIONER YAKI: Thank you very much, Madam Chair. And thank all of you for your great testimony today as we deal with a crisis that our nation has probably not seen since the second World War.

I just have a brief question for all of you because it goes to a point that was made early on in the crisis and then seemed to disappear and that is

what is really the availability of PPE, testing center supplies, testing equipment protective gear for your front line health workers where each of you reside because we've been told over and over again that everyone has enough PPE. Everyone has enough testing. I just want to know what your experience is on the ground.

PRESIDENT NEZ: Madam Chair, Jonathan Nez here, and Commissioners. Commissioner Yaki, thank you for that question.

I think for the Navajo Nation, as large as we are, 27,000 square miles, we are in three states and 350,000 Navajos, half of those living on our lands.

You know, early on we had to -- Navajo Nation, I'm not speaking for other tribes, but Navajo Nation, we actually had to compete with other governments, other states in trying to attain the personal protection equipment because everybody was really looking at that time California and New York and many of those personal protection equipment were going there.

And so it seemed like the highest bidder got these PPEs. And tribal communities, Navajo, we didn't have that large amount of finances to purchase

these. So it seems like the person who had the most money got the personal protection equipment.

But yet we were still waiting for the CARES Act funds to come to our Nation so that we could use that money to get PPE. But bless the hearts of our friends of the Navajo Nation who stepped up and donated personal protection equipment.

Now fast forward to today, still the same shortage. At least we're going, you know, flattening out the curve and going down in cases here in the Navajo Nation. But like I said, all around us there is a spike. And so now there's a demand for personal protection equipment, and we are, again, in a shortage.

And so much uncertainty we all know about this virus that I wish we could be able to begin to stockpile, if you want to call it that, for the future. But right now we can't because we're back to the highest bidder gets that finite resource.

Thank you, Commissioner Yaki.

CHAIR LHAMON: Thank you, President Nez. I understand Chief Sharp also had an answer to that. Chief Sharp, you are on mute.

PRESIDENT SHARP: Thank you. I think I am off mute now. Yes. I, too, would like to address

this question.

We do have PPE. Here at the Quinault Nation I've been informed and briefed that we have PPE that will last, under normal circumstances, about a 30 day supply. But in the event of an outbreak, it would just take a couple of days for all of that PPE to be utilized.

And so while we have available PPE right now in the event of an outbreak, we would simply not have enough resources. And when we tried to secure PPE early in the pandemic, we were informed that much of it was deployed in the State of Washington, to King County and the Seattle area where the first outbreak occurred at the nursing home in Kirkland, which meant out here in the rural communities and within the tribal nations in the rural parts of the State of Washington, we were at the backend of receiving supplies.

And so we started to reach out and aggressively advocated for direct access for tribal nations to the Strategic National Stockpile. While that was the subject of debate in the CARES Act, ultimately the CARES Act was passed without that provision.

And so we continue to advocate for tribal

nations to have direct access to the National Strategic Stockpile. That is one concern.

The other is we are aware that the Indian Health Service, IHS, prior to the pandemic, sought to create a national stockpile for equipment for tribal nations.

And when we questioned them about the progress and updates on that effort, at this point they were too busy dealing with the pandemic to go back to creating this National Strategic Stockpile. That was the response that I received.

And so one way or the other we need to be able to access a stockpile. We also recognize early in the pandemic that outside of the United States, the World Health Organization began to do a callout for public-private partnerships in establishing the UN Foundation with the Swiss Philanthropy Fund. That signaled to us that there are some who have experience in dealing with global pandemics.

Look at the possibility that the scale of this pandemic might exceed public resources that necessitates public-private partnerships. And we saw that early in this country when it was clear that we simply didn't have the equipment. There was a callout to Ford to build, you know, ventilators. I mean, just

all of the different calls out to action for the private sector to build, to construct, to manufacture PPE.

And so we know in the calculus if a scale of this pandemic continues to exceed public resources, tribal nations have an effective death sentence because we'll be at the end of the line in terms of getting financial resources, and we're at the end of the line in securing PPE.

So that is our concern. We need to have an access to the stockpile, and we also need to have access to an unbroken supply chain, whether that's directly through congressional appropriations and resources and/or public-private partnerships.

CHAIR LHAMON: Thank you, President Sharp. Chief Malerba?

CHIEF MALERBA: I'd like to address a couple of things. One is I agree with the national stockpile. What's happened was we did not have access to the national stockpile and instead Indian Health Services were required to use other sources such as the National Supply Services Center and then tribes had to go through them, which created lots of barriers, lots of delays.

And I don't think there's going to be a

first wave and a second wave. I think we're just going to be in a wave until we get a vaccine. So we need to really think about how we amass the necessary PPE for our healthcare providers but also perhaps for our elders who are home and have to go to doctor's visits and have to, you know, go out of their homes when they may not need to.

The other issue that I wanted to address was the testing. And the public-private partnerships are good if we can ramp up. But what happens with public-private partnerships are then, you know, the free market takes advantage of tribes. And so whoever can afford the services and supplies that are being provided are the ones that will receive those services.

We use the Abbott ID ready test, you know, the rapid test. We tried it. There were so many false negatives so we didn't think it was safe for our community to use.

So not only do we worry about PPE, but we worry about validated tests because a false negative is very dangerous in our community. If you test negative and you don't understand that perhaps all it means is that the virus hasn't shown yet or that the machine you're using isn't good yet, you're going to

go out and be a super spreader.

And so I think that was a real failure with some of those public-private partnerships in that we rushed these, you know, testing devices to the tribes in particular and the data that we were getting was not helpful. And we actually returned ours and went back to serology testing.

CHAIR LHAMON: Thank you. Next I understand Ms. Crevier has an answer?

MS. CREVIER: Yes. Thank you. So very quickly in terms of availability, I think it's important to note, and I am sure this is the same for all of us, like, any PPE we do have, we've had to close other services down such as dental.

I know a lot of us had to close dental for a long time. Those masks are vital to dentistry, but obviously in this pandemic, which helps us fund our clinics and make sure they stay open. And so that has been, you know, a very painful thing, I think, for a lot of us, which is where, you know, the provider relief fund and those types of funding are essential.

And then testing equipment, IHS received the Abbott test at the time, and we received zero of those. To date, I don't know. I think maybe one program, our Santa Clara program, is just now

receiving one for the first time. And so we really don't have access to the testing equipment needed and then supplies, cleaning supplies and all those things.

And then, you know, one of the other things that I think is impactful here is that with this pandemic, you know, our people are losing their jobs. They're not able to pay their rent. And they need food.

And so a lot of -- the domestic violence rate, behavioral health rates, have just absolutely skyrocketed. And so those things have really, you know, pushed our facilities to try to address those needs as well. And so they still need more food.

Our urban programs are not eligible for some of the food distribution programs but have tried to find out what those public-private partnerships to make sure that those supplies are needed. Because regardless of whether or not you have COVID, you still have to pay your rent, keep your lights on, eat.

And so we're really trying to address that. And some of the funding even has been very limited. The funding will say for testing and the interpretation is just for tests and not the staff needed for the tests or the other components when it comes to calling to schedule an appointment, working,

you know, with our programs.

And then, and I know this is very big, you know, on the Reservation as well, like, we don't want our elders going into the facilities and hurting themselves, you know, and providing more access.

And so having more Community Health Representatives to be able to attend to our elders or attend to our vulnerable populations maybe, you know, to go testing, some of our programs have been able to do drive-through testing.

But we still need the staff and we need the equipment and all of these other things necessary to make it happen. And so one of those things besides additional funding and resources, there is flexibility in that, you know, to ensure compliance. Thank you.

CHAIR LHAMON: Thank you, Ms. Crevier. I understand that Commissioner Kladney has a question. Commissioner Kladney, go ahead.

COMMISSIONER KLADNEY: I'm sorry, Madam Chair. Chief Smith raised his hand. I didn't know if he still wanted to talk or not.

CHAIR LHAMON: Oh, thank you, Commissioner Kladney, why don't we pause? And I didn't see Chief Smith. So I apologize. Go ahead, Chief Smith.

CHIEF SMITH: Thank you very much. In

Alaska as we shared, we have many communities and homes with no running water. So we're not able to follow the CDC guidelines on handwashing and social distancing.

We need basics including hand sanitizers. And we struggle with the rest of the Indian Country as we watch the news reports on HHS instead of CDC.

As it was reported that allotment of resources will be determined by the data submitted. And we don't know how this will impact the availability of resources.

And we agree with President Nez at this point that it's a real concern because Alaskan cases have gone up 396 percent since Memorial Day.

And in my little tribe, Valdez Native Tribe, we got Conexes for supplies, but they're empty and we haven't even built our shelter over them for our snowfall for the winter. So at the Valdez Native Tribe, there are just empty Conexes and we are relying on the community of Valdez Alaska to support us. And they may have enough supplies right now, but when the second wave hits, the availability of the resources after that is unsure of.

And like I said, without running water and without sanitation, it's really hard to follow the

guidelines in the housing. Yes, the resources may be there but if the second wave, and they say it's coming, and we see the increase every day, especially in Alaska with the non-residents coming to Alaska for the fishing industry, the rise in COVID and what has to be done to separate the economy, the fishing economy, from the local villages. So, when the second wave hits, the supplies will probably not be there. Thank you.

CHAIR LHAMON: Thank you, Chief Smith. I'm just going to take a pass through and see if there are any other hands raised. I'm not seeing them. We'll go to Commissioner Kladney for your question.

COMMISSIONER KLADNEY: Thank you, Madam Chair. It seems to me in reviewing our 2018 Report of Broken Promises that the basic problem is that the Indian nations had no really good infrastructure to begin with in terms of medical care.

So what I was wondering is, is there an inventory where the Indian nations have gotten together and have inventoried what their infrastructure is and the needs that they have overall that we could get our hands on or that kind of thing?

The same thing is the need for broadband in Indian nations. I live in Nevada. And I know that

we have a variety of Reservations throughout the state, some very rural and some very urban. We have an Indian Health Center here that was built in 2008. But I think that's more a rarity when it comes to Native nations.

So I was wondering if anybody would like to comment on that. Thank you.

CHAIR LHAMON: So I see Chief Malerba raising her hand. Go ahead.

CHIEF MALERBA: I do. There are reports from Indian Health Services that talks about the number of clinics and IHS hospitals. And when we think, and I don't have the exact number, but I believe that there's only 46 hospitals throughout the United States if I remember correctly. And of those hospitals only 20 have emergency rooms and only about 20 have operating rooms.

So when you think about infrastructure then what happens is tribes must be sending their patients out using purchased and referred care and so they have to travel long distances. There is no tertiary care facility, meaning there's no NICU, there's no open heart surgery. There's, you know, none of that support.

When you think about some of the clinics

tribes have, I would say that very few have negative pressure rooms, which you need to isolate your patients in. And they don't have the capacity to even quarantine patients.

So when we think about, you know, infrastructure, we think about how we're looking to provide, you know, a full-funded model that supports all of the health infrastructure. We need to establish a budget that will allow us to create the infrastructure for all Indians throughout the nation to access care in a timely manner and one that provides the best care possible at that time.

So, again, when we think about your report, we've used your report for advocacy on health, but there's a lot more work to be done.

When we talk about that Marshall Plan, you know we talk about what needs to happen in Indian Country. You know, we donated all of this land so all of the resources and the revenues that are created economically in this country are because we donated the land.

It's time for the United States to recognize that and rebuild all of our communities. So whether it's healthcare, education, our tribal

economies, our taxing authorities, all of that needs to be taken into account. And if we could do that in Europe in 15 years, we could surely do it here.

CHAIR LHAMON: Thank you, Chief Malerba. We're very glad to hear about our reports being put to good use. I see lots of hand raised. I'm just going to go in order. So, Mr. Blackwell, you are next.

MR. BLACKWELL: So I'd like to take the opportunity to address the second half of that question and thank you very much for asking it. One of the major features of the problem of the tribal digital divide is a lack of accurate data and a lack of data that is genuinely available to address the actual problems.

So the FCC's broadband map is area reported data that is really very industry-centric. And the way in which the data is derived, the map in itself is questionable because it treats an area as served if there are only a few homes served within that area.

It does not cross-reference major community institutions that were just mentioned by Dr. Malerba. So we do need to push the restart button on quantifying the problem, both from a qualitative and a quantitative situation.

We know that there is a large amount of missing middle mile fiber in Indian Country. And I placed into my testimony in the previous administration a number of inter-tribal organizations worked on their own and within their own auspices and not in the federal government auspices to quantify this missing middle mile fiber.

One need only look at the map of fiber in the United States, and it almost matches one to one tribal lands. And there are programs that would bring that connectivity to certain core community institutions if those were leveraged with the right data with a new tribal broadband fund.

Those are the reasons that would bring connectivity to Indian Country. For you see we don't have the population density that can just be the basic predicate the way that most of the broadband in the United States has been deployed. We really have to design intelligent project development to get the core backbone out there into Indian Country. Thank you.

CHAIR LHAMON: Thank you, Mr. Blackwell. I think President Sharp also wanted to speak.

PRESIDENT SHARP: Yes, thank you. And thank you, Commissioner, for that question. And it provides an opportunity to once again applaud the work

of the Commission because historically funding for tribal nation's healthcare has just been built budget after budget without a real connection to the outcomes and the results and the disparities on the ground.

And we looked at budgetary increases in Congress for healthcare. And while there are increases over time, they've not kept up with the rates of inflation, the rates of rising medical costs. And so the gap has just widened. And since the very first report, the Quiet Crisis report to the Broken Promises report, we find that gap has only widened.

And so I thank you so much for being able to do some fact finding to really document the outcomes of a failed system and a failed healthcare delivery program from a trustee that has a sworn obligation to actually fulfill a treaty commitment to assure healthcare.

We, among all U.S. citizens, are the most vulnerable. We have health rates in every sector, in every measurement off the charts. And so it is so important to build that Marshall Plan to connect -- where we stand today and those funding disparities.

But in terms of a comprehensive healthcare system, I would also suggest in addition to the base level healthcare that we're looking at, simply just

delivering access to healthcare, that in and of itself is a significant problem. But there's a whole other level of significant challenges.

In any healthcare system, there has to be quality of care. And outside of tribal communities and tribal nations, there are health boards and health commissions that connect oversight in the delivery of healthcare systems to make sure that there's both access and quality of healthcare.

We don't have those systems in Indian Country. We barely have enough funding to fund a doctor, to fund a pharmacist. That when you look at a comprehensive healthcare delivery system that assures a citizen and a body is not only healthy but they're able to be treated medically in all of those sectors and benchmarks for healthy lifestyles, we don't even have the tools to deliver let alone assure good quality care.

And because we don't have those mechanisms in place and because we live in remote areas, it's always a challenge to recruit and attract and retain quality medical providers.

And so in terms of looking at a comprehensive healthcare delivery system, I so appreciate that question because it just illustrates

many layers of barriers and challenges that we've had to face.

And we try to overcome that gap by backfilling the failure of the federal government to fund these through our systems of taxation, through commercial operations and enterprises. And it's just a challenge to close a gap to provide basic healthcare to the most vulnerable in this country.

(Native term used.) Thank you.

CHAIR LHAMON: Thank you. I saw Chief Smith raise his hand.

CHIEF SMITH: Thank you. Tribes were left behind on the development of public health infrastructures. As a result, many tribal lands can't do public health surveillance, can't do emergency preparedness and can't provide sufficient public health education.

Tribes don't have access to CDC public health emergency prep programs even though the fundings go to all 50 states and most territories. But tribes can't receive it. The HEROES Act fixes this problem among many other problems, and we are pushing for it to pass.

The National Health Board has a public health capacity scan that it will be released very

soon. The information in this scan will provide greater insight into the public health priorities of the tribes. It is the most comprehensive public health record ever in Indian Country. And up to 80 percent of Alaskan villages don't have broadband. Thank you.

CHAIR LHAMON: Thank you, Chief Smith. I think Ms. Crevier had her hand raised.

MS. CREVIER: Thank you so much, Chair. First I would like to say that, you know, every tribal nation is very different and has very different needs. So it's similar to asking, you know, did Italy and France have, you know, comprehensive together? You know, every tribe has very, very different needs, and there's over 574. And so I think, you know, the answers will definitely vary based on a lot of those other factors.

And then at NCUIH, you know, we represent 41 of the urban Indian organizations, so we're much smaller in that regard.

So we've conducted several surveys of urban programs identifying their needs. And back in March 83 percent of our facilities noted that they had to cut services and recently 86 percent of them reported needing new and/or upgraded infrastructure.

Our programs have been stretched to the

limit during this pandemic and without supplies and our programs are having to pay for expensive supplies out-of-pocket. And we can't underscore how the government has failed at the beginning to just give us any supplies and help.

They've had supplies for weeks, and we were just buying them from third-party vendors trying to make that happen at premium rates. And all of this has exacerbated the need of the Indian Health System, which is quite chronically underfunded and leads to devastating impacts.

There also has not been a lot of funding for tribal public health infrastructure. States get billions of dollars from CDC for public health infrastructure, and tribes are just simply left out of that. And so that is another part of our infrastructure needs.

And then our urban programs, they don't get any funding for infrastructure in general, which has been a true challenge. And we are going to see a lot of our health disparities get much worse because of this pandemic.

Our residential treatment centers, they used to be able to serve 80 patients. Now they can serve only eight because of the lack of -- for social

distancing purposes. So now we're looking at -- you're having to look at things like modular buildings, which require plumbing, which require construction. And all these things are -- just absolutely completely underfunded, like not funded at all.

And so if you went from serving 80 patients in your residential treatment center to just 8, what happens to the other 72?

And so that's just kind of one of the points that I wanted to make regarding infrastructure that it's definitely needed, you know, true, true investment, both currently and with public health infrastructure, to make sure that we have all the tools necessary. Thank you.

CHAIR LHAMON: Thank you, Ms. Crevier. I saw Chief Malerba has another answer to this question.

CHIEF MALERBA: Well, thank you. One of the things that I neglected to talk a little bit about is just the oversight and the accountability with this funding.

You know, we believe wholeheartedly that Indian Health Services overestimates the amount of funding that gets to tribes, as does OMB. And that's why we did make the recommendation that we need to have a tribal desk at OMB.

But I also wanted to talk a little bit about the fact that as we think about infrastructure, think about housing and homelessness, you know, again, I think President Sharp talked about the fact that if you have providers that need housing, how are you providing them housing?

How are we caring for our homeless people and how are we making sure that they're being cared for when we can't actually access the funds for that?

And so when we think about the infrastructure and the funding, that's why grants don't work for tribes. We are very holistic in our approach. And when we're having to apply for grants that are targeted for a very specific issue, it doesn't impact our tribal nations, and we may not even be able to apply for the grants because they are so limiting.

We know what our communities need. And we should be able to have the flexibility to provide the services. And also, when I go back to Geoffrey Blackwell's comment with the broadband, you know, not only do we need broadband access, but we need to be able to bill for telehealth from Medicare and Medicaid for our services because we can reach out to our community in ways that we wouldn't be able to

otherwise.

CHAIR LHAMON: Thank you. Commissioner Gilchrist, I saw you raised your hand.

COMMISSIONER GILCHRIST: Thank you, Madam Chair. And let me just thank all of you for your wonderful testimony today.

A quick question for you. In the CARES Act, the allocation that was allocated to our tribal nations in the country, has that resource reached all of our tribal nations or is there still a backlog with trying to get those resources out to our tribal nations?

CHAIR LHAMON: Looking for hands. I think I see President Nez, but you're on mute. There you go, President.

PRESIDENT NEZ: Thank you, Madam Chair and Commissioners, again and tribal leaders. In terms of the question, thank you for the question, Commissioner. You know, the Broken Promises report, I appreciate Congress finally looking into the relationship between the federal government and tribes throughout the country. And now with this pandemic, Commissioners, we have seen Indian Country, their stories being told in the national media. And now U.S. citizens are learning the plight of tribes throughout

this country.

And I have heard people say that 30 to 40 percent of Navajo citizens don't have running water is unacceptable in the most powerful country in the world where we send aid and relief to rebuild countries in other parts of the world.

Now, again, if that's not discrimination, then what is it? Tribes are always pushed aside since the time visitors came to this land and the treaties. So when people say how come tribes aren't protesting during this time of protests and rallies throughout this country, I say tribes have been protesting ever since Columbus came across the ocean and have been protesting ever since those treaties because those treaties we hold sacred to us.

But broken promises, better infrastructure, health care, education, we're talking about broadband infrastructure projects right now, you know, and healthcare. Let me talk about healthcare right now.

Under-funding of the Indian Health Services since its start. Some tribes have their own self-governance facilities, and we're taking self-determination very seriously. But when funds get given to programs to administer on behalf of the

tribes and then we have to in turn apply for these funds, that's unacceptable.

It should be direct funding to the tribes as was mentioned earlier. That's true self-sufficiency, self-government. I mean, you've got states that get money directly. And look at what happened with the CARES Act. I love to use the CARES Act funding as an example.

We had to take the federal government once again to court just to get our share of relief while the rest of this country immediately got their money. And it is no wonder why we had big spikes and surges in our healthcare system in Indian Country.

So for the federal government to now say, well, we gave them the money. That's the reason why they're flattening out. Their numbers are going down. No way. People help each other out. Their resilience was shown of our people all across the country.

And you saw stories of that. Not just in Indian Country, but all across the globe. All in this country where people of color came together and helped each other out during this pandemic.

And I, again, applaud the friends of the Navajo nation for assisting us. We need more doctors.

We need more nurses in our communities.

What we found out, too, public safety, a little bit over 200 officers that are patrolling the Navajo nation, the size of West Virginia, 27,000 square miles.

So we sent a white paper to Congress, back to the executive order. The President signed an executive order saying to his cabinet members that cabinet members can waive and set aside certain federal regulations. We've got to do that in Indian Country.

So that's why it gets frustrating, and I apologize for the tone of my voice. But I think all Indian Country is very frustrated in this. And you, as Commissioners, thank you for having us on.

And I think you as Commissioners have the ability to let our congressional leaders know and our administration know that they need to support and hold each other accountable to fulfill those promises that were made by the founding fathers to the tribes. Thank you. I'll stop there.

CHAIR LHAMON: Thank you, President Nez. Chief Malerba?

CHIEF MALERBA: There has been a lot of delay in getting the funding to tribes. And one of

the problems that we experienced was we gave consultation and advice to various agencies, in particular the CDC and others asking that the funding be sent through contracts and compacts through Indian Country because that's the quickest and easiest way to get the funding out.

And yet despite that advocacy and that guidance, CDC decided to send out the funding through grant mechanisms, which then further delayed you have staff on furlough and now you're trying to get people in to write a grant and apply for grants.

And another agency, you know, we applied for a grant through -- their system broke down and when we finally got through, they said, well, we can't give you any technical assistance even though you're still within the time frame because we have way more applicants than we have funding.

And that agency actually talked about tribes winning grants. Now that is not the trust and treaty obligation that we know the United States to hold. So that's one. So we had a lot of headaches accessing the funding.

But two, now what we're worried about are these arbitrary timelines to spend the funding, non-statutory requirements that, you know, the agencies

are layering onto tribes and being very prescriptive in how we are going to be able to spend the money.

So once again I think we need to think about how do we get to contracting and compacting? How do we get to, you know, making sure that tribes get the funding?

You know, the federal government wants to hold the tribes to a certain standard, but yet we are unable to hold them to a certain standard. So we need to find a way to make sure that there is oversight on the federal side as well. So thank you for that question. We appreciate it.

CHAIR LHAMON: Thank you, Chief. President Sharp, I'm seeing you have an answer.

PRESIDENT SHARP: Yes. Thank you and thank you for that question. The simple answer to the question is it has not been fully deployed yet. The CARES Act (audio interference) --

CHAIR LHAMON: Can you hear me? Maybe sit back from the microphone. Somehow it's coming in not well. We cannot hear you very well. Now I can't hear you at all.

PRESIDENT SHARP: How's that?

CHAIR LHAMON: Why don't we pause and see if we can help you get to a better sound quality, and

we'll go to another person and get back to you. I apologize. But we're just not able to hear you.

I know that Commissioner Adegbile had a question also.

COMMISSIONER ADEGBILE: Yes. Thank you. Thank you, Chair Lhamon. Thanks to all the witnesses for your thoughtful testimony in helping us dig further on some of the issues that we identified as broken promises in the context of the COVID crisis.

It seems to me that there are some themes running through your testimony. And one arguably is that the COVID crisis has hit Indian Country so hard in part because the nation's investment in the needs of Indian Country has been wanting for so longer that it's foreseeable that threats to society at large will have a special impact on the most vulnerable.

So whether it's plumbing or broadband or healthcare infrastructure, there's so many issues that aren't being adequately attended that when this tidal wave of sorts comes, it really wreaks havoc on Indians.

The specific suggestions that all of you have had, I think are very important for us to think about as we think about a way forward. But I'm also hearing in part the frustration and to some large

extent sharing it.

And so I want to ask what do you think are the most important things that the federal government could do if it wanted to have a meaningful reset in the way that it thinks about the needs in Indian Country more broadly. I think that there are some things that you shared with us, for example, elevating some of these needs to a cabinet level.

I'm just seeing that there's so many cross-cutting needs across agencies and the network of regulation and the like that too often what I'm hearing is that there are programs and policies but Native American people get left out or are the last to receive the benefit of the larger effort.

And so I'm wondering if each of you had to pick a most important structural reform to do better using this COVID crisis as an example of why we need to do better, what would that be? Thank you very much for your testimony.

CHAIR LHAMON: Thank you, Commissioner Adegbile. I'm looking to see what hands are raised. I got a note that Ms. Crevier had wanted to answer Commissioner Gilchrist's question. So maybe we'll start with that while people are thinking about answers for yours. Ms. Crevier?

MS. CREVIER: Thank you so much, Chair. So, yes, I will address that last question. So in addition to the funds that tribes have been waiting for, especially for things like CDC, urban programs have also received zero dollars from CDC from the CARES Act funding specifically.

Congress directed CDC to distribute a minimum of $125 million to tribes, tribal organizations and urban Indian organizations. CDC only recently announced an opportunity for some of those funds to go to tribes and tribal organization and has yet to provide any indication of when and how much funding will be available to urban programs.

This is just one example of a failure to get critical resources healthcare providers need and ultimately it is our Native people that suffer as a result. And we've had plenty of calls and even letters that have not responded in a way that answers the question, which begs even the intent of, you know, is CDC following the intent of Congress?

In terms of supplies, there's been a backlog from the start. When you start from behind, how do you catch up? The government has left us in a lurch for months.

Finally we're getting supplies and tests

months after the rest of the country received them. So now there are testing backlogs. People are waiting three weeks or more for testing or for their results. So how can they work if they don't know if they have the virus or not, and we have no contact tracing solutions.

When a vaccine comes, you can be sure Indian Country will be last on the list as well. CDC cannot even answer us if we're going to get the vaccines. And we don't know if we'll have a vaccine.

And some of the specific solutions, I think, fully fund IHS is a good start in all of our Indian programs. So to fund, you know, over $30 billion is, you know, over a $24 billion investment to IHS for the first few years over what they're currently paying, I think we would start to see some really good, you know, progression there.

I think, you know, just treating us the way that they treat the rest of the country in terms of just basic human rights, it would be a great solution.

And then while they would be funding it at over $30 billion, you know, then they can do some more studies on what else would be needed to kind of get us -- because that would just get us parity, which we

desperately needed and I think it would improve the lives of our people, but we would still need more investments on how to deal with the historical trauma that's happened and to get us to a better place. So that's one of my recommendations. Thank you.

CHAIR LHAMON: Thank you, Ms. Crevier. I see that President Sharp is back. Let's try and see how the internet connection is working.

PRESIDENT SHARP: Can you hear me now?

CHAIR LHAMON: Yes. Thank you very much.

PRESIDENT SHARP: This is an example of why broadband is so important in Indian Country.

CHAIR LHAMON: I like it.

PRESIDENT SHARP: If a tribal leader can't access -- case in point. So I wanted to address the question that was asked earlier and that was whether our research is having deployed, and the simple answer is no. We still have over $600 million of CARES Act funding that's been withheld and two appeals pending so the CARES Act as well as the dollars that are targeted for the Alaska Native corporations. And so I wanted to answer that question as simply.

I also wanted to point out that there are a number of other funding streams, $50 million for the Department of Ag that has not been deployed. None of

those funds have been released.

And so there are many revenue streams that have come into Indian Country through the pandemic and many have been withheld. Many have been delayed. There is also a significant delay in access to PPP, Paycheck Protection Program.

Initially SBA found that tribal governments are commercial enterprises. We're not eligible. Through a lot of advocacy, we finally secured a letter where SBA ruled that we were finally eligible but by that time, there was nothing left and there was another reauthorization. So we missed two windows of opportunity. And we have a $39 billion industry with tribal gaming, the 12th largest industry in the country, and we weren't able to secure any funding to backfill an industry which is effectively our tax base since we don't have taxing authority.

So millions of dollars are still withheld. They're not deploying. They've long exceeded the deadline that Congress gave to Treasury to deploy those resources and our needs just continue to grow. Thank you.

CHAIR LHAMON: Thank you, President Sharp. I understand Mr. Blackwell wanted to answer Commissioner Adegbile's question and Chief Malerba, I

see you raised your hand. We'll go to you next. Mr. Blackwell?

MR. BLACKWELL: I do have an answer that relates to both of these questions. Actually it's the second question by Commissioner Adegbile.

CHAIR LHAMON: Adegbile.

MR. BLACKWELL: Adegbile, I apologize. And it also is a lace-through idea from several of the answers that have come from the other panelists, our tribal leaders.

When it comes to broadband telecommunications in the United States, what we really need is a healthy push of the restart button. In my written testimony, I explained that there are two huge missing pieces, this whole digital divide in Indian Country. One is access to spectrum. There is so much spectrum across Indian Country that is licensed, but tribes have absolutely no access to it.

The other is a dedicated tribal broadband fund. And I believe there are three or four who have mentioned this in the context of this hearing.

The reason why the need for the tribal broadband fund is because we've had four universal service mechanisms working at the Federal Communications Commission for almost 25 years now.

We've been pouring billions into those four programs, which are essentially corporate subsidy for operational and capital expenditures, low income program, healthcare program and education program.

We've been pouring billions into those programs, and we are only this far. We are only this far. Our economics, our terrain, the entire situation, geopolitical situation associated with tribal nations is different because we were set apart. We do suffer from historical periods where tribal nations were not included in national planning.

So, I really do like this idea of the Marshall Plan as it involves Indian Country and broadband because pushing that restart button it will be intelligently designed spending.

As I said before we do not have the predicate numbers to just rely on population density for competition. And the Broken Promises report recognized that.

But you asked a very important question about if there was one major thing to do. It is really hitting the restart button and starting over. It's been 20 years that the FCC has been trying to inspire and incentivize industries to serve Indian Country and to approach Indian Country the way that it

needs with its critical community institutions and that very important connection between urban Indians and rural tribal lands. And it just simply is not happening. We need to stop trying to force a round peg into a square hole. Thank you very much.

CHAIR LHAMON: Great. Thank you. And we'll go to Chief Malerba. And just to say to all we're at about 7 minutes left, and I have a question and I know there's another question. So let's speed this up.

CHIEF MALERBA: All right. So, you know, I think the most important thing is for the U.S. to be honest about how it came into being and to uphold its trust and treaty obligations.

When you think about the fact that Indian Country land and natural resources are a key to U.S. power, we shouldn't have to be coming hat into hand to the United States to uphold their trust and treaty obligations. And so we need to fundamentally make sure that the United States upholds its trust and treaty obligations.

And I think the cabinet is a good start to that. Because if our country acknowledges that, then they will decide how they shall behave in budgeting, in policy and in enacting those things that impact our communities greatly.

CHAIR LHAMON: Thank you. Chief Smith?

CHIEF SMITH: Thank you. Let me put it this way. The CARES Act gave the VA almost $16 billion for the medical care, but IHS only got about $1 billion. And as you all know, I am a Vietnam vet and Congress must give priority to the VA and Indian Health Service MOU.

The problem is Congress has given billions of dollars to corporate with no questions asked. But when it comes to funding to the tribes, the question is always how much will it cost? This is unacceptable.

There are also many different pots of funds that have gone out. Many ensure that the tribes get funds from other pots and have been left out.

Tribes have been excluded from all but two provider relief funds. Alaska was excluded entirely from the high impact funding and the first distribution of the safety net hospital fund and for the provider relief fund.

To totally fund the IHS per recommendation tribal budget formulation, the budget formulation has put forth $48 billion to fully fund the IHS in 2020. IHS funding was only $6 billion.

And just like I said, President Nez says

that it's not only the United States, it's global. If you check history, what the Choctaw Indians did to the Irish people after their trail of tears spiel and how they funded the Irish people and how did the Irish people repay the American Natives? That's global. We are indigenous people all over the world, and we need help to combat this COVID and take care of ourselves. Thank you.

CHAIR LHAMON: Thank you, Chief Smith. I understand President Sharp has a quick answer also?

PRESIDENT SHARP: Yes. Thank you. And I will be very quick. The simple answer for me if there was one thing, it would be directly engaging with tribal nations in developing a Marshall Plan.

We have a very clear vision of what is minimally necessary to grow and advance of our economies to serve our communities. We do a lot of these hearings. There's a lot of fact finding. But rarely do we have an opportunity to sit down and talk about solutions around dual taxation, around international trade.

We have an incredible brain trust in Indian Country. If the United States is not going to fulfill its trust responsibility and fund us, at least get out of our way and support us and support our

tribal sovereignty with a vision that we have that we simply can't access because the United State is in our way.

So I would simply suggest a bilateral, multilateral discussion with the United States on solutions because we have plenty of them. We just need the support of our sovereign authorities.

CHAIR LHAMON: Thank you very much. As we can all see there's just tremendous interest in this topic, and you all have just a wealth of expertise. So I thank you for it.

I'm going to do my last question and hope that we can do lightning round responses, and I'll just remind you all that if there's more that you would like to say to us, you can submit it in written testimony by the 24th, and we will be able to incorporate that as well.

So here's my question. The CDC has reported that it has a COVID-19 tribal support unit that can deploy staff to tribes for epidemiological and contact tracing teams and water access teams among kinds of assistance.

And I haven't heard any of you mention having received that support. Are you aware of any tribe that has? Has it been effective? Is it

sufficient? That's my question. I'm looking for hands raised. Mr. Blackwell?

MR. BLACKWELL: I was unaware of that until you just said it. And I'm unaware of any tribe in the region where I live here in the Southwest that's aware of that resource as well. Thank you.

CHAIR LHAMON: Thank you. President Nez?

PRESIDENT NEZ: Thank you, Madam Chair for that. And hopefully I'm not on mute again.

CHAIR LHAMON: No. You're good.

PRESIDENT NEZ: Yes, I got it. Yes, thank you.

Madam Chair and Commissioners, you know, we do have support, not just CDC. I guess this is because we're the biggest tribe and maybe we're the loudest, too, in really holding our federal government accountable.

But once we hit the peak and telling the rural that there's a failure in sending for help from the federal government, they sent some staff to us. You know, we have CDC here. We have a unified command group where federal agencies like FEMA, the National Guard, CDC, but they are just there for support in helping us with some of the guidelines that are established on possibly spending some funds.

You know, they have given us small amount of funds, CDC. I'm not sure some tribes know about that that we have to submit an application, right, for that funding and wait a few weeks while they vet it and then give an answer.

And back to my point about direct funding, you know, that money should have come directly to tribes. And with the previous discussion, it's all about self-determination. We are in a self-determination era and the recognition of the federal government that Native Americans and the government have the ability to govern themselves but yet there is so much red tape.

The question that was mentioned earlier about the immediate actions, we have a bill in Congress now, the whole Utah Water Rights element, that's been sitting on the desk of Congress for years now that will give running water to the Utah Navajo citizens, $200 million, but yet we have to wait until, you know, an impeachment hearing was completed.

And I'm sure there's a lot of other tribes that have legislation that were pending. And it seems like much of the improvement that tribes want are overseen by federal action and congressional action. So --

CHAIR LHAMON: President Nez, I'm sorry.

PRESIDENT NEZ: So we need that Navajo Utah Water Rights Settlement Act approved and the white paper. And I think the dual taxation is one that needs to be addressed immediately. So thank you, Madam Chair. I'm sorry. Go ahead.

CHAIR LHAMON: Thank you very much. I'm sorry for rushing you. I know that Chief Malerba and Chief Smith also want to answer this question. So I'm going to go to Chief Malerba and invite the short answer.

CHIEF MALERBA: The short answer is I believe CDC did reach out to all the regions. And within USET, the USET region, they are working through our tribal epidemiology center, and I believe there is five people assigned. So we thank them.

CHAIR LHAMON: Thanks very much.

Chief Smith?

CHIEF SMITH: Yes. We in Alaska are not aware of this. And this is just once again that the CDC is not reaching out and not communicating with all the tribes. So this is something that really needs to be fixed because it's apparently that a lot of tribes are not aware of this. And thank you for that information.

CHAIR LHAMON: Thank you. I understand that Mr. Blackwell you have a last word and then we'll have to closeout this part of the briefing.

MR. BLACKWELL: Madam Chair, I just wanted to say on behalf of the Muscogee Creek family, thank you very much for referencing the McGirt decision at the top of this. My family in one way or another was involved both in this case and in the prior case.

And from a family that took part in the wars and the removal and the terrible things that happened in the creation of statehood, thank you very much for mentioning that. We are a nation of rights and we are a nation that does keep its promises. So (Native term used.) Thank you.

CHAIR LHAMON: Thank you. Thank you to you and thank you to each of you for your expertise, for taking your time today, for participating this first virtual briefing. I look forward to being able to report on the important information that you shared with us, and I thank all of my fellow Commissioners for your participation and for your questions as well.

So thank you all. And we will take a brief break and reconvene for the Commission's business meeting at noon Eastern Standard Time. Thank you very much.

(Whereupon, the above-entitled briefing went off the record at 11:50 a.m.)