IMPROVING AND EXPANDING INFRASTRUCTURE IN TRIBAL AND INSULAR COMMUNITIES

OVERSIGHT HEARING

BEFORE THE

SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

OF THE

COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

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CONTENTS

OVERSIGHT HEARING ON IMPROVING AND EXPANDING INFRASTRUCTURE IN TRIBAL AND INSULAR COMMUNITIES

Thursday, March 9, 2017

U.S. House of Representatives

Subcommittee on Indian, Insular and Alaska Native Affairs

Committee on Natural Resources

Washington, DC

The Subcommittee met, pursuant to notice, at 10:03 a.m., in room 1324, Longworth House Office Building, Hon. Doug LaMalfa [Chairman of the Subcommittee] presiding.

Present: Representatives LaMalfa, Young, Radewagen, Bergman, Colón, Bishop; Torres, Bordallo, Sablan, and Soto.

Also present: Representative Westerman.

Mr. LAMALFA. Good morning. The Subcommittee on Indian, Insular, and Alaska Native Affairs will come to order. Welcome, everyone.

The Subcommittee is meeting today to hear testimony on the hearing titled, "Improving and Expanding Infrastructure in Tribal and Insular Communities." Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chairman, our gracious Ranking Minority Member, the Vice Chair, and the Vice Ranking Member. This will allow us to hear from our witnesses sooner, and help Members keep to their schedules.

Therefore, I ask unanimous consent that all other Members' opening statements be made part of the hearing record if they are submitted to the Committee Clerk by 5:00 p.m. today, or the close of the hearing, whichever should come first.

Hearing no objection, so ordered.

All right, opening statements. Recognizing myself, first.

STATEMENT OF THE HON. DOUG LAMALFA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. LAMALFA. As we know, infrastructure plays an extremely important role in providing the basic services to people, no matter where they live. Quality infrastructure boosts economic development, creates jobs, and quality of life increases. Nowhere is this more important than tribal and insular communities.

There is, however, a great need in tribal communities, especially with tribal healthcare infrastructure. Established in 1955, the Indian Health Service (IHS) provides health care for approximately 2.2 million American Indian and Alaska Native community members. Today, there are approximately 650 IHS and tribal health facilities throughout the Nation. IHS facilities offer a range of care, including primary care services, pharmacy, laboratory services, only to name a few.

In recent years, several reports to Congress have highlighted the state of many health facilities to fall into dire conditions. Most facility capacity is about 52 percent of need. This creates crowded and unsafe conditions which affect the delivery of health care.

In 2016, the average age of IHS hospitals was estimated to be about 40 years old. The average age of hospitals throughout the United States is said to be about 10 years.

This information is not unfamiliar to those in Indian Country. Both the Centers for Medicare and Medicaid Services and the HHS Office of the Inspector General have found that aging facilities are direct threats to patient care. Again, this is not something new to Indian Country; this problem has existed for decades.

Beginning in the 1990s, early 1990s, as directed by Congress years prior, the Indian Health Service developed a Health Care Facilities Construction Priority List. Nearly 30 years later, IHS is still working through that priority list. At the current appropriation levels for facility construction, if a new facility were built today, it would not be replaced for another 400 years.

Infrastructure needs in Indian Country do stretch beyond health care. I also look forward to discussing these, too, and creative ways to address all infrastructure needs in Indian Country.

Today we will also be hearing from the Acting Assistant Secretary of the Office of Insular Affairs on the Capital Improvement Project (CIP) grant program. The CIP grant program is the largest resource offered to the territories by the Office of Indian Affairs (OIA), and provides upwards of $27.7 million annually for vital infrastructure projects in some of the country's most remote locations in the Pacific and the Caribbean.

[The prepared statement of Mr. LaMalfa follows:]

PREPARED STATEMENT OF THE HON. DOUG LAMALFA, CHAIRMAN, SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

Infrastructure plays an extremely important role in providing basic services to people no matter where they live.

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Mr. LAMALFA. At this point I would like to recognize our Ranking Minority Member, Mrs. Torres, for any opening statement.

STATEMENT OF THE HON. NORMA J. TORRES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. TORRES. Good morning, and thank you, Mr. Chairman. First, let me say I am honored to have the opportunity to serve as Ranking Member of this Subcommittee for the 115th Congress. I am also pleased to serve alongside you, Mr. Chairman. We had the opportunity to work together in the State Assembly, and I am really looking forward to continuing our work together in this Committee.

Indian Country continues to face significant disparities in access to health care and education, as well as few opportunities for job growth and economic development. Mr. Chairman, I look forward to working with you to find bipartisan solutions to these challenges.

I also want to welcome our witnesses, especially the tribal leaders, who have traveled to be here with us this morning.

Mr. Chairman, our Federal trust responsibility and obligations to tribes is laid out in many treaties, as well as hundreds of years of Federal legislation. We must do a better job of honoring our obligations. Investment in tribal infrastructure has not even remotely kept up with local needs—a direct result of the lack of investment by Congress.

Over the years, this lack of investment has drastically and disproportionately affected the health, well-being, and livelihoods of Native people. The Indian Health Service (IHS), faces substantial backlogs in the construction of healthcare facilities, and with the maintenance of existing facilities. The average age, as you stated, of IHS hospitals is now 40 years, almost four times older than the average U.S. hospital. At the existing replacement rate, a new 2016 facility would not be replaced for 400 years, if we continue at this rate.

While the focus of this hearing is IHS facilities, I would be remiss if we did not highlight other infrastructure shortfalls in Indian Country, because infrastructure is more than buildings, roads, and bridges. Over a half-million people in Native communities across the United States do not have access to reliable water sources, clean drinking water, or basic sanitation.

Again, lack of investment by the Federal Government has resulted in a backlog of needed sanitation facilities, construction projects estimated to be $2.8 billion.

Native Americans also live in some of the worst housing conditions in the country. Forty percent of on-reservation housing is

considered substandard. The majority of BIA-run schools are in substandard condition, and estimates to replace or repair these facilities exceed $1.3 billion.

Overall, it is estimated that there is $50 (five zero) billion in unmet infrastructure needs in Indian Country. It seems like a lot to hear, but it is not an insurmountable problem. It simply requires a commitment and focus from this Congress and this Administration to address the issue head on.

Today, I look forward to hearing ideas on how we can streamline the process, especially to provide flexibility to tribes. But we must not use these ideas as an excuse to reduce our financial commitment to Indian Country. The solution is a renewed focus and increased investment in Indian Country infrastructure, combined with tribal self-determination and self-governance. But the longer we wait, the higher the price tag. We must seize this opportunity to revitalize Indian Country.

I want to conclude by touching on one last underserved population: the U.S. Insular Areas, which have unique challenges to providing the infrastructure necessary for economic development. My colleagues from the territories will expand further on those challenges during their questioning. But first, let me state that any infrastructure bill considered this Congress must include a significant investment in the Insular Areas. And, going forward, any future authorizations or appropriations must prioritize the improvement and modernization of their infrastructure.

Thank you again, Mr. Chairman, and I look forward to a productive discussion, and I yield back.

[The prepared statement of Mrs. Torres follows:]

PREPARED STATEMENT OF THE HON. NORMA J. TORRES, RANKING MEMBER, SUBCOMMITTEE ON INDIAN, INSULAR AND ALASKA NATIVE AFFAIRS

Thank you, Mr. Chairman.

First, let me say, I'm honored to have the opportunity to serve as Ranking Member of this Subcommittee for the 115th Congress.

I am pleased to serve alongside you, Mr. Chairman. We had the opportunity to work together a while back in the State Assembly and I hope we are able to have the same productive relationship here.

Indian Country continues to face significant disparities in access to health care and education, as well as few opportunities for job growth and economic development.

Mr. Chairman, I look forward to working with you to find bipartisan solutions to these challenges.

I also want to welcome our witnesses, especially the tribal leaders, who have traveled to be here with us today.

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Thank you, Mr. Chairman. I look forward to a productive discussion, and I yield back.

Mr. LAMALFA. Thank you, Ranking Member Torres. Indeed, I look forward to working with you in the friendly way we have been able to, and I am very excited to be the Chairman of this Subcommittee. It is the first time I ever chaired anything, coming from California, as you know. So, I am looking forward to a great bipartisan discussion on these issues that will be coming up.

Now we will introduce our witnesses here. Again, thank you for your travel. It is always something else, trying to get to Washington, DC, especially, as we know, from the West Coast—but the rural areas of the country. So, thank you for your time and efforts to get here to be part of today's hearing.

First we have the Honorable Herman G. Honanie, Chairman of the Hopi Tribe. Next, we have Mr. Andy Joseph, Jr., who is also chairman of the Northwest Portland Area Indian Health Board, and a member of the Colville Business Council; Ms. Victoria Kitcheyan, Great Plains Area Representative for the National Indian Health Board; the Honorable Aaron Payment, Secretary of the National Congress of American Indians; Mr. Andy Teuber, Board Chair and President of the Alaska Native Tribal Health Consortium; and Mr. Nikolao Pula, Acting Assistant Secretary for the Office of Insular Affairs.

Welcome. Let me remind you that, under our Committee Rules, witnesses are to limit their oral statements to 5 minutes, but their entire written statement will appear in the hearing record. So, if it is beyond 5 minutes, know that we have it in the record.

As a reminder, of course, when you begin, the lights on the witness microphone will turn green. After 4 minutes, the yellow light

will come on. Your time expires when the red light comes on. So if you don't want to find out what is behind door number 3, please finish up at that red light.

And further, the microphones are not automatic. You need to press the talk button right in front of you before speaking into the microphone.

With that said, we will let the entire panel make your presentation before questions will come from the Members up here. So, let's go ahead and start.

I will recognize Chairman Honanie for his testimony.

STATEMENT OF HERMAN G. HONANIE, CHAIRMAN, HOPI TRIBE, KYKOTSMOVI, ARIZONA

Mr. HONANIE. [Speaking native language.] Thank you very much. [Speaking native language] from the Hopi Tribe. [Speaking native language.]

I want to express my appreciation on behalf of my Hopi people to be here this morning, and on behalf of my people from northeastern Arizona. I appreciate the time.

Good morning Chairman LaMalfa, Ranking Member Torres, and honorable members of Subcommittee. It is a pleasure to be here today to testify on some of the infrastructure challenges facing the Hopi Tribe. My name is Herman Honanie and I have the privilege of serving as chairman of the Hopi Tribe. I am Pipwugwa tobacco clan from Kykotsmovi, which sits below Orazivi, the oldest continuously inhabited community in North America. Today this village has no modern infrastructure.

The Hopi Reservation is located in northeastern Arizona and is the size of Rhode Island. Our reservation is unfairly landlocked by the Navajo Nation, which completely surrounds us. We have approximately 14,000 enrolled citizens across the 12 villages. Our reservation is plagued by poverty and suffers from a 60 percent unemployment rate. Due to its remoteness, economic development on the reservation is incredibly difficult.

Today, I will discuss three issues: arsenic contamination of the reservation's water supply, our lack of a detention facility, and a Navajo generating station.

The Hopi Reservation's water supply is contaminated by arsenic. In the mid-1960s, the Federal Government designed and constructed our water well supply and wells. In 2001, the EPA decreased the allowable level of arsenic. Today, arsenic levels in Hopi are up to three times the maximum contaminant level allowed by the EPA.

The Hopi Tribe, Indian Health Service, and EPA work together to develop a Hopi arsenic mitigation project. We concluded that treating the water is not practical, and the best solution is to find a new source of arsenic-free water. The project will pipe water to villages to the First and Second Mesa. The entire project is estimated to cost between $18 and $20 million. This is a shovel-ready project that is only awaiting the necessary capital to begin construction.

The tribe is working on a Federal funding package, but time is of the essence. The tribe recently received notice of violation from EPA, due to the elevated arsenic levels. The reality is that every

day we do not solve the problem is another day that Hopis are drinking water contaminated by arsenic.

Another major concern is the BIA's closure of the tribe's detention facility, which caused me to declare an emergency on the reservation in December 2016. Originally built as a treatment center in 1981, it was never intended for incarceration. But over the past years, the BIA converted it into a detention facility. The building's condition began to deteriorate in the early 2000s.

In February 2015, BIA informed the tribe that it would provide a new facility. However, in October 2016, before a new facility was obtained, the BIA condemned the detention facility and closed it. BIA did not consult with the tribe prior to the closure, nor did they inform the tribe of its actions. The BIA said that it would deliver a temporary facility by November 2016, but to date none has been delivered.

The lack of a detention facility has created a public safety situation on the reservation. Law enforcement is forced to book suspects from their squad cars, and await a transport to take the suspects to the detention facility more than 80 miles off the reservation. This has put a substantial hardship and strain on our already limited law enforcement personnel. At any given time there may be only two officers on duty to patrol an area the size of Rhode Island.

We also learned that officers are practicing cite-and-release and de-prioritizing low-level crime because of the lack of resources. The tribe is concerned that low-level crimes will escalate into major crimes because of lack of deterrents.

The BIA informed us last week that it has money to pay for a permanent structure, but it is awaiting construction funds from DOJ. The tribe cannot operate and continue to have the patience for a facility that is no longer there. We need the facility.

The final issue I want to touch on is the Salt River Project, with the closure of SRP wanting to close the NGS station. This will be disastrous for the tribe, because 80 percent of our revenue comes from the sale of coal. In light of this, the tribe is focusing on economic diversity.

One area where this Subcommittee can assist the Hopi Tribe is by assisting us in fulfilling the Act of 1996, Hopi Land Dispute Act. This settlement will require 50,000 acres of land to replace lands illegally taken from us. So with this, on behalf of the Hopi Tribe, I humbly ask of this Committee to assist us in any way possible to achieve these goals, as far as the 1996 Land Settlement Act is concerned.

Thank you very much for your attention.

[The prepared statement of Mr. Honanie follows:]

PREPARED STATEMENT OF THE HON. HERMAN HONANIE, CHAIRMAN, HOPI TRIBE, KYKOTSMOVI, ARIZONA

Good morning Chairman LaMalfa, Ranking Member Torres, and honorable members of the House Natural Resources Subcommittee on Indian, Insular, and Alaska Native Affairs. It is a pleasure to be here today to testify on improving and expanding critical infrastructure in Indian Country. My name is Herman Honanie and I have the privilege of serving as chairman of the Hopi Tribe. I am Pipwugwa (tobacco) clan from Kykotsmovi, which sits below Orazivi, the oldest continuously inhabited community in North America. Today the village has no modern infrastructure.

The Hopi Tribe's ancestral lands span across northern Arizona and include the Grand Canyon. The Hopi people have resided in this area since time immemorial. The Hopi Reservation is located in the northeast corner of Arizona and is approximately 2.5 million square miles, which is about the same size as the state of Rhode Island. The Hopi Tribe has 14,282 enrolled tribal citizens, over half of whom reside on the Hopi Reservation—this number does not include non-Indian and non-enrolled Indians living on the Hopi Reservation.

The Hopi Reservation is plagued by poverty and suffers from a 60 percent unemployment rate. Due to the remote nature of the Reservation economic development is incredibly difficult leaving the tribe to rely on only a few sources of income. This situation is exacerbated by the fact that the Hopi Reservation is completely landlocked and surrounded by the Navajo Reservation making it difficult to create off-reservation economic development opportunities. The Hopi Tribe does not have a casino facility and its only meaningful economic development opportunity on the Reservation is revenue generated by coal royalties.

I would like to take this opportunity to cover several difficult situations that the Hopi Tribe is coping with when it comes to infrastructure development.

I. LANDLOCKED NATURE OF THE RESERVATION

The Hopi Reservation is completely surrounded by the Navajo Reservation landlocking the tribe and forcing it to cross Navajo Nation lands to reach the outside world. When the Federal Government created the Navajo Reservation and encircled our reservation, it did not retain a utility corridor right-of-way for the Hopi Tribe. The Hopi Tribe has no natural access to the Western Area Power Grid, to cellular 911 emergency call service, utility distribution and natural resources transportation corridors. This means that anytime the Hopi Tribe needs access to off-reservation services it must pay the Navajo Nation for a right-of-way across the Navajo Reservation to connect to fiber optic networks, the electrical grid, and other utilities. This significantly increases the cost for the Hopi Tribe for on-reservation economic development. The landlocked nature of the Hopi Reservation also makes it difficult to create off-reservation economic development because of the distances the tribal citizens must travel to embark on those enterprises.

II. IMPLEMENTATION OF THE 1974 NAVAJO AND HOPI RELOCATION ACT

With the enactment of the Navajo and Hopi Indian Relocation Act of 1974 (the Relocation Act), referred to as Public Law 93–531, as amended by Public Law 96–305, the Office of Navajo and Hopi Indian Relocation (ONHIR) was created to facilitate the relocation of tribal members to their respective reservation land. One purpose of ONHIR was to "insure that persons displaced are treated fairly, consistently and equitably so that these persons will not suffer the disproportionate, adverse, social, economic, cultural and other impacts of relocation." 25 CFR SS 700.1.

This has not held true for our Hopi relocatee families, who have not been treated fairly, consistently, or equitably, as witnessed by the U.S. House Appropriations Subcommittee leadership on their visit to the Hopi relocatee community of Yuh Weh Loo Pahki in January of 2015. These Hopi relocatees have consistently asked that funds be provided to meet the needs of the families for safe and sanitary housing, roads, infrastructure, and economic benefits as proscribed by the Relocation Act, but their pleas go ignored.

For example, in the early 1990s a road feasibility study was conducted by ONHIR for 13 miles of upgraded roads near Yuh Weh Loo Pahki at a cost of $6.0 million dollars, but ONHIR later rejected the proposal, informing the tribe and families that it was not feasible to serve the Hopi relocatee families. Meanwhile, ONHIR has built entire communities (Coalmine Mesa, Pinon, Tuba City, etc) for Navajo relocatees on the Navajo Nation and New Lands-Sanders/Chambers with infrastructure, fire suppression, and paved roads, even a replacement of a bridge over the Rio Puerco River. The Hopi relocatees, especially the residents of Yu Weh Loo Paki, have requested assistance numerous times from the ONHIR for discretionary funds to improve their living conditions, make home repairs, and to provide for essential community needs. ONHIR has finally in the past 5 years provided a community building-modular trailer. This structure is insufficient to meet the long-term needs of the relocatee families. These measures are minimal and do not meet the intent of the Act. The Hopi relocatee families should be entitled to the same benefits allowed for Navajo relocatee families.

A high school and medical center/hospital were also to be built under the Relocation Act. The Hopi Junior-Senior High School was finally built in 1986, but was scaled down due to increased costs. The Hopi Health Care Center was built in 1996, but only as an ambulatory care center with less than 16 beds for patients. The Hopi

Tribe had to lobby and submit funding requests to build these facilities, while on Navajo—specifically New Lands—schools and a hospital with complete, modern infrastructure were built using ONHIR funds. Without proper funding for the Hopi Health Care center, Hopi tribal citizens still have to be flown out to off-reservation hospitals for care on a regular basis, including in emergency. It is apparent that the Hopi Tribe has received far less and has given up the most under the Act.

III. IMPLEMENTATION OF THE 1996 NAVAJO-HOPI LAND DISPUTE SETTLEMENT ACT

The Navajo-Hopi Land Dispute Settlement Act (Settlement Act) was enacted in 1996. See Pub. L. 104–301. The Settlement Act was a successor to the Relocation Act and was meant to provide the Hopi Tribe with appropriate compensation for Navajo families illegally residing on and occupying Hopi Partitioned Land. The U.S. Government interceded to find a mutually acceptable settlement. It is important to note that the only parties to the settlement were the Hopi Tribe and the Federal Government; not the state of Arizona or the Navajo Nation.

The Settlement Act sought to allow Navajo families to remain on Hopi land subject to a 75-year lease agreement. In exchange for these leases and the loss of lands the Hopi Tribe was promised replacement lands. Since the Navajo Reservation completely surrounds the Hopi Reservation, these replacement lands would need to be located outside of the existing reservation.

The Settlement Act provides the Tribe with the ability to regain lands and have them placed into Federal trust status; this includes interspersed Arizona State trust lands. *Id*. § 6. In order to obtain Arizona State trust land the Settlement Act requires the State to concur that the acquisition is in the interest of the State and the Tribe must pay the State the fair market value of the land. *Id*.

The Settlement Act states that "it is in the best interest of the Tribe and the United States that there be a fair and final settlement of certain issues remaining in connection with the Navajo-Hopi Land Settlement Act of 1974, including the full and final settlement of the multiple claims that the Tribe has against the United States." *Id*. § 2 (2). However, it has been over 20 years and the Hopi Tribe does not have its fair and final settlement because the state of Arizona refuses to initiate condemnation proceedings to allow the Tribe to obtain the 144,000 acres of interspersed State trust land. The State and the Tribe have been in negotiations but to no avail and those talks have often stalled or been delayed over the years. The Tribe is eager to have its full and final settlement but it needs engagement from the State.

The United States has a duty to provide the Tribe the "full and final settlement" it promised under the terms of the 1996 Settlement Act. The severe delay in implementing the Settlement Act sets a bad precedent and could serve to cool settlement negotiations between the United States and other tribal nations.

It also prevents the Tribe from engaging in meaningful economic development off-reservation. The land has increased in value over the interceding 20 years making the eventual purchase of it from the state of Arizona even more expensive. Meanwhile, the Hopi Tribe is paying the State for grazing rights on the State trust land. This situation is untenable and the United States must live up to its obligations under the Settlement Act and its trust responsibility to the Hopi Tribe.

IV. HOPI ARSENIC MITIGATION PROJECT

The Hopi Tribe's water infrastructure was funded and engineered by the Federal Government. In 2001, the Environmental Protection Agency ("EPA") revised its drinking water regulations and decreased the allowable level of arsenic in drinking water. In 2006, EPA funded a study to assist the Tribe in evaluating existing conditions for public water systems in the First and Second Mesa areas that were known to exceed the maximum contaminant level (MCL) for arsenic and recommend viable engineering solutions to ensure regulatory compliance. Beginning in 2008, the Hopi Water Resources Program began working with the Indian Health Service ("IHS") and EPA to complete an arsenic mitigation study. As a baseline, the following data was collected at local well sites to quantify the water quality issues relating to arsenic and begin the process of seeking sustainable solutions.

		First Mesa		Second Mesa				
		Keams Canyon, Wells 2 & 3 Composite	Polacca Well #8	Lower Sipaulovi - Mishongnovi Well	Upper Sipaulovi Well	Second Mesa Day School Well	New Shungopavi Well (Drilled 2008)	Shungopavi Well
Parameter	Units	Result	Result	Result	Result	Result	Result	Result
Alkalinity	mg/L	340	320	280	270	290	240	240
Iron, Total	mg/L	<.05	0.11	0.26	<.05	<.05	0.22	<0.050
Arsenic, Total	ppb	38	20	18	18	19	33	15
Arsenic, Trivalent	mg/L	0.026	0.016	<0.0020	0.0022	<0.002	Unknown	0.005
Calcium	mg/L	<5	<5	<5	<5	<5	<5	<5
Magnesium	mg/L	<5	<5	<5	<5	<5	<5	<5
pH	pH Units	9.4	9.6	9.7	9.7	9.7	9.94	9.8
Solids, Total Dissolved	mg/L	460	380	350	330	340	350	300
Sulfate	mg/L	26	17	18	16	15	22	21
Turbidity	NTU's	<1	<1	3.3	<1	<1	2.4	<1.0
Silica	mg/L	13	15	18	18	17	24	19
Vanadium	mg/L	<.05	<.05	1.5	1.5	1.7	Unknown	0.33
Average Well Production Rate	gpm	150*	100	90	9	50	(Offline) Unknown	65
* Value represents combined yields of Well #2 & #3 assuming pumping rate of 75 gpm per well								

As indicated in the table above, all wells serving the First and Second Mesa region exceed the MCL for arsenic which is set at 10 parts per billion (ppb). Generally, the arsenic concentrations in Second Mesa range from 15–20 ppb and increase as one moves eastward toward First Mesa where Keams Canyon wells register the highest arsenic concentration in the region at 38 ppb. The exception to this trend occurs at the newly drilled Shungopavi well which was sampled after drilling and was shown to have an arsenic concentration of 33 ppb. Also noted was the unusually high pH of the tested waters coupled with high alkalinity and the absence of hardness (calcium and magnesium). This odd combination of water quality attributes makes the water of this region very difficult and potentially expensive to treat for arsenic removal. All of the treatment techniques evaluated (adsorption, coagulation filtration (CF), reverse osmosis, ion exchange) to remove arsenic from the regions' groundwater will require pH adjustment which will prove difficult and costly given the high buffering capacity indicated by the high alkalinity. Also noted, was the likelihood that water in the First Mesa area would require preconditioning through a process known as oxidation to convert the naturally occurring arsenic into a form that has a higher affinity for removal.

These, among other complicating factors led the arsenic mitigation team to advise against water treatment options if a non-treatment solution could be identified. Based on the stated observations, high anticipated operating cost of treatment facilities, the operational difficulties experienced by existing local treatment systems and lack of financial resources, the team looked elsewhere to identify a higher quality water source that could be developed to serve the region.

After reviewing Hopi area wells, research identified a region 15 miles north of the Hopi Cultural Center referred to as "Turquoise Trail/Tawa'ovi" which, according to a report completed by Thompson Pollari and the WLB Group in 2005, has an existing well with superior water yield potential and an arsenic concentration of 3–4 ppb. The report contains pump test data and water quality information for the Navajo Aquifer in the Turquoise Trail region that suggests favorable conditions that may support development of this area as a primary water source for the villages that are currently out of compliance with Federal regulations related to arsenic. Alternate locations were evaluated for well field development near the Hopi Veteran's Center (HVC) near Kykotsmovi. Although the existing wells in the HVC area demonstrate compliant arsenic concentrations of 7 ppb, they do not yield anywhere near the quantity of water that is obtainable in the Turquoise Trail region.

Below is a table generated using data presented by TetraTech EM Inc in a Hopi Source Water Assessment conducted from 2005 to 2006. The table offers a summary of water usage statistics organized by each of the public water systems that are out of compliance with the arsenic rules.

Public Water System	PWSID #	*Average Daily Water Usage (GPD)	Equivalent Continuous Pumping Rate Based on 12 hr Day (GPM)
Polacca FMCV, Including Hospital & Polacca Day School	090400106	77900	108.2
Hopi High School	090400395	57600	80.0
Shungopavi	090400259	34000	47.2
Hopi Cultural Center	090400260	6000	8.3
Lower Sipaulovi/Mishongnovi	090400107	14100	19.6
Upper Sipaulovi/Mishingnovi	090400394	7600	10.6
Second Mesa Day School	0400057	11000	15.3
Total, Minimum Required Yield		**208200**	**289.2**
* Source Hopi Source Water Assessments, TetraTech EM Inc., January 2006			

As indicated above, the minimum required yield needed to serve the identified users is 208,200 gallons per day or a continuous equivalent pumping rate of 289.2 gallons per minute based on a 12-hour day. It is anticipated, based on the previously discussed existing well data, that the Turquoise Trail region is capable of supporting wells that can produce as much as 500 GPM+. As reported in the Thompson Pollari-WLB Group report, the existing well (Tawa'ovi/Turquoise) was pump tested at 345 GPM for 21 hours with a corresponding drawdown of 125 feet. The static water level was 521 ft bgs prior to pumping and the terminal dynamic water level was measured at 646 ft bgs at the end of the test. The pump was set at 1,700 ft bgs so at the end of the pump test there was still a water column of 1,054 ft over the pump. This is emphasized to demonstrate that the final pumping rate of 345 gpm was likely a limitation of the test pump and not necessarily reflective of the true yield potential of the well/aquifer.

After assessing the water needs of the area and reviewing the Turquoise Trail well data, the Hopi Water Resources Department, IHS and EPA collaboratively developed the Hopi Arsenic Mitigation Project concept. This concept proposes to develop a new well field in the vicinity of the existing Turquoise Trail well to take advantage of the higher quality water which appears to be available in sufficient quantity to serve the First and Second Mesa villages. The water would be delivered to each of the communities by a large piped network that would be constructed over the course of several construction phases. The concept-level cost estimate to design and construct the proposed water system is between $20 to $25 million. It is anticipated that the cost estimate will vary as the concept is further developed through the collection of design data during the ongoing planning process. During the past 5 years, the EPA and IHS have committed grant funding to further explore and develop the arsenic mitigation concept.

HAMP Proposed Wellfield and Piping Route

Over the course of the years, several informational meetings pertaining to the arsenic mitigation concept have been held with various stakeholders including community members, community leaders, utility operators, Federal water system regulators and Federal funding agencies. At each of the individual gatherings there has been overwhelming support for the project as the meeting participants acknowledge that this is a project devised to improve the health of the served communities. On the other hand it has been difficult to assemble multi-community meetings which will be critical as the arsenic mitigation team solicits comments from the affected communities to determine how best to operate and maintain a shared water system. This project is substantially larger in scope and cost than ordinary sanitation projects in the area. The Tribe has been informed that in order to qualify for Federal grants for this project it must have a defined plan detailing how the system would be operated and maintained.

The Hopi Arsenic Mitigation Project (HAMP) will pump water from the Turquoise wellfield located approximately 15 miles north of Second Mesa and pipe it to the Hopi villages at First and Second Mesas and to the Keams Canyon Water System and the water systems for Hopi Junior-Senior High School and Second Mesa Day School. HAMP will provide water that complies with the Safe Drinking Water Act and will replace the use of low-producing, high arsenic wells in the vicinity of First and Second Mesa and Keams Canyon. The new water supply will allow the villages at First and Second Mesa to come into compliance with Safe Drinking Water Act standards and will provide a permanent alternative water supply to Bureau of Indian Affairs and Bureau of Indian Education facilities that does not require the interim use of expensive and difficult to maintain arsenic removal technology.

At this point, several million Federal dollars have been invested into the project, and various impacted agencies remain fully supportive of the project and reaching operation of the new wells. Through discussion with Tribal Council, the Tribe is now considering next steps and how to proceed with this project. An outline of remaining action items and options follows:

A. Project Summary

In January 2014, the Tribe provided a briefing to the Department of the Interior. The summary included highlights of the project, which heavily featured the creation of the Hopi Tribe's Public Utility Authority. The new Utility Authority is responsible for setting water rates and addressing other regulatory requirements for HAMP.

The largest funding for this project will come from the USDA-RD application. Several other Federal agencies have invested millions of dollars into this project and

continue to support the effort, they are of the understanding that the newly created utility will run HAMP.

This need is urgent in light of EPA planning to bring an enforcement action against the Tribe and/or village(s) out of compliance, potentially this year.

i. Action items left for the Utility Authority

- Staffing and setting up the utility accounting operation; initially the Hopi Public Utility Authority will oversee completion of the HAMP planning followed by management of HAMP construction
- Tribal Council agreed to contribute $350,000 to get the Public Utility Authority and Utility Commission up and running
- Both agencies need to sign the Indian Affairs and Hopi Tribe MOA to get the work done that was proposed by IHS in their Planning Agreement—the Planning Agreement will then develop the information to allow the BIA/BIE connections to be part of HAMP and the USDA-RD Application

ii. USDA-RD Application

- A significant amount of work has been done on this application, which will ultimately secure $13–16M for HAMP

iii. IHS Preliminary Engineering Report

- The expected USDA loan amount is $1,978,500, after a total of $2.25 million in up-front cash and grant contributions from the Tribe
- Estimated user costs for the HAMP are expected to be a $35/month plus $2.55 per 1,000 gallons of water used per month—total costs per home is $49.82/month, plus local delivery costs
- This is made with the understanding that these stets remain:
  - — Submission of the USDA funding application
  - — Formalization of agreements between Tribe and the villages
  - — Staffing the new Hopi Public Utility Authority
  - — Acquiring full construction funding and awarding a construction contract, construction of project
  - — Transfer of the new facilities to the HPUA

B. The BIA's Relationship to the HAMP

- The BIA wishes to partner with HAMP to be included on a construction line
- The Tribe and the Department of the Interior (DOI) initiated a potential HAMP related partnership, which would provide a source of revenue to tribe via user fees
- A draft MOA was being reviewing by IHS counsel but no progress has been made since
- The Preliminary Engineering Report will need to be amended if BIA/BIE and Tribe enter into agreement

The HAMP is absolutely essential to the health and safety of Hopi tribal citizens. The Tribe is greatly appreciative of its Federal partners in this project.

V. HOPI DETENTION FACILITY

The Hopi Tribe has been in need of a detention facility for several decades. The detention facility that was initially established on the Hopi Reservation in 1981 was not intended for incarceration. The existing adult detention facility in First Mesa was originally built as a treatment facility. Over the years the building was converted and used as an adult detention facility. With the security requirements and special operation needs, the building did not meet the standards for a secure and safe detention facility.

In 2005, Hopi Tribal Council authorized Tribal Resolution H–042–2005, which established the Hopi Detention Facility Steering Committee and directed the committee to pursue the planning, design and construction of a new Hopi Detention Facility on the Hopi Reservation. The committee was tasked with the responsibility of searching for funds to build a permanent facility. The Tribe allocated $1 million to the committee to fulfill this project. The committee was able to develop plans for a permanent facility; however the Tribe was unable to secure funding to build a facility. At the same time, similarly to the Relocation issues raised above, the Federal Government built a new detention facility for the Navajo Nation in Tuba City. That facility is now approximately half empty while the Hopi Tribe does not have any

detention facility at all. In 2016, by Tribal Council resolution, the committee was disbanded because Tribal Council did not see any progress being made.

The committee was a direct result of actions taken by the Office of Inspector General in 2004. In 2004, the Office of Inspector General conducted a health and safety inspection, which resulted in the immediate closure of the juvenile correctional component. Up until that time, corrections held minors with adults in joint spaces. Juveniles are currently being housed in Navajo County Jail in Holbrook, Arizona.

Despite these serious issues facing Hopi, the Navajo Nation was provided a detention center at that time while Hopi's needs for detention space and a psychiatric treatment facility has yet to be addressed.

In February 2015, David Little Wind, Director of Bureau of Indian Affairs-Office of Justice Services, met with tribal leaders, including myself, and Councilman Mervin Yoywtewa, Chairman of the Law Enforcement Task Team, to discuss the building of a new detention facility. BIA-OJS recognized that there was a need for a new facility and the recommendation at that time was to repair by replacement.

The detention facility was still being used and operated to incarcerate inmates who had either been sentenced to 30 days or less or were awaiting hearings in the Hopi Tribal Courts. Between 2013 and 2015, there had been an inspection of the facility, which resulted in portions being deemed unsafe and uninhabitable. Those inmates who had been formally sentenced to more than 30 days of incarceration were transported to other facilities. These facilities included Navajo County Jail, in Holbrook, Arizona; Coconino County Jail, in Flagstaff, Arizona; Arizona State Prison Complex, in San Luis, Arizona; and Chief Ignacio Adult Detention Facility, in Towoac, Colorado. However, the facility remained partially open.

In October 2016, the Hopi Detention Facility was formally closed. Structural issues were cited as the cause of closure. As part of the closure, all inmates and staff were to evacuate the building immediately. Any new arrestees were to be booked and transported to Navajo County Jail within 1 hour of being booked. The Tribe was not given any notice of the closure. A charge of orders was issued from BOI-OJS Hopi Agency instructing all officers that the officer would have to conduct the transport related to any arrests they made. This instruction was also given to the Hopi Resource Enforcement Services (HRES) officers. HRES acts as a secondary law enforcement agency when services are requested by BIA-OJS. There was no formal agreement from the Hopi Tribe on the charge of orders. Due to the high costs and liability concerns associated with the courtesy transport the Hopi Tribe concluded it could no longer provide this support and have declined any transports of arrestees.

BIA-OJS was aware for the need for a new facility and had indicated plans for a transition from the old facility to a temporary facility while the new facility was constructed. BIA-OJS Hopi Agency met with Chairman Honanie in late October 2016 to discuss the temporary facility. The temporary facility would include two components to cover the needs of the Correctional staff and Administrative staff. The temporary facility would also allow detaining individuals for up to 8 hours. The Hopi Tribe through various meetings was verbally told that the temporary facility would be in place by November 2016. However, as of this date, the temporary facility has not been received; BIA-OJS has cited administrative issues as the cause of delay.

Not having a facility places a burden on the personnel and administrative costs continue to rise. Officers conduct booking of arrestee from their units. Additional costs are being incurred in the areas of transportation, additional staff hours, and incarceration.

The BIA informed the Tribe last week that it costs the BIA $100,000/month in contract costs to house the inmates at other facilities.

The irony of this situation is that the BIA-OJS has the money to replace the facility, but the BIA does not receive construction dollars for installation. The BIA-OJS is meeting with the Department of Justice to find out if the DOJ would be able to provide the construction funding for the project.

As the Hopi community waits to have its detention facility needs met, crime does not cease. As a result of having no facility, law enforcement officers must use their own personal discretion when arresting individuals who have committed violations of the Hopi Code. There is no deterrent factor to keep individuals from committing crimes when they know they will not be arrested. It is only a matter of time until a minor incident turns into a much more serious crime of violence.

VI. HOPI TELECOMMUNICATIONS

The Federal Communications Commission considers the Hopi Reservation a high cost project area. Anytime that the Hopi Tribe seeks to connect to the outside world it must cross the Navajo Nation, Indian allotments, and State land. This requires the Hopi Tribe to pay massive amounts for easements in order to lay or connect fiber. The cost of building telecommunications projects on Hopi land is 27 percent more than in other parts of Arizona. The Hopi Tribe received an American Recovery and Reinvestment Act ("ARRA") to construct and purchase fiber and electronics to connect to the internet. The Tribe was not allowed to use ARRA funds to purchase the rights-of-way so Hopi Telecommunications Inc. ("HTI") had to absorb those costs. The entire project cost to build a fiber optic cable route from Jeddito Community to Holbrook, Arizona—roughly 61 miles—cost the HTI was $3.3 million. Included in this cost was $500,000 paid in right-of-ways, which accounts for approximately 15 percent of the entire project cost. If this same fiber optic route was constructed on non-Indian land it would cost approximately $2.4 million (or 74 percent of the cost for building it on tribal land).

VII. HOPI ROAD INFRASTRUCTURE

The Hopi Department of Transportation ("HDOT") is charged with 1,235.1 miles of Hopi's official inventoried road mile consists of:

- 625.1 miles of unimproved earth roads
- 5.8 miles of gravel roads
- 99.6 miles of asphalt surface roads
- 405.5 miles of jeep trail roads
  - 1,136 total BIA & Tribal road miles
- 99.1 total miles of AZ State Highways
  - 1,235.1 combined total Hopi inventory road miles
- 10 bridges with a combined length of 1,258.0 feet

The Tribal Transportation Program ("TTP") is the only continuous funding source for Hopi's construction program inclusive of all components from planning, design, and construction and now including road maintenance as result of the need expressed in Indian Country that regulations be amended to allow use of TTP funds for road maintenance. The remote nature of the Hopi Reservation has led the cost to construct new roads to increase from $900,000/mile in 2013 to $1.2 million/mile now. Dealing with these technical challenges increases operational costs at an estimated rate of 3 percent annually. The current TTP annual allocation provides for at least for 3 miles of roadway construction with support to the road maintenance program of $500,000 and now includes the Hopi Senom Transit Program.

The Interior Appropriation allocations for the road maintenance program have not kept up with true costs for the past 30 years. The Hopi Tribe had no other options but to take responsibility for the BIA's road maintenance duties/program as the threat to life and safety were becoming more evident on Hopi's roadways. In order to achieve maintenance goals the Tribe has been forced to draw from its construction accounts but is necessary as lives are being impacted. In addition to the already severe and inadequate funding, Hopi sustained a severe decrease to its road maintenance allocation by 40 percent in Fiscal Year 2012 from $500,000 to $300,000 with no justifiable or adequate reasoning taken by the BIA. We have repeatedly met with the BIA requesting them to remedy this reduction.

The majority of HDOT's calls relate to the construction of new roadways and maintenance issues on existing roadways (an average of 15/week). The lack of suitable material and resources to maintain the 625.1 miles of unimproved roads makes traveling them a potentially life-threatening situation. Roads within the hearts of villages where the majority of residents reside are no better than outside of the villages. HDOT is responsible for maintaining the roads for emergency service providers, school buses, and everyday commuters but it is a daunting task given the lack of available resources.

HDOT continue its daily assessment and documents challenges with not just BIA roads but with state highways as well. The state highways are no better than the BIA roads. It leaves the Tribe to believe that it has been forgotten by the Federal Government and the state of Arizona. There are currently no major plans to remedy these unsafe roadways on the part of either the Federal Government or the State.

VII. CONCLUSION

I appreciate the Subcommittee's time and attention to the Hopi Tribe's infrastructure concerns and challenges. The Tribe encourages the Subcommittee and its staff to visit the Hopi Reservation to witness the issues covered in my testimony firsthand.

Mr. LAMALFA. Thank you, Chairman Honanie. We will now recognize Chairman Joseph.

STATEMENT OF ANDREW JOSEPH, JR., CHAIRMAN, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; MEMBER, COLVILLE BUSINESS COUNCIL, NESPELEM, WASHINGTON

Mr. JOSEPH. Good morning, Chairman LaMalfa and Ranking Member Torres. [Speaking native language.] My name is Andy Joseph, Jr. I am a chair of the Northwest Portland Area Indian Health Board, and also a member of the Colville Business Council, Confederated Tribes of the Colville Indian Reservation. I chair the Health and Human Services Committee.

I thank you for this opportunity to provide testimony today on the challenges that Colville Tribe and other tribes in the IHS Portland area face in getting healthcare facilities built under the IHS system. The board and the Colville Tribes request the Committee and Congress to address Indian health facilities construction as part of the administrative infrastructure initiative. In doing so, we specifically ask that all IHS areas access benefits from the facilities construction funds, and not just a handful.

By way of background, the Northwest Portland Area Indian Health Board is a tribal organization of 43 tribes of Washington, Idaho, and Oregon. The Colville Tribes is a member of the board. And the present-day Colville Reservation is located in north central Washington State. Most of the 1.4 million-acre Colville Reservation is rural timberland, ranch land. The tribe has a large IHS service area, and its four main communities are separated by significant drive times. The tribe's primary Indian health facility is located in Nespelem, Washington, and residents from Inchelium that require care there must drive, in many cases, more than 90 minutes through two mountain passes.

Health facilities have always been a challenge for Colville and other Portland area tribes. For the past three decades, most of the IHS facilities construction dollars have gone to projects in the Health Care Facilities Construction Priority List. The priority list was last updated in 1991, and no new projects have been added to the list since then. Projects built on a priority list receive reoccurring funds from IHS for an 80 percent facility staffing needs.

The construction priorities in the priority list were last updated 26 years ago. The current IHS funding for facilities construction is inadequate, because it provides a disproportionate share of funding to a few select tribal projects on the priority list, based on decades-old data. In many cases, the priority list either did not reflect facility needs at the time, or do not reflect the current needs of tribal communities.

For example, in the 1980s, the Colville Tribe sought to replace the Nespelem facility with a new facility. A Nespelem facility was

originally constructed in the 1920s, as a U.S. Department of War building, and was converted to use in the 1930s as a clinic for the U.S. Public Health Service. We were told by a former IHS official that at one point the tribe requested a new facility, and Nespelem was near the top of the priority list, but was removed because of concerns the facility was a historical site.

The Colville Tribe ended up using tribal dollars to build a new facility with no increase in staffing. The lack of staffing remains a chronic problem for the Colville Tribe—none of the more than 40 tribes in the IHS Portland area have ever had a facility constructed under the priority list system. Several of the IHS areas are in the same situation. Going forward on the Committee, we should direct IHS to develop and update priority list methodology, accurately reflecting current needs, and allow for changes.

The Area Facility Distribution Fund (ADF)—When Congress reauthorized the Indian Health Care Improvement Act in 2010, it included a new section 301(f), that authorized IHS to establish a new area facility fund. We believe that the ADF is a path forward, ensuring all IHS areas receive benefits from any funds made available and administration. A joint Federal-Tribal advisory committee, called the Facilities Appropriations Advisory Board, developed the ADF concept as a compromise to allow existing projects to be grandfathered into the priority list, while at the same time allowing for new proposals to be considered and funded.

The ADF is intended to allow each IHS area to improve, expand, or replace existing healthcare facilities. ADF makes it possible for IHS to extend the benefits and appropriate funds to a significantly larger number of tribes and communities than the priority list alone.

ADF was supported by 7 of the 12 IHS area organizations, representing more than 500 tribes, but despite that the IHS has not taken steps to implement the ADF in the intervening years since its enactment.

Again, I thank you for this opportunity to testify before you.

[The prepared statement of Mr. Joseph follows:]

PREPARED STATEMENT OF THE HON. ANDREW JOSEPH, JR., CHAIRPERSON, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, AND COUNCIL MEMBER, CONFEDERATED TRIBES OF THE COLVILLE RESERVATION, NESPELEM, WASHINGTON

Good morning Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee. On behalf of the Northwest Portland Area Indian Health Board ("NPAIHB" or the "Board") and the Confederated Tribes of the Colville Reservation ("Colville Tribes"), I thank you for this opportunity to provide testimony.

I am here today to discuss the challenges that the Colville Tribes, and other Indian tribes in the Indian Health Service ("IHS") Portland Area, face in getting healthcare facilities constructed under the existing programs administered through the IHS. These issues are of great importance to the Colville Tribes and to other Indian tribes in other IHS areas where IHS facility construction dollars have not traditionally been available. My testimony is on behalf of both the Board and the Colville Tribes.

The Board and the Colville Tribes urge the Subcommittee to do everything in its power to ensure that Congress addresses Indian health facilities needs when it drafts legislation to implement the expected Trump administration infrastructure initiative. In doing so, we also urge this Subcommittee to ensure that all IHS areas benefit from facilities construction and not just a handful of projects.

BACKGROUND ON THE NPAIHB AND THE COLVILLE TRIBES

Established in 1972, the NPAIHB is a P.L. 93–638 tribal organization that represents 43 federally recognized tribes in the states of Washington, Oregon, and Idaho on healthcare issues. The NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

The present-day Colville Reservation is approximately 1.4 million acres and occupies a geographic area in north central Washington State that is slightly larger than the state of Delaware. The Colville Tribes has more than 9,500 enrolled members, about half of whom live on the Colville Reservation. In terms of both land base and tribal membership, the Colville Tribes is one of the largest Indian tribes in the Pacific Northwest.

Most of the Colville Reservation is rural timberland and rangeland and most residents live in one of four communities on the Reservation: Nespelem, Omak, Keller, and Inchelium. The Colville Tribes has a large IHS service area and these communities are separated by significant drive times. The CCT's primary IHS facility is located in Nespelem, WA, and residents from Inchelium that require care there must drive in many cases more than 90 minutes through two mountain passes.

HEALTH FACILITIES UNDER THE IHS SYSTEM

There are currently three IHS programs that allow Indian tribes to construct new health facilities. The first is the Health Care Facilities Construction Priority List ("Priority List"), which has been in effect for more than two decades and provides funding for construction of the facilities included on the list, as well as 80 percent of the annual staffing costs. The projects on the Priority List have been locked since 1991 and in the intervening decades Congress has directed most of the IHS health facilities construction funding to projects on the Priority List.

The second is the Joint Venture (JV) program, which requires an Indian tribe to pay the up-front cost of constructing a facility in exchange for the IHS providing a portion of the annual staffing costs. Because the JV program provides for the possibility of recurring staffing for selected projects, it is extraordinarily competitive. The IHS has solicited applications for the JV program only twice over the past decade.

The third is the Small Ambulatory Health Center Grants program, which is the opposite of the JV program in that the IHS provides funds for the construction of the facility, but not for recurring staffing. Congress has not provided any funding to this program in more than a decade.

It is important to note that when new facilities are constructed under the Priority List and JV programs, it carries a budgetary commitment for staffing packages that must be funded on a recurring basis. The construction priorities in the Priority List were last updated 26 years ago. As the NPAIHB has noted in previous testimony, the current IHS funding for facilities construction is inequitable in that it provides a disproportionate share of funding to a few select tribal communities based on decades-old data.

In many cases, the Priority List either did not reflect facilities needs at the time or do not reflect the current needs of tribal communities. For example, the Colville Tribes sought in the 1980s and the early 1990s to replace its Nespelem, WA facility with a new facility. The Nespelem facility was originally constructed in the 1920s as a U.S. Department of War building that was converted for use in the 1930s as a clinic for the U.S. Public Health Service and, later, the IHS. The Colville Tribes were told by former IHS officials that at one point, its request for a new clinic in Nespelem was near the top of the priority list but was removed because of concerns that the facility was a historical site. None of the more than 40 tribes in the IHS Portland Area, of which the Colville Tribes is a part, have ever had a facility constructed under the Priority List system.

It has been more than 17 years since the Interior Appropriations Subcommittee directed the IHS to revamp its facilities construction system. The IHS, however, has ignored this request and has never provided an updated facilities construction Priority List system. Going forward, this Committee should direct the IHS to develop an updated Priority List methodology that accurately reflects current needs and allows for changed circumstances.

THE AREA DISTRIBUTION FUND WOULD PROVIDE A MECHANISM TO MORE EQUITABLY DISTRIBUTE FACILITIES CONSTRUCTION RESOURCES

When Congress reauthorized the Indian Health Care Improvement Act in 2010, it included a new Section 301(f) that requires the IHS to consult with Indian tribes

and tribal organizations in developing innovative approaches to address all or part of the total unmet needs for construction of health facilities. That section also provides that the IHS may establish an Area Distribution Fund ("ADF") in which a portion of health facility construction funding could be devoted to all IHS areas.

The Facilities Appropriations Advisory Board, a joint Federal-Tribal advisory committee, developed the ADF concept as a compromise to allow existing projects to be grandfathered into the health facilities Priority List, while at the same time allowing a method for new proposals to be considered and funded. The ADF is intended to allow each IHS area to improve, expand, or replace existing healthcare facilities. The IHS could extend the benefits of appropriated funds to a significantly larger number of tribes and communities throughout Indian Country than would be possible by relying solely on funding for line-item projects.

Section 301(f) was supported by more than 500 Indian tribes represented in 7 of the 12 IHS Areas, including Alaska, Bemidji, California, Nashville, Oklahoma, Phoenix (Nevada tribes), and Portland. Since then, the National Tribal Budget Formulation Workgroup has recommended that Congress fund the ADF. That Workgroup's recommendations are based on consensus. Despite the tribes' support, the IHS has not taken steps to implement Section 301(f) in the intervening years since its enactment into law.

The Board and the Colville Tribes urge the Subcommittee to do everything in its power to ensure that Congress addresses Indian health facilities needs when it drafts legislation to implement the expected Trump administration infrastructure initiative. We specifically urge the Subcommittee to direct the IHS to distribute a significant portion of any facilities construction funds that may be available under an infrastructure initiative through the ADF to ensure that all IHS areas have an opportunity to address facility needs.

This concludes my testimony. I would be happy to answer any questions that the Subcommittee may have.

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SUPPLEMENTAL TESTIMONY SUBMITTED FOR THE RECORD FROM THE HON. ANDREW JOSEPH, JR.

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March 20, 2017

Hon. DOUG LAMALFA, *Chairman*,
Hon. NORMA TORRES, *Ranking Member*,
House Committee on Natural Resources,
Subcommittee on Indian and Alaska Native Affairs,
1324 Longworth House Office Building,
Washington, DC 20515.

Dear Chairman LaMalfa and Ranking Member Torres:

On behalf of the Confederated Tribes of the Colville Reservation, thank you again for inviting me to testify at the March 9, 2017, oversight hearing on "Improving and Expanding Infrastructure in Tribal and Insular Communities." The hearing was timely in that it illustrated the need for infrastructure in Indian country and offered potential solutions, specifically for health facilities.

Chairman Bishop asked me the following question regarding the remaining projects on the Health Care Facility Construction Priority List: "As you look at the 13 remaining projects, do you think they represent the greatest need?" The beginning of my response did not accurately reflect my entire answer or my written statement, and I would like to clarify it for the record.

The projects on the Priority List reflect criteria that IHS utilized nearly three decades ago and there has not been an intervening examination of whether those remaining projects reflect actual, current need. Much has changed in 30 years, and since then some tribes have been able to obtain new facilities through the Joint

Venture program or through congressional directed spending prior to the adoption of rules prohibiting earmarks.

I am not familiar with all 13 of the remaining projects on the Priority List. To the extent, however, that any of those projects were included on the Priority List because the applicable tribe may not have had any IHS facility at the time but have since been able to obtain an IHS facility through the Joint Venture program or by congressional directed spending, then the list does not reflect current need.

Regardless, and as noted in my written statement, the Priority List must updated. In fiscal year 2000, the Interior Appropriations Committee directed the IHS to update its facilities construction system. The IHS, however, has never done so, and the Committee should now direct the IHS to develop an updated Priority List methodology that accurately reflects current needs and allows for changed circumstances.

Finally, I would like to reiterate that should funds be made available in any infrastructure initiative, a significant portion should be distributed through the Area Distribution Fund authorized in Section 301(f) of the Indian Health Care Improvement Act so that all IHS areas can benefit. In 2009, Congress appropriated $227 million for IHS facilities construction in the American Recovery and Reinvestment Act of 2009, all of which went to only two projects on the Priority List. If directing a significant portion of funding through the ADF is not feasible, then the funding should instead be directed to IHS's Maintenance and Improvements or Sanitation Facilities programs, which do not utilize antiquated priority lists and would benefit a larger number of tribes and regions.

Please feel free to contact me with any questions and thank you again for holding this important hearing.

Sincerely,

ANDY JOSEPH, JR.,
Chair, Health and Human Services Committee
Colville Business Council

Mr. LAMALFA. Thank you, Chairman Joseph, for your testimony. I appreciate it. Now we will be hearing from Victoria Kitcheyan from the National Indian Health Board, who is our Great Plains area representative. Thank you.

STATEMENT OF VICTORIA KITCHEYAN, GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, WASHINGTON, DC

Ms. KITCHEYAN. Good morning, Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee. On behalf of the National Indian Health Board, thank you for allowing me this opportunity to offer testimony on healthcare infrastructure in Indian Country. My name is Victoria Kitcheyan, and I am a member of the Winnebago Tribe of Nebraska, where I also serve as Tribal Treasurer on the Tribal Council.

As you are aware, Federal promises to improve Indian health services were made long ago. Our people entered into treaties with the Federal Government to provide health care in exchange for tribal land and peace. Unfortunately, the Federal Government has yet to live up to this trust responsibility. Our people live sicker, they die younger, and most times unnecessarily. On average, 4.5 years younger and, in some states, 20 years.

While IHS is funded far below need, the infrastructure and the facilities improvements are some of those most critical needs in Indian Country. Indian Health Service is made up of 45 hospitals, 529 outpatient facilities, and, on average, these facilities, as you mentioned, are 40 years old, four times that of other healthcare

facilities in the United States. And these facilities are expensive, 26 percent more expensive to operate than a 10-year facility. These facilities are not only expensive, but have caused huge barriers to providing quality patient care and improving the safety of our patients.

Improving healthcare facilities is essential for reducing medical errors in facility-acquired infection rates, and improving staff and operational efficiency. In fact, the poor quality of some of these federally operated facilities have been documented, and have led to direct threats to the patient care. They have been documented by HHS Office of Inspector General, Government Accountability Office, and, most recently, the Centers for Medicare and Medicaid Services. They are literally shutting hospitals down because of these shortcomings.

As Congress considers investments in infrastructure, we urge you to look to the Indian Health Service as a top priority. From 2010 to 2016, the construction budget has been about 76 million. And you mentioned if there was one built today, it would be 400 years until that facility would be considered for improvements.

So, currently, IHS uses its healthcare facility construction appropriations to fund these grandfathered projects. But even then, these 13 remaining projects on the grandfathered list are estimated to cost $2.1 billion. Once those 13 projects are funded, the remaining $8 billion of need is funded on a revised priority list. As Congress looks to improve infrastructure, it should turn to IHS and its list of priorities in line for development. The need is there, we just need the funding, and we would easily be able to expend that—not "we," IHS.

Congress should also consider major fiscal improvements and maintenance of current facilities, which would greatly lead to improved patient care. Investments in sanitation facilities for tribal communities has also been a major direct correlation with improving health outcomes for American Indians and Alaska Natives. The current backlog for that is $2 billion.

The Committee should also consider investments in creating staffing quarters. That has been identified as a barrier to recruitment and retention in some of our most remote reservations and healthcare facilities. We need the qualified medical professionals to come to our communities and live amongst our tribal members, and we lack the capability to offer that housing.

In addition to basic infrastructure needs, it is critical that Congress provide necessary resources for IHS to make serious upgrades to the Health Information System. Failing to do this puts patients at risk, and will leave IHS unequipped for the 21st century healthcare environment. This includes allocating $3.5 billion to replace the current Health Information System and other investments to increase network bandwidth. A robust telecommunications infrastructure is critical to a modern healthcare delivery system.

The vast majority of IHS and tribally-operated facilities are in rural areas lacking connectivity, and it is much slower than urban settings. Capabilities such as telehealth, patient access to records, and medical data and images are severely hampered by the bandwidth insufficiency. Upgrading bandwidth is extremely expensive,

and often paid out of the health care's already-underfunded operating budget.

Due to some of these constraints, IHS cannot take full advantage of some of the technology, telehealth. And while some areas have been successful in telehealth, it is not IHS-wide, and the infrastructure is not there. It is our understanding that the IHS estimates an operational enterprise telehealth program could cost $75 million. These would have to be new resources, as IHS does not have the ability to transfer funds from one program to fund telehealth. But once these funds would be made available, there would be great cost savings to the agency.

The current IHS Health Information System is called the Resource and Patient Management System, or RPMS, and it is a comprehensive suite of applications supporting virtually all clinical and business operations. There is limited funding available to continue to upgrade and maintain this old system. This old system is a ticking time bomb, and if we continue to put Band-Aids on this, we are going to have a much greater problem than if we were to modernize it.

We call on Congress to make these investments in Indian Country, and to update RPMS, or completely replace it. Our facilities can have a fully functioning health IT system, which could lead to better health outcomes for Alaska Natives and American Indians.

In conclusion, I would like to thank you for this attention to these issues. I urge you to continue considering health investments in any infrastructure plan, going forward. Failing to make these improvements will result in continuing neglect of the trust responsibility, and we thank you for your consideration in this time, and we just look forward to continuing this dialogue as we work toward better health outcomes for all Native people.

[The prepared statement of Ms. Kitcheyan follows:]

PREPARED STATEMENT OF VICTORIA KITCHEYAN, GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, WASHINGTON, DC

Chairman LaMalfa, Ranking Member Torres, and members of the Subcommittee, thank you for the opportunity to offer this testimony on "Improving and Expanding Infrastructure in Tribal and Insular Communities." On behalf of the National Indian Health Board (NIHB) and the 567 tribal nations we serve, I submit this testimony on Fiscal Year 2018 budget for the Department of Health and Human Services (HHS).

The Federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the Federal Government have acknowledged the Nation's obligations to the tribes and the special trust relationship between the United States and tribes. The United States assumed this responsibility through a series of treaties with tribes, exchanging compensation and benefits for tribal land and peace.[1] In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the Federal Government to American Indians and Alaska Natives (AI/ANs), declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[2]

Yet, when it comes to facilities and infrastructure in Indian health, the Federal Government has not lived up to its responsibility. The Indian Health Service (IHS) was founded in 1955 to help the Federal Government fulfill the trust responsibility

[1] The Snyder Act of 1921 (25 U.S.C. 13) legislatively affirmed this trust responsibility.
[2] 25 U.S.C. 1602.

for health. As part of the Indian health system, more than 650 IHS and tribal facilities operate across the country to serve about 2.2 million AI/ANs.

Yet, Congress has never provided IHS with enough funding to meet the needs of Indian Country, and the infrastructure budget is no different. Federally operated IHS hospitals range in size from 4 to 133 beds and are open 24 hours a day for emergency care needs. IHS facilities offer a range of care, including primary care services, pharmacy, laboratory, and x-ray services. Therefore, IHS facilities infrastructure is directly tied to improved quality of healthcare for AI/ANs. With a life expectancy of 4.5 years less (and in some states more than 20 years) AI/ANs continue to lag behind the rest of the country when it comes to access to health services. It is clearly time to do something about health facilities and infrastructure for Indian Country.

The following testimony will focus on ways that Congress can improve health in AI/AN communities through infrastructure improvements. This includes not only construction and maintenance of brick and mortar facilities but investments in the Health IT infrastructure which will make meaningful progress toward improving patient care, and health outcomes while serving the dual purpose of providing Congress with more information about what care looks like at IHS.

IMPORTANCE OF STRONG INFRASTRUCTURE

The Indian Health Service health infrastructure is comprised of 45 hospitals (26 IHS operated, 19 tribal) and 529 outpatient facilities (125 IHS operated, 411 tribal). At these facilities in 2016, there were an estimated 39,300 inpatient admission as 13.7 million outpatient visits.

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations
IHS	26	51	N/A	32
Tribal	19	287	163	79

On average, IHS hospitals are 40 years of age, which is almost four times as old as other U.S. hospitals with an average age of 10.6 years.[3] A 40-year-old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized—about 52 percent of need—for the identified user populations, which has created crowded, even unsafe, conditions among staff, patients, and visitors. In many cases, the management of existing facilities has relocated ancillary services outside the main health facility; oftentimes to modular office units, to provide additional space for primary healthcare services. Such displacement of programs and services creates difficulties for staff and patients, increases wait times, and create numerous inefficiencies within the healthcare system. Furthermore, these aging facilities are largely based on simplistic, and outdated design which makes it difficult for the agency to deliver modern services.[4] Improving healthcare facilities is essential for:

- Eliminating health disparities
- Increasing access
- Improving patient outcomes
- Reducing operating and maintenance costs
- Improving staff satisfaction, morale, recruitment and retention
- Reducing medical errors and facility-acquired infection rates
- Improving staff and operational efficiency
- Increasing patient and staff safety

The absence of adequate facilities frequently results in either treatment not being sought; or sought later, prompted by worsening symptoms; and/or referral of patients to outside communities. This significantly increases the cost of patient care and causes travel hardships for many patients and their families. The amount of aging infrastructure escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. AI/AN populations have

[3] *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176–179): https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/.

[4] *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. Indian Health Service. July 6, 2016. Accessed at https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_Facilities NeedsAssessmentReport.pdf on November 7, 2016, p. 12.

substantially increased in recent years resulting in severely undersized facility capacity relative to the larger actual population, especially the capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services even if staffing levels are adequate.

Over the last several years, investigators at the Centers for Medicare and Medicaid Services (CMS) and the HHS Office of the Inspector General (OIG) have cited outdated facilities as direct threats to patient care. For example, in more than half of the hospitals surveyed by the OIG in 2016, administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance" with the Medicare Hospital Conditions of Participation (CoPs).[5] "Further, according to administrators at most IHS hospitals (22 of 28), maintaining aging buildings and equipment is a major challenge because of limited resources. In FY 2013, funding limitations for essential maintenance, alterations, and repairs resulted in backlogs totaling approximately $166 million."[6] In fact, over one-third of all IHS hospitals' deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Other facilities are just not designed to be hospitals, and IHS has had to work around historical buildings which are not equipped for a modern medical environment.[7]

For many AI/AN communities, these outdated and inefficient facilities are the only option that patients have. Tribal communities are often located in remote, rural locations, and patients do not have access to other forms of health insurance to treat them elsewhere.

IHS FACILITIES CONSTRUCTION

From 2010 to 2016, IHS facilities infrastructure construction budget has been about $76 million annually. At that rate, a new facility built today would not be replaced for another 400 years![8] Currently, IHS uses its Health Care Facility Construction (HCFC) appropriations to fund projects off the "grandfathered" HCFC priority list until it is fully funded. This priority system was developed in the late 1980s at the direction of Congress. The original priority list was developed in the early 1990s with 27 projects on the list. There are 13 remaining projects on this "grandfathered" list which is currently estimated to cost $2.1 billion. Once those 13 projects are funded, the remaining $8 billion can be funded with a revised priority system that will periodically generate updated lists.

The appropriations provided to Congress are the primary source for new or replacement healthcare facilities. Because of the shortage of appropriations, IHS funds multiple projects over several fiscal years which allows projects to move forward simultaneously and helps distribute the funds geographically benefiting more than one service area. Importantly, the IHS development process ensures that the newly designed facilities are culturally appropriate, and are done in consultation with the tribes they serve.

As Congress looks to create infrastructure investments, it should turn to IHS which has a list of projects in line for development. The need is there, and IHS could easily be ready to expend these funds if they were to be available. We request that IHS construction projects be given priority in any infrastructure investments, as these projects are directly correlated with safer patient care, meaning improved health outcomes for AI/ANs, even saved lives.

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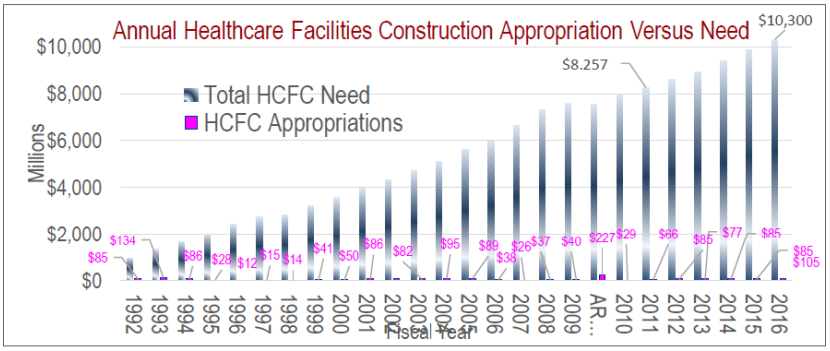
[5] Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI–06–14–00011.

[6] *Ibid, p. 14.*

[7] *Ibid, 15.*

[8] "*Federal Indian Trust Responsibility: The Quest for Equitable and Quality Indian Healthcare—The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2018 Budget.*" June 2016. P. 64.



MAINTENANCE AND IMPROVEMENT

As noted above, deteriorating maintenance of facilities in the IHS system poses a huge challenge for health administrators. Maintenance is necessary to comply with hospitals and facility accreditation standards and meet basic safety codes, but since 2011, the agency has not received enough appropriations to keep up with need resulting in a $500 million backlog that will only increase the longer it is not addressed. By 2015, appropriations were only about 80 percent sufficient to cover the costs. Currently, Maintenance and Improvement is funded at $73.6 million.

According to OIG, some facilities have been cited for sewage leaking into an operating room and equipment that is no longer suited for a modern medical environment.[9] America is too great a nation to allow health facilities to languish in this condition. Congress must invest in keeping up with aging IHS facilities to ensure that our patients have basic, and safe delivery services.

EQUIPMENT

Hand in hand with deferred construction and maintenance is the aging equipment at IHS health facilities. Up-to-date equipment is necessary to ensure effective mental diagnosis, treatment and for recruiting medical staff. Medical and laboratory equipment has a useful life of 6 years, but in IHS facilities it is used twice as long.[10] However, aging or outdated equipment plagues facilities throughout the IHS. In November 2015, for example, CMS surveyed the Rosebud Indian Hospital located in the Great Plains Region of the IHS. Among the many findings in their report, they found that the sterilization machine had been broken and medical staff were washing surgical instruments by hand; an exam table had exposed foam rendering it unable to be sanitized; and that dental x-ray equipment had not been installed for several years because of inadequate wiring.

Again, critical investments in equipment for IHS are critical to ensuring patient safety and ensuring that IHS can function as a 21st century healthcare delivery system.

SANITATION FACILITIES AND CONSTRUCTION

Since 1959, IHS has used Sanitation Facilities Construction to as an "integral component of IHS disease prevention activities" which has decreased mortality rates from environmentally related diseases by 80 percent since 1973.[11] "However, as of the end of FY 2015 about 24,200, or 6 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 188,228 or approximately 47 percent of AI/AN homes were in need of some form of sanitation facilities improvements."[12]

Currently, IHS estimates the backlog for sanitation facilities at $2.5 billion. IHS maintains a priority system for construction projects known as the Sanitation

[9] Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care. Department of Health and Human Services, Office of the Inspector General. October 2016. OEI–06–14–00011, p. 14–15.

[10] "The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress," p. 10.

[11] IHS FY 2017 Congressional Budget Justification, CJ 168.

[12] Ibid, CJ 169.

Deficiency System (SDS). Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. *Congress should also make considerable investments in sanitation infrastructure to ensure that the health of AI/ANs is not jeopardized by substandard sanitation facilities*.

HOUSING FOR MEDICAL PROFESSIONALS

As a rural healthcare provider, IHS currently has over 1,550 vacancies for medical staff across the system, which impacts the direct delivery of healthcare. IHS has many challenges to recruit and retain medical professionals including competition from other providers; lack of opportunities for families in rural areas; and a low number of AI/ANs going to medical school. However, we have long heard from healthcare professionals on isolated reservations that a lack of housing and quality education are barriers to long-term tenure at Indian health facilities. To rectify this, there will need to be further collaboration among the tribes, government agencies such as HHS and the U.S. Department of Housing and Urban Development (HUD), and Congress to make investments in housing so that people working in IHS facilities have adequate living quarters available. It is also critical to provide support for schools so that the families of medical providers will have access to adequate educational opportunities.

Congress should provide a separate stream of funding as part of infrastructure reform to make major investments in staff quarters on tribal lands for not only medical staff but other professionals like teachers as well.

HEALTH IT

In addition to basic infrastructure needs, it is critical that Congress provide resources necessary for the IHS and other Federal health providers like the Department of Defense (DoD) and Veterans' Administration (VA) to make serious upgrades to their health information technology system. Failure to do puts patients at risk and will leave IHS behind unequipped for the 21st century healthcare environment. *When investing in infrastructure projects, Congress should prioritize Health IT needs for health facilities in Indian Country. This includes allocating $3.5 billion to replace the current Health Information System, and other investments to increase network bandwidth*.

The biggest barrier to achieving this has been the lack of dedicated and sustainable funding to adequately support health information technology infrastructure, including full deployment and support for Electronic Health Record (EHR). Resources, including workforce and training, have been inadequate to sustain clinical quality data and business applications necessary to provide safe quality health services to the 2.2 million AI/ANs. The IHS/Tribal/Urban health delivery system represents some of the most remote locations in the United States and many reservations and villages are further isolated by lack of roads and public utilities.

Telecommunications Infrastructure

A robust telecommunications infrastructure is critical to a modern healthcare delivery system, not just for providers but for patients and their families as well. The vast majority of IHS and tribal healthcare facilities are in rural locations with connectivity that is much slower and less reliable than that available in urban settings. Capabilities such as telehealth, patient access to records, staff and patient education, clinical decision support, and transmission of medical data and images, are severely hampered by bandwidth insufficiency. Upgrading bandwidth can be extremely costly and often must be paid from the facility's health care operations budget. In some cases, local telecommunications providers are simply unable to provide the upgrades needed for the healthcare facilities. An unacceptable proportion of network IT equipment at IHS facilities has exceeded reliable operating life span and vendor support, but insufficient funds exist to upgrade this equipment.

Network bandwidth is a key requirement to successfully provide healthcare services. Many IHS sites are experiencing challenges to fund the cost of the necessary bandwidth upgrades to make telehealth services successful. Approximately 75 percent of IHS sites are located in areas defined as 'rural' by the Federal Communications Commission (FCC). These rural sites pay a higher percentage of their operating budget than urban locations on monthly circuit costs. When bandwidth upgrades are required, rural IHS sites are frequently asked to fund the capital costs of these upgrades. These projects can range from tens of thousands to over

a million dollars in cost, and can take years to complete. In some cases, telecommunication providers are not able to offer any upgrade options for IHS locations.

At rural IHS sites, circuit outages and restoration times are above industry averages, due to outdated equipment and small regional telecommunication providers covering large geographical areas with long travel times and limited staff. This creates challenges and risks in relying on network connectivity to provide clinical services. During 2016, IHS upgraded network bandwidth at over 50 locations. Furthermore, IHS is moving away from slow speed circuits such as T1 lines (1.5 Mbits) to Ethernet circuits which offer bandwidth in the 10 to 100 Mbits range. To help fund the monthly recurring circuit costs associated with these upgrades, IHS is increasingly leveraging the financial support provided by the Healthcare Connect Fund (HCF). The HCF is an FCC program to provide rural healthcare providers with financial support for bandwidth charges.

However, large numbers of IHS facilities do not currently have sufficient bandwidth to offer telehealth and related services. Approximately 50 percent of the IHS sites are still depending on circuit connections based on one or two T1 lines (3 Mbits). Their circuits are constantly saturated with staff experiencing slow response times when using traditional IT applications. The addition of telehealth and mobile health services is not an option at these locations. Services like this are critical in rural communities where recruitment and retention of medical professionals is continually a challenge.

Telehealth

The successful utilization of a variety of telehealth technologies and services in Indian Country is well documented. However, these successes were achieved on a largely regional basis, driven by visionary leaders, with various and not reliably sustainable funding sources. The IHS has not yet been resourced to establish either a sustainable telehealth infrastructure or governance program that would prioritize resources in accordance with identified need, establish and promote best practices, and formally evaluate and report on successes and issues. The IHS recently awarded a large contract for tele-emergency and other specialty telehealth services in the Great Plains Area, but the costs for this have been imposed on already underfunded Service Units, and again without any program structure that will ensure success and apply lessons learned to future telehealth initiatives. While we applaud this necessary investment to address urgent quality of care issues brought through congressional oversight, we must urge that equal investments be made in the rest of Indian Country who suffer similar issues of poorly resourced facilities and lack of capacity to bring up standards of care to minimal level of safety, much less to meet national accreditation standards.

It is our understanding that the IHS estimates a fully operational enterprise telehealth program could be supported at a cost of $75 million annually. These would have to be new resources, as the agency has no capacity to transfer dollars from other programs to support telehealth. Operational costs would be augmented by third party revenues generated from telehealth encounters, but these revenues will not be sufficient to enable the telehealth program to exist without additional appropriations.

Biomedical Equipment

As noted above, medical equipment at IHS facilities is far older than the average for the rest of the country. The current inventory of biomedical equipment at IHS facilities is valued at approximately $500 million. This does not include equipment located at tribally-operated facilities, which are far more numerous. According to the American Hospital Association, medical equipment has a typical life span of 5 to 6 years. This means that the IHS should budget $90 million annually for biomedical equipment upgrades and replacement at Federal facilities. However, for most of the past decade and more, the IHS has funded only about a quarter of the level of need. This limited funding has only been able to replace the very oldest equipment. As a result, most IHS facilities continue to use outdated health technology with unacceptable probability for failure and consequent risks to patient safety.

With the evolving state-of-the-art in biomedical technology, the majority of medical devices are embedded with microprocessors that connect to the hospital or clinic network via Bluetooth, wireless or Ethernet connections. The cybersecurity risks these devices pose both to the facility and the connected enterprise are substantial. Government organizations including the IHS are obligated to ensure compliance with applicable statutes and regulations (Clinger-Cohen, FISMA, FITARA, etc.) in order to minimize these risks. The Congress must take this additional layer of acquisition planning and governance into consideration with all funding decisions.

Health Information Systems

The information systems that support quality healthcare delivery are critical elements of the operational infrastructure of hospitals and clinics. The current IHS health information system is called the Resource and Patient Management System (RPMS), and is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most tribal facilities, from patient registration to billing. The IHS remains the only Federal agency to have successfully certified its electronic health record (EHR) product according to criteria published by the Office of the National Coordinator for Health Information Technology (ONC).

The explosion of Health Information Technology (HIT) capabilities in recent years, driven in large part by Federal regulation, has caused the IHS health information system to outgrow the agency's capacity to maintain, support and enhance it. The IHS was fortunate to receive Recovery Act dollars and benefit from incentives available through the HITECH Act, and used these dollars to grow RPMS in response to the new regulatory requirements. However, those funds are no longer available, and no new funds have been appropriated to support operations and maintenance for the certified RPMS suite. This has resulted in a mass exodus of Self Governance Tribes who have opted to withdraw their IT shares to seek other commercial HIT solutions which promise to more readily address their needs; and, in fact, this has caused a domino effect in that the IHS agency technology budget is decreasing more rapidly because of the withdrawal of these IT shares. For example, one large tribe recently withdrew its shares, resulting in a −$2.5 million impact (−3.7 percent) on the Headquarters IT budget. This is a harbinger of the vicious cycle that will result if the IHS cannot sustain the RPMS and related systems. Tribal programs, concluding that IHS solutions no longer support the best quality of care and patient safety, will be forced to adopt commercial solutions at considerable expense. They should not have to do this because HIT is among the programs and services that the Federal Government has historically provided for the tribes. But, without a realistic investment in RPMS, they will have no choice if they are to fulfill their responsibilities to their people, and the resulting diminution of resources retained with the IHS will further injure both the direct service tribes and those self-governance tribes continuing to rely on IHS HIT.

There is no question that the IHS electronic health record and other health information systems need to be further modernized to build on the growth in recent years. The agency just awarded a new development contract that, if sufficiently funded going forward, will go far in addressing this need, and will enhance the RPMS as a public utility that serves both Indian Country and any other healthcare entity that chooses to adopt it. Failure to sufficiently fund RPMS modernization by at least doubling the IHS HIT budget, will not only hasten but ensure the collapse of the HIT infrastructure in Indian Country.

If the joint tribal-IHS decision is for replacement of RPMS as the IT-solution, there is an urgency to expedite the decision-making process to allow time to acquire the software and ensure a smooth transition. It will take a minimum of a year to select a replacement and a couple of years beyond that for a complete transition to be planned and implemented. The operating system that RPMS currently runs on is a ticking time bomb, and needs immediate investment to modernize it. Microsoft is expected to put it on an end of life schedule in the near future. Its predecessor, Server 2008, which was released a year prior to 2008 R2 has already been put on an end of life schedule. This creates urgency for strategic decisions which must be made now.

To further illustrate the urgency to act now, there is a cautionary tale of a medium-sized city that similarly failed to upgrade their enterprise software. Opting instead to forgo their annual maintenance, they supported the application in house. When Microsoft ended support for Windows XP, the enterprise software needed to be upgraded. The resulting replacement budget cost the city approximately $45 million. In contrast, the maintenance contract that would have allowed the city to keep up with upgrades only cost $750,000. There's a real lesson to be gathered here about not forgoing maintenance and acting with a sense of urgency in imperative for cost controls. We are quickly moving past the point of no return.

Some may be tempted to quickly suggest that the best answer is to that IHS should follow the lead of the Department of Defense (and possibly the Department of Veterans Affairs at some point) in adopting commercial HIT solutions. It is critical to understand that, while this might be a desirable and perceived easy solution, such an approach is not possible without a massive allocation of new funding. The IHS estimates that it could cost up to $3.5 billion, over 2–3 years to transition the agency from RPMS to a full commercial suite of comparable capability (the entire annual budget of the IHS is under $5 billion). *As Congress invests in infrastructure improvements it should certainly include the replacement of RPMS as one of the top*

priorities by adding supplemental appropriations of $3.5 billion to purchase or develop a new HIT system for the I/T/U system. Any such investment must be preceded and informed by an independent expert and thorough analysis of alternatives, with full consultation and collaboration by the tribes.

CONCLUSION

Clearly the needs for improved facilities maintenance and construction across the Indian Health System is a critical need. Facilities improvements are critical to ensuring that the health of American Indians and Alaska Natives is able to reach the highest possible levels. For too long, appropriations have not met up with the demand for improved IHS facilities, which in some cases are among the most outdated in the United States. As Congress considers infrastructure improvements it should ensure that Indian health receives critical investments. IHS already maintains a priority list of projects ready for funding so actual construction would be able to begin in a relatively expedient manner. Furthermore, investments in staff housing will have major impacts for Indian Country who are trying to attract needed health and other professionals.

Additionally, in order for the I/T/U system to function in the 21st century, it is essential that major investments are made in the Health IT infrastructure in order to ensure that I/T/U facilities are safe and efficient places to receive care. This means, a major financial investment to improve HIT also network improvements. Because IHS provides services in mainly rural and remote areas, there is much to be gained by embracing new methods of care like telehealth. But there are few areas where this capability is possible due to network constraints and a lack of IHS-wide infrastructure to support such a program. Congress should not hesitate to supplement additional funding to make these needed upgrades so the health of AI/ANs can improve.

Mr. LAMALFA. Thank you, Ms. Kitcheyan. We appreciate your testimony today.

The next witness will be the Honorable Aaron Payment from the National Congress of American Indians. Welcome. Good to see you.

STATEMENT OF AARON PAYMENT, SECRETARY, NATIONAL CONGRESS OF AMERICAN INDIANS, WASHINGTON, DC

Mr. PAYMENT. Good morning, Chairman LaMalfa; Ranking Member Torres; my Congressman, Jack Bergman; and members of the Committee. My name is Aaron Payment. I am the Secretary for the National Congress of American Indians (NCAI), and also Chairperson for the Sault Ste. Marie Tribe of Chippewa Indians. Thank you for holding this very important hearing on improving and expanding infrastructure in Indian Country.

NCAI is encouraged by the conversations that have been occurring in Congress and the Administration focusing on comprehensive infrastructural planning. That this Committee has chosen to focus on tribal infrastructure for your first hearing is heartening, thank you. In order for a national infrastructure investment plan to be truly comprehensive and transformative, it must include Indian Country.

For Indian tribes across the country, there is no more important issue than providing for our tribal citizens and our communities. To do so, tribal governments require investment in infrastructure, which will not only provide for the basic services to our citizens, but also spur long-term economic opportunities which benefit surrounding communities.

The infrastructural needs in Indian Country are long-standing and result from sustained under-investment for decades. In 2009, a Senate letter to the Administration estimated $50 billion in

unmet need for infrastructure on Indian reservations. When you consider our greatest infrastructure needs are related to healthcare facilities, school construction and maintenance, roads, broadband, water and sanitation facilities, and housing, it becomes clear that lack of adequate infrastructure has a significant impact on the social, physical, and mental well-being of tribal communities.

Unmet infrastructure needs also impact job opportunities on and near tribal lands, which has the potential to benefit our neighbors. The lack of economic development and job opportunities in Indian Country is evident in places where key infrastructure, such as roads, water access, and broadband is under-developed or in disrepair.

If there is one benefit to a long history of unmet needs, it is that Federal agencies have a record of these needs in Indian Country. And, while not ideal, there are systems in place for addressing the backlogs. While there is little agreement on how to prioritize funding, in most cases existing travel programs provide an efficient system to distribute infrastructural investments. This is especially true for housing and transportation-related programs.

Other programs, such as construction of health facilities or schools, have priority lists developed through agency mechanisms designed to address the needs of those facilities in most need of construction or repair. A sustained and targeted funding investment by Congress is required to have the significant and long-term lasting impact on the existing infrastructure backlog. Funding should be supplemented by mechanisms that encourage government parity and self-determination.

NCAI urges the Committee to look at ways to streamline the regulatory process and modernize outdated regulations and statutes to provide tribes with flexibility and greater control over decision-making; government parity to ensure that tribal governments are offered the same opportunities as states and local governments; opportunities where tribes can collaborate with local governments and private and industry partners to develop solutions to infrastructural needs; and coordination and collaboration when multiple Federal agencies are involved in projects, due to the nature of the Federal relationship with tribal governments.

In addition to requesting direct and proportional funding for tribal governments in the infrastructural package, we urge you to ensure that tribes are able to fully participate in any funding that may be derived from tax incentives. This includes direct access to Federal tax credit programs, such as the new markets and low-income housing tax-credit programs, as well as tax-exempt bond authority. These incentives would also help encourage public-private partnerships in Indian Country.

As Congress and the Administration consider large-scale infrastructure projects across the United States, tribal lands and natural resources will inevitably be impacted. It is imperative that tribes are a part of the planning process when developments occur on or near reservations, ancestral, or sacred lands.

NCAI advocates for inclusion of tribal nations from the earliest stages of decision-making and permitting. Tribal governments seek economic development opportunities and recognize that infrastructure projects benefit both tribal and neighboring communities.

Early consultation and informed prior consent with respect to deference to the Federal trust obligations can ensure that projects meet the needs of all parties, and can proceed in a timely and efficient manner.

In closing, I want to thank you again for holding this important hearing to make sure that Indian Country priorities are included in the infrastructural package. To aid in your work, I request that NCAI's tribal infrastructure report, this comprehensive report, be included for the record of this hearing, and I am happy to answer any questions that you may have.

And NCAI stands ready to help as a resource, going forward, with your continuing work to identify infrastructure needs in Indian Country. Thank you.

Mr. LAMALFA. Thank you. That will be admitted, without objection.

[The prepared statement of Mr. Payment follows:]

PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS

On behalf of the National Congress of American Indians (NCAI), thank you to the opportunity to provide testimony on "Improving and Expanding Infrastructure in Tribal and Insular Communities." NCAI is the oldest and largest national tribal organization in the United States that is dedicated to protecting the rights of tribal governments to achieve self-determination and self-sufficiency. As such NCAI looks forward to working with Chairman LaMalfa, Ranking Member Torres and members of this Committee to address the infrastructure needs of Indian Country, and we look forward to working with you to address tribal policy in the 115th Congress.

There is growing support to address the vast infrastructure needs in the United States, and it is vital that tribes are part of any infrastructure plan that is proposed by Congress of the Administration. NCAI has prepared a report detailing many of the infrastructure needs of Indian Country, "Tribal Infrastructure—Investing in Indian Country for a Stronger America." This report (attached) is intended as a resource to Congress and the Administration as the Federal Government undertakes legislation to address the infrastructure needs in Indian Country.

For Indian tribes across the country, there is no more important issue than providing for tribal citizens and tribal communities. To do that, tribal governments require investment in infrastructure which will not only provide the basic services to tribal citizens, such as water, housing, safe roads, healthcare facilities and schools, but also the opportunity to attract jobs and economic development on tribal lands. Indian Country is poised to partner with the Federal Government on any legislative or administrative efforts and seeks to do so as a governmental partner, keeping in mind the following:

Tribal Nations are governments: As recognized by the U.S. Constitution, Tribal Nations are part of the original American family of governments, possessing a legal and political status equivalent to that of state governments and foreign nations. Today, the inherent sovereignty of Tribal Nations is exercised by 21st century tribal governments that are full-fledged governments in every sense of the word. They are determining their own citizenship, establishing and enforcing criminal and civil laws on their lands, administering justice, taxing, licensing, and regulating, among many other functions. They are providing a wide range of governmental services, from education to healthcare to environmental protection. Like other governments, tribal governments recognize and accept the fundamental responsibilities of governance—with building and maintaining the vital infrastructure upon which their constituents rely among the most critical responsibilities. As governments, Tribal Nations need and deserve to be at the decision-making table when it comes to developing and implementing an infrastructure investment plan for the Nation. They deserve to be at the table because they have the capacity, experience, and know-how to craft, inform, and execute solutions to the infrastructure challenges facing their communities and those of their neighbors.

Indian Country's infrastructure needs are acute and long-standing: The infrastructure crisis facing Indian Country is not a recent phenomenon. For generations, the Federal Government—despite abiding trust and treaty obligations—has substantially under-invested in Indian Country's infrastructure, evident in the

breadth and severity of its unmet infrastructure needs as compared to the rest of the Nation (see the following sections for details). In 2009, as one indication, a contingent of U.S. Senators penned a letter to the Administration citing a $50 billion unmet need for infrastructure on Indian reservations. The number of "shovel ready" infrastructure projects in Indian Country remains too many to count, and many of those have been that way for years if not decades. This chronic underinvestment and the growing backlog of critical infrastructure projects not only negatively impacts the social, physical, and mental well-being of tribal and neighboring communities, it hampers the ability of Tribal Nations to fully leverage their economic potential and the ability of their citizens to fully participate in the American economy. The more than $3 billion in funding designated for Indian Country by the American Recovery and Reinvestment Act supported important first steps in addressing Tribal Nations' needs for justice infrastructure, health facilities, roads projects, water systems development, and other vital infrastructure projects, but collectively they amounted to a "drop in the bucket" of what it will take to energize self-determined, sustainable community development and economic opportunity in tribal communities.

Tribal governments prove that local decision making and solutions work best: An extensive body of research built over the past three decades concludes that tribal self-determination/self-governance is a successful policy which allows tribes the ability to meet the needs of tribal citizens through local decision making. Tribal governments know best the nature and intricacies of the particular challenges their communities face, and are best-positioned and best-equipped to make innovative decisions that address the needs of tribal communities. As President Ronald Reagan astutely recognized in 1988, "Tribes need the freedom to spend the money available to them, to create a better quality of life and meet their needs as they define them. Tribes must make those decisions, not the Federal Government." Tribal governments also boast a growing track record of partnering with other surrounding governments (state, county, municipal) to construct and enact solutions aimed at addressing shared community challenges, from healthcare to law enforcement to public transit.

Much of Indian Country is an integral part of rural America: Rural America faces its own distinct and often daunting infrastructure challenges—from existing infrastructure (telecommunications, transportation, water and energy infrastructure, etc.) that has long since fallen into disrepair to the pressing need to develop the tech-driven infrastructure necessary to make rural areas economically viable now and in the future. Compounding these challenges are the high costs of addressing them as compared to more densely populated areas. What's more, the vast majority of this country's land area (72 percent) is rural. Meanwhile, Indian lands—totaling more than 100 million acres spread across 34 states—are predominantly rural, inextricably linking the state and fate of Indian Country's infrastructure with that of the rest of rural America. For any infrastructure investment plan to be truly national, it will need to assess and account for the particular and often shared infrastructure needs of rural communities—both Native and non-Native. It must also draw on the innovative infrastructure development fixes that tribal and other governments that serve rural geographies together have forged—including the growing number involving intergovernmental and public-private partnerships—for they offer important lessons for how to undertake such development elsewhere.

Tribal Nations have proven success in innovative solutions to infrastructure needs: In the 1960s, rural Neshoba County in Mississippi—home to the Mississippi Band of Choctaw Indians—was one of the most economically impoverished areas in the United States. The infrastructure was undeveloped with most houses in substandard condition, 9 in 10 had no indoor plumbing, and a third had no electricity. Seeking to uplift its community, the Band embarked on creating a diversified, sustainable economy, appropriately targeting the strategic building of its physical infrastructure as a critical first order of business. Fifty years later, the Band has not only transformed its reservation's quality of life, it has become a major economic engine in its part of the state, employing thousands of Natives and non-Natives through its suite of Band-owned enterprises. A growing number of other Tribal Nations are authoring equally impressive stories of community revitalization and local and regional economic success empowered by strategic investments in infrastructure development. From the Citizen Potawatomi Nation's Iron Horse Industrial Park to the Tulalip Tribes' state-of-the-art waste water treatment facility to Ohkay Owingeh's Tsigo Bugeh Village, Tribal Nations across the country are turning tribal, Federal and other investments in their infrastructure into lasting economic and social benefits for Native people and other local residents who rely on said infrastructure to support a good quality of life.

However, there still remains great need for infrastructure investment in Indian Country. The following chart estimates unmet needs for some of the major infrastructure projects in Indian Country along with details regarding each of these programs:

Estimates of Unmet Needs for Infrastructure in Indian Country

In Billions of Dollars	Construction Backlogs	Deferred Maintenance
IHS Health Care Facilities, New and Replacement Cost	10.3	
IHS Sanitation Facilities Construction backlog	2.5	
IHS Maintenance & Improvement deferred maintenance backlog		0.5
IHS Workforce Staff Quarters, new and replacement units	0.4409	
BIE to replace or rehabilitate the 68 worst schools	1.3	
BIE Deferred Maintenance Backlog		0.3889
BIA Safety of Dams Deferred Maintenance		0.556
BIA Irrigation Program—Rehabilitation Deferred Maintenance		0.567
BIA Roads Maintenance Deferred Maintenance Backlog		0.289
Indian Housing, additional 68,000 housing units	33	
Construction of Tribal Multi-Justice Centers and Detention Facilities	0.21189	
Total	**47.8**	**2.3**

Indian Health Service Health Care Facilities, New and Replacement Cost: $10.3 billion

- Estimated costs to construct the needed additional 18 million ft^2 of new and replacement space totaled $10.3 billion in 2016.
- Existing space in IHS facilities (14 million ft^2) is substantially less than required (~27 million ft^2) for the 2015 AI/AN user-population. Insufficient capacity and resources severely restrict healthcare services that can be provided. An additional 4.7 million ft^2 is becoming outdated and should be replaced. Unless these needs are addressed, the growing AI/AN population and gradual deterioration of older space will further expand the need.
- At the existing replacement rate, a new 2016 facility would not be replaced for 400 years.
- Of the U.S. annual health expenditures, about 5 percent are investments in healthcare facility construction. In 2013, $118 billion investment in healthcare facility construction equaled about $374 per capita. IHS healthcare facility construction appropriation of $77 million is about $35 per AI/AN. Thus the U.S. per capita annual investment in healthcare facility construction is over 10 times the amount for IHS healthcare facility construction per capita.

Sanitation Facilities Construction backlog: over $2.5 billion

- A recent cost benefit analysis indicated that, for every dollar IHS spends on sanitation facilities to serve eligible existing homes, at least a 20-fold return in health benefits is achieved.
- Projects are cooperatively developed and transferred to tribes who assume responsibility for the operation of safe water, wastewater, and solid waste systems, and related support facilities. The SFC program receives funds for three types of projects:
  - — Water, Wastewater, and Solid Waste facilities for Existing Homes and/or Communities,
  - — Water, Wastewater, and Solid Waste facilities for New Homes and/or New Communities, and
  - — Special or Emergency projects. The sanitation project need is almost $2.5 billion, including almost 14,000 AI/AN homes without potable water.
- With inflation, new environmental requirements, and population growth, the current sanitation appropriations are not reducing the backlog.

IHS Maintenance and Improvement deferred maintenance, alteration and repair backlog: $500 million

- In 2015, the maintenance budget ($53.6 million) was sufficient to cover only 77 percent of maintenance needs arising annually even with deferring needed improvements to outdated space. The reported backlog of deferred maintenance, alteration and repair as of the end of year 2015 was approaching $500 million.

IHS Workforce Staff Quarters: $440.9 million needed for new and replacement units

- Staff Quarters unmet need at existing healthcare sites is $440.9 million. 1100 units are needed to staff IHS and tribal healthcare facilities (recruit and retain health professionals).

Bureau of Indian Education

Need: $1.3 billion to replace or rehabilitate the 68 worst schools
BIE Deferred Maintenance Backlog: $388.9 million

- The 2010 estimate for upgrading BIE schools in poor condition to satisfactory condition was $1.3 billion.
- At the end of FY 2015, BIA has 82 schools in "good" condition, 46 in "fair" condition and 55 in "poor" condition with an overall average of building conditions at "fair" as measured by the Facilities Condition Index. This means the majority of BIE schools (approximately 55 percent) are in either poor or fair condition.

BIA Safety of Dams

Deferred Maintenance: $556 million

- The Bureau of Indian Affairs (BIA) currently lists 31 high- or significant-hazard dams; fund the High-Hazard Indian Dam Safety Deferred Maintenance Fund authorized at $22.75 million annually for FY 2017–2023; fund the Low-Hazard Indian Dam Safety Deferred Maintenance Fund authorized at $10 million annually for fiscal year 2017–2023.

BIA Irrigation Program—Rehabilitation

Deferred Maintenance: $576 million

- The BIA Irrigation Program provides irrigation water to 17 projects spanning over 780,000 acres. Among other things, this water helps with the production of over $300 million a year in gross crop revenues. However, most of these projects are nearly 100 years old, reached or exceeded their useful life span, were never fully completed, and/or have extreme deferred maintenance.

*BIA Roads Maintenance Deferred Maintenance Backlog: $289 million**

**Not including tribal roads*

- The BIA has maintenance responsibility for approximately 29,000 miles of roads and 900+ bridges. The road mileage consists of 7,150 miles of paved, 4,720 miles of gravel, and 17,130 miles of unimproved and earth surface roads. The total public road network serving Indian Country is 140,000+ miles according to the National Tribal Transportation Facility Inventory. The Office of Indian Services Division of Transportation in Washington, DC provides oversight and distribution for the annual maintenance program.

Indian Housing Block Grant needs additional 68,000 housing units (cost): $33 billion

- A recent report stated it would take approximately 33,000 new units to alleviate overcrowding and additional 35,000 to replace existing housing units which are in grave condition. To meet the total need of approximately 68,000 housing units (new and replacement), with the average development cost of a three-bedroom home, the total cost is in excess of $33 billion.

Construction of Tribal Multi-Justice Centers and Detention Facilities

Unmet Need: $211,898,628 (as of FY 2011)

Prioritization of Infrastructure Projects: As is detailed above, the need for infrastructure development in Indian Country is great. The lack of sufficient funding has created backlogs that in many cases will take decades or longer to clear. The existing process Priority In many cases, existing processes at the Federal agencies determine how projects are prioritized especially in the case of schools, and health clinics.

How IHS Uses and Distributes Health Care Facilities Construction (HCFC) Funds. In the late 1980s Congress directed IHS to develop the HCFC priority system. The system was implemented in the early 1990s with 27 projects on the initial list. Most projects are major capital investments exceeding annual HCFC funding resulting in projects being funded over several fiscal years. Projects are funded in phases according to acquisition, engineering, and project management requirements. Portions or phases of several projects are funded during a given fiscal year. This allows several projects to move forward simultaneously and helps distribute the funds geographically benefiting more than one Area.

There are separate lists for facility types, for instance, Inpatient, Outpatient, Youth Regional Treatment Facilities or Staff Housing. Budget documents identify the specific projects off the grandfathered HCFC List, the phases and the estimated costs for that fiscal year. There are 13 remaining facility projects on the "grandfathered Priority List" with a current estimated completion cost of $2.1 billion. Once those 13 projects are funded, the remaining $8 billion can be funded with a revised priority system that will periodically generate updated lists.

The current "Grandfathered" HCFC Priority List consists of the following sites:

- Gila River PIMC SE ACC, AZ
- Salt River PIMC NE ACC
- PIMC Central Hospital & ACC
- Whiteriver, AZ
- Gallup, NM
- Ft. Yuma, AZ
- Rapid City, SD
- Winslow-Dilkon, AZ
- Alamo Navajo, NM
- Pueblo Pintado, NM
- Bodaway Gap, AZ
- Albuquerque West
- Albuquerque Central
- Sells, AZ

Bureau of Indian Education Construction List. The BIA Education Construction Program reconstructs and rehabilitates BIE schools and dormitories. There are 183 BIE schools and dormitories in 23 states, and serve approximately 48,000 students from K through 12th grade. In addition, BIE owns and operates two post-secondary institutions. The Facilities Condition Index is a system used by the BIA to calculate, manage and develop constructions plans for repair and rehabilitation of school facilities. In FY 2015, there were 82 schools that were considered in good condition, 46 in fair condition, and 55 in poor condition. It would take approximately $388 million in deferred maintenance to bring the schools up to good conditions.

For Fiscal Year (FY) 2016, the National Review Committee identified the 10 schools listed below and invited those schools to present at a public meeting in February 2016, in Albuquerque, New Mexico.

- Blackwater Community School
- Chichiltah-Jones Ranch Community School
- Crystal Boarding School
- Dzilth-Na-O-Dith-Hle Community School
- Greasewood Springs Community School
- Laguna Elementary School
- Lukachukai Community School
- Quileute Tribal School
- T'iis Nazbas Community School
- Tonalea Redlake Elementary School

Improving Infrastructure Permitting Processes to Consult With Indian Tribes and Gain Consent. As Congress and the Administration consider large-scale infrastructure projects across the United States, tribal lands and natural resources will inevitably be impacted. Because tribal lands and natural resources are a primary source of economic activity for tribal communities it is imperative that tribal governments are part of the planning process when those projects are located on, or near, reservation or on ancestral lands.

Tribal Nations should be included in infrastructure decision making from the very earliest stages, including being involved in key decisions regarding priorities for development and tribes should also be included in any discussions regarding particular projects. For instance, as soon as Federal agencies are discussing projects with private parties or state governments, they should also be talking to Tribal Nations. Early consultation ensures that problems are identified and resolved in a timely fashion, preventing costly delays down the line.

An important part of addressing the Nation-to-Nation relationship is, in the context of infrastructure decision making, the need for responsible economic development, with a specific focus on how tribes can benefit from infrastructure development. Based on the input from tribal leaders across Indian Country, NCAI developed a set of Principles and Best Practices for Infrastructure Permitting Relating to Tribal Nations and the Federal Trust Responsibility that we believe can fit into the existing regulatory framework.

For any project affecting tribal lands, waters, treaty rights, or sacred spaces, at the outset the United States must expressly consider the following five principles: (1) recognition of tribal sovereignty; (2) respect for treaty rights; (3) compliance with the Federal trust responsibility, including seeking tribal informed consent; (4) upholding all statutory obligations; and (5) ensuring environmental justice. How these principles were addressed should be reflected in the written record for any decision.

We also recommend that the Federal Government implement the following seven best practices: (1) regional mapping and tribal impact evaluation; (2) consultation in early planning and coordination; (3) early, adequate notice and open information sharing; (4) funding for tribal participation in processes; (5) training for agencies to improve understandings of Tribal Nations; (6) creation of tribal impact statements and a Trust Responsibility Compliance Officer; and (7) evaluation of cumulative impacts and regional environmental impacts.

Infrastructure permitting must respect the Federal responsibilities to Tribal Nations who continue to struggle to protect their lands, resources, sacred sites, and cultures in processes that too frequently authorize projects despite their threats to these Nations. Time invested early to identify a project site that avoids ecologically or culturally sensitive areas can lead to a more efficient process and shorter overall project time frames, and can even avoid the need for Federal reviews, approvals, or licenses pertaining to those resources. Similarly, project planning and the submitted proposal should reflect the results of early consultations with tribal leaders to ensure the proposed project accounts for tribal perspectives and needs up front.

Streamlining Regulatory Processes. Tribal Nations have also consistently requested that the Federal Government modernize outdated regulations and statues to provide them with more flexibility and the option of greater control over decision-making and self-governance, the ability to be more responsive to the needs of their citizens, and to bolster economic development in Indian Country. The trust relationship and responsibility must be modernized to be consistent with self-determination and rooted in inherent sovereign authority to create a 21st century trust for 21st century tribes.

The first step in this process will be to nominate an Under Secretary for Indian Affairs, and implement the Indian Trust Asset Management Reform Act. Last year Congress passed an important new law authorizing the Secretary of the Interior to establish an Under Secretary for Indian Affairs. When established, the Under Secretary will report directly to the Secretary and serve as a cross-agency advocate for Indian Country to ensure that all agencies and bureaus within the Department work together efficiently on tribal issues and implement policies that consider their trust obligations to Indian tribes. The position will address a major issue that has been raised in every significant study of trust management at Interior: the lack of clear lines of authority and responsibility to ensure accountability for trust reform efforts by the various divisions of the Department of the Interior.

We also urge that the Department of the Interior consider working with tribal leaders to adopt many of the latest innovations in streamlining approvals for tribal projects. For major projects, the agency should develop a Coordinated Project Plan in consultation with the tribal applicant. This plan must designate a lead Federal agency for project approval, to avoid the problems of stovepiping that so frequently

cause approvals to bog down. Federal permitting and review processes must rely upon early and active consultation with tribal governments to schedule the necessary permits and approvals, set deadlines with oversight, avoid conflicts or duplication of effort, resolve concerns, and allow for concurrent rather than sequential reviews.

Innovation in Financing of Infrastructure Projects in Indian Country. As a primary matter, we urge that tribal governments must be fully and proportionally included in the direct funding for any infrastructure package. These dollars are a sound investment in development in rural America, and also a part of the Federal trust responsibility to Indian tribes.

If funding is derived from tax incentives, we urge that tribal government be fully included and eligible. Tribal governments should be provided with direct access to Federal tax credit programs such as the New Markets and Low Income Housing Tax Credit programs—among other Federal incentives, which will help spur public-private partnerships to rebuild Indian Country infrastructure.

We urge Congress to consider the urgent and continuing need for economic development on Indian reservations in the context of the Indian Employment Tax Credit and Accelerated Depreciation for on-reservation business infrastructure. Both expired on December 31, 2016. Congress should make both tax incentives permanent so employers can rely on the incentives when planning to locate their business on tribal lands.

Congress should also empower Tribal Governments to access tax-exempt bond markets. Currently, tribes may only use tax-exempt bonds for "essential government functions." The IRS has interpreted this provision to exclude economic development as a governmental function, while state and local governments frequently use tax-exempt financing for development projects. This unnecessarily prevents tribes from securing the funding needed to revitalize their communities.

CONCLUSION

Investing in Indian Country's infrastructure furthers tribal self-governance and self-determination by acknowledging tribal governmental parity and the Federal trust responsibility. For any national infrastructure investment plan to be effective, it will need to emerge from the concerted, coordinated efforts of all governmental players, including tribal governments.

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The following document was submitted as a supplement to the National Congress of American Indians' testimony. This document is part of the hearing record and is being retained in the Committee's official files:

— "Tribal Infrastructure—Investing in Indian Country for a Stronger America," by the National Congress of American Indians.

Mr. LAMALFA. All right, thank you for your testimony.

Next, I would like to recognize our Chairman Emeritus of the Committee on Natural Resources, the gentleman from Alaska, to make an introduction of our next panelist.

Mr. YOUNG. Thank you, Mr. Chairman. And Emeritus means I have been here so long I can't be Chairman again.

[Laughter.]

Mr. YOUNG. Everybody gives a sigh of relief. But I want to congratulate you, and I am confident you will do a great job. You have a fantastic Minority partner, and I think we can work together on these issues. So, congratulations to both of you.

Mr. LAMALFA. Thank you, sir.

Mr. YOUNG. I am sitting, listening to this testimony, and I couldn't help but think I have been on this Committee of Indian Affairs for a long time, and we have come a long way from where we were when we started. We still have a long way to go, and we can only do that through leadership. And we have some great

Alaskan leaders, Native leaders in the state of Alaska. We have done a good job, but we are still short. It is a big area, lots of different tribes, small tribes, and the larger ones, too.

But today we have a witness, Andy Teuber, who has been a friend of mine. He has been—well, a young man, good leader. He is the president of the Alaska Native Tribal Health Consortium, which covers the whole state. He also serves as the president of the Kodiak Area Native Association.

Again, I want to stress the fact that we have built a lot of clinics. And one of the biggest problems we have, Mr. Chairman, is actually running the clinic. Once you build something, you have to have the money, you have to have the staffing, the maintenance. Otherwise, you defeat yourself.

So again, Andy, I welcome you to testify before this Committee.

And, Mr. Chairman, congratulations. And I am willing to listen to what Andy has to say now.

Andy, you are up.

STATEMENT OF ANDY TEUBER, BOARD CHAIR AND PRESIDENT, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM, ANCHORAGE, ALASKA

Mr. TEUBER. Thank you, Chairman LaMalfa and Ranking Member Torres. And, most especially, thank you, Chair Emeritus, Representative Young. I appreciate you providing my testimony for me this morning.

[Laughter.]

Mr. TEUBER. Indeed, we are good friends, and we rely on our Congressman. He is our only Congressman, and he is, in fact, a champion of the infrastructure that is so badly needed across the state of Alaska.

As I was introduced, my name is Andy Teuber. I serve as the Chairman and the President for the Alaska Native Tribal Health Consortium (ANTHC) in Anchorage, Alaska. We co-manage the Alaska Native Medical Center with the Southcentral Foundation. And that Alaska Native Medical Center is Alaska's only Alaska Native tertiary hospital, which serves all 229 tribes in the state, and also 158,000 Alaska Native people.

In addition, I also serve in a primary care capacity, managing the Kodiak Area Native Association, a small island in the Gulf of Alaska that serves seven communities.

I want to thank the members of this panel of witnesses for their testimony. They covered a great deal of what I intended to cover today, and those are three items: the IHS Health Care Facilities Construction Priority List, which Mr. Andy Joseph, Ms. Kitcheyan, and Aaron Payment have also referred to; also, I intend to cover the Sanitation Facilities Construction Program; and the Village-Built Clinic Leasing Program.

First, I will start with the Sanitation Facilities Construction Program, as it plays a critical role in the health of our communities. Babies born in communities without adequate sanitation are 11 times more likely to be hospitalized for respiratory infections, and 5 times more likely to be hospitalized for skin infections. In villages with very limited water service, one in three infants requires hospitalization each year for lower respiratory tract infections.

In Alaska, there are more than 49,000 people in 140 communities who would significantly benefit from critical water and sewer projects, including 31 communities that have never had access to water or sewer service. IHS sanitation facilities construction funding complements funding provided through the EPA and the USDA. However, both agencies have minimum operation and maintenance score requirements, as well as requiring certified operators, while the IHS has neither of those requirements.

Many of the majority of the unserved communities cannot be served by a traditional piped water system, and possess virtually no ability to generate the needed revenue to employ full-time certified operators. This reality requires regulatory flexibility and, in many cases, alternative technology to bring water and sewer services to the remaining unserved rural Alaska communities.

With support from the IHS in December of 2013, ANTHC began a pilot program, what ultimately became known as PASS, or the Portable Alternative Sanitation System, to install completely home-based systems to address basic sanitation needs in nine homes. We would like to expand PASS to other homes in Kivalina, as well as other communities in Alaska, and hope for expanded support from IHS for the PASS program. But such alternatives are necessary to reach communities in Alaska that cannot be otherwise reached by a conventional piped water system.

Next, I intend to cover the Village-Built Clinic Leasing Program (VBC), which was established in 1970, and serves as the foundation of the tribal healthcare delivery system in Alaska, providing the only local source of care for over 44,000 Alaska Native people living in rural isolated communities across the state.

As of June 2016, there were over 160 clinics supported through the VBC program. These clinics are primarily staffed with community health aides, mid-level practitioners, or community health practitioners, and serve as the base for visiting physicians, mid-level practitioners, pharmacists, dentists, optometrists, and other medical specialists. VBC has also served as the patient referral link to the tribal regional hospitals and to the Alaska Native Medical Center based in Anchorage.

Over time, the cost to operate and maintain VBCs has increased, due to the expanding scope and level of medical services provided, expanded healthcare programming, and technology to better integrate clinics into the tribal healthcare delivery system, as well as meeting the higher accreditation standards necessary for certification by accrediting agencies like the AAAHC and Joint Commission.

The IHS has responsibility to fully fund the VBCs. IHS provided the first step in fulfilling its responsibility by providing an increase of $2 million in payments in Fiscal Year 2016 for full-service leases that are not eligible for maintenance and improvement—or M&I—funds, and a larger-step by including an additional $7 million in the IHS Fiscal Year 2017 congressional justification for such clinics. It is essential that the IHS provide funding for VBCs that adequately cover the cost to operate them.

In conclusion, additional funding support and policy changes are needed to address the current deficiencies of the Indian healthcare

infrastructure, and meet the needs of American Indian and Alaska Native people.

Thank you to the members of this Committee, Mr. Chair, Ranking Member, Chair Emeritus. I look forward to answering any questions.

[The prepared statement of Mr. Teuber follows:]

PREPARED STATEMENT OF ANDY TEUBER, CHAIRMAN AND PRESIDENT, ALASKA NATIVE TRIBAL HEALTH CONSORTIUM; PRESIDENT AND CEO, KODIAK AREA NATIVE ASSOCIATION, ANCHORAGE, ALASKA

My name is Andy Teuber, I am the Chairman and President of the Alaska Native Tribal Health Consortium (ANTHC), a statewide tribal health organization that serves all 229 tribes and more than 158,000 Alaska Native and American Indian (AN/AI) people in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AIs in Alaska. ANTHC also provides statewide health services, including construction and operational support for rural sanitation projects, and technical assistance to other tribal health organizations for the maintenance and repair of regional hospitals and clinics including construction of new facilities.

I am also the President and CEO of the Kodiak Area Native Association (KANA), a regional non-profit tribal organization formed in 1966 to provide health and social services to AN/AI people in the Kodiak Island Area. The KANA service area includes the city of Kodiak and six Alaska Native villages. ANTHC and KANA are both self-governance tribal organizations that compact with IHS to provide health services to AN/AIs under the authority of the Indian Self-Determination and Education Assistance Act, P.L. 93–638.

My testimony today will focus on the health care and public health infrastructure needs in tribal communities. The healthcare infrastructure in tribal communities is in great need of improvement and expansion. While there have been some increases in Indian Health Service funding over the past several years, the large majority of it went toward inflationary and fixed costs, for things such as population growth and pay costs increases, which has left the Indian healthcare infrastructure largely behind.

I am going to limit my discussion to three areas in particular where, in addition to increased funding, policy changes could improve the current system—IHS healthcare facilities construction, sanitation facilities construction and village built clinics.

HEALTH CARE FACILITIES

According to the IHS 2016 Report to Congress on healthcare facilities need, over half of all IHS-owned healthcare facilities are over 30 years and the average age of IHS hospitals is 40 years old, nearly four times the average age of private-sector hospitals. And unfortunately the number of antiquated IHS facilities is only going to get worse unless things change. At the recent rate of IHS healthcare facility construction funding, a new facility built in 2016 would not be scheduled for replacement for over 400 years.

As existing facilities age, without renovation or expansion, they become increasingly inefficient to operate and costly to maintain. The age of facilities also negatively impacts the ability of IHS and tribal health programs to efficiently and effectively provide healthcare services to AN/AIs in overcrowded and outdated facilities. The quality of health care is also compromised when facilities are not adequately maintained and kept up to date.

The IHS report estimated that a total of $10.3 billion would be needed for construction of adequate healthcare facilities to serve all AN/AIs. The estimated cost just to complete the 13 inpatient and outpatient facilities currently on the IHS planned facilities construction list is approximately $2.1 billion. At the current level of funding for IHS healthcare facilities it would take 20 years to complete construction of the existing list, before any funding would be available to address the other $8.2 billion needed for facilities construction. In Alaska alone, there is a need for $2.16 billion for healthcare facility construction, and there are no Alaska facilities on the existing construction priority list. As no funds are currently provided to IHS for renovation or expansion of existing facilities, the current system leaves most IHS Areas, all of which have very old facilities, without a way to improve them.

One way to ensure that all IHS Areas have access to at least some resources to renovate and expand existing IHS and tribal health facilities would be to ensure

that the IHS Maintenance and Improvement (M&I) line item is increased. Beginning in FY 2011 through 2015, the funding for IHS M&I was insufficient for even basic maintenance and repair deficiency needs. This has led to a backlog at the end of 2015 of nearly $500 million for deferred maintenance, alteration and repair.

Another option to ensure that all IHS Areas have access to resources to address facility needs would be to establish an area distribution fund. The reauthorization of the Indian Health Care Improvement Act (IHCIA) in 2010 (S. 1790) amended section 301 of IHCIA to direct the Secretary ensure that the "renovation and expansion needs of Service and non-Service facilities . . . are fully and equitably integrated into" the IHS healthcare facility priority system, and to consult and cooperate with tribes to develop innovative approaches to address unmet need for construction of health facilities.

The establishment of an area distribution fund for the renovation and expansion of existing healthcare facilities would provide funding for all IHS Areas and also address the dire unmet need to renovate and expand existing IHS and tribal health facilities to provide more efficient and better care to AN/AIs throughout Indian Country.

SANITATION FACILITIES CONSTRUCTION

Sanitation facilities play a critical role in the health of our communities. Babies in communities without adequate sanitation are 11 times more likely to be hospitalized for respiratory infections and 5 times more likely to be hospitalized for skin infections. In villages with very limited water service, one in three infants requires hospitalization each year for lower respiratory tract infections. In Alaska alone we had over $1.2 billion in unmet need for sanitation facilities construction in 2016. Funding for IHS sanitation facilities construction finally saw an increase in FY 2016, but that was after many years of no increases. Given the enormous, growing unmet need and the significant health benefits derived from sanitation facilities continued support of IHS sanitation facilities construction is essential, but regulatory and policy flexibility is also needed.

In Alaska, there are more than 49,000 people in 140 communities in rural Alaska who would benefit from critical water and sewer projects, including 31 communities that have never had water or sewer service. According to the state of Alaska in 2015, over 3,300 rural homes have been identified as lacking running water and a flush toilet. Most of these are Alaska Native homes in the 31 unserved communities.

IHS sanitation facilities construction funding complements funding provided through EPA and USDA. Unlike funding through the Environmental Protection Agency (EPA) and the United States Department of Agriculture (USDA), IHS funding has no minimum operation and maintenance score requirements. While systems that have robust operation and maintenance programs are more likely to be funded, this does not prevent funding from being allocated. Additionally, rural Alaska communities often struggle to obtain qualified and certified operators. EPA funding requires systems be operated by certified operators, whereas IHS funding does not have this requirement.

Because of regulatory barriers on USDA and EPA grants for water and sewer, IHS' cooperation and support is critical to providing water and sewer services to most of the 31 remaining unserved rural Alaska communities. Many of these unserved communities cannot be served by a traditional piped water system, and therefore need an alternative solution.

With support from IHS, in December of 2013 ANTHC began a pilot project, what ultimately became known as the portable alternative sanitation system (PASS), to install completely home-based system to address basic sanitation needs in nine homes. A report on PASS was just issued (see Attachment) that was very positive regarding the effectiveness of the system. We would like to expand PASS to other homes in Kivalina as well as other communities in Alaska and hope for expanded support from IHS for PASS or other such alternative systems that are necessary to reach the communities in Alaska that cannot be reached by conventional piped water systems.

VILLAGE BUILT CLINIC LEASE PROGRAM

Established in 1970, the Village Built Clinic (VBC) program serves as the foundation of the tribal healthcare delivery system in Alaska, providing the only local source of care for over 44,000 Alaska Native people living in rural, isolated communities across the state. As of June 2016, there were over 160 clinics supported through the VBC program.

These clinics are primarily staffed with Community Health Aides (CHAs) or Community Health Practitioners (CHPs), both essential to carrying out the

congressionally-mandated Community Health Aide Program (CHAP) authorized by section 119 of the Indian Health Care Improvement Act. Over 80 percent of clinics supported by VBC leases are owned and operated by small, rural communities.

VBCs serve as the base for visiting physicians, mid-level practitioners, pharmacists, dentists, optometrists, and other medical specialists, as well as the referral link to the tribal regional hospitals and to the Alaska Native Medical Center based in Anchorage. VBCs are the local contact and emergency station for public health and emergency preparedness efforts in these communities.

Over time, the cost to operate and maintain VBCs has increased due to the expanding scope and level of medical services provided; expanded healthcare programming and technology to better integrate clinics into the tribal healthcare delivery system; as well as meeting the higher accreditation standards necessary for certification by the Joint Commission.

Yet current funding from the Indian Health Service only covers approximately 30 percent of the clinic's ongoing operating costs. Current lease payments for most of the clinics have not been significantly increased in over 20 years, aside from a small increase in FY 2016. In addition, the current VBC lease amounts provide virtually no funds for basic rent, long-term maintenance and improvements, depreciation, or replacement reserves needed to sustain services in the community. This lack of funding poses an immediate and significant threat to the substantial investment made by the Federal Government in establishing the VBC program.

Without adequate VBC funding, community health aides are forced to provide services in unsafe facilities with insufficient resources. Individual communities are increasingly forced to subsidize the day-to-day operating costs of their clinics, defer long-term maintenance and improvement projects, reduce clinic operations, and forgo funding depreciation and replacement reserve funds. Nearly all of these communities are not located on the road system and without access to the electrical grid, have virtually no tax or revenue base.

Many of Alaska's villages are unable to maintain support of their VBC, with serious consequences for the health and safety of residents living these remote communities. Tribal health organizations have subsidized emergency and routine costs with their limited funds, but they cannot sustain these subsidies while continuing to operate their other programs.

In fact, some VBCs have closed, suspending CHAP services and cutting off the only local source of care. This lack of access at the local level necessitates costly travel as primary and preventive services become increasingly unavailable, diminishing the otherwise available resources at the secondary and tertiary levels of care.

The IHS has a legal responsibility to fully fund the VBCs. IHS provided the first step in fulfilling its responsibility by providing an increase of $2 million in payments in FY 2016 and a larger step by including an addition $7 million in the IHS FY 2017 Congressional Justification. It is essential that IHS provide funding for VBCs that adequately cover the costs to operate them.

CONCLUSION

I commend this Committee for holding this hearing on this important subject. It is clear that additional support and policy changes are needed to address the sagging Indian healthcare infrastructure. Thank you for the opportunity to provide this testimony.

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The following document was submitted as a supplement to Mr. Teuber's testimony. This document is part of the hearing record and is being retained in the Committee's official files:

—Portable Alternative Sanitation System, Final Report—Kivalina, Alaska, by the Alaska Native Tribal Health Consortium.

Mr. LAMALFA. Thank you, Mr. Teuber. I appreciate it. The Chair now recognizes Mr. Pula to testify.

STATEMENT OF NIKOLAO PULA, ACTING ASSISTANT SECRETARY, OFFICE OF INSULAR AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR, WASHINGTON, DC

Mr. PULA. [Speaking native language] from Guam and Commonwealth of the Northern Mariana Islands. And good old top of the morning from the U.S. Virgin Islands.

Mr. Chairman and members of the Subcommittee on Indian, Insular, and Alaska Native Affairs, thank you for the opportunity to speak regarding the Office of Insular Affairs capital infrastructure projects program for the U.S. territories of Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

The 1996 passage of Public Law 104–134 established the CIP program, approximately $28 million in annual current mandatory funding. CIP funds address a variety of infrastructure needs in the U.S. territories, including critical infrastructures such as hospitals, schools, wastewater, and solid waste systems. These critical infrastructure improvements not only benefit the local population, but they attract new investment and economic development to the territories.

These funds are allocated among ports, hospitals, schools, water, public buildings, solid waste, energy, and public safety. This allocation is depicted in my written statement as a pie chart to show the relative emphasis given to each category of projects. For example, 30 percent goes to schools.

OIA CIP program often yields positive results for our island communities. For example, in Guam, the $3 million public health environmental laboratory was completed last year. It was designed to identify vector-borne diseases that make way across the Pacific.

In American Samoa, $8 million went to procure a 134-foot ship, the *MV Manu'atele*, that now plies the waters between Manu'a and the main island of Tutuila, providing both cargo and passengers transport.

In the Virgin Islands, the 388-year-old Fort Christian was renovated just in time for the centennial celebration commemorating the transfer of the United States Virgin Islands from Denmark to the United States. They will be commemorating that at the end of this month. It will be a significant tourist attraction.

In the CNMI, $29 million in CIP funds facilitating the transformation of the Puerto Rico dump into a public park next to the lagoon for residents and tourists to enjoy. It will be dedicated next week.

Last year, $4.9 million in CIP funding was used to replace the HVAC equipment at the Saipan Hospital, and it was later certified by CMS.

While numerous CIP projects are locally conceived and promoted, OIA has assisted on numerous occasions with substantial sums of CIP funding that have brought territorial compliance with Federal directives and court orders. The funding serves a wide variety of purposes, and enjoys the support of the local communities and governors.

Beginning with 2004, OIA implemented a competitive allocation system for the $28 million in mandatory CIP grants. The annual allocation is made on the basis of set competitive criteria that

measured a demonstrated ability of the governments to exercise prudent financial management practices, and to meet Federal grant requirements. OIA CIP program has two goals: assist territorial governments with infrastructure funding, and encourage improved financial management by the territorial governments.

The governors of Guam, American Samoa, the U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands assert that capital improvement needs in the U.S. territories amount to over $1 billion. Much of the public infrastructure in the U.S. territories is well used, and difficult for small communities to replace or upgrade. Overall, the territory school facilities average 40 years of age, and show the marks of generations of school children and the effects of the tropical climate.

The governors' top priorities for the new and replacement infrastructure include hospitals in American Samoa and the U.S. Virgin Islands; high schools in Guam; and enlargement of the landfill in Saipan, Northern Mariana Islands.

Aging infrastructure can create risks to human health, a diminishment of educational opportunities for youth, and a less-than-desirable environment for cultivating an investment in territorial economies.

In conclusion, thank you for this opportunity to present testimony on the Office of Insular Affairs' capital infrastructure project program, and we look forward to continuing to work with the Committee on this issue. Thank you.

[The prepared statement of Mr. Pula follows:]

PREPARED STATEMENT OF NIKOLAO I. PULA, ACTING ASSISTANT SECRETARY OF THE INTERIOR FOR INSULAR AREAS, WASHINGTON, DC

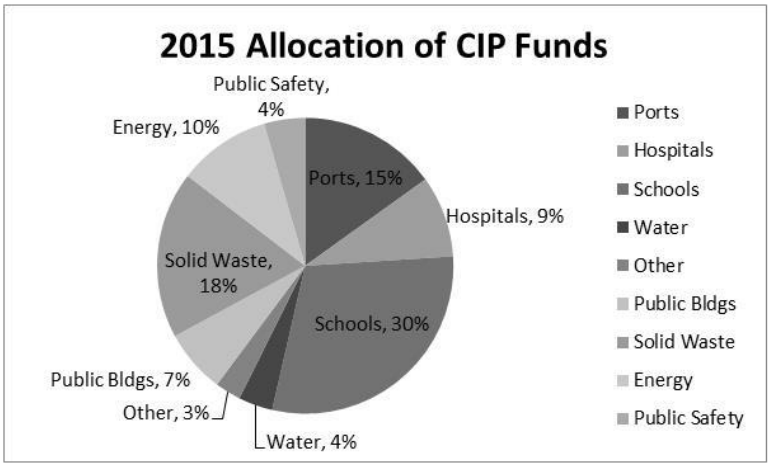
Mr. Chairman and members of the Subcommittee on Indian, Insular, and Alaska Native Affairs, thank you for the opportunity to speak regarding the Office of Insular Affairs' (OIA) capital infrastructure project (CIP) program for the U.S. territories of Guam, American Samoa, the United States Virgin Islands and the Commonwealth of the Northern Mariana Islands (CNMI).

THE CIP PROGRAM OF THE OFFICE OF INSULAR AFFAIRS

The 1996 passage of Public Law 104–134 established the CIP program with $27.72 million in annual current mandatory funding. CIP funds address a variety of infrastructure needs in the U.S. territories, including critical infrastructure such as hospitals, schools, wastewater and solid waste systems. These critical infrastructure improvements not only benefit the local population, but they attract new investment and economic development to the territories.

ALLOCATION OF OIA CIP FUNDS

OIA CIP funds are allocated among ports, hospitals, schools, water, public buildings, solid waste, energy, and public safety. This allocation is depicted in my written statement as a pie chart to show the relative emphasis given to each category of project.



POSITIVE RESULTS

OIA's CIP program often yields positive results for our island communities. For example—

In Guam, the $3 million public health environmental laboratory was completed in 2016. It was designed to identify vector-borne diseases that may make their way across the Pacific.

In American Samoa, the $8 million, 134-foot ship, the *MV Manu'atele*, now plies the waters between Manu'a and the main island of Tutuila, providing both cargo and passengers transport.

In the Virgin Islands, the 388-year-old Fort Christian was renovated just in time for the centennial celebration commemorating the transfer of the United States Virgin Islands from Denmark to the United States. It will be a significant tourist attraction.

In the CNMI, $29 million in CIP funds facilitated the transformation of the Puerto Rico dump into a beautiful public park next to the lagoon for residents and tourists to enjoy. It will be dedicated this month. In 2016, $4.9 million in CIP funding was used to replace the HVAC equipment at the Saipan hospital. CMS certification followed.

While numerous CIP projects are locally conceived and promoted, OIA has assisted on numerous occasions with substantial sums of CIP funding that have brought territorial compliance with Federal directives and court orders. The funding serves a wide variety of purposes and enjoys the support of the local communities and governors.

COMPETITIVE ALLOCATION SYSTEM

Beginning with 2005, OIA implemented a competitive allocation system for the $27.72 million in mandatory CIP grants. It is based on a premise that the annual $27.72 million will be limited to defraying capital costs for the U.S. territories.

The governments of the U.S. territories compete each year for a portion of the guaranteed funding, which they use for CIP in addition to other assistance or local funding that might be available.

Base level funding was established in 2005, utilizing historic CIP trends with an overlay of the competitive allocation system requirements. The allocation system was adjusted for fiscal year 2012 and again for 2017. The performance of each territory was analyzed, as required in the Covenant section 702 funding agreement of 2004 between OIA and the CNMI.

For fiscal year 2017, OIA's CIP funding will be distributed follows:

American Samoa	$9,780,000
CNMI	9,249,000
Guam	5,911,000
U.S. Virgin Islands	2,780,000
TOTAL	$27,720,000

The determination of the annual allocation is made on the basis of a set of competitive criteria that measure the demonstrated ability of the governments to exercise prudent financial management practices and to meet Federal grant requirements.

OIA's CIP program has two goals: assist territorial governments with infrastructure funding, and encourage improved financial management by the territorial governments.

THE TERRITORIES' STATED CAPITAL IMPROVEMENT PROJECT NEEDS

The governors of Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands assert that the capital improvement needs in the U.S. territories amounts to over $1 billion. Much of the public infrastructure in the U.S. territories is well-used and difficult for the small communities to replace or upgrade. Overall, the territories' school facilities average 40 years of age, and show the marks of generations of school children and the effects of the tropical climate. The governors' top priorities for new and replacement infrastructure include hospitals in American Samoa and the Virgin Islands, high schools in Guam and enlargement of the landfill in Saipan, Northern Mariana Islands. Aging infrastructure can create risks to human health, a diminishment of educational opportunities for youth, and a less than desirable environment for cultivating tourism and investment in territorial economies.

CONCLUSION

Thank you for this opportunity to present testimony on OIA's capital infrastructure project program, and we look forward to continuing to work with the Committee on this issue.

QUESTIONS SUBMITTED FOR THE RECORD BY REPRESENTATIVE SABLAN TO NIKOLAO PULA, ACTING ASSISTANT SECRETARY, OFFICE OF INSULAR AFFAIRS

Mr. Pula did not submit responses to the Committee by the appropriate deadline for inclusion in the printed record.

Question 1. When was the CNMI baseline under the CIP program reduced from $11 million to $9 million and why?

Question 2. How would you say that the amount of funding provided under CIP compares to the infrastructure needs of the Insular Areas? Is it enough to meet the needs?

Question 3. As you know, President Trump is proposing a $1 trillion program to improve our Nation's infrastructure. Naturally, the Insular Areas are hoping that they will be able to benefit from this initiative to finally have some of their long-standing addressed.

Has OIA have done an inventory or assessment of the infrastructure needs of the territories?

Question 4. You mentioned that insular governors are asserting that their capital improvement needs exceed over $1 billion. What accounts for infrastructure projects generally being more costly in the islands? Is it because all project materials have to imported over long distances?

Question 5. Questions have been raised in the past by GAO and others, about internal control weaknesses in insular governments which have led to mismanagement of OIA grants. Do you have a sense of whether such concerns have been corrected? Are you still seeing cases of abuse or fraud in the expenditure of CIP grants?

Question 6. U.S. territories have had a history and culture of using diesel engines to generate energy. This has led to much higher prices delivering energy to residents, $.25 and higher per/kilowatt hour. However, I understand that OIA began an initiative in 2010 to encourage utilizing advanced energy systems to help bring their costs down by burning less fuel and taking advantage of indigenous sources of energy.

Can you comment on whether OIA continues to support its past initiative, how it has assisted our Insular Areas create new energy, and are you able to quantify any savings (past and future) that territories will realize resulting from continuing to pursue advanced energy system solutions?

Mr. LAMALFA. Thank you, Mr. Pula, for your testimony. And again, we thank the panel for all of your participation today, and the effort that it takes to get here and to be prepared for it.

And now, reminding our members of the Committee that there is, under Rule 3(d), a 5-minute limit on questions—we have to live under the same rules as everybody else, as American people. The Chairman will now recognize Members for any questions they may wish to ask the witnesses. And, as I see, our Chairman of the Natural Resources Committee, Mr. Bishop, is here. I would offer you that first shot.

He wants to go last. OK. Also, normally, the Chairman would go first. But, as I know, our Ranking Member has two places to be at one time. I would offer her the first question, and I will go second, if you wish.

Mrs. TORRES. That is very kind of you. Thank you very much, Mr. Chairman. And, once again, thank you to our witnesses for being here.

Mr. Payment, I want to applaud you on the report that you highlighted and entered into the record on tribal infrastructure that your organization, NCAI, recently released. And I wanted to commend you and the staff at NCAI for putting together such a comprehensive document. This is very informative, and I would recommend my colleagues to review it for further information.

I specifically like the connection that you have made, or that the report has made, between the infrastructure of rural America and Indian Country, and how their fate is tied together. I wonder if you could expand more on that, how rural communities and tribes could possibly work together on infrastructure needs. What does that look like? Is it JPAs that must be formed between the two governmental organizations? What is your opinion on that?

Mr. PAYMENT. Oh, I have a perfect example for you. I am glad you asked me that question.

In my community, the last time that we had access to some infrastructural investment dollars a few years back, we acquired additional property outside of the city limits and outside of our existing reservation. And when we first started, we put all the systems in place for wells and septics, and found there was a contaminant, a carcinogen. So, we were doing bottled water for a long time.

Then, we gained access to these infrastructural dollars. We partnered with IHS sanitation dollars, with the city, with the township, and with the county. So, it was a win-win-win-win situation. In doing so, we helped pay down the infrastructure for the city by 20 percent of the time period for their debt retirement; and, in doing so, we did a contractual annex through the township, which

is not easy to do, as you know, in local government. But everybody had a piece of the pie, and everybody benefited from it.

And in our rural communities, that is essential. In the Upper Peninsula of Michigan, we are all rural. In order for us to reach out and provide basic sanitation and sewer to our communities, we have to have those partnerships. So infrastructure, as we look forward for infrastructure investment, anything that can facilitate that kind of cooperation with tribes and local governments and the state to benefit from it, I would encourage that.

Mrs. TORRES. How could we do more of that, encouraging other tribes and local governments to do more of that?

Mr. PAYMENT. I would say create incentives for it, tax bond financing incentives, to collaborate with tribes to do that.

But I also think, while we are requesting specific funding for Indian Country, I think if we build into the infrastructural request incentives for states and local governments to collaborate with tribes; it doesn't happen automatically. And in our community, we have a long-term good relationship with the local community. But I think creating those incentives might facilitate that.

Mrs. TORRES. Rural communities, though, in itself, they don't have, necessarily, employees and the technical expertise to be able to do that. Is there a need to help, in order to bring those two together, to collaborate in projects? Is there a need to increase support for technical assistance for such partnerships?

Mr. PAYMENT. Absolutely. If we limit our talent pool from what we already have, when we know we already do not have resources, then we are unduly limiting ourselves.

So, additional technical expertise to identify need—we are limited in transportation funding and housing funding, based on our collection of data. So, providing technical assistance to bring tribes along to help collect this data—we look like we are going into an era of being able to justify our programs and services and funding. I think that technical assistance is critical.

Mrs. TORRES. I have less than a minute, so let me refer to Ms. Kitcheyan.

Can you expand on how lack of funding for the housing for medical professionals is affecting Indian Country, especially in rural tribal areas?

Ms. KITCHEYAN. There is a lack of housing on the reservation, and many of our rural areas do not have the capability to recruit or retain our health professionals. They drive great distances to come to work, and they——

Mrs. TORRES. Is this another partnership that could be realized between rural communities and Indian Country, to build housing outside of reservations?

Ms. KITCHEYAN. I think tribes need to start looking and thinking outside the box in looking for other funding sources outside of private investors, philanthropy, and different things that could be available to tribes, through building those partnerships.

And these doctors burn out. They work long shifts, and then they have to drive great distances.

Mrs. TORRES. Thank you. My time has expired, I yield back. Thank you, Mr. Chairman.

Mr. LAMALFA. You are welcome. Recognizing myself, let me follow up with Mr. Payment here on what you were just speaking of.

Beyond tax incentives, what other incentives might be available that Congress could consider to be helpful? Yes, Mr. Payment, yes.

Mr. PAYMENT. OK. So new markets and low-income housing tax credits. But specifically, what I am looking for is, in the announcement that we put drivers in place that encourage local municipalities that have their infrastructural needs as well to reach out to and give points and credits toward the infrastructural dollars that might be available.

Again, in some communities, it is not automatic. And I think it is a win-win situation when we bring to bear and we collaborate with local government.

Mr. LAMALFA. All right, thank you.

Ms. Kitcheyan, coming back to some of our earlier testimony, as well, the IHS also maintains a priority list for sanitation facility projects. So, hearing how it has gone with the hospital priority system, are they similar? Do you know? Is that priority list established using a similar methodology or criteria, so to speak, as the healthcare facility construction, which again, we are going back to the 1980s in its establishment and 1990s in implementation.

Ms. KITCHEYAN. We understand that list is to be re-evaluated, but tribes do not have control over that list. So, we look toward IHS to give full consideration——

Mr. LAMALFA. Well, I understand IHS maintains that list for sanitation facilities. But I just wondered, is it the same system, or is it as old a system as the hospital construction priority system that we were speaking of earlier?

Ms. KITCHEYAN. It is a dated system, and it continues to address our real needs. So, along with our data technology, we have a dated system of prioritizing these needs.

Mr. LAMALFA. Well, you say it is a data system, but again, is it the same as the hospital one, or more or less only for sanitation?

Ms. KITCHEYAN. Yes, it is the same.

Mr. LAMALFA. So is it about as——

Ms. KITCHEYAN. The criteria is different, but we will provide some follow-up information to explain the differences.

Mr. LAMALFA. OK. Do you find there is some of the same frustration? Is it as speedy as it is for the hospital construction system?

Ms. KITCHEYAN. It is extremely frustrating, and——

Mr. LAMALFA. OK, all right. I thank you for that.

Last month, the GAO added Indian health on its biannual risk list. What are some of the unmet need impacts for the quality of care being provided at health facilities with that new information?

Ms. KITCHEYAN. What is—excuse me, I don't understand.

Mr. LAMALFA. Well, I said the GAO added Indian health on its biannual high risk list. Can you discuss how the unmet need impacts the quality of care being provided at the health facility?

Ms. KITCHEYAN. Certainly. It is the underfunding of these facilities and these equipments that are leading to the inequality of patient care across America. We have sanitation equipment that is being—we have people washing tools by hand. We have sanitation equipment that is dated and broken. And, rather than the lack of

funding to address those needs, we have facilities who are making their own way. And that is extremely dangerous for the patient, for that infection in the hospital.

And for something as simple as that, I had mentioned unnecessary deaths. This underfunding leads to unnecessary deaths. And it is like a domino effect.

Mr. LAMALFA. What about the Health Information System, the IT system used by IHS? Is that keeping up?

Ms. KITCHEYAN. RPMS is old. I mentioned it is a ticking time bomb. It is more expensive to continue to drag it out than it is to provide the resources to just do away with it. But the technical assistance is not there, the programmers are retiring, and it is just not feasible for tribes to continue to put money into this system with no positive outcome.

Mr. LAMALFA. OK. Thank you.

Mr. Honanie, indeed, natural resources are a very important part of your tribe's economic base and, you know, coal being very important to the tribe's income. What are you facing these days in the further development of coal or other energy possibilities that would be, indeed, an important part of your economic base? What kind of regulations or other infrastructure challenges are there that might be keeping you from developing more?

Mr. HONANIE. Thank you for that question, sir. The current situation is the coal mining on the reservation, the coal is sold to the Navajo generating plant for producing electricity. But with the proposed closure after 2 years, we face this dilemma. And our dilemma and challenge is who do we market this coal to, much less how do we transport the coal from mining area to, say, a railroad to deliver the coal to, say, the West Coast, East Coast, wherever we may have a market for. So——

Mr. LAMALFA. Is the transportation of the coal also impeded by being surrounded?

Mr. HONANIE. The transportation of coal is strictly from the mine to the generating plant at this time.

Mr. LAMALFA. OK.

Mr. HONANIE. It does not go beyond that. So, our thought is that we would need infrastructure, such as a railroad, to be able to mine the coal and to transport the coal to the rail line that runs across northern Arizona to ports where we can export it or sell to other potential customers.

Mr. LAMALFA. OK, thank you. I have blown through my time. I will now recognize our Chairman Emeritus for his 5 minutes of questions.

Mr. YOUNG. Thank you, Mr. Chairman.

Andy, I appreciated your testimony. But in your testimony is that the IHS funding covers approximately only 30 percent operating costs of the villages clinics built in Alaska. Can you describe the impact of that, the underfunding, and how is it made up? Who pays the 70 percent?

Mr. TEUBER. Thank you, Chair Emeritus, for your thoughtful question. The challenges that are confronted in rural Alaska and elsewhere, where funding is lacking for the ongoing operations of these clinics, is one of many challenges. Workforce, transportation

costs, the communications that were referred to by members of this panel of witnesses, all of these things compound and cascade.

When the IHS fails to fully fund the ongoing operations and maintenance of these village-built clinics, for instance, it hampers those communities in the delivery of health care. In many of our communities across the state, hours have to be restricted, the hours of operation, obviously, are important for access to care. The clinics fall into a state of disrepair. The opportunity for improving energy efficiency and effectiveness is lost, and the increasing costs are exacerbated by the ability of these tribes and organizations to recruit individuals who would be working in those facilities.

Many of our clinics across the state have had to close. Basic health services, when they are not provided, compound, and we find that the ongoing costs for delivery of services to individuals who have been precluded from accessing primary care and preventative care services early on in their communities is exponentially higher in treating some of the healthcare disparities and outcomes that we have seen encountered across our state, outcomes like the highest levels of heart disease, cancers, diabetes and pre-diabetes, childhood obesity, many of the behavioral health issues that we are seeing across the Nation, opioid addictions. So, I appreciate your question.

Mr. YOUNG. Well, Mr. Chairman, this all leads up to money. That is really our problem.

But I want to stress, Andy, again. I have a clinic in Fort Yukon. Is that clinic leased to the IHS for the Tanana chiefs, or is that clinic operated by the Tanana chiefs? And how does that work, as far as dollars go? I mean do we just add more money and it gets there, or—who pays for that clinic, when they only cover 30 percent?

Mr. TEUBER. Yes, thank you for your question. Oftentimes, and in Fort Yukon, the communities end up owning facilities that they end up leasing to the Indian Health Service. The Indian Health Service then reserves those facilities for the use and occupancy by providers that are either direct service or self-governance individuals who provide those services within those communities.

So, in Fort Yukon and across the state, when village-built clinic leases are in the $1,000- to $2,000-a-month range, and the cost of fuel exceeds $3,000 or $4,000 a month, the community has to find ways to just keep the heat on and the lights on.

So, the problem is 10-fold when it comes to the deterioration of those communities' clinics; and so the answer, as you have stated, is money, and that if the tribes and tribal organizations that operate these clinics had more resources, then they could do a better job delivering sufficient health care.

Mr. YOUNG. Mr. Chairman, I suggest to staff—remember, the President does not write the budget, we do. And I think we have a responsibility to make sure that the Indian Health gets some money. We all should work for that, so we can take care of some of these problems, because we do have a responsibility, a trust responsibility to make sure it works.

I want to thank the panel and thank you, Mr. Chairman.

Mr. LAMALFA. Thank you, sir. I appreciate it. We now recognize Ms. Bordallo for 5 minutes.

Ms. BORDALLO. Thank you very much, Mr. Chairman. And I would like to congratulate you on your leadership role with this Subcommittee, and also our Ranking Member, who had to leave, and to our witnesses for being here.

The territories face unique challenges when dealing with infrastructure projects and the needed resources. And many times we are not included in Federal funding opportunities or formulas that do not truly recognize our needs.

Further, I would like to point out our distance from the U.S. mainland. And I have five Members here this morning, including our esteemed leader, Mr. Bishop, and American Samoa—I think she just stepped aside—and Ms. Puerto Rico, and the CNMI, and Guam. We all traveled there on a CODEL. Very interesting. We visited all the territories, and so forth. But they can attest to the long distance. And this makes it difficult to source needed materials, and often we are forgotten when it comes to funding.

Additionally, due to our local workforce, it is not being sufficient among our own labor, so we have to rely on foreign labor to supplement these workforce challenges. And I will just let you know that Guam is about—Guam and CNMI—approximately 9,000 miles from the mainland. So, all of this contributes greatly to increased cost of our infrastructure.

As Guam's representative, I have worked to have Guam and the other territories treated equitably in Federal funding opportunities. But it has been inadequate. And I am even more concerned with findings by the OIA that, out of about $80 million in Federal infrastructure funding available to the territories, only about $20 million was utilized last year. And that is including all of us—I mean the $20 million divided among all of us. And at a time when our governments are financially strained, those resources could have been used for capital improvement projects that have been stalled, due to lack of funding.

For example, Guam's only commercial port is endeavoring to expand its capabilities, but lacks a dedicated funding source that TIGER grants have been insufficient in providing. Additionally, Guam's public auditor recently reported that on Guam agencies spend about $14 million per year in renting space.

So, I hope that the OIA and Federal partners will provide further guidance and assistance to territories, so that we can better utilize Federal opportunities. I do appreciate the small increase that Guam received from OIA's CIP grant program, and let me explain that. Twenty-eight million dollars was allocated. Guam received $6 million. And, with that increase last year, only $900,000. Very small. But again, I think we are utilizing a disproportionate share of resources available to us.

I have a question for Mr. Pula. Mr. Pula, as I noted, Guam's challenge is that many of our infrastructure projects have been lacking funding for years and years. And, aside from much-needed upgrades to our port, for example, there are several uncompleted bridge and road projects in southern Guam that make it nearly impossible for normal traffic flow. It is a safety hazard, a quality of life issue, and an environmental liability.

So, my question is how is the Department of the Interior working within the Administration to consider funding for the territories,

and ensure that we are included in increases in funding, as the Trump administration plans much, much more money for infrastructure?

Mr. PULA. Thank you, Congresswoman. You are absolutely correct about the needs and the demands in the U.S. territories for years, and the limited funding that the Department has in the CIP program, with the Office of Insular Affairs.

To respond to your questions, as I had mentioned in my testimony, the governors of the four territories have submitted their list, and it is about $1 billion of their needs for infrastructure. With the new Administration's notion on infrastructure increase, it is too early to say anything about how that is going to develop. But we are working within the Department, and also with the list provided by the governors. Hopefully, as time goes on and it is fleshed out, we will be able to do some work in that regard for the territories.

Ms. BORDALLO. Well, my only answer to that is I hope that your voice is going to be loud and clear for the territories, Mr. Pula.

Mr. PULA. We will do our best.

Ms. BORDALLO. Mr. Chairman, I have a second round, but I am going to give the others an opportunity.

Mr. LAMALFA. All right. Thank you, Ms. Bordallo. Recognizing now our new Vice Chair of the Subcommittee, Ms. González. Congratulations, as Vice Chair.

Miss GONZÁLEZ-COLÓN. Thank you, Mr. Chair. Buenos dias to the people of Puerto Rico.

I have a question to you, Assistant Secretary Pula. What is the estimated total cost of the capital improvements needed in the U.S. territories?

Mr. PULA. I am sorry, I missed—total cost of?

Miss GONZÁLEZ-COLÓN. Of the capital improvement needs in all territories.

Mr. PULA. Oh, in all the territories? As I mentioned, the list that we have just received from the four governors—not including Puerto Rico, of course, because it is not under our auspices—is over $1 billion.

I recall, over 20 years ago, the Army Corps of Engineers did an assessment of infrastructure needs of the territories at the time, and it was around, over $600 million. So, just to answer your question, now it is up.

Miss GONZÁLEZ-COLÓN. Can you provide a list of those requirements from the governors to this Committee?

Mr. PULA. We can.

Miss GONZÁLEZ-COLÓN. In your statement, you say that the capital improvement projects program has two goals. One, assist the territorial governments with the infrastructure funding, and to encourage improved financial management by territorial governments. Are there any aspects of the program that need improvement?

Mr. PULA. With the notion that we—in 2005 we began to have categories because, as I mentioned, we only have $27.7, or approximately $28 million of mandatory funding for the CIPs. So, historically, because CNMI and American Samoa are the smaller communities and Guam and the U.S. Virgin Islands have better economic activities and are much larger, we provided about $9 or

$10 million for American Samoa and CNMI, and the rest divided between Guam and the U.S. Virgin Islands.

Now, when we developed the categories to assist them, within the baseline that we usually set every 5 years a territory could improve their financial management, in terms of getting their single audits clean, providing in time, so that the other Federal agencies will also benefit, especially that they don't get a high risk, and then the improvements of their financial systems. Those are the two categories we looked at, and we kind of score. So, a territory can go between $2 million up or $2 million down, based on these categories, as we do the scoring.

Miss GONZÁLEZ-COLÓN. So, besides money, you don't need anything from this Committee?

Mr. PULA. Oh. Well, as the Chairman Emeritus said, I think everybody here needs money.

Miss GONZÁLEZ-COLÓN. Yes, but besides that.

[Laughter.]

Mr. PULA. Well, along with—I think, as one of my colleagues here on the panel mentioned, it is not just the infrastructure. The economic bases of Indian Country, as well as the territories, thrives on this infrastructure in many ways.

For example, when the incentives have been taken away, for example, the tax incentives like section 936, and these kind of things, therefore the territories miss those opportunities to kind of have their activities. In the CNMI—well, actually, in the Virgin Islands, with the rum fund that they receive, with that economic activity in that island, that really helps them. And when the other territories don't have as much of economic activity, it doesn't really help them.

So my point about the infrastructure, because it really helps companies' economic activity to move, and the tax base start to increase, so that they can help themselves in having funds to build these things.

Miss GONZÁLEZ-COLÓN. If you have any direct recommendation of those possible amendments, I would be more than glad to have them here.

Mr. PULA. Thank you. We would be happy to do that.

Miss GONZÁLEZ-COLÓN. And one last question.

Mr. PULA. Sure.

Miss GONZÁLEZ-COLÓN. I am just curious. You mentioned the restoration of Fort Christian on St. Thomas, the fort that has been designated a national historic landmark in 1977, and that received Federal money to their restoration. I am just wondering. We have La Fortaleza in San Juan, Puerto Rico, which is a 477-year-old building that was also designated as a national historic landmark in 1960.

I am just curious, if La Fortaleza would qualify for capital improvements grants as restoration at Fort Christian in the U.S. Virgin Islands, can we compete on that?

Mr. PULA. Puerto Rico is under——

Miss GONZÁLEZ-COLÓN. I know that part.

Mr. PULA [continuing]. The White House——

Miss GONZÁLEZ-COLÓN. I know, but both parks are national historic landmarks.

Mr. PULA. Yes.

Miss GONZÁLEZ-COLÓN. So that is the question here.

Mr. PULA. Well, the only problem there—well, for Puerto Rico—is because the mandatory funding that the Department of the Interior has is just for the four territories.

Mr. LAMALFA. I will have to ask you to——

Miss GONZÁLEZ-COLÓN. Thank you. I yield back.

Mr. LAMALFA. We can do a second round of questions here in a little bit, if Members wish.

I would like to recognize Mr. Sablan now for 5 minutes.

Mr. SABLAN. Yes. Thank you very much, Mr. Chairman. Before I start, I would like to submit additional questions for Mr. Pula, because I do have a lot of questions. I appreciate it.

And thank you. Your timing for this hearing is actually perfect. The President promised a $1 trillion infrastructure program in his address to Congress last week. Now our job is to make sure that the U.S. Insular Areas and Indian Country, the tribal communities, participate fully in the President's plans.

Insular and tribal people are among the Nation's poorest. And the key to raising standards of living and developing our economies is first-rate infrastructure. Today's hearing can establish a strong record for what our infrastructure needs are so that, when the President's proposal is legislated, this Subcommittee will be able to advocate for the islands and the tribes.

For that reason I would like to request, Mr. Chairman, that the record remain open until my governor, Ralph Torres, has had sufficient time to submit his testimony. Notice for this hearing was short. The governor wants his response to be substantive and to reflect the real complexities of the infrastructure needs, so he was not able to provide his views to us today, but he promised that he would do it as soon as possible.

Mr. LAMALFA. [No response.]

Mr. SABLAN. Yes, I need a "without objection."

Mr. LAMALFA. Yes, I understand. So, pursuant to Committee Rules, you are allowed up to 10 days for——

Mr. SABLAN. We will try and get it in in 10 days.

Mr. LAMALFA. OK, thank you.

Mr. SABLAN. Thank you very much, Mr. Chairman. The $27.72 million CIP program that Mr. Pula spoke of originated in the covenant agreement that brought the Northern Mariana Islands and the United States into political union. The funds were meant to help the Marianas "achieve a progressively higher standard of living, and to develop the economic resources needed to meet the financial responsibilities of local self-government." And the money has been instrumental to that economic growth of our islands, and we are very grateful to the American taxpayers for that.

However, over time the money was diverted so that now, in Fiscal Year 2016, the Marianas receive only $9 million, less than one-third of what we agreed to in the covenant, less than one-third of what was promised to the Northern Marianas. The diversion occurred before the Northern Marianas was represented in Congress. Now I think it is time to re-evaluate where that money is going and for Congress to have a role in deciding.

So, Nik, Mr. Pula, the criteria OIA uses to divide up the Marianas covenant funds all have to do with financial management and grant reporting. And I appreciate very much the importance of fiscal responsibility. But, according to EPA, the main island in the Marianas, Saipan, is the only U.S. municipality without 24-hour running water available to residents. To me, that is a serious public health concern.

Don't you think—with a yes-or-no answer—that it is time for us to develop new criteria so that public health and safety needs are prioritized, or at least considered when funds are distributed?

Mr. PULA. [No response.]

Mr. SABLAN. Please. I don't have too much time, Nik. Yes or no?

Mr. PULA. As I mentioned, every 5 years we do that. But based on your question, the Office of Insular Affairs will take that into consideration.

Mr. SABLAN. I appreciate that. That is a yes? OK.

Mr. PULA. Not really, but——

Mr. SABLAN. How about the amount of money, Mr. Pula? The $27.72 million Marianas covenant grant was set up in 1978, nearly 40 years ago. Do you think this annual money is adequate to address the infrastructure needs of today?

Mr. PULA. Well, as I mentioned before, Congressman, the needs are a lot more than the money that——

Mr. SABLAN. So that is a no. Thank you. What would that $27.72 million be today, if we adjusted for inflation?

Mr. PULA. If we adjusted for inflation, that would be approximately around $42 million.

Mr. SABLAN. Thank you. And again, Mr. Pula, every Thanksgiving I write to each Member of Congress, thanking them and the American people for their generosity to the Northern Marianas.

Electricity in the Insular Areas costs about three times the national average. And I am going to a set of questions, but I want to say this one thing to our Native Indian tribes and Native Americans. In another committee I served on, we had a hearing on Bureau of Indian Education schools, and I will tell you this much—I was appalled at the conditions that students in BIA schools were, the conditions their schools were. It was embarrassing. Schools where snow goes to 8 feet, and the heaters do not work. You have schools with not enough desks for students. It is appalling, at the very least. And I am with you. I am with you, sir.

Do we have second round? OK, I will yield for now. Can I take my second round right now?

[Laughter.]

Mr. SABLAN. I am in the groove.

Mr. LAMALFA. You are on a roll, but we will come back to you.

Mr. SABLAN. All right. No, no, thank you.

Mr. LAMALFA. Thank you. I appreciate that, Mr. Sablan.

Mr. SABLAN. Thank you.

Mr. LAMALFA. It is my honor, as the new Chairman of this Subcommittee, to recognize our Chairman of the entire Natural Resources Committee, Mr. Bishop, for 5 minutes.

Mr. BISHOP. Thank you. And you will notice he did not make me go first. There is protocol, right? Inside joke, I am sorry.

Let me ask—let me see how many of these things I can get, a whole bunch of questions. As we now go forward from this hearing in trying to come up with priorities that we are going to submit to the overall approach to things, let me ask a couple of questions.

Let me start with Ms. Kitcheyan, if I can, first. As we are looking at these priorities, would you give equal weight or preference either to replacing facilities or maintenance and repair of facilities? If we have to prioritize, where do we go with that?

Ms. KITCHEYAN. If we had to prioritize, I think we could do more with maintaining what we have at this point.

Mr. BISHOP. Maintenance would take precedence.

Ms. KITCHEYAN. Maintenance. Not with IT, though. IT, we need a complete new infrastructure for IT and telehealth. But in other terms of infrastructure, we need to maintain what we have.

Mr. BISHOP. All right.

Ms. KITCHEYAN. If that is——

Mr. BISHOP. I appreciate that. I realize that there is a priority list with I think 13 projects that have been grandfathered. It is based on—it has been there for decades on data that was decades old, as well.

Maybe, Mr. Joseph, if I could ask you. At one time, it seems to me that Congress has provided at least one creative idea to approach construction. But IHS has never implemented it. From the outside looking in, it seems like there is a culture that they don't really want to be interested in new, creative approaches.

So, beyond funding, should priorities be tailored to each of the different regions to update the requests of tribes in those different regions?

Mr. JOSEPH. Well, using my tribe as an example, I have been on my Council for 14 years. When I first came on Council, I wanted to have a hospital built to replace the old building that used to be a hospital, was built by the Department of War back in the 1920s. When they put us on a historical site, then we kind of got knocked off that priority list. So, it is almost 100 years of waiting.

Our tribe built our own clinic in that area with our dollars, and we never got any kind of staffing change from back in those years when IHS first became the provider.

Mr. BISHOP. So the historic site was one of the problems you had faced, then.

As you look at the 13 remaining projects, do you think they really represent the greatest need?

Mr. JOSEPH. I would say they do. An area facility distribution plan would give every area a pot of money so that we could work on the list. Right now, the Portland area, at the rate that IHS's facilities are funded, would never see a facility in over 30 years. And you know, that causes a really big problem.

Mr. BISHOP. All right. I am going to come back to you on some creative ways we can leverage construction funds. But let me ask a couple other questions.

First of all, I want to follow up on what Miss González was talking about to Mr. Secretary. That fort, San whatever-it-is in the Virgin Islands?

Mr. PULA. In St. Thomas, yes.

Mr. BISHOP. Why are we using CIP funds to do that? That is a Park Service project. Why isn't the Park Service paying for it?

I mean, to me, CIP is not for restoration of Park Service property. That is Park Service property. Why isn't the Park Service funding that restoration?

Mr. PULA. Mr. Chairman, I think it is not a Park Service project. It was a request from the Government of the Virgin Islands——

Mr. BISHOP. Is——

Mr. PULA [continuing]. To use their CIP——

Mr. BISHOP. The fort is not federally owned?

Mr. PULA. I don't——

Mr. BISHOP. And not part of the Park Service? It is part of the Park Service? It is not part of the Park Service.

Mr. PULA. It is not—the one in St. Thomas is not part of the Park Service.

Mr. BISHOP. Who owns it?

Mr. PULA. The local Government of Virgin Islands.

Mr. BISHOP. All right. Then that is a different question, then, again.

Look, I will do this very quickly. Mr. Honanie, are there other barriers to infrastructure development? Specifically, does NEPA pose a problem? Is it an asset to getting those development projects going forward, or are there problems with it in this old law that has never been updated in my lifetime?

Mr. HONANIE. Could you repeat? I didn't quite catch everything, I am sorry.

Mr. BISHOP. Actually, I have 18 seconds. I will come back to you in the next round. But I am asking specifically about how NEPA—does that process provide an asset to you in getting this development, or is it a hindrance. I will let you think about that, because I don't have enough time to do it in this round. I will yield back.

Mr. LAMALFA. All right. Thank you, Mr. Chairman. That concludes our first round of questions for our panel. I am going to go ahead and recognize you, Mr. Chairman, for the first question of the second round.

Mr. BISHOP. All right. Mr. Honanie, how does NEPA help you? Is NEPA a help or a hindrance?

Mr. HONANIE. I think, with regard to rules and regulations, things of that sort, when it comes to health issues and so forth, they are both a hindrance and a help. Hindrance, in terms that it is very demanding, these are very stressful violations that are being imposed upon us; in terms of fines, for example, with regard to our arsenic, that is a hindrance. It forces us to move, it forces us to act.

As far as helping us, it is a way to be able to bring this type of situation to the attention of the Federal Government—for example, to this Committee—in hopes of garnering support, in hopes of being able to raise and bring the capital to the reservation, so that we can resolve such a pressing issue at this time, as well as other matters that may be facing us.

So, it just depends on the situation, the timing, and how long we may have had a situation before us that we have been trying to resolve so many challenges on the reservation.

Mr. BISHOP. All right. I thank you with that.

Mr. Joseph, are there any ideas or ways that the tribes can leverage these construction funds?

Mr. JOSEPH. There is the joint venture project. There are 38 of them that were applied last go-around. Our tribe applied for them, and the price of construction will go up every year. The joint venture is where the tribes build the facility and then the government staffs them.

And, using new market tax credits and working with that, and also utilizing our third-party billing that we are able to generate some of those dollars could also help in funding the projects.

Mr. BISHOP. That would be helpful. Are there other things that the Colville Tribes or tribes in the Northwest have done that are creative to address shortages of construction funding?

Mr. JOSEPH. Well, the joint ventures is one where the tribes would invest their dollars. And looking at how tribes could bill third party, it would generate a lot of added funding with the new market tax credits. The area facility distribution that I talked about would be another way where every area, their tribes would get a pot of that funding.

We are looking at the dental aid therapy program and generating more funding and providing dental services to our area. Our state finally authorized us to do dental aid therapy. And, to me, that will really help a lot.

Mr. BISHOP. All right. I appreciate that. I appreciate the panel being here. Thank you for allowing me to go this time. Mr. Chairman, I will yield back.

Mr. LAMALFA. I will now recognize Ms. Bordallo for a second round of questions.

Ms. BORDALLO. Thank you, Mr. Chairman. And I am very happy that we are recognizing protocol.

[Laughter.]

Ms. BORDALLO. I want to start out by saying, although I and Mr. Sablan here are representing the territories, I do support the needs of all our witnesses today. And I understand your shortcomings in your areas and the needs you have.

As I stated previously, I hope that we do move forward with more investments in our infrastructure, and that the territories will be fully included in these plans, Mr. Pula. Specifically, I hope that any infrastructure bill would also include funding to address access to broadband, and for expanding the IT and telecommunications economies in the territories, which bring enormous socio-economic potential to our islands. And this is critical to Guam, especially since I believe that we should leverage our position in the Asia-Pacific region to be the hub between the United States and Asian countries.

Mr. Pula, has OIA given serious consideration to funding broadband infrastructure needs in the territories? For example—and I am sure you are well aware of this—several years ago, the CNMI was cut off from the internet, which severely and negatively impacted their economy. A potential redundant system is in the works, and that type of project should seem appropriate to be funded out of CIP funds.

So, my question. Will you give serious consideration to funding broadband infrastructure needs to the territories?

Mr. PULA. Thank you, Congresswoman, for the question. I would like you to know that the CIP funding that the Office of Insular Affairs has, we have funded laying of cables and that kind of thing in the past—again, based on the request from the governors. If that is their priority, then it is something that is allowable, or has been done through the CIP funding.

Ms. BORDALLO. So sometimes request and funding do not always——

Mr. PULA. You got it right.

Ms. BORDALLO. So you will do everything you can.

Mr. PULA. Yes, ma'am.

Ms. BORDALLO. Thank you. And I yield back, Mr. Chairman.

Miss GONZÁLEZ-COLÓN [presiding]. Thank you, Ms. Bordallo. At this time we recognize the lady from American Samoa, Mrs. Radewagen.

Mrs. RADEWAGEN. I want to thank you, Chairman González, for holding this hearing today. And I want to thank the panel for being here, especially Acting Assistant Secretary Pula, who has worked closely with my office in the past, to ensure that our island infrastructure needs are being met.

I also want to humbly thank Chairman Bishop for the recent congressional delegation to the territories, where Members and staff were able to witness firsthand some of the unique challenges our islands face in maintaining our infrastructure. American Samoa, in particular, is engaged in a never-ending fight to make sure that our islands are on equal footing as the states and other territories.

A primary example is the LBJ Tropical Medical Center in American Samoa, which remains under-equipped and understaffed, forcing many of our island's residents, especially our veterans, to seek off-island care. That said, the CIP program does help alleviate some of our funding issues, going not only toward healthcare projects, but also education, transportation, and other infrastructure projects. And I would love to see the grant program not only continue, but possibly be expanded.

I am also looking forward to a continuation of the well-executed oversight practices regarding the program. And I am thankful to have colleagues on this Committee, the Department of the Interior, and the local American Samoa government work closely with me and each other to ensure that the CIP grants are utilized to their fullest.

I have a couple of questions for you, Assistant Secretary Pula. Since being designated as high risk by OIA, as recommended by the General Accounting Office and the Office of Inspector General, how has the American Samoa government managed to improve accountability for Federal funds? And can you tell me whether the American Samoa government has completed any of the requirements necessary for compliance in order to remove the high risk designation by OIA?

Mr. PULA. Thank you for the question, Congresswoman. There are a variety of, I guess, high risk. I think the U.S. Department of Education has designated the American Samoa government with the education as high risk.

But your particular question regarding the Office of Insular Affairs, I have to say a lot of the categories, or the things that needed to be done, have been done by the American Samoa government, so there has been improvement there. But there are still some final things that needed to be done, and we have to kind of circle back and work with the government so that we can lift the high risk. At this point we have not completed everything.

Mrs. RADEWAGEN. Thank you. And would you care to comment on what can be done to ensure that American Samoa continues to receive increased CIP funding in the future?

Mr. PULA. Well, as you have heard, the allocation of the CIP funding is made on the basis of competitive criteria, and measured a demonstrated ability of the government to exercise prudent financial management practices, as well as the Federal grants requirements.

The best things for American Samoa that can maximize on the share of the CIP—because this is mandatory funding, so we will continue the program—is to have clean audits, and submitted on time, as well as timely executions of the conditions of the grants, the terms of the grants.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

Mr. LAMALFA [presiding]. Thank you, Mrs. Radewagen. Continuing our first round of questions, I recognize Mr. Soto for 5 minutes.

Mr. SOTO. Thank you, Mr. Chairman. I have the honor of representing Florida up here. And we are home to several major tribes, including the Seminole Tribe, Miccosukee, and others, so we deeply care about these issues. And I just wanted to get a sort of overall view from all the panelists about how should we in Congress decide how and where to fund infrastructure development in Indian Country.

I realize there is a 1992 high-priority list, but it would be great to know if there is a more updated list, and if there is consensus among high-priority infrastructure projects among our various prominent tribes here in the United States.

And it is for the entire panel. We could start from left to right. How does that sound?

Mr. HONANIE. I think one way to address such questions and points is—I wholeheartedly believe that committees such as yourself really consider the idea of coming to the respective reservations and literally seeing who we are, what we have, and what we are facing, the challenges as far as bringing in infrastructure.

Again, I relate to the point that, as far as Hopi is concerned, we are landlocked, surrounded by Navajo, and it is a challenge to bring in any kind of infrastructure onto reservation, because we have to pass through Navajo. It is not an easy task. We have to go practically to court to be able to try this concept of access by necessity.

These are the kind of challenges. And many of the infrastructures that exist currently on the reservation are old, they probably do need replacement. While we do replace them, it is a continual challenge. And the funding, as far as these projects are concerned, are nil, as far as the tribal reserves are concerned. We are very, very isolated, and so we depend on outside funding, we depend on

the Federal Government to be able to come to our assistance, and so forth.

But sometimes many of these issues occur naturally, such as the arsenic situation here in the water. That is a very serious issue. That is an issue that is impacting our health care, our health of the people. And I want to remind you that we have five schools that are affected, one high school, and scores and scores of elderly. And again, young people——

Mr. SOTO. Thank you, Chairman Honanie. I want to make sure we get everybody to be able to——

Mr. HONANIE. All right.

Mr. SOTO [continuing]. Speak a little bit on it.

Chairman Joseph, is there consensus on a list that we could draw from? What would your thought be?

Mr. JOSEPH. What I would recommend is that you look at the current needs that exist. Basic healthcare needs should be projects that should be, I would say, funded first, so that we are able to at least get basic healthcare needs. I would rather have my people getting the basic healthcare needs taken care of, so that we are not being admitted to the hospital later on when it becomes a chronic issue, where we are in emergency care, and it costs the government a whole lot more.

So, if we had the basic medical needs, and had the adequate amount of providers to provide services to our people, we would be able to keep us out of the hospitals. And to me, that is more important. It would save more lives, it would be more preventative-type medicine, but——

Mr. SOTO. Thank you. Thank you, Chairman Joseph.

Representative Kitcheyan, what would you say about consensus and priority?

Ms. KITCHEYAN. From the National Indian Health Board's perspective, the main priority would be meaningful consultation with the over 500 federally-recognized tribes, and to have current data to drive and facilitate that conversation.

Mr. SOTO. And Secretary Payment?

Mr. PAYMENT. OK. So this report, we have taken a stab at it through the National Congress of American Indians, and it is ongoing. I would say be careful not to throw the baby out with the bath, because the existing priority lists were built on criteria based on consultation. So, the only problem is that they are underfunded, and so there is a backlog.

But I would also say to look—be creative, to create match incentives for states. We would like at least $20 billion of that $1 trillion that might be coming. But I would also say look creatively to seed financing, because you are not going to fund everything. And if you can create a way to provide seed financing, so that tribes can go out in a self-determined way to be able to help fulfill their needs, I think that would be something that would be different than what we have done in the past.

Mr. SOTO. Thank you. President Teuber?

Mr. TEUBER. Thank you for your question. I think, with respect to health care, which is much of the area that I have covered, consensus is difficult to achieve in a local community, much more so across the United States with 500-plus tribes. But the area

distribution fund that was referred to earlier is an opportunity for us to ensure that there is some level of equitable distribution of funds for those priorities that exist within each of the regions, or each of the areas.

Also, the sanitation deficiency list that has been created for sanitation projects, I would refer to that, but I would allow tribes to continue to update that as a process for distribution of resources.

Mr. SOTO. Mr. Chairman, at your discretion, would it be OK for the Secretary to comment?

Mr. LAMALFA. Second round, OK? I have to maintain some type of discipline here a little bit, right? Thank you.

All right. Recognizing myself on a second round here, I will back up with Ms. Kitcheyan. Well, first, let me go to Mr. Joseph.

Again, we are talking about, Chairman Joseph, a 30-year-old list that maybe does not necessarily match the needs of today's needs. Should IHS be more active in ensuring that the list is more up to date, especially for you in the Oregon-Portland area?

Mr. JOSEPH. I also serve on the National Facilities Advisory Committee that IHS has, and there we are looking at working on doing that. About 17 years ago, they worked on a master plan for each of the tribes in the United States. So, they have a master plan that showed the needs that would be good for up to 15 years.

To me, I think that if the work group was to work on looking at that, that is where the area facility distribution plan came out of that work group, and it also came up with a fair way to score tribes on facility needs. Before that, there were tribes that had 20-year-old projects that were getting brand-new facilities built by earmarks. That is why they established that work group, to do that type of work.

Mr. LAMALFA. OK, thank you. Updating is needed.

Let me come back to, again, Ms. Kitcheyan—when we were talking about the need for update and more current technology, let's come back to that information system once again we talked about. As you mentioned, I think also, that there is no updating what you have. You need a new system. Tell us about that a little bit, on what that might take. What will it be, cost-wise? What will implementing it look like? How far and wide, if you can.

Ms. KITCHEYAN. It would be $3.5 billion to entirely overhaul the whole system, and it would take time to implement that update across Indian Country, and right now, some of the tribal facilities have gone outside and sought private-sector products. We have huge bargaining power in Indian Country, and if we leverage our resources and our bargaining power, we can really come up with something that would serve all of Indian Country and be of a consistent system that is manageable and would operate in this 21st century healthcare environment.

Mr. LAMALFA. All right, thank you.

Chairman Honanie, coming back to your situation there, when I asked you earlier about your ability to, your main economic core with coal, and the transportation issues you have with that, that is primarily a railroad problem, again, that you need infrastructure upgrades on? Or develop that a little more, please.

Mr. HONANIE. Well, the ideal would be to construct a railroad line to be able to transport the coal once we identify buyers or a

market for it. But again, let me bring up the point that we would have to work with Navajo to cross their reservation onto Hopi. And we are already hearing a little bit of grumbling as that goes. So, this is really going to be a challenge. And if we can be able to sit down and negotiate with them, fine and great. That rail line would certainly add to our ability to create that economic viability, as far as coal is concerned.

Mr. LAMALFA. Are they interested in being a partner on that at all, or is it strictly a right-of-way that you are seeking?

Mr. HONANIE. It would be a right-of-way, and we would need to just market, so that we do achieve the goal of establishing this railroad.

Mr. LAMALFA. OK. A couple of times in the testimony the arsenic issue has come up here. I don't think I heard you recognize what is the source of the arsenic problem in the water?

Mr. HONANIE. We have been told that it is a naturally occurring phenomenon. Because of the groundwater tables, the amount of water that has been pumped, but Mother Nature, in its own way, presents arsenic into the water as time goes. So——

Mr. LAMALFA. Let me follow up on that, then, because, indeed, they changed the arsenic action level a few years ago, federally. The number was a little higher, what was allowable. Then that number was——

Mr. HONANIE. Right.

Mr. LAMALFA [continuing]. Lowered. Was it OK at the higher number, or was it outside of it at either action level?

Mr. HONANIE. Yes, you could say that because the higher number allowed us to be able to move forward and to plan, and so forth. But now that it has been lowered, it really presents a challenge, it really presents this pressing situation that we have to deal with to essentially try to resolve this arsenic issue as soon as possible.

The EPA is certainly keeping a watchful eye on us and, in fact, threatening with daily fines upon a certain point that we reach and do not resolve this matter. So it——

Mr. LAMALFA. Were you in compliance at the old number but not the new number? Do I have that correct?

Mr. HONANIE. The lower numbers are what we are trying to achieve and work with.

Mr. LAMALFA. OK, thank you. I will yield to Mr. Sablan, waiting patiently for that second round.

Mr. SABLAN. Thank you, again, Mr. Chairman.

Mr. Pula, I meant to mention earlier—I wanted to let you know and thank you, that your field representative in the Northern Marianas, the retired Colonel Blanco is free again to come and visit the congressional office, and to discuss issues of mutual benefits to the constituencies of OIA and the congressional office. Apparently, before you, he was put on a leash. But he is again free, and I want to thank you for that.

Electricity in the Insular Areas costs about three times the national average. And in 2014, in Public Law 113–235, Congress directed the Interior Department to establish teams of technical policy and financial experts to develop energy action plans for the Insular Areas. The plans were to include recommendations on how

to lower the cost of electricity. Can you please give me a short update on the status of these plans required by law?

Mr. PULA. Thank you, yes. The office and, of course, the NREL folks have joined together and helped each of the territories come up with their action plans, and—so that has been going forward. And already we have utilized some of the funding for energy projects to be used in the territories already. So, I just wanted to give you that update.

Mr. SABLAN. Well, thank you. And one of the witnesses mentioned earmarks. The last time I read the United States Constitution it says that Congress has the power to control the purse. And yet, here we are discussing—Ms. Bordallo brought up the issue of who decides which capital improvement project gets funded, and it is based on recommendations by the governors. Now, it should be appropriate that it is Congress that decides that, I think.

And, Mr. Pula, in the past—and I was one of the special representatives—we negotiated with the special representative of the President a 7-year capital improvement project plan. And we came to an agreement of $128 million for 7 years. But with the full faith and credit of the United States, we were able to raise $144 million. The timing was just right for the markets. And that investment was—we were able to do projects up front, front-loaded.

And actually, that investment up to today, the Commonwealth Development Authority, who managed some of the funds, are receiving benefits, are receiving the payments for projects that are revenue-generating projects that—and that is a good way. If we could, again, explore a possibility of doing it that way, it probably will be beneficial.

But I want to go back to one more thing. I mention this because the Bureau of Indian Education schools—your office, Mr. Pula, and the Army Corps of Engineers assessed every public school building in the Insular Areas in 2013. I was actually joining them in one of the schools on Saipan. And they were looking for immediate hazards to student safety: the potential for falling concrete, electrocution, and fire system problems. They identified a priority need for $16.7 million to provide a safe environment for students, and a total of $177 million overall for deferred maintenance to schools.

Now, your office, the Office of Insular Affairs, is providing $1 million annually for each Insular Area. At this rate, could you tell us how long it will take to make all the necessary repairs at all island schools? And this is for the Virgin Islands, the Northern Marianas, Guam, and American Samoa. How long, at $1 million a year?

Mr. PULA. Seven hundred years—I am just kidding, sir. I will have to look at that and come back and provide it to the Committee.

Mr. SABLAN. Yes. Mr. Pula, I want to thank you, sir, for the many years of service you have provided the Northern Marianas and, of course, the Insular Areas in your position as Director of OIA. We do not always see eye to eye, but your service, sir, has not gone unnoticed, as well.

We turn to you for so many things, and we appreciate your—please know that I, for one, appreciate your service, and I want to thank you.

And, Mr. Chairman, I yield back.

Mr. LAMALFA. Thank you——

Mr. PULA. Thank you, Congressman. Just to respond to your question about the $1 million a year, based on the program that we participated with the Army Corps, it will take about 44 years, based on this.

Mr. SABLAN. If you give us the $44 million at one time——

Mr. PULA. That would be nice, if we had that.

Mr. SABLAN. But that is for all the territories, not just for us.

Mr. PULA. OK, thank you.

Mr. LAMALFA. Thank you again. Our Vice Chair has no further questions? OK.

Then Mr. Soto, bring it home, if you have any more.

Mr. SOTO. Very briefly, Mr. Chairman, and thank you for your indulgence.

I would strongly encourage you all to update the list, and consensus is the key word. It is already going to be precarious, whether or not we have a large infrastructure bill or not. I believe that consensus gives you all the best shot to really have a chance to get the kind of funding that you are requesting. And, obviously, you all made the case today that the need is there.

I just wanted to ask one question. Are there any legal changes that we would need to make to allow you all to combine your buying power for infrastructure needs such as health care, roads, sewers, et cetera? Or does that legal authority already exist? That is to anybody who feels like they can respond to it.

Mr. JOSEPH. I would recommend that the Congress ask that the IHS Director, I guess, enact what has been asked for in the Indian Health Care Improvement Act to authorize them to move forward with the area facility distribution plan, and also to have the existing tribes that are on the joint venture list, to have that revolve until that list is complete, because that would allow tribes to move forward with building their facilities that are ready. They are shovel-ready, a lot of them.

And, to me, they would be able to move forward if they—out of the 38, only 7 were authorized to move forward. So, the rest of them are just waiting; and the longer we wait, the more it is going to cost. Thank you.

Mr. SOTO. Anybody else? Any legal changes we need to make to allow you all to harness united buying power?

Ms. KITCHEYAN. I would encourage the Committee to empower, and the congressional people to empower our agency, the IHS. They have the relationships with the tribes, the direct service, and self-governance tribes, and it makes sense that we empower IHS to make some of these moves and negotiations on behalf of the patients that they serve.

Mr. PAYMENT. I would say tax-exempt bond financing, qualifying tribes to participate in that; providing seed funding through the agencies, so that they can work with tribes to identify the joint needs; and just to reinforce RPMS. That is something that we are

obligated, through the system, to utilize. Right now, with electronic records, it causes crashes, it is antiquated.

But that is an example of a joint effort and joint buying power that, if we had some incentive to be able to finance through that, we could help participate in finding the solution for that by participating with other tribes.

Mr. HONANIE. I would also like to respond that the Indian Health Care Improvement Act is in existence, and I would like to think that it will move forward. But I think even the question and some of the issues being raised here, that that be taken a look at and embellished or be enhanced, so that issues like this can be addressed accordingly through a legislation appropriately.

So that is why I would like to say. Thank you.

Mr. TEUBER. We have recently enjoyed some successes, both legislatively and judicially, around contract support costs. And we would be remiss if we did not mention that, where support costs are not associated with direct program dollars, those direct program dollars oftentimes are diluted. So, ensuring that legislation and—robust legislation around the contract support cost appropriations is there is important, but also to ensure that our agencies and departments are not returning funds to Treasury that could and should be used for the purposes that they were appropriated.

Mr. SOTO. I yield back, Mr. Chairman.

Mr. LAMALFA. All right. Thank you, Mr. Soto.

With that, we are at the end here. So I, again, wish to thank our witnesses for their valuable testimony and your travel in order to be part of today's Committee hearing. And the Members, for their questions.

If members of the Committee have additional questions for the witnesses, we would ask for you to respond to these in writing. Under Committee Rule 3(o), members of the Committee must submit witness questions within 3 business days following the hearing, and the hearing record will be held open for 10 business days for these responses.

So, if there is no further business, without objection, our Committee stands adjourned.

[Whereupon, at 12:04 p.m., the Subcommittee was adjourned.]

[ADDITIONAL MATERIALS SUBMITTED FOR THE RECORD]

PREPARED STATEMENT OF RALPH DELEON GUERRERO TORRES, GOVERNOR OF THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

Mr. Chairman and members of the Subcommittee on Indian, Insular, and Alaskan Native Affairs, thank you for allowing me to submit testimony for the record on the infrastructure needs and priorities of the Commonwealth of the Northern Mariana Islands (CNMI).

As the Subcommittee of Jurisdiction on the affairs of the Insular Areas, you are well aware of the challenges of creating and sustaining a viable economy in our islands due to geographical isolation and limited economic resources.

Despite these challenges, the Insular Areas, like the CNMI continue to pursue measures to build an economy that can provide for increased standards of living for our people. At the forefront of these efforts continues to be the development and the improvement of our infrastructure.

The CNMI has benefited greatly from the work of the U.S. Department of the Interior's Office of Insular Affairs and the funding provided under the Capital Infrastructure Project (CIP) Program. Most recently, the CNMI has completed the transformation of the former Puerto Rico dump site into a community park that has added a benefit to the CNMI residents and an added attraction to our growing

tourism industry. This project, along with the $4.9 million allocated to replace the HVAC equipment of the Commonwealth Health Care Corporation's hospital on Saipan and the Garapan Water Quality Restoration Project, are notable examples of CIP projects that have greatly contributed to building an infrastructure that can support and sustain a growing population and economy.

In December 2016, I received a message from the National Governor's Association (NGA), who at the behest of then President-Elect Donald Trump's Transition Team requested a listing of the top infrastructure priorities for each of the states and territories for consideration into a national infrastructure investment plan.

Following receipt of that request, I took an earnest look into the immediate needs of the CNMI people and the economy to delineate the most urgent infrastructure demands of our community. The list I provided to the NGA and the Transition Team included five major infrastructure development projects that would allow for economic growth and enhanced public well-being and the resulting list was as follows:

1. Saipan Waterline Modernization Project
2. Saipan Wastewater Facility Modernization Project
3. Power plant Rehabilitation and Modernization Project
4. Saipan International Airport expansion and improvement Project
5. Marpi Landfill Completion Project

The priorities were assembled through conversations with the CNMI Capital Improvement Program Office, the Commonwealth Utilities Corporation, various departments within the CNMI central government and the Commonwealth Ports Authority. Each of these projects is essentially the redevelopment of existing components of the CNMI infrastructure network, which following decades of use, demand large-scale rehabilitation or expansion to keep pace with a growing island community.

I am thankful that the President's Transition Team offered the Territories and Commonwealths of the United States the to opportunity provide input into this important conversation about the state of our Nation's infrastructure. Despite much appreciated Federal assistance throughout the history of the Northern Mariana Islands' relationship with the U.S. Government, we are still a developing economy that requires larger capital investments into our vital, yet aged public infrastructure.

In addition to the development priorities provided to the President's Transition Team, we have other serious concerns, which I believe merits mention. For example, our roads, hospitals, schools and the CNMI's healthcare physical facilities are all in need of attention and improvement in order to continue to provide basic services and improve the quality of life for the citizens and residents living in our islands. Likewise, inter-island transportation is also a tremendous problem and compounds the issues associated with trying to bring growth and economic opportunity to the lesser populated islands in the Northern Marianas.

While we are in the process of developing a comprehensive proposal for consideration on the listed priorities, I respectfully request that we continue to advance the needs and priorities of the U.S. Insular Areas in any future legislation on investments to our Nation's infrastructure.

Geographically isolated populations such as ours are heavily dependent on a stable and reliable infrastructure system. The unfortunate reality is that the CNMI has only just begun to grow from years of deep and persistent economic decline. While in the midst severely reduced economic activity, difficult choices were made in the allocation of very scarce resources. In this environment, maintenance and investment into our islands' infrastructure was deferred, only adding to the need for repair and the costs for doing so today.

However, as Congress may endeavor to move forward with a national infrastructure investment package, I firmly believe, for a relatively small investment compared to the needs of others, together we can build a modern and stable infrastructure network in the CNMI that will usher in possibilities for a diverse and stable economy and will allow us to make dramatic strides toward improving the quality of life for the many American citizens living on our shores.

I thank you for the time you have provided for this important dialogue and for allowing the inclusion of this testimony.