

STATEMENT
OF
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U.S. DEPARTMENT OF HOMELAND SECURITY
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“Evaluating the Response and Mitigation to the COVID-19 Pandemic in Native Communities.”

Submitted
By

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Good afternoon, Chairman Hoeven, Vice Chairman Udall, and distinguished Members of the Committee. My name is Robert Fenton, and I am the Region Nine Administrator of the Federal Emergency Management Agency (FEMA). Thank you for the opportunity to discuss FEMA's response and the actions underway to protect tribal nations during the coronavirus (COVID-19) pandemic.

I would like to begin today by acknowledging and providing my condolences to the families and relatives of the 126,000 Americans who have lost their lives to COVID-19. My thoughts, and those of the men and women of FEMA, are with you.

For the first time in the United States' history, there are 57 concurrent Major Disaster Declarations encompassing every inch of our country and impacting all 574 federally recognized Indian tribes: from the native villages of Alaska, to the pueblos of the Southwest and the tribal communities of the Northern Plains, Mississippi Valley and Eastern Seaboard. The scale of this historic event has required FEMA to adapt its response practices and workforce posture in order to both respond to COVID-19 and simultaneously maintain mission readiness for more common disasters such as hurricanes, earthquakes, floods, or wildfires.

Regardless of the challenges that FEMA continues to confront, the bedrock of our mission remains constant: helping people before, during, and after disasters. Although—and indeed because—COVID-19 has changed our daily lives and the scope of its impact is unprecedented, the Nation is counting on us to accomplish our mission and we will do so in accordance with our core values of compassion, fairness, integrity, and respect. FEMA will continue to leverage the Whole-of-Government response to serve all of America.

Engaging with sovereign tribal nations is a key component of this Whole-of-America response, and overcoming the unique challenges confronting tribes has been a strategic prioritization for FEMA from the beginning of the response to the pandemic. Many tribes are in locations with limited transportation, medical, and communications infrastructure which can complicate response efforts during any disaster. Within the context of COVID-19, social determinants of health and disproportionate percentages of chronic illnesses combined with these infrastructural limitations to create particular challenges for potentially at-risk tribes.

In direct reflection of the magnitude of this historic event, FEMA's unprecedented support for tribal governments is measured beyond financial support or the distribution of personal protective equipment (PPE). FEMA's response has served to stabilize lives in the most fundamental ways. For example, when the shelves of grocery stores became barren and members of two tribes in New York were unable to purchase scarce supplies, FEMA's emergency food distribution services were able to fill that critical void. This is one simple example of FEMA's understanding that emergency management is about putting people first – both the disaster survivors we serve and those who serve them.

FEMA Headquarters and FEMA Regional Offices have provided expanded services in support of tribal governments across the country in response to the pandemic since the National Emergency Declaration was declared on March 13, 2020. Each of the ten FEMA regional offices have dedicated Tribal Liaisons within their workforces to coordinate with tribes located in that respective region. Regional Tribal Liaisons and Regional Administrators serve as the primary point of contact regarding FEMA assistance, and serve as the conduit to connect tribes with FEMA leadership and program subject matter experts, as needed, for information sharing, technical assistance and resource coordination. As part of these efforts, FEMA Regions, with the support of our federal partners, have hosted weekly meetings and conference calls with tribal leaders and tribal emergency managers to answer any of their questions during this pandemic response. In Washington, D.C., FEMA has a dedicated, permanent National Tribal Advisor Desk that further supports coordinated federal response efforts to support tribes during any major disaster or emergency activation within FEMA's National Response Coordination Center (the NRCC) – which is located in FEMA Headquarters. The NRCC has served as the fulcrum for coordinating the federal interagency response to the COVID-19 pandemic. The NRCC Tribal Desk, as is commonly referred to, was activated on March 15th and has been staffed every day to support response and recovery efforts.

Today's testimony will offer an overview of FEMA's response efforts and strategies for COVID-19, the types of assistance we have provided, and the ways in which FEMA has augmented the leading efforts of our federal partners at Health and Human Services (HHS), including the Indian Health Service (IHS), to protect the lives of tribal citizens.

Overview of FEMA's Support for Tribal Partners

Public Assistance Category B

On March 13th, 2020, President Trump declared a nationwide emergency pursuant to section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). As a result, FEMA's involvement in the federal response was vastly expanded. As part of this unprecedented nationwide declaration, all state, local, tribal, and territorial (SLTT) partners became immediately eligible for FEMA Public Assistance (PA) Category B, emergency protective measures as authorized by section 403 of the Stafford Act and funded by the Disaster Relief Fund. Such assistance includes, but is not limited to, funding for tribal medical centers, Alternate Care Facilities, non-congregate sheltering, community-based testing sites, disaster medical assistance teams, mobile hospitals, emergency medical care, and the transportation and distribution of necessary supplies such as food, medicine, and personal protective equipment (PPE).

Subsequent to the President's emergency declaration, all 50 states, five territories, the District of Columbia, and the Seminole Tribe of Florida have been approved for Major Disaster

Declarations. As a direct result of every single state receiving a Major Disaster Declaration, every single tribal government in the country became covered by a Major Disaster Declaration.

To provide flexibility, tribal governments have parallel paths through which they can seek assistance from FEMA. They can either request to be direct recipients under the nationwide emergency declaration, or they can seek assistance as a direct recipient or subrecipient under a State's Major Disaster Declaration. Tribal governments also have the option to request a specific Major Disaster Declaration directly to the President through FEMA. Regardless of the way in which tribal governments pursue FEMA assistance, FEMA Regional Offices and their Tribal Liaisons are available to provide technical assistance.

In total, FEMA is working directly with 85 tribes under this framework including partners such as the Hidatsa and Arikara Nations of North Dakota, the Choctaw Nation of Oklahoma, and the Mashpee Wampanoag Tribe of Massachusetts. In keeping with the Stafford Act, FEMA allocates funding to cover 75 percent of costs, and tribal governments are responsible for the remaining 25 percent.

Cost Share Adjustments for Public Assistance Category B

Many state and tribal governments have requested adjustments to the 75:25 cost-share ratio due to the economic hardship and loss of tax revenue associated with the COVID-19 pandemic. As of June 25th, 42 states and 28 tribes have requested a cost share waiver. The Stafford Act authorizes the President of the United States to make cost share if warranted.

Tribal government recipients may request cost share adjustments from the President through their FEMA Regional Administrator.

FEMA will then make a recommendation to the President regarding the request and the President has the authority to make final cost share adjustment determinations.

When federal obligations meet or exceed \$149 per tribal member FEMA will recommend the President increase the federal cost share from 75% to not more than 90%. As part of this calculation, FEMA will use a tribal government's population on or near tribal lands, as reported by a tribal government, to determine per capita obligations for each tribal government that makes a request. FEMA also considers qualitative factors such as the historical context of recent disasters within the specified area.

CARES Act Funding for Cost-Share Considerations

To help tribal governments affected by COVID-19, the Department of Treasury recently announced that Coronavirus Relief Fund dollars, provided under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, may be used to pay for FEMA's cost share requirements under the Stafford Act. This is yet another example of increased flexibilities offered to tribal governments to nimbly respond to and recover from COVID-19.

Managing Critical Shortages: FEMA Resource Distributions to Tribal Partners

On March 19th, FEMA's role in the pandemic response changed. Under the direction of the White House Coronavirus Task Force, FEMA moved from playing a supporting role in assisting the U.S Department of Health and Human Services (HHS), which was designated as the initial lead federal agency for the COVID-19 pandemic response, to leading the Whole-of-Government response to the COVID-19 pandemic.

From the outset, a key element of FEMA's response has been managing shortages of medical supplies needed to combat the pandemic, such as PPE, ventilators, swabs, and the chemical reagents required for testing. This effort alone has presented a historic challenge for FEMA and its federal partners such as IHS and HHS. COVID-19 has been a global crisis—leaders across over 150 countries have simultaneously been competing for the exact same medical supplies. We have been further challenged as most of the manufacturing for PPE occurs in Asia, where the virus significantly slowed down private sector production capabilities.

Concurrently, American medical professionals on the front lines of the pandemic have required an exponentially greater volume of PPE and other medical supplies. On average, the United States began consuming a year's worth of PPE in a matter of weeks. FEMA worked closely with HHS to ensure that locations in danger of running out of supplies within 72 hours received lifesaving equipment from the Federal government's reserve within the Strategic National Stockpile (SNS), as administered by HHS.

Many of the earliest shipments to tribal governments and IHS originated from HHS's SNS. From the beginning, FEMA and HHS understood and acknowledged that the SNS alone could not fulfill all our Nation's requirements. The SNS was never designed or intended to fully supply every state, territory, tribe and locality in the United States concurrently, and cannot be relied upon as the single solution for pandemic preparedness. It was principally designed as a short-term stopgap buffer to supplement state and local supplies during an emergency.

Expedited international shipments within Project Airbridge facilitated by FEMA's Supply Chain Stabilization Task Force helped to supplement IHS and tribal nations' PPE or medical needs until global supply chains could begin to stabilize. Once flown in via the Air Bridge, 50 percent of the supplies on each plane were sent by distributors to customers in areas of greatest need, such as hotspots within the Navajo Nation.

Although FEMA was never intended to be the primary source of supplies for any entity, our Agency was able to augment the vast donations and supplies distributed through our partners at HHS and IHS. In addition to our federal partner donations, FEMA facilitated the distribution to tribal governments of 19,400 boot covers. 13,755 coveralls. 65,204 face shields. 1,276,800 gloves. 32,000 goggles. 15,000 KN90 masks. 139,670 KN95 Respirators. 397,030 N95 Respirators. 107, 911 gowns. 1,825 Powered Air Purifying Respirators. 1,506 surgical gowns. 120,450 surgical masks and 1,200 Tevek headcovers.

In addition, FEMA distributed more than 26,880 meals and 17,136 bottles of water to tribal communities and constructed five Alternate Care Facilities, in partnership with the U.S. Army Corps of Engineers, to assist the San Carlos Apache Tribe, Hualapai Tribe, and Navajo Nation.

An Example: FEMA Support for the Navajo Nation

I do not need to remind the Members of this Committee that the breadth of challenges facing Indian tribes and Alaska Native Villages are as diverse as the United States itself. For example, certain tribes within the Yukon territory of Alaska must deal with the difficulties of being entirely inaccessible by roads and overcome the consequential challenges of receiving medical aid by small boats or aircraft. Conversely, other tribes in the continental United States must adapt to the difficulties of being directly accessible by major highways, and the exponentially increased risk of exposure to COVID-19 brought by international travel. To best exemplify the ways in which FEMA has been able to assist tribal governments and their wide variety of needs, I would like to share our experiences in supporting one of most impacted tribal nations within my jurisdiction: the Navajo Nation.

Similar to the challenges faced by other tribal nations across the country, limited medical infrastructure and high rates of chronic illnesses combined to create a vulnerable demographic amongst the Navajo Nation. To further complicate matters, the Navajo Nation is spread out across Arizona, New Mexico, and Utah. Consistent with other aspects of the COVID-19 response, a key component of FEMA's efforts to protect the lives of the Navajo Nation was close coordination with our federal and state partners as part of the Whole-of-Government response.

To address the immediate shortages of PPE needed to support medical workers on the front line in the Navajo Nation, FEMA and HHS worked together to deliver critical PPE such as 159,000 N95 masks, 111,000 gloves, 30,000 face shields and 18,000 Tyvek suits. As part of the Whole-of-America response, FEMA and HHS were able to further augment these shipments to the Navajo Nation by facilitating donations of 102,967 gowns and an additional 30,500 gloves. To address ventilator shortages, FEMA and HHS also facilitated the delivery of 50 ventilators to Navajo Area IHS and 100 ventilators to the State of Arizona, to be available to tribal nations, as needed.

Experience has demonstrated that emergency management is most effective when federally supported, state or tribe managed, and locally executed. As such, FEMA and Arizona State

Health mission sent a Disaster Medical Task Force to Tuba City Regional Health Care, which provided subject matter expertise and other assistance. Furthermore, FEMA has deployed an incident management assistance team to support the Navajo Nation led response through joint planning, operations and logistics at the Navajo Nation Health Command Operations Center.

Testing is also an important aspect of the strategy to combat COVID-19 within the Navajo Nation. In keeping with lessons learned elsewhere in the country, FEMA supported HHS efforts to prioritize rapid testing for at-risk populations within the Navajo Nation. Prioritizing the limited number of rapid tests for populations with underlying health considerations was key to facilitating a rapid response and the strategic distribution of scarce supplies. COVID-19 diagnostic platforms with longer turnaround times were found to be more appropriate in situations with lower risk of rapid spread and escalation. Rapid testing, as supported by HHS, IHS, and FEMA, has allowed for increased diagnostic screenings above the national average.

In addition to FEMA's traditional role, we worked in nontraditional ways as well. Through our relationship with the Department of Homeland Security HQ, we deployed a "Tactical Technical Assistance Strike Team" into the Navajo Nation during the peak of the crisis there. This team not only helped with the traditional response, but also vectored nontraditional NGO partners like The World Central Kitchen and Community Organized Relief Effort into the Navajo Nation.

Lastly, understanding that emergency management practices must put people first, FEMA deployed a six-person Incident Support Base (ISB) team to support staged commodities, if needed or requested by the Navajo Nation. FEMA staged four 52-foot trailers with cots, blankets, water, and meals.

I commend our partners at HHS and IHS for working with the Navajo Nation and using this experience to prepare for future emergencies. For example, IHS is working with the Centers for Disease Control and Prevention, also within HHS, and the Navajo Nation to recommend solutions, identify resources and begin implementing plans to expand water access on the Navajo Nation. These actions will potentially assist in reducing the spread of the illness and lessen the burden on the Navajo Nation's health care delivery infrastructure.

Conclusion:

As the Regional Administrator of an area that serves 157 tribal governments, including the Navajo Nation, I am acutely aware of how critical FEMA's work is to the lives of Indian tribes, and I, and the entire FEMA team, am committed to ensuring we address the critical needs of tribal members during this challenging time.

Finally, I would also like to recognize the men and women of FEMA, as well as our partner departments and agencies for their adaptability, hard work, and endurance during this unprecedented response and express our appreciation to Congress and the President for providing FEMA with the necessary resources to meet very complex mission requirements and conditions.

This historic and unprecedented response will continue to require a Whole-of-America effort, and FEMA looks forward to closely coordinating with Congress as we work, together, to protect the health and safety of the American people during the COVID-19 pandemic.

Thank you for this opportunity to testify. I look forward to answering any questions that you may have.