National Indian Health Board

Testimony submitted by the National Indian Health Board
The Disproportionate Impact of COVID-19 on Communities of Color
United States House of Representatives
Ways and Means Committee
June 10, 2020

Chairman Neal, Ranking Member Brady, and Members of the Committee, thank you for holding an important hearing on May 27, 2020 to discuss the disproportionate impacts of COVID-19 on communities of color. On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign Tribal Nations we serve, NIHB submits this testimony for the record.

The recommendations outlined in this testimony encompass critical policy needs to help protect and prepare American Indian and Alaska Native (AI/AN) communities in response to the current COVID-19 pandemic. These are necessary for the Indian health system to be fully functional to address the pandemic and other related critical health care priorities. NIHB has identified several policy priorities within the jurisdiction of the Committee that we urge you to address:

1. **Ensure Parity in Medicare Reimbursement for Indian Health Care Providers**

2. **Include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to IHS, Tribal, and Urban Indian Health Programs**

3. **Expand Telehealth Capacity and Access in Indian Country by Permanently Extending Waivers under Medicare for Use of Telehealth and Enacting Certain Sections of the CONNECT to Health Act**

4. **Pass H.R. 6448 – Indian Health Service Health Professions Tax Fairness Act of 2020 – which would make the IHS Scholarship and Loan Repayment Program Tax Exempt**

Background

Each department and agency of the United States federal government has trust and treaty responsibilities to AI/AN Tribes and Peoples. These responsibilities were established through over 350 Treaties between sovereign Tribal Nations and the United States, and reaffirmed in the United States Constitution, Supreme Court case law, federal legislation and regulations, and presidential executive orders.

Congress further reaffirmed the federal trust responsibility under the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) when it declared 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 to effect that policy."

It is essential to remember that these obligations exist in perpetuity. As such, the federal government must ensure that Tribes are meaningfully and comprehensively included in congressional COVID-19 response package.

While we appreciate the resources allocated for Indian Country thus far – including the $1.032 billion appropriated to Indian Health Service (IHS) under the CARES Act, and the additional $2.1 billion proposed under the House-passed HEROES Act – it is clear that these resources are insufficient to fully stem the tide of this pandemic in Indian Country. In particular, there are critical Medicare, telehealth, and tax-specific priorities that we urge the Committee to include in pandemic response packages that are discussed in further detail below.

Underlying Factors Placing AI/ANs at Higher Risk for COVID Disparities

American Indian and Alaska Native people are disproportionately impacted by health conditions that the Centers for Disease Control and Prevention (CDC) has specifically identified increase the risk of a more serious COVID-19 illness. Among these are heart and lung disease, diabetes, and respiratory illnesses. Among AI/ANs 18 years of age and over, rates of coronary heart disease are 1.5 times the rate for Whites, while rates of diabetes among AI/ANs in the same age group are nearly three times that of Whites. Studies have shown that AI/ANs are also at increased risk of lower respiratory tract infections, and in certain regions of the country are twice as likely as the general population to become infected and hospitalized with pneumonia, bronchitis, and influenza.

The COVID-19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID-19, the Indian health system was beset by an average 25% clinician vacancy rate[1], and a hospital system that remains over four times older than the national hospital system.[2] Limited intensive care unit (ICU) capacity to address a surge of COVID cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services. Overall, per capita spending within IHS ($3,779) is at only 40% of national health spending ($9,409), making IHS the most chronically underfunded federal health care entity nationwide and thus severely ill-equipped to respond to COVID-19.

For example, while CDC has noted that hand-washing is the number one way of protecting against a COVID-19 infection, water and sanitation infrastructure in Indian Country is significantly underdeveloped. Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.[3] In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of "honey buckets" that are disposed in environmentally hazardous sewage lagoons.

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[1] Government Accountability Office (GAO-18-580). https://www.gao.gov/products/GAO-18-580

[2] Indian Health Service. 2016. IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

[3] US Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States_DIGITAL.pdf

Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households *roughly 71 times higher* than the cost of water in urban areas with municipal water access.[4] In fact, in a new peer-reviewed study of 287 Tribal reservations and homelands, COVID-19 cases were found to be 10.83 times more likely in homes without indoor plumbing.[5]

Health disparities in Indian Country are exacerbated by the chronic underfunding of the Indian health system, and statutory restrictions in access to federal public health funding streams. For instance, per capita medical expenditures within Indian Health Service (IHS) in FY 2018 were $3,779, compared to $9,409 in national per capita spending that same year.

Impact of COVID-19 in Indian Country

As of June 8, 2020, IHS has reported 13,487 confirmed positive cases of COVID-19. As of June 6, there are 12,930 positive cases reported by Indian Health Service (IHS), with the overwhelming majority of positive cases reported out of the Phoenix and Navajo IHS Areas. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribal health programs, which constitute roughly two-thirds of the Indian health system, is voluntary. Reporting by state health departments has further highlighted disparities among AI/ANs.

- In New Mexico, AI/ANs represent roughly 10% of the population, yet account for over 55% percent of all COVID-19 cases.[6]
- In May 2020, Navajo Nation surpassed New York City for the highest COVID-19 infection rate.
- As of this writing, the Oyate Health Center in South Dakota has conducted 348 COVID-19 tests, with 72 confirmed positive case results (20.6%). Of those 72 cases, 30 were reported between May 19 and May 26, representing a 169% increase in cases in Pennington County in just one week.
- In Wyoming as of June 7, 2020, AI/ANs accounted for nearly 34% of all COVID-19 cases statewide despite representing only 2.9% of the state population.[7]
- Similarly in Montana, where AI/ANs constitute about 6.6% of the state population, over 12% of confirmed COVID-19 cases are among AI/ANs.[8]

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[4] Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. *Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society*, *38*(3), 031003. https://doi.org/10.1116/1.5142283

[5] Rodriguez-Lonebear, Desi PhD; Barceló, Nicolás E. MD; Akee, Randall PhD; Carroll, Stephanie Russo DrPH, MPH American Indian Reservations and COVID-19, Journal of Public Health Management and Practice: July/August 2020 - Volume 26 - Issue 4 - p 371-377 doi: 10.1097/PHH.0000000000001206

[6] New Mexico Department of Health. COVID-19 in New Mexico. https://cvprovider.nmhealth.org/public-dashboard.html

[7] Wyoming Department of Health. COVID-19 Map and Statistics. https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-map-and-statistics/

[8] Montana Department of Public Health and Human Services. https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics

- In Oregon as of June 3, 2020 AI/ANs ae experiencing the second highest case rates by population type at 18.8 cases per 10,000 compared to 6.5 per 10,000 for Whites.[9]

Most poignantly, in a new data visualization of COVID-19 case rates per 100,000 by Tribal Nation created by the American Indian Studies Center at the University of California Los Angeles, **it was found that if Tribes were states, the top five infection rates nationwide would all be Tribal Nations**.[10]

Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS, Tribal governments have innovatively found ways of maximizing third party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third party collections can constitute up to 60% of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third party reimbursement shortfalls ranging from $800,000 to $5 million per Tribe, per month.

These funding shortfalls have forced Tribes across the lower 48 and Alaska to furlough hundreds of workers, curtail available healthcare services, or close down clinics entirely. For example, Tribes in the Bemidji Area reported that nearly 20% of their healthcare system and 35% of their government services staff were forced to be furloughed due to revenue shortfalls. Meanwhile, Tribal business closures have compounded the devastation of the COVID pandemic in Indian Country.

Such astronomical losses in Tribal healthcare and business revenue are exacerbating the already disproportionate impact of COVID-19 infections in Indian Country, and are further reducing available resources for Tribes to stabilize their health systems and provide critical COVID-19 and related health services to their communities.

Policy Recommendations

To effectuate more robust and comprehensive access to COVID-19 prevention, control, and response efforts across Indian Country, we urge that the Committee work to pass the following policy priorities:

1. Ensure Parity in Medicare Reimbursement for Indian Health Care Providers

IHS and Tribal facilities are experiencing significant economic disruption and loss of third party revenues, including Medicare billing, as a result of the COVID-19 pandemic. This crisis is exacerbated by the fact that Indian health care providers are not fully reimbursed for the cost of providing Medicare covered services. Unlike other Medicare providers, Indian health care providers do not bill the AI/AN Medicare patients they serve. This means that as a general rule,

[9] Oregon Health Authority. COVID=19 Weekly Report (Published June 3, 2020) https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Emerging%20Respitory%20Infections/COVID-19-Weekly-Report-2020-06-03-FINAL.pdf

[10] University of California Los Angeles. American Indian Studies Center. Coronavirus in Indian Country: Latest Case Counts. Retrieved from https://www.aisc.ucla.edu/progression_charts.aspx

Indian health care providers only receive 80 percent of reasonable charges, and are not paid the remaining 20 percent by their patients. As a result, IHS and Tribal facilities are only being paid 80 cents on the dollar by the Medicare program compared to other providers.

It is essential that Medicare reimburses Indian health care providers in full for Medicare services they provide to AI/AN people, and to ensure that AI/AN people can seek services outside the Indian health system without having to face significant cost sharing burdens they may not be able to afford. The United States has a trust responsibility in perpetuity to provide health care for AI/AN people, and cost-sharing requirements are inconsistent with this obligation. Medicaid exempts AI/AN People from cost-sharing, and Medicare should do the same.

2. **Include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to IHS, Tribal, and Urban Indian Health Programs**

There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country. Because of this shortage, Indian healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists. LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, CSWs, and psychologists do.

Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including tobacco cessation, and medication-assisted treatment (MAT) for substance use disorders. All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead. This deprives Indian Health programs of critically needed federal reimbursement for vital healthcare services to AI/ANs, which is critical to an effective COVID-19 response.

3. **Expand Telehealth Capacity and Access in Indian Country by Permanently Extending Waivers under Medicare for Use of Telehealth and Enacting Certain Sections of the CONNECT to Health Act**

COVID-19 has dramatically increased the need to connect patients to their providers through telehealth for medical and behavioral health services. In response, CMS has temporarily waived Medicare restrictions on use of telemedicine. Yet for many Tribes that lack broadband and/or telehealth capacity and infrastructure, it is not financially feasible to purchase expensive telehealth equipment for a short-term authority. Making the telehealth waivers permanent would ensure that the telehealth delivery system remains a viable option for delivery of essential medical, mental and behavioral health services in Indian Country, and helps close the gap in access to care.

The bipartisan Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 (S. 2741) was introduced in October 2019 and has the broad support of over 100 health organizations. Section 3 of the CONNECT to Health Act would provide the U.S. Department of Health and Human Services (HHS) with the ability to waive certain telehealth restrictions outside of the national emergency context. These are critical authorities to

ensure flexibility in delivery of mental and behavioral care. Section 8 of the CONNECT to Health Act would eliminate originating site requirements with respect to facilities operated by IHS, a Tribe or Tribal organization which make it very difficult to deliver mental and behavioral health care.

Originating site requirements currently mandate that a patient be in a particular location such as a physician's office, hospital, or other specified clinical setting. These requirements prevent AI/AN patients from being able to receive telehealth services in their homes, community centers, or other non-clinical locations. In addition, Sections 4, 5, 7, and 14 of the CONNECT Act affect use of telehealth for mental health services, emergency care, rural health clinics, and Federally Qualified Health Centers (FQHCs); and also expands the list of health professionals who may provide services through telehealth – all of which have immediate and long-term benefits to the Indian Health system.

With the urgent need to maximize telehealth flexibility in response to COVID-19, Tribes strongly recommend that Congress not only permanently extend the existing waiver authority for use of telehealth under Medicare, but to also enact certain sections of the CONNECT for Health Act.

4. Make the IHS Scholarship and Loan Repayment Program Tax Exempt

IHS and Tribal health programs have been dealing with chronic and severe provider shortages that existed long before the COVID-19 pandemic. However, the pandemic is further straining the heavily under-resourced and understaffed Indian health system. According to a 2018 Government Accountability Office (GAO) report, average vacancy rates for physicians, nurses, nurse practitioners, and other provider types across eight IHS regions is at 25%, but stretches as high as 31%. IHS has tried to implement incentives to better recruit and retain quality providers, but lack of competitive salary rates and benefits have inhibited this, among other challenges. These vacancies are leading to more rationed and less accessible care for AI/AN People in response to COVID-19.

The IHS Health Professions Scholarship provides financial aid to qualified AI/AN undergraduate and graduate-level students in exchange for fulfillment of a minimum two-year service commitment at an IHS or Tribal facility. Similarly, under the IHS Loan Repayment Program, health professionals agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding.

However, unlike similar federal loan repayment and scholarship programs like the National Health Service Corps Scholarship and Loan Repayment Program or the Armed Forces Health Professions Scholarship and Financial Assistance Program, the IHS programs are not tax exempt. In fact, up to 20% of IHS appropriations for its Scholarship and Loan Repayment Programs are going towards federal taxes. This translates into less funding to recruit and retain providers, and also disincentives any substantive increases to appropriations for IHS Health Professions.

The COVID-19 pandemic has reaffirmed the urgency of making the IHS Scholarship and Loan Repayment Programs tax exempt. **We urge Congress to enact the bipartisan Indian Health**

Service Health Professions Tax Fairness Act of 2020 (H.R. 6448) introduced by Representatives Gwen Moore and Tom Cole.

Conclusion

The federal government's trust responsibility to provide quality and comprehensive health services for all AI/AN Peoples extends to every federal agency and department. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for those affected with COVID-19 and all of Indian Country. We applaud the Ways & Means Committee for holding this important hearing, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for all AI/ANs, and raises health outcomes.