

**Testimony of the National Indian Health Board
Health Care Inequality: Confronting Racial and Ethnic Disparities in COVID-19 and the
Health Care System
United States House of Representatives
Energy and Commerce Committee
Subcommittee on Health
June 25, 2020**

Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee, thank you for holding an important hearing on June 17, 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. Eliminate the sunset provisions under Section 30106 of HEROES so that removal of the “four walls” Medicaid billing restriction and extension of 100% FMAP to urban Indian organizations are made permanent**
- 2. Authorize Indian Health Care Providers (IHCPs) to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act (IHCA) – called “Qualified Indian Provider Services” – when delivered to Medicaid-eligible American Indians and Alaska Natives**
- 3. Enact Certain Sections of the CONNECT to Health Act**
- 4. Pass the bipartisan H.R. 2680 – Special Diabetes Program for Indians Reauthorization Act – with new authority to allow Tribes and Tribal organizations to receive awards through P.L. 93-638 self-determination and self-governance contracts and compacts**
- 5. Pass the bipartisan H.R. 7056 to fund critical water sanitation projects in Indian Country**

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 Medicaid, public health, and telehealth 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 rate¹, 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

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

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.

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 22, 2020, IHS has reported 17,669 confirmed positive cases of COVID-19 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. According to data analysis by APM Research Lab, **AI/Ns are experiencing the second highest aggregated COVID-19 death rate at 36 deaths per 100,000.**⁶ The Centers for Disease Control and Prevention (CDC) reported on June 6, 2020 that **age-adjusted COVID-19 hospitalization rates among AI/ANs are higher than any other ethnicity, at 194 per 100,000.**⁷ Reporting by state health departments has further highlighted disparities among AI/ANs.

- In New Mexico, AI/ANs represent roughly 8% of the population, yet account for over 53% percent of all COVID-19 cases.⁸

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

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 APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. <https://www.apmresearchlab.org/covid/deaths-by-race>

⁷ Centers for Disease Control and Prevention. COVID-19 Data Visualization. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/data-visualization.htm>

⁸ New Mexico Department of Health. COVID-19 in New Mexico. <https://cvprovider.nmhealth.org/public-dashboard.html>

- As of this writing, the Oyate Health Center in South Dakota has conducted 544 COVID-19 tests, with 114 confirmed positive case results (20.9%). Of those 114 cases, 13 were reported between June 10 and June 16.⁹
- In Wyoming, AI/ANs account for over 30% of all COVID-19 cases statewide despite representing only 2.9% of the state population.¹⁰
- Similarly in Montana, where AI/ANs constitute about 6.6% of the state population, over 13% of confirmed COVID-19 cases are among AI/ANs.¹¹
- In Oregon as of June 17, 2020 AI/ANs are experiencing the second highest case rates by race at 26.3 cases per 10,000 compared to 7.1 per 10,000 for Whites.¹²

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.**¹³

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

⁹ Great Plains Tribal Chairman's Health Board. CEO Update: Oyate Health Center To Host Mass Testing, New Website Launches. <https://gptchb.org/news/ceo-update-oyate-health-center-to-host-mass-testing-new-website-launches/>

¹⁰ 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/>

¹¹ Montana Department of Public Health and Human Services. <https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics>

¹² Oregon Health Authority. COVID=19 Weekly Report (Published June 17, 2020) <https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/DISEASESAZ/Emerging%20Respiratory%20Infections/COVID-19-Weekly-Report-2020-06-17-FINAL.pdf>

¹³ 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

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. Eliminate the sunset provisions under Section 30106 of HEROES so that removal of the “four walls” Medicaid billing restriction and extension of 100% FMAP to urban Indian organizations are made permanent

Currently, IHS and Tribal providers are largely restricted from billing for medical services outside the four walls of a clinic. This means that home visits, telehealth, and other necessary outpatient COVID response services can’t be reimbursed, leading to serious gaps in accessibility of care. In March 2020, in an effort to improve access to services during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) announced that it would not review claims for compliance with the four walls restriction before January 30, 2021. This means that if Section 30106 of HEROES were to be enacted as is, the fix to the four walls restriction would only be in effect for five months. Delaying the four walls issue does not solve it. In addition, there is very little incentive for states to work with Tribes to amend their Medicaid programs for only a five month fix to the four walls issue, especially given the resources that go into that process. However, Tribes and NIHB are vehemently opposed to extending 100% FMAP to non-Indian Health Care Providers (IHCPs) as part of the legislative fix to the four walls restriction.

We appreciate that Section 211 of H.R. 1425 – Patient Protection and Affordable Care Enhancement Act – would make permanent the fix to the four walls billing restriction and extension of 100% FMAP for urban Indian organizations. In addition, the language under Section 211 would ensure that the four walls billing restriction is resolved for both services provided by IHCPs outside the four walls, and those services provided on the basis of a referral. We urge immediate passage of Section 211.

2. Authorize Indian Health Care Providers (IHCPs) to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act (IHCIA) – called “Qualified Indian Provider Services” – when delivered to Medicaid-eligible American Indians and Alaska Natives

Currently, IHCPs only receive reimbursement for health services authorized for all providers in a state. Therefore, although IHCIA authorizes medical services such as long-term care and mental/behavioral services that are crucial for Tribal communities to respond to COVID-19, an IHCP will not be reimbursed for these services if they are not covered by the state Medicaid program. Because of chronic underfunding of IHS, many Tribes utilize third party collections from payers like Medicaid to constitute up to 60% of their healthcare operating budgets. But without the authority to bill for services already authorized under federal law, it is further straining Tribal COVID response efforts.

This provision reinforces the direct relationship between Tribes and the federal government by ensuring that IHCPs are reimbursed at 100% FMAP for all services authorized under IHCIA, at no cost to the states.

3. Enact 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. Pass the bipartisan H.R. 2680 - Special Diabetes Program for Indians Reauthorization Act - with new authority to allow Tribes and Tribal organizations to receive awards through P.L. 93-638 self-determination and self-governance contracts and compacts

According to the CDC, diabetes is one of the highest risk factors for a more serious COVID-19 illness. Diabetes rates among AI/AN people are twice the rate of the national average, placing AI/AN communities at significantly higher risk of contracting a more serious COVID-19 infection. Congress established the Special Diabetes Program for Indians (SDPI) to address high rates of

Type-2 diabetes among American Indians and Alaska Natives. It has worked. SDPI is one of the most successful public health programs ever implemented. Because of SDPI, rates of End Stage Renal Disease and diabetic eye disease have dropped by more than half. In fact, a report from the Assistant Secretary for Preparedness and Response found that SDPI is responsible for saving Medicare \$52 million per year. Despite its great success, SDPI has been flat funded at \$150 million since 2004, and has lost over a third of its buying power to medical inflation.

On top of that, since September 2019, Congress has renewed SDPI four times in short increments of just several weeks or several months. Right now, SDPI is set to expire on November 30, 2022. These short-term extensions have caused significant distress for SDPI programs and have created undue challenges for our patients and community members. They have also led to the loss of providers, curtailing of health services, and delays in purchasing necessary medical equipment due to uncertainty of funding – all while Tribes are also battling the COVID-19 pandemic. A permanent reauthorization with added flexibility for Tribes to receive funds through contracts and compacts would ensure IHS, Tribal, and urban Indian programs have the necessary funds to address diabetes and the increased risk it poses for a more serious COVID-19 illness.

The bipartisan H.R. 2680 would reauthorize SDPI for 5-years at an increase to \$200 million per year. This vitally important bill would provide long-term stability to the program with 5-years of guaranteed funding, and the increase to \$200 million would permit more Tribes to benefit from this life-saving initiative.

However, we urge that new authority be included in H.R. 2680 to allow Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 self-determination and self-governance contracts and compacts. This would permit more local Tribal control over programming, and give Tribes greater flexibility to tailor their programs to the unique needs of their community, thus maximizing the potential for positive health outcomes. Further, allowing SPDI awards to be included in Tribal contracting and compacting agreements would entitle Tribes to more administrative and operational support, including access to Contract Support Costs from the Indian Health Service. Tribal Nations have drafted legislative language that would achieve this goal, and it is included below.

“(2) DELIVERY OF FUNDS.— On request from an Indian tribe or tribal organization, the Secretary shall award diabetes program funds made available to the requesting tribe or tribal organization under this section as amounts provided under Subsections 106(a)(1) and Subsection 508(c) of the Indian Self-Determination Act, 25 U.S.C. § 5325(a)(1) and § 5388(c), as appropriate.”

5. Pass the bipartisan H.R. 7056 to fund critical water sanitation projects in Indian Country

According to the World Health Organization (WHO) and the CDC, the provision of safe water, sanitation, and hygienic conditions is essential to protecting human health in response to the COVID-19 outbreak. Unfortunately, according to the 2018 Annual Report to Congress on Sanitation Deficiency Levels for Indian Homes and Communities, over 31% of homes in Tribal

lands are in need of sanitation facility improvements, while nearly 7% of all AI/AN homes do not have adequate sanitation facilities.

Even more troubling is that roughly 2% of AI/ANs do not even have access to safe drinking water. It is impossible for AI/AN communities to abide by CDC's sanitation and hygiene standards in response to COVID-19 without the necessary water and sanitation infrastructure. It is essential that these funds be made flexible enough to address other related new and existing housing support projects for AI/AN individuals and families. In the same 2018 report, IHS reported that \$2.67 billion is needed to raise all IHS and Tribal sanitation sites to a Deficiency Level 1 classification. If Indian Country is to follow CDC guidelines for disease prevention, there is urgent need for passage of the bipartisan H.R. 7056. This bill would ensure that all IHS and Tribal facilities have the critical funding resources to modernize and construct essential water and sanitation projects.

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 Subcommittee on Health 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.