National Indian Health Board
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Testimony of the National Indian Health Board
Senate Finance Committee Hearing:
COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned
Wednesday, May 19, 2021

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for holding this critical hearing *"COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned."* On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

Background – COVID-19 Flexibilities and Impact in Indian Country

As of June 1, 2021, the Indian Health Service (IHS) reported 197,459 positive COVID-19 cases, with a cumulative percent positive rate of 8.8% across all 12 IHS Areas[1]. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribally-operated health programs, which constitute roughly two-thirds of the Indian health system, are voluntary. According to data analysis by APM Research Lab, AI/ANs are experiencing the second highest aggregated COVID-19 death rate at 51.3 deaths per 100,000. On March 12, 2021, the CDC reported that AI/ANs were 3.7 times more likely than non-Hispanic white people to be hospitalized and 2.4 times more likely to die from COVID-19 infection. Reporting by state health departments has further highlighted disparities among AI/ANs

- According to the Centers for Disease Control and Prevention (CDC), AI/AN People are 1.7 times (70%) more likely to be diagnosed with COVID-19 when compared to non-Hispanic white people.
- According to the CDC, AI/ANs are 3.7 times (370%) more likely to require hospitalization when compared to non-Hispanic white people.
- According to the CDC, AI/ANs are 2.4 times (240%) more likely to die from COVID19-related infection when compared to non-Hispanic white people.
- There have been 6,206 AI/AN deaths related to COVID-19 complications since the pandemic was declared. Nearly 60% of these deaths are from New Mexico, Arizona, and Oklahoma[2].
- In Alaska, 34.8% of the total state's deaths are reported to be AI/ANs[3].
- The disparity in COVID-19-related death rates is not evenly shared across all AI/AN age groups. Young AI/ANs are experiencing the most significant disparities. Among AI/ANs aged 20- 29

[1] Indian Health Service. COVID-19 Cases by IHS Area. https://www.ihs.gov/coronavirus/
[2] National Indian Health Board. May 26, 2021 CDC Provisional Death Report, 6,533 Deaths, an increase of 51 weekly Deaths https://public.tableau.com/app/profile/nihb.edward.fox/viz/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths
[3] National Indian Health Board. May 26, 2021 CDC Provisional Death Report, 6,533 Deaths, an increase of 51 weekly Deaths https://public.tableau.com/app/profile/nihb.edward.fox/viz/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths/May262021CDCProvisionalDeathReport6533Deathsanincreaseof51weeklyDeaths

years, 30-39 years, and 40-49 years, the COVID-19-related mortality rates are 10.5, 11.6, and 8.2 times, respectively, higher when compared to their white counterparts[4].

- Across 23 states, the cumulative incidence rate of laboratory-confirmed COVID-19 infections was 3.5 times (350%) higher among AI/ANs persons than non-Hispanic white persons[5].

Unfortunately, the adverse effects of COVID-19 in Indian Country extend beyond these sobering public health statistics. Collectively, the IHS, Tribal, and Urban health system (known as the I/T/U), has been chronicly underfunded since its inception, and has relied on third-party revenue to stay afloat. Despite its underfunding, Indian Health Care Providers (IHCPs) have found innovative ways to provide quality care, even during the pandemic. The I/T/U system has taken full advantage of the flexibilities that CMS extended, allowing for leverage of new technologies; and recouping what would have otherwise been lost revenue, which is sorely needed.

One key flexibility is the "Four Walls" waiver that is extended through October 2021.This waiver, while not direcetly a result of the pandemic, has been crucial for the I/T/U system in dealing with COVID-19 This extension allows I/T/U clinics to receive the Medicaid 100% Federal Matching Assistance Percentage (FMAP) for services provided to an AI/AN Medicaid Beneficiary at sites outside the "for walls" of a clinic. These external sites can include remote vaccination and testing sites that have been commonplace in the public health emergency and allow treatment in otherwise underserved communities. These ancillary sites for care have long been important to providing quality care throughout Indian Country. Still, once this extension expires, an essential source of revenue for the I/T/U system will be diminished.

Telehealth has proven to be an invaluable tool to provide quality care during the public health emergency, and the flexibilities for its usage and reimbursement have been crucial to its expanded adoption. According to IHS, since initiating telehealth expansion, the agency has experienced an 33-fold increase in telehealth visits[6]. Additionally, the Government Accountability Office (GAO) released a report analyzing the federal response to COVID-19, showing IHS allocated $95 million of the $1.032 billion in total funding received under the CARES Act toward telehealth. While this adoption of telehealth as an alternative to in-person care is useful, much of Indian Country faces structural challenges to leveraging this new technology. Due to a significant lack of broadband infrastructure, only 46.6% of houses on Tribal lands have access to fixed terrestrial broadband at standard speeds established by the Federal Communications Commission (FCC)[7]. Many of our Tribal citizens are unable to access necessary telehealth-based care from the safety of their homes.

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[4] Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3external icon

[5] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169. DOI: http://dx.doi.org/10.15585/mmwr.mm6934e1

[6] Todet, R. A. M. (2021, April 28). IHS expanded telehealth to provide care during COVID-19 pandemic. Indian Health Service Newsroom. https://www.ihs.gov/newsroom/ihs-blog/april2021/ihs-expanded-telehealth-to-provide-care-during-covid-19-pandemic/.

[7] U.S. Department of the Interior. (2020). *Expanding Broadband Access*. Indian Affairs. https://www.bia.gov/service/infrastructure/expanding-broadband-access.

Our Tribal communities have endured a great many pandemics and tragedies in our history. Our people experience significant historical and intergenerational trauma resulting from genocide, forced relocation from our homelands, forced assimilation into western culture, and persecution of our Native cultures, customs, and languages. As a result, AI/ANs experience some of the highest rates of suicide, drug overdose, post-traumatic stress, and mental illness compared to all other races. While Indian Country remains resilient and committed to solutions, the COVID-19 emergency has reignited the historical trauma experienced at the hands of historical plagues such as smallpox and tuberculosis.

Congress reaffirmed the federal trust responsibility for healthcare 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 any congressional review of COVID-19 flexibilities and support. While we appreciate the resources and flexibilities allocated for Indian Country thus far – including the $1.032 billion appropriated to Indian Health Service (IHS) under the CARES Act, the $64 million under the Families First Coronavirus Response Act, the $1 billion under the Consolidated Appropriations Act of 2021, and the $6.094 billion under the American Rescue Plan– these one-time additional funding increases and temporary regulatory flexibilities are not sufficient to stem the tide of decades of underfunding and neglect.

Policy Recommendations

To ensure that the efficiencies in healthcare delivery, put in place as a response to the public health emergency, are built upon and not lost, we urge the committee to pass the following policy priorities.

1. **Amend the Social Security Act to ensure that all services provided through an Indian health care program are eligible for reimbursement at the OMB all-inclusive rate.**

In 2016, CMS issued a Dear State Health Official (SHO) letter explaining that only services rendered within the Four Walls of an IHS or Tribal (I/T) clinic are eligible for Medicaid reimbursement at the all-inclusive rate (100% FMAP). CMS's interpretation means that if a service is rendered *outside* the Four Walls of a clinic by an IHS or contracted provider, the provided health service is not eligible for the same reimbursement under Medicaid. It is common practice within the Indian health care system to use an ancillary site (like a school) or send providers into the community to deliver health care services. In the SHO letter, CMS offered a solution that requires two actions, one by the Indian health program and another by the State Medicaid Agency. If IHS or Tribal clinics want to receive the "clinic" rate for Medicaid services provided outside the four walls, the I/T facilities must first convert to Federally Qualified Health Centers (FQHC). The state also needs to file a State Plan Amendment (SPA) to grant the Tribal FQHCs authority to bill at the "clinic" rate. With CMS approval, the Indian health program can receive the encounter rate, and the state is automatically paid at the 100% FMAP—increasing reimbursement to the I/T clinics while reducing the state's contribution to Medicaid

This presents multiple issues – first, Indian health programs may not want to convert to FQHCs for reasons other than to receive the reimbursement, as the conversion itself is burdensome. Second, not all States

have good working relationships with the Tribes, and if no relationship (or a poor one) exists, the state may not see the benefits of amending its Plan. (One advantage is that Medicaid services to AI/ANs are reimbursed at 100 percent FMAP). Because this reimbursement depends on the state's action, it adds to the uncertainty for the Tribes, and in some ways, undermines the Tribes' status as sovereign governments.

This year CMS authorized an extension to its four walls grace period through October 31, 2021, to allow more I/T clinics to convert to Tribal FQHCs. One can expect that another extension will be requested given the CMS solution's onerous burden. The solution CMS proposed in its SHO letter and subsequent Frequently Asked Questions (FAQs) was only a band-aid. The agency's actions do not sufficiently address the reimbursement parity Tribes seek for delivering Medicaid services in a community-centered way. NIHB and other Tribal Organizations have advocated for a permanent fix to CMS's Four Walls issue for more than three years.

2. **Expand the Medicaid 100% FMAP to Urban Indian Organizations**

The COVID-19 pandemic has created significant financial hardships for IHCPs. While I/T/U clinics receive 100% FMAP for services provided to AI/AN Medicaid beneficiaries, this FMAP does not permanently extend to Urban Indian Organizations (UIOs). In the American Rescue Plan, signed into law on March 11, the 100% FMAP was expanded to UIOs for two years. While this temporary extension is crucial in providing additional federal dollars to UIOs to provide quality care, this FMAP increase must be made permanent to fulfill the Federal Government's trust responsibilities to AI/AN individuals.

3. **Increase flexibility in Medicare Definition of Telemedicine Services.**

COVID-19 has demonstrated the importance of telehealth to increase access to providers during the pandemic. But it has also demonstrated it can increase access to needed primary, specialty, and behavioral health services, particularly in rural areas. The telehealth flexibilities Medicare has made available during the public health emergency should be made permanent to the maximum extent possible. In addition, much of Indian Country is located in rural areas and lacks access to more advanced audio and video real-time communication methods. As a result, Medicare should allow telehealth to be provided through audio-only telephonic and two-way radio communication methods when necessary, and grant maximum reimbursement for services rendered through these modalities.

4. **Expand access to telehealth in the Indian Health System through increased funding and technical fixes.**

Limitations in the availability of AI/AN-specific COVID-19 data are contributing to the invisibility of the adverse impacts of the pandemic in Indian Country within the general public. Senior IHS officials, including Chief Medical Officer Dr. Michael Toedt, have stated publicly that existing deficiencies with the IHS health IT system are inhibiting the agency's ability to adequately conduct COVID-19 disease surveillance and reporting efforts[8]. Lack of health IT infrastructure has also seriously hampered the ability of IHS and Tribal sites to transition to a telehealth-based care delivery system. While mainstream hospitals

[8] Toedt, R. A. M. (2021, May 21). Testimony from RADM Michael Toedt on Examining the COVID-19 Response in Native Communities: Native Health Systems One Year Later before Senate Committee on Indian Affairs. HHS.gov. https://www.hhs.gov/about/agencies/asl/testimony/2021/04/14/examining-covid-19-response-native-communities-native-health-systems-one-year-later.html.

have been able to take advantage of new flexibilities under Medicare for the use of telehealth during the COVID-19 pandemic, IHS and Tribal facilities have not because of insufficient broadband deployment and health IT capabilities. The IHS Tribal Budget Formulation Working Group previously outlined the need for a roughly $3 billion investment to fully equip the Indian health system with an interoperable and modern health IT system. It is critical that Congress provide meaningful investments in health IT technologies for the Indian health system to ensure accurate assessment of AI/AN COVID-19 health disparities and equip IHCPs with the tools to seamlessly provide telehealth-based health services.

5. Permanently Extend Waivers under Medicare for Use of Telehealth

CMS has temporarily waived Medicare restrictions on the 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 delivering essential medical, mental and behavioral health services in Indian Country, and helps close the gap in access to care.

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 Indian Country. We continue to appreciate your dedication to Indian health priorities and remain committed to working with you to protect and preserve the mental, physical, behavioral, and spiritual health of Indian peoples in the future.