National Indian Health Board

June 2, 2020

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
S-230 U.S. Capitol Building
Washington, DC 20510

The Honorable Charles E. Schumer
Minority Leader
U.S. Senate
S-221 U.S. Capitol Building
Washington, DC 20510

**Re: COVID-19 Relief Packages**

Dear Majority Leader McConnell and Minority Leader Schumer:

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, we strongly urge that as negotiations continue on the next congressional relief package to address the novel 2019 coronavirus (COVID-19) pandemic, **that you maintain and build upon each of the critical Tribally-specific funding and legislative provisions included in the Health and Economic Recovery Omnibus Emergency Solutions or "HEROES" Act**. While HEROES included crucial Tribal policy and funding priorities in response to the COVID pandemic, a number of key provisions critical to the Tribal COVID response were omitted.

As such, in addition to the Tribal provisions outlined in HEROES, we strongly request that the next pandemic relief package include the following Tribal healthcare and public health priorities:

- **Provide minimum $1 billion for safe water and sanitation development across IHS and Tribal facilities**
  - In order to stem the tide of the COVID-19 pandemic in Indian Country, it is essential that Congress make meaningful investments in water and sanitation development across IHS and Tribal facilities.
    - HEROES only outlined $30 million overall for water and sanitation development in Indian Country ($10 million within IHS, and $20 million within Bureau of Indian Affairs). This is severely below the level of need to protect and preserve health in AI/AN communities.
  - According to the Centers for Disease Control and Prevention (CDC), hand-washing is the number one way to protect against a COVID-19 infection. Yet approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.[1]
    - 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.[2]

- **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**

[1] 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

[2] 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

- 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 as part of the legislative fix to the four walls restriction**.

- **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.

- **Permanently reauthorize the Special Diabetes Program for Indians**
  - According to the Centers for Disease Control and Prevention (CDC), diabetes is one of the strongest risk factors for a more serious COVID-19 illness. Because AI/AN communities have the highest rates of type II diabetes, they are at much higher risk to contract the virus.
  - SDPI is a proven model for both preventing diabetes and providing resources for diabetes management in Indian Country, both of which lead to a lower risk of COVID-19. As a direct result of SDPI, a recent study found that the prevalence of diabetes in AI/AN adults decreased from 15.4% in 2013 to 14.6% in 2017.[3]
    - Despite its incredible success, SDPI has experienced *four short-term extensions* since September 2019. While we appreciate that the CARES Act extended SDPI through November 30, 2020, SDPI programs cannot continue to sustain short-term extensions.
  - Permanent reauthorization honors the success of SDPI and gives programs the necessary certainty to effectively continue improving diabetes outcomes in Indian Country and responding to the COVID pandemic.

- **Permanently Extend Waivers under Medicare for Use of Telehealth**
  - COVID-19 has dramatically increased the need to connect patients to their providers through

[3] Bullock A, Sheff K, Hora I, et al. Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006–2017. BMJ Open Diab Res Care 2020;8:e001218. doi:10.1136/ bmjdrc-2020-001218

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.

- **Enact Certain Sections of the Bipartisan CONNECT to Health Act**
  - 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 waivable restrictions include limitations on provider types, technology, geographic area, and services. 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 patients from being able to receive mental and behavioral health services from 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.

- **Include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to Indian Health Care Providers**
  - 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.

- **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, 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.

**Background**

We are very pleased that each previous COVID-19 relief package included Tribal healthcare and public health provisions, such as the $1.032 billion in funding for Indian Health Service (IHS) under the CARES Act, and the baseline $750 million Tribal set-aside in testing under the Paycheck Protection and Healthcare Enhancement Act. Despite these meaningful investments, it is clear that they have been insufficient to address the grave impacts of COVID-19 in Indian Country.

As of May 31, 2020, IHS has reported 11,220 confirmed positive cases of COVID-19. In New Mexico, American Indians and Alaska Natives (AI/ANs) represent roughly 10 percent of the population, yet account for over 57 percent of all COVID-19 cases. Earlier this month, 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 307 COVID-19 tests, with 61 confirmed positive case results (19.8%). Of those 61 cases, 30 were reported between May 19 and May 26, representing a 169% increase in cases in just one week. 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**.[4]

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[5], 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

---

[4] 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

[5] Per capita spending at IHS in FY 2018 equaled $3,779 compared to $9,409 in national health spending per capita; $9,574 in Veterans Health Administration spending per capita; and $13,257 per capita spending under Medicare.

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.

According to the Harvard Project on American Indian Economic Development (HPAIED), before COVID-19 hit, Tribal governments and businesses employed 1.1 million people and supported over $49.5 billion in wages, with Tribal gaming enterprises alone responsible for injecting $12.5 billion annually into Tribal programs. **During the six week period (through May 4, 2020) whereby all 500 Tribal casinos were closed in response to COVID-19 guidelines, Tribal communities lost $4.4 billion in economic activity, with 296,000 individuals out of work and nearly $1 billion in lost wages.**[6]

Extrapolated across the entire U.S. economy, collectively $13.1 billion in economic activity was lost during the same time period, in addition to $1.9 billion in lost tax revenue across federal, state and local governments. In a new visualization created by NIHB, over 193,000 AI/ANs have become uninsured as a result of COVID-19 job losses, with the vast majority of these individuals (72%) lacking access to IHS as well.[7]

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. As such, it is critical that as the Senate takes up consideration of another pandemic relief package, that the existing Tribal provisions outlined in the HEROES Act are preserved, and that each of the recommendations outlined at the top of this letter are added.

Thank you for your consideration of the recommendations outlined in this letter. We look forward to working with you to ensure that Indian Country's health care concerns and priorities are comprehensively addressed, as we respond to the COVID-19 pandemic.

Sincerely,

Stacy A. Bohlen
CEO
National Indian Health Board

---

[6] Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming

[7] National Indian Health Board. Estimating Covid-19 caused increases in Uninsured AIANs due to job loss. https://public.tableau.com/profile/edward.fox#!/vizhome/EstimatingCovid-19causedincreasesinUninsuredAIANsduetojobloss/EstimatingIncreaseinAIANUninsuredduetoCOVID-19JobLoss_