

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD – LISA ELGIN, SECRETARY
SENATE COMMITTEE ON INDIAN AFFAIRS – OVERSIGHT HEARING ON ‘EVALUATING THE RESPONSE AND MITIGATION
TO THE COVID-19 PANDEMIC IN NATIVE COMMUNITIES’
JULY 1, 2020

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, thank you for holding this critical oversight hearing to “Evaluate the Response and Mitigation to the COVID-19 Pandemic in Native Communities.” On behalf of the National Indian Health Board and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, I submit this testimony for the record.

Our nation is gripped by the most unprecedented public health crisis in generations. As of June 28, 2020 there are over 2.5 million COVID-19 cases nationwide and over 125,000 COVID-19 deaths, according to the Centers for Disease Control and Prevention (CDC). Public health data continues to demonstrate that not only are new cases *not* subsiding, they are dangerously increasing in countless jurisdictions nationwide. **According to the CDC, on Thursday June 25, the United States recorded 40,588 cases - the highest number of cases reported in a single-day since April 6.** In a data analysis from Kaiser Family Foundation, from June 11 to June 25 a total of 26 states reported increased COVID-19 cases including many with large AI/AN populations including Arizona, Oklahoma, Michigan, Nevada, Wisconsin, Washington, Wyoming, Montana, California, and Oregon.¹

But similar to every prior public health crisis, there are disparate and disproportionate impacts on underserved and marginalized communities, and Indian Country is at the epicenter. **According to CDC, people with chronic obstructive pulmonary disease (COPD), type 2 diabetes, and chronic kidney disease are at higher risk for a more serious COVID illness. AI/AN populations are disproportionately impacted by all three of these underlying health conditions.** In 2017, CDC reported that age-adjusted percentages of COPD were highest among AI/ANs (11.9% vs 6.2% across all populations).² While rates of End Stage Renal Disease have dropped by 54% among AI/ANs as a result of the Special Diabetes Program for Indians (SDPI), AI/ANs continue to experience a significant burden of kidney disease. Similarly, in 2017 it was reported that AI/ANs experienced the highest diabetes prevalence at 15.1%, at more than double the percentage for non-Hispanic Whites.³

Despite alarming gaps nationwide in population-specific COVID-19 health disparities data, available information clearly demonstrates that Tribal communities are facing the brunt of this public health crisis. The federal government has treaty and trust obligations to fully fund healthcare in perpetuity for all Tribal Nations and AI/AN Peoples, and it is imperative that this obligation be met in the face of the COVID-19 pandemic.

To that end, we are pleased that each previous COVID-19 relief package has included important Tribal health provisions, such as the \$64 million in funding for Indian Health Service (IHS) under the Families First Coronavirus Response Act; \$1.032 billion in funding for IHS under the CARES Act; and the baseline \$750 million Tribal set-aside in testing under the Paycheck Protection and Healthcare Enhancement Act. But despite these meaningful investments, it is clear that they have been insufficient to address the grave impacts of COVID-19 in Indian Country.

¹ Kaiser Family Foundation. 2020. States with Upward of 14-Day Trends in COVID-19 Cases and Positivity Rates. <https://www.kff.org/coronavirus-covid-19/slide/states-with-upward-of-14-day-trends-in-covid-19-cases-and-positivity-rates/>

² Wheaton AG, Liu Y, Croft JB, et al. Chronic Obstructive Pulmonary Disease and Smoking Status — United States, 2017. MMWR Morb Mortal Wkly Rep 2019;68:533–538. DOI: http://dx.doi.org/10.15585/mmwr.mm6824a1external_icon

³ Department of Health & Human Services, Centers for Medicare & Medicaid Services. 2018. LTSS Research: Diabetes in Indian Country Annotated Literature Review. <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/pdf/Emerging-LTSS-Issues-in-Indian-Country-Diabetes-in-Indian-Country-Annotated-Literature-Review.pdf>

Recommendations

On June 2, 2020 NIHB submitted a letter to Senate Majority Leader McConnell and Minority Leader Schumer urging that as the Senate began negotiations on the next relief package, that all of the Tribally-specific funding and legislative provisions outlined in the House-passed HEROES Act be maintained and built upon by addressing critical areas of unmet need. To that end, NIHB has outlined several top priorities – some of which fall squarely under the Committee’s jurisdiction, and others that we urge Committee members to work on in lockstep with colleagues serving on Interior Appropriations, Finance, and Health, Education, Labor and Pensions. **NIHB also strongly supports the bipartisan S. 3650 and urges the full Committee to pass this important bill.**

1. Ensure timely passage and meaningful increases to the overall Indian Health Service (IHS) budget for Fiscal Year 2021 in line with the Tribal Budget Formulation Workgroup Recommendations

- Without an enacted FY 2021 IHS budget that is passed on-time, the Indian health system will be left significantly unprepared to tackle a potentially stronger wave of infections in the fall and winter months ahead.
 - Therefore, it is imperative that IHS not be subject to another continuing resolution or face the threat of another government shutdown.
- While we appreciate the \$1.032 billion appropriated to IHS under the CARES Act, and the additional \$2.1 billion proposed under the House-passed HEROES Act, these investments do not replace the need for strong and meaningful investments in the annual appropriated IHS budget.
 - **The IHS Tribal Budget Formulation Workgroup (TBFWG) has outlined the need for \$9.1 billion for IHS in FY 2021 to be able to effectively address healthcare needs.**
- AI/ANs continue to face significant health disparities, especially for conditions like diabetes and respiratory illnesses, which increase the risk of a COVID-19 infection. Without a bold and substantive FY 2021 IHS budget to equip the Indian health system with the tools to address these disparities, they will continue to go unaddressed, leaving Indian Country more vulnerable to COVID-19 outbreaks.

2. Pass the bipartisan S. 3937 – Special Diabetes Program for Indians Reauthorization Act of 2019 – with slight changes to the new “Delivery of Funds” language to ensure Tribes and Tribal organizations are able 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 strongest risk factors for a more serious COVID-19 infection. AI/AN communities are diagnosed with diabetes at more than double the rate for Whites, and higher than any other population nationwide.
- The Special Diabetes Program for Indians (SDPI) is the only program that has effectively reduced incidence and prevalence of diabetes, and is responsible for a 54% reduction in rates of End Stage Renal Disease and a 50% reduction in diabetic eye disease. In a 2019 federal report, SDPI was found to be largely responsible for \$52 million in savings in Medicare expenditures per year.
 - Despite its documented success, since September 30, 2019, SDPI has gone through four short-term extensions, with the most recent extension occurring under the CARES Act. SDPI is currently set to expire on November 30, 2020.
- The bipartisan S. 3937, introduced by Senator McSally, and supported by Senator Murkowki and Senator Sinema, would provide 5-years of guaranteed funding for SDPI at an increase to \$200 million per year overall. **This represents the first increase to SDPI in over sixteen years, and the longest reauthorization in over a decade.**
- Significantly, S. 3937 would also authorize Tribes and Tribal organizations to receive SDPI awards through P.L. 93-638 self-determination and self-governance contracting and compacting agreements, thus allowing for greater local Tribal control over the life-saving program.

- However, Tribes and NIHB are requesting slight technical tweaks to the new language in S.3937 to further clarify the authority and prevent any potential administrative delays in implementation. We urge the Committee to pass S.3937 with the requested changes 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.”

3. Provide minimum \$1 billion for 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.
- The HEROES Act 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 2018 IHS Sanitation Facilities Infrastructure Report, roughly \$2.67 billion is needed to bring all IHS and Tribal sanitation facilities to a Deficiency Level 1 designation.

4. Provide meaningful increases to the IHS budget for telehealth, electronic health records and health information technology (IT) infrastructure development

- 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.
 - 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 have been able to take advantage of new flexibilities under Medicare for use of telehealth during the COVID-19 pandemic, IHS and Tribal facilities have not because of insufficient broadband deployment and health IT capabilities.
- The TBFWG has 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 Indian Health Care Providers with the tools to seamlessly provide telehealth-based health services.

5. 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; Clarify the four walls language to ensure that the fix to the billing restriction is made both for services provided by an Indian Health Care Provider outside the four walls, and those services on the basis of a referral

- 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. In addition, the four walls language under Section 30106 only fixes the four walls billing restriction for services on the basis of a referral, not those services provided by Indian Health Care Providers (IHCPs) outside the four walls – such as in patient’s homes, schools, jails, or other locations. **Not only is it critical that the four walls fix be made permanent, it is equally critical that the fix to the four walls billing restriction be made for both services provided by IHCPs outside the four walls, and those services on the basis of a referral.**
- 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.**

6. 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.

7. 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.

8. 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.

9. Permanently Extend Waivers under Medicare for Use of Telehealth

- 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 permanent the telehealth waivers for both video and audio-based telehealth services 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 Numbers: COVID-19 in Indian Country

As of June 24, IHS has reported 18,240 positive cases, with roughly 67% of positive cases being reported out of the Phoenix and Navajo IHS Areas alone. 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, are 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.**⁴ The CDC reported that from March through June 13, 2020 **age-adjusted COVID-19 hospitalization rates among AI/ANs were higher than any other ethnicity, at 221.2 per 100,000.**⁵ Reporting by state health departments has further highlighted disparities among AI/ANs.

⁴ 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>

⁵ Centers for Disease Control and Prevention. COVID-19 Data Visualization. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>

- In New Mexico, AI/ANs represent roughly 8% of the population, yet account for over 53% percent of all COVID-19 cases.⁶
- 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 16.⁷
- In Wyoming, AI/ANs account for over 27% of all COVID-19 cases statewide despite representing only 2.9% of the state population.⁸
- 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.⁹
- In Arizona where AI/ANs account for roughly 5% of the state population, as of June 28, 2020 they represented 15% of those hospitalized for COVID and roughly 9% of all COVID cases statewide.¹⁰

Most poignantly, in a 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.**¹¹

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 rate¹², and a hospital system that remains over four times older than the national hospital system.¹³ 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.¹⁴ 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

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

⁷ 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/>

⁸ 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/>

⁹ Montana Department of Public Health and Human Services. <https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics>

¹⁰ Arizona Department of Health Services. COVID Data Dashboard. <https://www.azdhs.gov/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/covid-19/dashboards/index.php>

¹¹ 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

¹² Government Accountability Office (GAO-18-580). <https://www.gao.gov/products/GAO-18-580>

¹³ 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

¹⁴ 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

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.¹⁵ 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.¹⁶

Gaps in COVID-19 AI/AN Public Health Data

These existing capacity and resource shortages meant that the Indian health system was woefully unprepared to prepare, prevent, and respond to the COVID-19 pandemic. Available data on AI/AN COVID-19 health disparities reaffirms this central point. Unfortunately, because of high rates of misclassification and undersampling of AI/AN populations in federal, state, and local public health disease surveillance systems, available data likely significantly underrepresents the scope of the impact in Indian Country. To be clear, misclassification of AI/ANs on disease surveillance systems is not unique to COVID-19.

Previous studies have found significantly higher rates of misclassification outside of IHS Contract Health Service Delivery Areas (CHSDA)¹⁷; for all-cause mortality rates in states like Oklahoma¹⁸; for HIV infections among AI/ANs across five states;¹⁹ and on death certificates reported to CDC.²⁰ However, the issue has taken a new level of urgency given the unprecedented devastation of this pandemic on underserved communities.

Multiple states with large AI/AN populations including but not limited to Minnesota, Michigan, New York and California are reporting thousands of COVID cases without any information on patient ethnicity, or categorizing cases as “other” on demographic forms. In California for instance, the state has noted that race/ethnicity data is missing for nearly 30% of reported cases. Multiple studies have demonstrated that AI/ANs are more likely to be misclassified as “other” or are omitted from surveillance systems entirely.

Thus, these structural challenges in data reporting only serve to render invisible the disparate impact of COVID-19 in Indian Country. Relatedly, Tribal Epidemiology Centers (TEC) continue to face significant barriers in exercising their statutory public health authorities by facing major hurdles in accessing federal and state public health surveillance systems, including for COVID-19 data.²¹ These issues continue to have a direct negative effect on health outcomes for AI/AN Peoples, and are exacerbating the impact of COVID-19 in Indian Country.

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 IHS²², Tribal governments have

¹⁵ 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>

¹⁶ 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

¹⁷ Jim, M. A., Arias, E., Seneca, D. S., Hoopes, M. J., Jim, C. C., Johnson, N. J., & Wiggins, C. L. (2014). Racial misclassification of American Indians and Alaska Natives by Indian Health Service Contract Health Service Delivery Area. *American journal of public health*, 104 Suppl 3(Suppl 3), S295–S302. <https://doi.org/10.2105/AJPH.2014.301933>

¹⁸ Dougherty, Tyler M. MPH, CPH; Janitz, Amanda E. PhD, BSN, RN; Williams, Mary B. PhD; Martinez, Sydney A. PhD; Peercy, Michael T. MPH, MT(ASCP)H; Wharton, David F. MPH, RN; Erb-Alvarez, Julie MPH, CPH; Campbell, Janis E. PhD, GISP Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015, *Journal of Public Health Management and Practice*: September/October 2019 - Volume 25 - Issue - p S36-S43 doi: 10.1097/PHH.0000000000001019

¹⁹ Bertolli, J., Lee, L. M., Sullivan, P. S., & AI/AN Race /Ethnicity Data Validation Workgroup (2007). Racial misidentification of American Indians/Alaska Natives in the HIV/AIDS Reporting Systems of five states and one urban health jurisdiction, U.S., 1984-2002. *Public health reports (Washington, D.C. : 1974)*, 122(3), 382–392. <https://doi.org/10.1177/003335490712200312>

²⁰ Centers for Disease Control and Prevention. 2016. The Validity of Race and Hispanic-Origin Reporting on Death Certificates in the United States: An Update. https://www.cdc.gov/nchs/data/series/sr_02/sr02_172.pdf

²¹ Centers for Disease Control and Prevention. Issue Brief on Tribal Epidemiology Center Legal Authorities. <https://www.cdc.gov/phlp/docs/tec-issuebrief.pdf>

²² 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.

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. **In a hearing before House Interior Appropriations on June 11, 2020, IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30-80% below last year's collections levels, and that it would likely take years to recoup these losses.** It is

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. 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.**²³

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.²⁴

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, we urge the Committee to work on the recommendations outlined at the top of this letter, and stand ready to work with you in a bipartisan manner to secure their passage.

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.

²³ Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from <http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming>

²⁴ 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-19causedincreasesinUninsuredAIANsduejobloss/EstimatingIncreaseinAIANUninsuredduetoCOVID-19JobLoss>