

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD – STACY A. BOHLEN, CEO
HOUSE APPROPRIATIONS SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES
JUNE 11, 2020

Chairwoman McCollum, Ranking Member Joyce, and Members of the Subcommittee, thank you for holding this important hearing on the impacts of the novel 2019 coronavirus (COVID-19) pandemic in Indian Country. 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 7, 2020 there are 1.92 million cases nationwide and over 109,000 COVID deaths, according to the Centers for Disease Control and Prevention (CDC). But similar to every prior public health crisis, there are disparate and disproportionate impacts on underserved and marginalized communities, and Indian Country is no different. 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.

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. We also commend the Subcommittee for proposing \$2.1 billion for IHS in the House-passed HEROES Act and remain committed to its passage. But despite these meaningful investments, it is clear that they have been insufficient to address the grave impacts of COVID-19 in Indian Country.

To that end, NIHB urges the Subcommittee to implement the following recommendations to ensure Indian Country has sufficient resources to tackle this pandemic.

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

- Public health leaders continue to stress that a second and likely stronger wave of COVID-19 infections are likely to occur in fall 2020 and beyond. Without an enacted IHS budget that is passed on-time, the Indian health system will be left significantly unprepared to tackle a stronger wave of infections.
 - 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. 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. To that end, **NIHB strongly supports H.R. 7056, introduced by Representative O'Halleran and Representative Young, which would invest \$2.67 billion per year for this need through 2024.**

3. 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.

4. Work with congressional authorizing committees to ensure the next pandemic relief package includes language permitting an interagency transfer of Tribally-specific funding streams from other Health and Human Services (HHS) operating divisions to IHS

- Tribes continue to stress the need for greater administrative flexibility that would authorize the transfer of Tribally-specific funding streams from other HHS operating divisions to IHS.
- This is because IHS continues to be the only HHS agency with the legal authority to allocate funds to Tribes through their preferred mechanisms, such as under the rules of the Indian Self-Determination and Education Assistance Act (P.L. 93-638).
 - We urge the Subcommittee to provide technical assistance to authorizing committees to facilitate the inclusion of this priority.

The Numbers: COVID-19 in Indian Country

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.¹
- 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.²
- 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.³

¹ New Mexico Department of Health. COVID-19 in New Mexico. <https://cvprovider.nmhealth.org/public-dashboard.html>

² 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/>

³ 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 are 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.⁴

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.**⁵

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 rate⁶, and a hospital system that remains over four times older than the national hospital system.⁷ 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.⁸ 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.⁹ In fact, in a new peer-reviewed study of 287 Tribal reservations and

⁴ Oregon Health Authority. COVID-19 Weekly Report (Published June 3, 2020)

<https://www.oregon.gov/oha/PH/DISEASES/CONDITIONS/DISEASES/AZ/Emerging%20Respiratory%20Infections/COVID-19-Weekly-Report-2020-06-03-FINAL.pdf>

⁵ 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

⁶ Government Accountability Office (GAO-18-580). <https://www.gao.gov/products/GAO-18-580>

⁷ 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_Facilities_NeedsAssessmentReport.pdf

⁸ 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

⁹ 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>

homelands, COVID-19 cases were found to be 10.83 times more likely in homes without indoor plumbing.¹⁰

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)¹¹; for all-cause mortality rates in states like Oklahoma¹²; for HIV infections among AI/ANs across five states;¹³ and on death certificates reported to CDC.¹⁴ 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

¹⁰ 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

¹¹ 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>

¹² 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

¹³ 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>

¹⁴ 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

data.¹⁵ 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 IHS¹⁶, 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.

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.**¹⁷

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.¹⁸

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 Subcommittee to implement the

¹⁵ Centers for Disease Control and Prevention. Issue Brief on Tribal Epidemiology Center Legal Authorities. <https://www.cdc.gov/phlp/docs/tec-issuebrief.pdf>

¹⁶ 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.

¹⁷ Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from <http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming>

¹⁸ 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>

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.

Sincerely,

A handwritten signature in black ink, appearing to read "Stacy A. Bohlen". The signature is fluid and cursive, with a long horizontal stroke at the end.

Stacy A. Bohlen
CEO
National Indian Health Board