National Indian Health Board

Testimony of the National Indian Health Board
Telehealth: Lessons from the COVID-19 Pandemic
United States Senate
Health, Education, Labor and Pensions Committee
June 26, 2020

Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for holding an important hearing on June 17, 2020 to discuss use of telehealth during the COVID-19 pandemic. 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 telehealth 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 in this space – some of which are strictly within the Committee's jurisdiction, and others that we urge you to work with your colleagues on the Senate Finance and Appropriations Committees to address**.

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

2. **Permanently Extend Waivers under Medicare for Use of Telehealth**

3. **Enact Certain Sections of the CONNECT to Health Act**

4. **Ensure that Medicare reimburses IHS and Tribal providers for telehealth services at the IHS All-Inclusive Rate or "OMB Rate"**

Background – Telehealth Availability and Impact of COVID-19 in Indian Country

The COVID-19 pandemic has transformed the way healthcare services are delivered, including for our Indian Health Service (IHS), Tribal, and urban Indian (collectively I/T/U) healthcare delivery systems. But as mainstream health facilities have more readily transitioned to virtual and telehealth based care delivery, our I/T/U systems lag far behind in this transition. Due to a significant lack of broadband infrastructure in which **only 46.6% of houses on Tribal lands have access to fixed terrestrial broadband at standard speeds established by the Federal Communications Commission (FCC), many of our Tribal citizens are unable to access necessary telehealth-based care from the safety of their homes**. In March 2020, IHS announced expanded telehealth services under the COVID-19 pandemic, in line with new guidance from the Centers for Medicare and Medicaid Services (CMS) easing restrictions on use of telehealth under the pandemic. Specifically, the agency issued guidance allowing IHS clinicians to utilize certain audio and visual technologies for all types of clinical services. According to IHS, since initiating telehealth expansion, the agency has experienced an 11-fold increase in telehealth visits, from roughly 75 visits per week before the expansion, to 907 weekly visits. According to a new Government

Accountability Office (GAO) report analyzing the federal response to COVID-19, IHS has allocated $95 million of the $1.032 billion in total funding received under the CARES Act towards telehealth.

While this news is encouraging, there remain significant gaps in access to telehealth in Indian Country. For instance, IHS's outdated and ineffective health information technology (IT) system has made it very difficult for I/T/U providers to take full advantage of existing telehealth capabilities. According to IHS Chief Medical Officer Dr. Toedt, deficiencies in the agency's health IT infrastructure have severely restricted disease surveillance, reporting, and contact tracing efforts. Moreover, lack of electronic health record (EHR) interoperability between IHS, Tribal, and external EHR systems means that providers don't have easy access to patient health records, further hampering expansion of telehealth.

Lost Tribal business revenue has forced our Tribes to furlough hundreds of workers, and even curtail our health services. Some of our Tribes have even been forced to shutter our clinics. These conditions are jeopardizing our People's access to critical care, leaving our Tribal communities at increased risk of serious ramifications for our mental, behavioral, and spiritual health as a result of this pandemic.

Indeed, our Tribal communities have endured a great many pandemics and tragedies in our history. Our people experience significant historical and intergenerational trauma as a result of genocide, forced relocation from our homelands, forced assimilation into western culture, and persecution of our Native cultures, customs, and languages. As a result, Indian Country experiences some of the highest rates of suicide, drug overdose, PTSD, and mental illness. 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 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 $64 million under the Families First Coronavirus Response 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.

Impact of COVID-19 in Indian Country

As of June 24, 2020, IHS has reported 18,240 confirmed positive cases of COVID-19 with roughly 67% of positive cases being reported out of the Phoenix and Navajo IHS Areas specifically. 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**.[1] 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**.[2] 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.[3]
- As of June 16, 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.[4]
- In Wyoming, AI/ANs account for over 30% of all COVID-19 cases statewide despite representing only 2.9% of the state population.[5]
- 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.[6]
- 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.[7]

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**.[8]

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

[1] 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
[2] Centers for Disease Control and Prevention. COVID-19 Data Visualization. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/data-visualization.htm
[3] New Mexico Department of Health. COVID-19 in New Mexico. https://cvprovider.nmhealth.org/public-dashboard.html
[4] 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/
[5] 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/
[6] Montana Department of Public Health and Human Services. https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics
[7] Oregon Health Authority. COVID=19 Weekly Report (Published June 17, 2020) https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Emerging%20Respitory%20Infections/COVID-19-Weekly-Report-2020-06-17-FINAL.pdf
[8] 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

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 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. 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 IHS Tribal Budget Formulation Working Group 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.

2. 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 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. To that end, we urge the Committee to make permanent all Medicare waivers for use of telehealth through both video-based and audio-based telehealth visits.

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. Ensure that Medicare reimburses IHS and Tribal providers for telehealth services at the IHS All-Inclusive Rate or "OMB Rate"

The COVID-19 pandemic has taken a significant financial toll on I/T/U health systems leading to reductions in availability of health care services. While IHS and Tribal sites already receive the IHS All-Inclusive Rate for telehealth services under Medicaid, Medicare is currently only reimbursing at the Part B rate, which is only approximately $14 per unit of care. Ensuring Medicare reimburses IHS and Tribal sites at the full encounter rate is a common sense and simple way of ensuring I/T/U providers can continue to utilize telehealth as a financially viable option to provide critically needed health care services to patients.

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