



Transmitted via email: BrokenPromises@usccr.gov

July 24, 2020

**NORTHWEST
PORTLAND
AREA
INDIAN
HEALTH
BOARD**

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Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
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Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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Catherine E. Lhamon

Chair

U.S. Commission on Civil Rights

1331 Pennsylvania Ave. NW, Suite 1150

Washington, DC 20425

Re: Assessing COVID-19 and the Broken Promises to Native Americans

Dear Chairwoman Lhamon and members of the U.S Commission on Civil Rights:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), we write to the U.S. Commission on Civil Rights (USCCR) ("herein the Commission") on the briefing "Assessing COVID-19 and the Commission's report: Broken Promises: Continuing Federal Funding shortfall for Native Americans". The novel coronavirus 2019 (COVID-19) public health emergency has underscored the chronic failure of the federal government to uphold its trust and treaty obligations to tribes.

Established in 1972, NPAIHB is a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, advocating on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific healthcare issues. NPAIHB operates a variety of important health programs on behalf of its member tribes, including the Northwest Tribal Epidemiology Center¹ and works closely with the IHS Portland Area Office.

We appreciate an opportunity to update the Commission regarding the ongoing COVID-19 pandemic in Indian Country. As *The Broken Promises Report* (Report) notes, the federal government chronically underfunds the Indian healthcare system and tribes depend on third party insurance reimbursements and tribal enterprise revenue to fill the gaps left by the unmet obligations of the federal government.²

The COVID-19 pandemic exacerbates the inequities found in the Report, and poses an immediate threat to the decades of improvement that have been made across Indian Country. As the Commission knows, millions of tribal acres of land holdings and natural resources were ceded to the United States. Tribes paid in advance for health (and other services), and the federal government has a fiduciary obligation and a trust responsibility to support the physical, social, and economic well-being of tribes

¹ A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."
sion on Civil Rights. The Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans (2018).

and tribal citizens. As documented in your Report, federal programs remain chronically underfunded and inadequately configured, leading to significant health disparities in tribal communities.

I. BACKGROUND

The COVID-19 pandemic disproportionately impacts AI/ANs and tribes during these unprecedented times in our Country.³ Tribal governments have closed businesses to protect their people, and those closures have eliminated financial resources. AI/ANs are also disproportionately impacted by COVID-19 due to the higher rate of chronic disease.⁴ As of July 22, the Indian Health Service (IHS) has reported over 435,500 individuals tested, with almost 29,000 positive cases.⁵ In the IHS Portland Area almost 17,000 individuals tested, and almost 1,300 positive cases. The federal government has stumbled in its response to COVID-19 in Indian Country, and continues to fail tribal programs in meeting basic needs.

II. SPECIFIC RECOMMENDATIONS

A. Broken Promises found that Native Americans experience distinct health disparities as compared to other Americans which are compounded by Native American healthcare programs being chronically underfunded. How has the outbreak of COVID-19 impacted these health disparities?

COVID-19 impacts the AI/AN population at higher rates than the non-native population because AI/ANs carry a heavier chronic disease burden and experience greater health disparities. Comorbidities that make COVID-19 treatment more complex, like diabetes and heart disease are more common among AI/ANs.

Due to pre-existing health conditions and health disparities AI/AN people are at high risk of contracting COVID-19. When these disparities are coupled with social determinants of health such as inadequate housing, lack of sanitation and inadequate infrastructure, as seen in some communities, the failure of our federal trustee to meet its treaty and trust obligations becomes further highlighted. The NPAIHB recommends immediate action be taken to fund sufficient housing, develop community infrastructure to ensure adequate water and sanitation, and fully fund the Indian healthcare system to ensure public health and clinical health services are available to all AI/AN people.

Tribal Health Clinic Capacity

Portland Area Tribal clinics have had to transition from community health clinics to urgent care centers because COVID-19 has changed how clinics need to care for their people. These changes have led to less resources for our chronic disease patients. As the pandemic progresses, there is a need for a dual model clinic with an emergent/urgent care clinic and a urgent care focus and a chronic disease focus and prevention focus. The majority of clinics in the Portland Area do not have sufficient resources to retool their clinics from the current model.

³ Mineo, Liz. For Native Americans, COVID-19 is the 'worst of both worlds at the same time' (2020).

⁴ Mineo, Liz. For Native Americans, COVID-19 is the 'worst of both worlds at the same time' (2020).

⁵ Indian Health Service. Coronavirus (COVID-19) Cases by IHS Area (2020).

Due to the fact that there are no tribal hospitals in Idaho, Oregon, or Washington, tribal clinics must purchase secondary and tertiary care from non-IHS providers with severely underfunded appropriations from the federal government for Purchased and Referred Care (PRC) program. Due to COVID-19, our clinics are strained and our focus has shifted. We are changing service delivery models from health promotion and management of chronic disease to addressing COVID-19, substituting tele-medicine for in-person care, and redesigning health care delivery while responding to this pandemic. All clinics in our region anticipate decreases in 3rd party insurance reimbursements due closing off parts of their health care delivery system to meet needs related to COVID-19.

Lack of Access to Data for Tribal Epidemiology Centers

State and federal agencies are not adequately documenting the race and ethnicity of COVID-19 patients. Data varies from state to state, which creates significant data issues for disease tracking in Indian Country because AI/ANs are not correctly represented.

The state of Oregon requires reporting of race, ethnicity, language and disability data (REAL-D). This allows more accurate data collection, and therefore better identifies COVID-19 positive people among AI/ANs. The NPAIHB recommends that reporting of race and ethnicity be made mandatory and tied to funding reimbursement for Medicare and Medicaid.

B. Broken Promises found that telecommunications infrastructure, especially wireless and broadband internet services, is often inaccessible to many Native Americans in Indian Country. These services are necessary to keep the community connected to telehealth services, remote education, economic development, and public safety. Has this lack of telecommunications created additional barriers for Native Americans in coping with and reacting to the pandemic?

Wireless and broadband internet services are part of the basic telecommunications infrastructure in the United States. Lack of infrastructure development in Indian Country will continue to hinder health, public health, economic development, education, and public safety in Indian Country. The COVID-19 pandemic demonstrates, again, that Indian Country is under-funded and under-resourced in telecommunications infrastructure. COVID-19 has dramatically increased the need to connect AI/AN patients to telehealth for health care and behavioral health services, including primary care, specialty care and chronic disease management. Telecommunications infrastructure is needed for contact tracing, public health communications, and community education. Due to the lack of access to adequate broadband, preventative care, telehealth, and tele-behavioral health services cannot be fully implemented.

Temporary Department of Health and Human Services (HHS) Changes for Telehealth Services

The Department of Health and Human Services (HHS) has approved important changes to temporarily allow for increased access to telehealth services that we request to continue permanently for Indian Country, including: (1) allowing a patient's home to qualify as an originating site; (2) expansion of reimbursable telehealth services under Medicaid and Medicare; and (3) relaxation of HIPAA privacy rules to allow virtual health care visits via landline calls and video applications (i.e. Zoom or FaceTime). The Drug Enforcement Agency (DEA), under the Department of Justice (DOJ) has provided temporary waivers for e-prescribing of pharmaceutical

drugs for behavioral and mental health care have been invaluable in maintaining critical patient care.

C. Have the congressional responses to the pandemic – especially the passage of the CARES Act and other stimulus packages – done enough to help Native people with the challenges posed by COVID-19?

The congressional response to the pandemic in Indian Country has been incomplete, and not fully funded tribal priorities to address COVID-19. In March and April, four legislative packages were signed into law by the President that provided COVID-19 funding to tribes for economic relief and to the Indian health system for health care and public health. Tribes across the nation are advocating to ensure inclusion of tribes in legislative actions to combat COVID-19.

The fundamental flaw built into the Coronavirus Aid, Relief and Economic Security (CARES) Act was the restrictions placed on how the funds can be used. Tribal Nations are disallowed from using the funds to replace lost 3rd party insurance reimbursement. Given the chronic underfunding of Indian Health Service, 3rd party reimbursement funds are used by many of our tribes to pay for health and social service programs. Tribes in our region anticipate significant gaps in 2020 and 2021 3rd party insurance reimbursement, and those gaps are causing layoffs, reductions in service, and additional hardship in tribal communities. The statements made by tribal governments in consultation have been disregarded, and tribal priorities become last-minute inclusions into legislation. This leads to small amounts of relief funding dedicated to Indian Country. Tribes are sovereign nations and should not need to lobby Congress and expend limited financial resources to be included in legislation.

Tribal-specific Funding Recommendations

Tribal leaders are entrusted with the health, safety, and well-being of their people. Tribes in the Portland Area have closed casinos and hotels, closed or reduced services in restaurants and markets, and reduced critical health and social services for their people due to the COVID-19 pandemic.

Tribal leaders have consistently requested that funding to tribes flow through existing funding agreements, be non-competitive, and be direct funding rather than grant based. These statements have been made in tribal consultation throughout the COVID-19 pandemic. The NPAIHB strongly recommends that the federal government follow the specific recommendations made by tribal leaders in consultation. Each administrative layer, each additional grant, each additional federal “partner” adds a layer of bureaucracy and reduces the actual amount of funds that flow to the tribes.

D. Has the Executive Branch’s responses to the pandemic – including its statutory interpretation and administrative implementation of laws passed by Congress – done enough to help Native peoples cope with the challenges passed by Congress?

Lack of Tribal Consultation

As previously mentioned, tribal leaders have repeatedly stated in consultation that funding needs to flow through existing funding agreements. The unequal treatment of tribal governments and lack of full recognition of their sovereign status by state and federal governments and by the Executive Branch diminishes self-determination and self-governance, negatively impacting

criminal justice, health, education, and housing. Tribes have not had a seat at the table where decisions are being made. The Executive Branch must ensure prompt and meaningful tribal consultation as to COVID-19 funding distributions, but in particular related to Medicaid, Medicare, and rural funding.

Eligibility Barriers for Coronavirus Relief Fund

The Executive Branch has limited tribal government eligibility for coronavirus relief funds. COVID-19 funding that does not flow through existing funding agreements have been delayed, complex to apply for, and burdensome to administer. It is the responsibility of the federal government to ensure Indian Health Care Providers have access to all COVID-19 funding. For example, the Health Resources and Services Administration (HRSA) limited eligibility for all providers to \$15 billion Medicaid/CHIP funding if they were eligible for the \$50 billion Medicare fee-for-service based funding. This restriction negatively impacts providers and clinics in the Indian healthcare system as a disproportionate percentage of AI/ANs are covered by Medicaid, and many of the Medicare patients are also dual-eligible.

E. What recommendations should the Commission make to Congress and the federal government to ensure that Native American communities can address the coronavirus pandemic?

Congress should honor the treaty and trust obligations of the federal government and pass an adequate and equitable spending package to fully address unmet needs that plague our ability to provide care to our people, targeting the most critical needs for immediate investment.

Rural Definition Technical Fix

All tribes have not been eligible for HRSA rural health-directed relief funds through the CARES Act. HRSA has a narrow definition of rural included in statute, which does not include all of the 43 federally recognized in the IHS Portland Area. Congress must ensure that all definitions of rural include all tribal governments because all tribal communities are healthcare shortage areas.

Expansion of Self-Governance Contracting and Compacting

Tribes should be able to receive funding directly to the tribe and/or IHS, as requested by a tribe through intergovernmental or interagency transfer agreements, or through their ISDEAA Title I and Title V contracts and compacts.

The Indian Self-Determination and Education Assistance Act (ISDEAA) was passed in an effort to improve the health and well-being of AI/ANs, expand self-governance in the administration of federal programs, and to recognize tribal sovereignty and self-determination. The legislative promises of ISDEAA should be funded and fulfilled.

Mental Health and Substance Use Funding

COVID-19 has accentuated the need for additional funding for behavioral health services in Indian country. COVID-19 has created a nationwide environment of fear, anxiety, and depression, worsening existing mental health conditions, and increasing the need for mental health services. Diminished 3rd party insurance reimbursements, coupled with limited existing IHS funding is insufficient to provide the proper prevention, intervention, treatment and aftercare programs

that combat alcohol and substance use among AI/ANs. Congress must provide immediate and emergency funding to the Indian health care system to address this need.

Medicaid Technical Fixes

Congress should enact technical fixes to federal Medicaid law that will enable tribal providers to develop integrated systems of care that expand the quality and accessibility of health services, and maximize third party insurance reimbursement for Indian health providers within the Indian health system. The technical fixes include (1) authorizing Indian Health Care Providers to bill Medicaid for the full suite of medical services authorized under Medicaid and the Indian Health Care Improvement Act- called “Qualified Indian Provider Services”; (2) a permanent fix to the so-called “four walls” billing restriction under Medicaid; and (3) the extension of 100% federal medical assistance percentage (FMAP) to urban Indian organizations.

Tribal Broadband Connectivity

Congress must enact legislation that will immediately and sufficiently fund broadband connectivity and telehealth infrastructure needs within tribal communities at the U.S. Department of Agriculture (USDA), HHS, the Department of the Interior (DOI), DOJ, the Department of Energy (DOE), and the Department of Veterans Affairs (VA). This funding must be dedicated, recurring, and sustainable funding for expansion and streamlined implementation of telehealth across IHS and tribal facilities.

Amendment to the Stafford Act

The Stafford Act imposes a 25% cost-share on tribes as well as local and state governments in order to receive public assistance from the Federal Emergency Management Agency. The cost-share is a significant barrier for tribes as tribes do not have tax revenue to cover this expense. The U.S. Department of Treasury has informed tribes that the Tribal Coronavirus Relief funds can be utilized for the cost-share. However, tribes have many other priorities that for which the relief funds must be designated. Congress must amend the Stafford Act to permanently waive the cost-share requirement for tribal governments due to the federal trust and treaty obligations and the lack of tax revenue and underfunding.

III. CONCLUSION

NPAIHB is appreciative of the Commission’s examination of the response to the COVID-19 pandemic and updates to the *Broken Promises Report*. The historical injustices and inequalities to our tribal governments are a fundamental barrier in exercising our self-determination and self-governance. COVID-19 is far from over, Indian Country’s crisis during this public health emergency should be a call to action for the federal government to meet its trust and treaty obligations. For questions or additional information please contact NPAIHB’s Health Policy Analyst, Sarah Sullivan at (703) 203-6460 or ssullivan@npaihb.org.

Sincerely,



USCCR Chair Lhamon

July 24, 2020

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Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council