MINUTES

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

QUARTERLY BOARD MEETING

JUNE 5, 2020

A VIRTUAL MEETING VIA ZOOM

QUARTERLY BOARD MEETING

Via Zoom

June 5, 2020

MINUTES

Summary of Minutes

Issue	Summary	Action	Follow-Up
FRIDAY JUNE 5, 2020			
APPROVAL OF AGENDA	**Approval of Agenda;** Motion by Tracey Rascon, Makah, 2nd by Brent Simocosky, Jamestown S'Klallam Question called; **MOTION PASSES**	**MOTION**	**PASSED**
APRROVAL OF JANUAY 2020 MINUTES	**Approval of January 2020 Minutes;** Motion by Greg Abrahamson, Spokane, 2nd by Sharon Stanphill, Cow Creek; Question called; **MOTION PASSES**	**MOTION**	**PASSED**
NPAIHB BLACK LIVES STATEMENT	**Discussion of the Board Black Lives Matter statement,** reviewed; Motion by Cassie Sellards-Reck, Cowlitz, 2nd by Tracey Rascon, Makah, Question called; **MOTION PASSES**	**MOTION**	**PASSED**
RESOLUTIONS	• **20-02-05** *Approving and Authorizing Waiver of Sovereign Immunity for Purposes of Insurance Policies with Standard Insurance* o **MOTION** by Ali Desautel, Kalispel; 2nd by Marilyn Scott, Upper Skagit; Question called; **MOTION PASSES** • **20-02-06** Declaration of Public Health Emergencies Related to COVID-19 and Recommendations to Shut Down Non-Essential Services and to Shelter in Place o **MOTION** by Marilyn Scott, Upper Skagit; 2nd by Ali Desautel, Kalispel; Question called; **MOTION PASSES** • **20-02-07** *Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMSHA) Tribal Opioid Response (TOR) Grant*	**MOTION** **MOTION**	**PASSED** **PASSED**

Summary of Minutes

	○ **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**	**MOTION**	**PASSED**
	• **20-03-01** *Resolution in Support of Northwest Native American Research Center for Health Grant Application* ○ **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**	**MOTION**	**PASSED**
	• **20-03-02** *Health Resources Service Administration Opioid-Impacted Family Support Program Grant to Support CHAP BHA Project-Funding Opportunity* ○ **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**	**MOTION**	**PASSED**
	• **20-03-03** *Public Health Recommendations for a Phased Approach to Reopening Tribal Non-Essential Business, Entities, and Public Spaces* ○ **MOTION to TABLE** Resolution by Debra Jones, Samish; 2nd by Ali Desautel, Kalispel; Question called; **RESOLUTION TABLED**	**MOTION**	**TABLED**
	• **20-03-04** *Support Grant Submission to Centers of Disease Control and Prevention Bold Public Programs to Address Alzheimer's Disease and Related Dementias", Native Elders Project* ○ **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**	**MOTION**	**PASSED**
	• **20-03-05** Opposition *to Expansion of 100% FMAP to Non-IHS/Tribal Medicaid Providers without a Care Coordination Agreement or Tribal FQHC Contract*		

Summary of Minutes

	○ **MOTION** by Tracey Rascon, Makah; 2nd by Brent Simcosky, Jameston S'Klallam; Question called; **MOTION PASSES** • **20-03-06** *NW Tribal Juvenile Justice Alliance* *Cassie Sellards-Reck asked who are members, research team, are there any deliverables. Stephanie Craig-Rushing fielded question and send the information to Lisa Griggs to send out to the Board.* ○ **MOTION** by Cassie Sellards-Reck, Cowlitz; 2nd by Sharon Stanphil, Cow Creek; Question called**: MOTION PASSES** • **20-03-07 S***ocial and Economic Development Strategies: Leveraging We R Native and We R Healers* ○ **MOTION** by Cassie Sellards-Reck, Cowlitz; 2nd by Marilyn Scott, Upper Skagit; Question called: **MOTION PASSES**	**MOTION** **MOTION** **MOTION**	**PASSED** **PASSED** **PASSED**
AUDIT REPORT - CHRIS TYHURST, REDW	*Please see PowerPoint Presentation*		
AREA DIRECTOR REPORT - DEAN SEYLER, PAO IHS DIRECTOR	**Division of Financial Management** **Indian Health Service FY 2020 Coronavirus (COVID-19) Funding Allocations** ❖ **Supplemental 1**: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (CPRSAA), PL 116-123, dated March 6, 2020, $70M ❖ **Supplemental 2**: Families First Coronavirus Response Act (FFCRA), PL 116-127, dated March 18, 2020, $64M ❖ **Supplemental 3**: Coronavirus Aid, Relief, and Economic Security (CARES) Act, PL 116-136,		

Summary of Minutes

dated March 27, 2020, $1.034B

- **HHS/IHS Inter-Departmental Delegation of Authority:** Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020), $750M

Indian Health Service FY 2020 Coronavirus (COVID-19) Funding Allocations

- **COVID-19 Funding Guidance for Tribes, Tribal Organizations and Urban Indian Organizations: https://www.ihs.gov/coronavirus/resources/**
  - Guidance on Indian Health Service COVID-19 Funding Distribution for Tribes, Tribal Organizations, and Urban Indian Organizations
  - Fiscal Year 2020 Coronavirus (COVID-19) Funding Allocations

Division of Business Operations Purchase Referred Care

FY19 Catastrophic Health Emergency Fund (CHEF)
Status as of May 27, 2020

90 Total Cases
41 Total Amendments
$4,556,234.00 Reimbursed
$0 Pending Reimbursements
100% Total Reimbursed
FY19 CHEF Balance: $6,749,364

FY20 Catastrophic Health Emergency Fund (CHEF)
Status as of May 27, 2020

18 Total Cases

Summary of Minutes

	6 Total Amendments $228,623.00 Reimbursed $222,329.99 Pending Reimbursements 50% Total Reimbursed **FY20 CHEF Balance: $50,083,629**		
QUARTERLY FINANCE REPORT – EUGEN MOSTOFI, ACCOUNTING MANAGER	**MOTION to except the Finance Report present:** MOTION by Cassie Sellard-Reck, Cowlitz, 2nd by Ali Desautel, Kalispel, Question called for: **MOTION PASSES**		

EXECUTIVE DIRECTOR REPORT, LAURA PLATERO, JD	**Highlights**
	1. Office & Administration
	2. Staff
	3. Executive Committee
	4. New Funding
	5. Personnel
	6. Recognitions
	7. Looking Forward
	
	Office & Administration
	• Physical office closed on 3/16/20
	  • All staff on telework status since 3/16/20
	  • Essential staff in office on staggered schedule – Finance/IT
	  • Calendar to manage visits other staff who visit the office
	  • Closure of office anticipated through at least August.
	• Security improvements due to theft on Sunday, 5/27/20		

Summary of Minutes

- Alarm system being installed on 6/9/20
- New door with push bar to be installed

- Finance
  - Audit completed
  - Electronic purchase order software (Microix) in implementation phase
  - Electronic payments to vendors – in process
  - MIPS consultant to generate additional financial statements/budget

Staff

- Communications with staff
  - Daily 30-minute coffee/tea check-ins
  - Monthly staff and project director meetings
  - Weekly management meetings
- Other staff activities
  - Wellness activities
  - Virtual 2020 Student Honoring and Blanketing Ceremony on 4/26/20
  - August picnic- virtual gathering will be scheduled

Executive Committee

- Since, 3/20/20, Executive Committee has met weekly (with a few cancelled meetings)
- Passed 8 resolutions– require ratification by the Board
  - 20-02-05 -- Approving and Authorizing Waiver of Sovereign Immunity for Purposes of Insurance Policies with Standard Insurance Company
  - 20-02-06 -- Declaration of Public Health Emergency Related to COVID-19 and Recommendations to Shut Down Non-Essential Services and to Shelter in Place
  - 20-02-07 – SAMHSA Tribal Opioid Response Grant

Summary of Minutes

- 20-03-01 – NIH Northwest Native American Research Center for Health (NARCH) Grant
- 20-03-02 – HRSA Opioid-Impacted Family Support Program Grant to Support CHAP BHA
- 20-03-03 – Public Health Recommendations for Phased Approach to Reopening Tribal Non-Essential Businesses, Entities, and Public Spaces
- 20-03-04 – CDC BOLD PH Program to Address Alzheimer's Disease and Related Dementias-Native Elders Project Grant
- 20-03-05 – Opposition to Expansion of 100% FMAP to non-IHS/Tribal Medicaid Providers without a Care Coordination Agreement or Tribal FQHC Contract

New Funding

Funder	Start	End	Amount	Program
U of TexasHealth Center, sub NIH	2/1/20	11/30/21	37,960	Online decision support re: sexual health education in Tribal Communities
Native American Agricultural Fund	1/1/20	12/31/21	150,000	Needs of Native Farmers
Native American Agricultural Fund	1/1/20		45,000	COVID-19 Rapid Response Funding
CDC COVID-19 CARES Supplement	4/6/20		3,005,628	Funding for NPAIHB tribes
IHS COVID-19 CARES Special Provisions	4/9/20		97,616	Funding for NPAIHB to respond to COVID-19
CDC, NACCHO	5/1/20	2/1/21	199,997	Native-Serving Org. to Identify Legal Strategies - PH Data Sharing
ICF, sub CDC	4/1/20	12/31/21	25,000	Cancer prevention interventions in childhood, demonstration NCCCP
OHA - HOWTO	3/10/20	3/31/23	995,844	Development of diverse culturally competent healthcare workforce
OHSU - RISE (Indians Into Medicine)	4/1/2020*	6/30/24	54,150	Health Professionals Recruitment for Indians
IHS Diabetes Management Systems	3/11/20		35,768	Incorporates training and education sessions into program
			$ 4,646,963	
*OHSU RISE started in 9/2019, but not at NPAIHB				

Personnel

<u>6 New Hires</u>

Summary of Minutes

- Barbara Gladue – OR Tribal Public Health Improvement Project Manager – 2-12-20
- Celeste Davis – Environmental PublPersonnel
- ic Health Director – 2-24-20
- Melino Gianotti – OR Tribal Public Health Improvement Project Analyst – 3-2-20
- Lael Tate – THRIVE Project Coordinator – 3-16-20
- Dr. Tom Becker - Medical Epidemiologist & Project Director 4-13-20
- Ashley Hoover – Communicable Disease Epidemiologist 4-14-20

5 PROMOTIONS/Transfer

- Nancy Bennett – WA Tribal Public Health Improvement Project Manager – 1-21-20
- Nora Frank-Buckner – Promotion to Food Sovereignty Initiatives Director & WEAVE-NW FS Project Manager – 1-27-20
- Ryan Sealy – Environmental Public Health Project Scientist – 2-24-20
- Antoinette Aguirre – Environmental Public Health Project Specialist – 2-24-20
- Mattie Tomeo-Palmanteer – Cancer Prevention Project Coordinator – 6-22-20

2 OPEN POSITIONS UPDATE

- ECHO Case Manager – closes June 15, 2020
- Part-time Asthma Project Coordinator – closes June 26, 2020

Recognitions

- Thank you Eugene Mostofi, Fund Accounting Manager, for 10 years at NPAIHB!

Looking Forward

- Ensure tribes are getting needs met as to COVID-19 response and on other NPAIHB programs
- Survey Staff on virtual work needs

Summary of Minutes

	• Revive my 60-Day Plan as Executive Director • Continue contract work with Cindy Darcy in D.C. • Work on organizational budget for FY 2021		
NW TRIBAL EPICENTER COVID-19 AND TRIBAL EPICENTER UPDATE, VICTORIA WARREN-MEARS, NWTEC DIRECTOR	*Please see PowerPoint Presentation*		
LEGISLATIVE & POLICY UPDATE, SARAH SULLIVAN, HEALTH POLICY ANALYST	**Report Overview** 1. General News 2. Appropriations & Budget Formulation 3. COVID-19 Legislation 4. COVID-19 New Federal Policies 5. U.S. v. Texas Litigation 6. DHAT State Legislative Update **General News** • Rear Admiral (RADM) Michael D. Weahkee Confirmation as IHS Director – 4/21/20: RADM Weahkee was confirmed as the Director of the IHS for a four-year term. Director Weahkee has served as the interim head of the agency for the past 3 years. • **Re-establishment of the White House Council on Native American Affairs** – 4/28/20: White House and Department of the Interior announced the re-establishment of the White House Council on Native American Affairs, which was originally established by		

Summary of Minutes

President Obama in 2013. The Council will continue to lead the Administration's coVID-19 inter-agency response coordination with Indian country, as well as lead other Administration policy priorities**.**

Appropriations & Budget Formulation

- FY 2021 Appropriations:
  - No markup hearings have been scheduled yet.
  - NPAIHB submitted IHS and HHS House and Senate testimony.
- FY 2022 Budget Requests:
  - NPAIHB submitted HHS/IHS testimony on 5/1/20.
  - National Tribal Budget Formulation Workgroup submitted testimony for IHS Funding on 5/1/20 https://www.nihb.org/legislative/budget_formulation.php
- FY 2022 IHS Budget Formulation Evaluation/FY 2023 Planning Meeting
  - Virtual meeting being scheduled.

COVID-19 Response Legislative Packages

- **Stimulus #1: H.R. 6074** (Public Law No. 116-123) Coronavirus Preparedness and Response Supplemental Appropriations Act 2020
  - –Signed into law on March 6. Provided $8.3B in emergency response funding with a focus on vaccine research, medical supplies procurement, and support for public health agencies and small businesses.
  - –IHS: Provided $30M to IHS Federal health programs and $40M to purchase PPE and medical supplies through IHS National Supply Service Center and for all IHS programs.
  - –CDC: Provided no less than $40M in CDC funding for Indian Country, CDC increased it to $80M.
- **Stimulus #2: H.R. 6201** (Public Law No. 116-127) – Families First Coronavirus Response Act

Summary of Minutes

	–Signed into law on March 18. Provided $3.5B in funding. – IHS: $61M to IHS and Tribal health programs for program increases in Hospitals & Health Centers sub-account • **<u>Stimulus #3: H.R. 748</u>** (Public Law No. 116-136) – Coronavirus Aid, Relief, and Economic Security Act (CARES Act) – Signed into law on March 27. Provided $2.2 trillion in overall funding. – IHS: $1.032B including mandatory set asides: at least $450M to tribes, EHR stabilization and support ($65M) and facility needs ($125M). There was a short term reauthorization of SDPI at the current level of $150M per year through 11/2020. – CDC: $125M for grants or cooperative agreements with tribes and urban Indian organizations to carry out preparedness and response activities. – SAMHSA: $15M for SAMHSA mental and behavioral health services for tribes. – HRSA: $15M for health surveillance and other needs under the HRSA Rural Health program. • **Stimulus #3.5: H.R. 266** (Public Law No. 116-139)– Paycheck Protection Program and Health Care Enhancement Act –Signed into law on April 21. Provided $75B for eligible health care providers, $25B for coronavirus testing ($750M dedicated to Indian Country). **<u>COVID-19 Relief Package #4: HEROES Act (H.R. 6800)</u>** • IHS: $2.1 billion to address health care needs o $1 billion to account for lost third party revenue o $64 million to assist urban Indian organizations o $10 million to assist with sanitation, hydration and hygiene needs o $500 million to provide health care, including telehealth services and to purchase medical supplies and PPE		

Summary of Minutes

	○ $140 million to expand broadband infrastructure and IT for telehealth and EHR system purposes. ○ $20 million to provide health care, housing and isolation units for domestic violence victims and homeless Native Americans ○ No les than $366 million to provide isolation or quarantine space • SAMHSA: no less than $150 million for tribes, tribal organizations urban Indian organizations, or health service providers to tribes across a variety of programs. • CMS: extends 100% FMAP to urban Indian programs from July 1, 2020 to June 30, 2021 and allows services with a referral from an IHCP outside of the ”four walls” of a clinic from July 1, 2020 to June 30, 2021. • VA: clarification for the VA and DOD to reimburse IHS and Tribes for PRC services, regardless of where services are obtained. • Guarantees IHS and Tribal health organizations direct access to the Strategic National Stockpile, just like all 50 other states. **<u>HEROES Act Tribal-specific Provisions</u>** • Eliminate the sunset provisions under Section 30106 of the HEROES Act so that removal of the “four walls” Medicaid billing restriction and extension of 100% FMAP to urban Indian organizations are made permanent. • Authorize IHCPs to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs. • Permanently extend waivers under Medicare for use of telehealth. • Include Pharmacists, Licensed Marriage and Family Therapists, Licensed Professional Counselors, and other providers as eligible under Medicare for reimbursement to IHCPs. • Ensure parity in Medicare reimbursement for IHCPs.		

Summary of Minutes

- Permanently reauthorize the Special Diabetes Program for Indians (SDPI)

CMS COVID-19 1135 Waivers and CMCS Informational Bulletin

- CMS Section 1135 Waiver Authorities:
  - CMS has waived certain conditions of participation and provider-based requirements to allow temporary expansion of hospitals, waived certain requirements for clinics to screen patients off-site, and have added over 80 additional services that can be reimbursed.
- 4/2/20 CMCS Informational Bulletin on Medicaid Telehealth Flexibilities:
  - Medicare program specifically addresses telehealth delivery methods and criteria for implementing those methods, but States have a lot more latitude to design telehealth delivery methods for Medicaid.
  - MAT can be delivered via telehealth delivery methods due to the high rates of SUD and behavioral health conditions in AI/AN populations.
  - States can elect to cover SUD treatment services via telehealth provided by School Based Health Centers (i.e. assessments, counseling, MAT, and medication management.

CMS Interim Final Rule: Medicare & Medicaid Policy and Regulatory Changes in Response COVID-19

- Issued 11/18/19; **Comments Submitted 6/1/20**
- Waived limitations on the types of practitioners that can furnish Medicare telehealth services.
- Expanded telehealth modalities to allow reimbursement for audio-only telehealth visits and to use smart phones and platforms like FaceTime/Skype.
- Extended telephone assessment and management services which extended virtual check-

Summary of Minutes

	ins and e-visits that do not usually involve face-to-face visits. • Allow direct physician supervision of non-physician providers to be furnished via interactive telecommunications technology during the pandemic. • Allow use of two-way telephonic devices to provide opioid treatment services that are furnished via audio-only telephone calls. • **Portland Area Recommendations:** – CMS must work with the Indian health system to authorize continued use of telehealth capabilities in delivery of health care services during and after the public health emergency. – Reimbursement rates for IHCPs are drastically different for onsite physician services and distant site telehealth services. NPAIHB requested permanent implementation of the OMB all-inclusive rate (AIR) for Medicare services for the in-person visit and the virtual or telephone visit. **IHS Recent DTLLS** • 5/22/20: Request for assistance in identifying priority health professions for inclusion into categories eligible for the 2021-2022 IHS Scholarship Program and the FY 2021 IHS Loan Repayment Program (Comments Due 6/15) • 5/20/20: Updates on the Special Diabetes Program for Indians (SDPI) authorizing all current SDPI grants to their full annual grant amounts and ability to switch to a continuation application process for FY 2021. • 4/3/20: Announces the creation of a new IHS Opioid Grant Pilot Program (OGPP) • 3/4/20: Update on IHS SDPI for the current fiscal year and provide decisions regarding the next SDPI grant cycle. **Litigation: U.S. v. Texas Update**		

Summary of Minutes

- 3/2/20: U.S. Supreme Court announced that it will hear consolidated cases addressing the validity of the Affordable Care Act's (ACA) individual mandate provision (granting petition for certiorari).
- **Amicus Brief Argument:** District Court's finding that the entirety of the ACA, including the IHCIA, was unconstitutional was flawed with respect to the IHCIA and other Indian-specific health provisions of the ACA. The IHCIA has an entirely separate genesis and purpose, and therefore, should remain in effect even if the individual mandate is unconstitutional.
- NPAIHB joined the national coalition of tribes and tribal organization amicus brief, which will be filed with the Supreme Court in California v. Texas.
- Likely that the Court's review ill come during its next term that begins October 2020.

Dental Therapy Legislative Update Oregon

- A statewide dental therapy bill was introduced and had one hearing in Senate Health Care and did not move forward. In a short 35-day session (that resulted in virtually no bills passing because of legislators walking out early) we knew going in this would likely be the year we introduced bill for further work next legislative session.
- Senator Monnes Anderson (retiring Senate Health Care committee chair) convened an interim work group that is currently meeting to attempt to resolve questions that came up. Miranda Davis, NPAIHB; Kelle Little, Coquille; and Vicki Faciane, CTCLUSI are seated on the workgroup, as well as other members of the Oregon Dental Access Campaign, the coalition working to authorize dental therapy in Oregon.
- Representative Tawna Sanchez (Shoshone-Bannock, Ute, and Carrizo) and Director of Family Services at NAYA will be sponsoring the bill in the 2021 session.

Dental Therapy Legislative Update Washington

- The statewide licensing bill did not move out of the House again this session, so we will

Summary of Minutes

	start over in Washington as well. NPAIBH and Washington Tribes continue to play a leadership role in the Washington Dental Access Campaign and will be helping to reshape the effort after exploring coalition strengths and weakness and how best to move resources into those strategic campaign areas that need it. • Questions? Please contact Pam Johnson, Native Dental Therapy Initiative Project Manager, pjohnson@npaihb.org		
ADJOURN	**A call to ADJOURN at 3:33 pm,** MOTION by Cassie Sellards-Reck, Cowlitz, 2nd by Marilyn Scott, Upper Skagit, **MOTION PASSES**	**MOTION**	**PASSED**

QUARTERLY BOARD MEETING

Zoom Meeting

June 5, 2020
MINUTES

FRIDAY JUNE 5, 2020

Call to Order: Shawna Gavin, Secretary

Roll Call: Shawna Gavin, Secretary, called roll:

Burns Paiute Tribe – **Absent**	Nisqually Tribe – **Absent**
Chehalis Tribe – **Present**	Nooksack Tribe – **Absent**
Coeur d'Alene Tribe – **Absent**	NW Band of Shoshone – **Absent**
Colville Tribe – **Present**	Port Gamble Tribe – **Present**
Grand Ronde Tribe – **Present**	Puyallup Tribe – **Absent**
Siletz Tribe – **Present**	Quileute Tribe – **Absent**
Umatilla Tribe – **Present**	Quinault Nation – **Present**
Warm Springs Tribe – **Absent**	Samish Nation – **Present**
Coos, Lower Umpqua & Siuslaw Tribes – **Present**	Sauk Suiattle Tribe – **Absent**
Coquille Tribe – **Present**	Shoalwater Bay Tribe – **Present**
Cow Creek Tribe – **Present**	Shoshone-Bannock Tribe – **Absent**
Cowlitz Tribe – **Present**	Skokomish Tribe – **Absent**
Hoh Tribe – **Absent**	Snoqualmie Tribe – **Absent**
Jamestown S'Klallam Tribe – **Present**	Spokane Tribe – **Present**
Kalispel Tribe – **Present**	Squaxin Island Tribe – **Absent**
Klamath Tribe – **Present**	Stillaguamish Tribe – **Present**
Kootenai Tribe – **Present**	Suquamish Tribe – **Absent**
Lower Elwha Tribe – **Absent**	Swinomish Tribe – **Present**
Lummi Nation – **Absent**	Tulalip Tribe – **Absent**
Makah Tribe – **Present**	Upper Skagit Tribe – **Present**
Muckleshoot Tribe – **Absent**	Yakama Nation – **Absent**
Nez Perce Tribe – **Absent**	

There were 22 delegates present, a quorum is established.

Approval of Agenda; Motion by Tracey Rascon, Makah, 2nd by Brent Simocosky, Jamestown S'Klallam Question called; **MOTION PASSES**

Approval of January 2020 Minutes; Motion by Greg Abrahamson, Spokane, 2nd by Sharon Stanphill, Cow Creek; Question called; **MOTION PASSES**

Discussion of the Board Black Lives Matter statement, reviewed; Motion by Cassie Sellards-Reck, Cowlitz, 2nd by Tracey Rascon, Makah, Question called; **MOTION PASSES**

RESOLUTIONS

- **20-02-05** *Approving and Authorizing Waiver of Sovereign Immunity for Purposes of Insurance Policies with Standard Insurance*
    - **MOTION** by Ali Desautel, Kalispel; 2nd by Marilyn Scott, Upper Skagit; Question called; **MOTION PASSES**

- **20-02-06** Declaration of Public Health Emergencies Related to COVID-19 and Recommendations to Shut Down Non-Essential Services and to Shelter in Place
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- **20-02-07** *Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMSHA) Tribal Opioid Response (TOR) Grant*
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    - **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**

- **20-03-02** *Health Resources Service Administration Opioid-Impacted Family Support Program Grant to Support CHAP BHA Project-Funding Opportunity*
    - **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**

- **20-03-03** *Public Health Recommendations for a Phased Approach to Reopening Tribal Non-Essential Business, Entities, and Public Spaces*
    - **MOTION to TABLE** Resolution by Debra Jones, Samish; 2nd by Ali Desautel, Kalispel; Question called; **RESOLUTION TABLED**

- **20-03-04** *Support Grant Submission to Centers of Disease Control and Prevention Bold Public Programs to Address Alzheimer's Disease and Related Dementias", Native Elders Project*
    - **MOTION** by Marilyn Scott, Upper Skagit, 2nd by Brent Simcosky, Jamestown S'Klallam, Question called: **MOTION PASSES**

- **20-03-05** Opposition *to Expansion of 100% FMAP to Non-IHS/Tribal Medicaid Providers without a Care Coordination Agreement or Tribal FQHC Contract*
    - **MOTION** by Tracey Rascon, Makah; 2nd by Brent Simcosky, Jameston S'Klallam; Question called; **MOTION PASSES**

- **20-03-06** *NW Tribal Juvenile Justice Alliance*
  Cassie Sellards-Reck asked who are members, research team, are there any deliverables. Stephanie Craig-Rushing fielded question and send the information to Lisa Griggs to send out to the Board.
    - **MOTION** by Cassie Sellards-Reck, Cowlitz; 2nd by Sharon Stanphil, Cow Creek; Question called**: MOTION PASSES**

- **20-03-07** *Social and Economic Development Strategies: Leveraging We R Native and We R Healers*
    - **MOTION** by Cassie Sellards-Reck, Cowlitz; 2nd by Marilyn Scott, Upper Skagit; Question called: **MOTION PASSES**

AUDIT REPORT - CHRIS TYHURST, REDW

Organization and History

- Founded in 1953, REDWLLC is one of the largest CPA and business consulting firms based in the Southwestern U.S.
- Nearly 200 team members in Albuquerque and Phoenix
- Serve Tribes and healthcare organizations throughout the country

Audit Team

- Chris Tyhurst, CPA - Principal
- Alex Mercer – Senior Associate
- Victoria Spragg – Associate

Required Communications to Those Charged with Governance

- Required by our professional standards
- Discuss our views on:
    - NPAIHB's accounting practices and policies
    - Management's judgments and estimates
    - Financial statement disclosures
    - Financial statement and federal compliance
    - Other

Status of Our Audit — continued

- Our financial statement audit and federal awards audit is completed for the year ended September 30, 2019.
- Our audit was conducted in accordance with:
  - U.S. generally accepted auditing standards
  - Government Auditing Standards
  - Uniform Guidance
- Audit objective: Obtain ***reasonable*** – not absolute – assurance the financial statements are free from material misstatements, whether due to fraud or error.
- Scope of work performed was substantially the same as we discussed in our earlier audit planning communications meeting.
- We issued unmodified opinions on the financial statements and major federal programs compliance, and released our report on April 10, 2020.
- Our responsibility for other information contained in the financial statements.
- All records and information we requested were freely available for our inspection.
- Cooperation was excellent from management and all levels within the organization.

Results of Our Audit

- Accounting Practices and Policies
  - Significant accounting practices and policies are included in Note 1 to the financial statements
    - They are appropriate, comply with GAAP and industry standards, and were consistently applied
  - A summary of recently issued accounting pronouncements is included in Note 1
    - Leases
    - Revenue from Contracts with Customers
  - Implementation of new accounting standard
    - Presentation of Financial Statements of Not-for-Profit Entities
  - Aside from above, there were no significant changes in accounting policies and practices during the year
- Accounting Estimates
  - Significant accounting estimates include:
    - Depreciation expense
  - Management made no significant changes to the processes or assumptions used to develop significant accounting estimates during the fiscal year.
- Correcting Journal Entries
  - Management provided entry to reduce Indirect Revenue:

Internal Control Over Financial Reporting

- Professional standards require us to communicate to you, in writing, the following types of internal control over financial reporting items:

- Professional standards require us to communicate to you, in writing, the following types of internal control over financial reporting items:

Deficiency in Internal Control	A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.
Significant Deficiency	A deficiency or combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.
Material Weakness	A deficiency or combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of AHCH's financial statements will not be prevented, or detected and corrected on a timely basis.

- In conjunction with our audit of the financial statements, we noted no material weaknesses.
- No significant deficiencies were reported.

Single Audit (Uniform Guidance)

- The following major programs were tested in accordance with OMB Uniform Guidance provisions:
- Finding: Subrecipient Monitoring – CFDAs 93.228, 93.243 and 93.788

Other Required Communications

- No significant changes were made to our planned audit strategy or significant risks initially identified and discussed with you in our earlier audit planning communications meeting.
- No matters relevant to the audit regarding NPAIHB's financial reporting that we were made aware of as a result of our inquiries of those charged with.
- No specialized skills or knowledge were needed, outside our core engagement team, to perform the audit or evaluate results related to significant risks.
- Since our earlier audit planning communication meeting, there were no significant changes in:
    - The basis for our determination that we can serve as principal auditor.
- We are not aware of any consultations about accounting matters, auditing matters, or GAAP application between management and other CPA firms.

- No disagreements with management about matters, whether or not satisfactorily resolved, that could be significant to the NPAIHBs financial statements or our auditor's report.
- No significant difficulties we encountered during our audit.
- No other matters significant to the oversight of the NPAIHB's financial reporting process not previously communicated.
- Various representations were requested and obtained from management in the form of a written letter.
- Our engagement letter describes our responsibilities in accordance with professional standards and certain regulatory authorities with regard to independence and the performance of our services.

Financial Highlights
Current Ratio

- A financial ratio that measures whether or not an organization has enough resources to pay its debts for the next 12 months.
- Calculated by dividing current assets by current liabilities.

See PowerPoint for additional graphics

Days cash on hand

- Defined as the estimated number of days an organization can meet operating expenses if no additional revenues were received.
- Computed by dividing annual cash expenditures (excluding depreciation and bad debt) by 365 to obtain average daily expenditures. Then total cash on hand is divided by the average daily expenditures.

AREA DIRECTOR REPORT - DEAN SEYLER, PAO IHS DIRECTOR

Division of Financial Management

Indian Health Service FY 2020 Coronavirus (COVID-19) Funding Allocations

- **Supplemental 1**: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (CPRSAA), PL 116-123, dated March 6, 2020, $70M
- **Supplemental 2**: Families First Coronavirus Response Act (FFCRA), PL 116-127, dated March 18, 2020, $64M
- **Supplemental 3**: Coronavirus Aid, Relief, and Economic Security (CARES) Act, PL 116-136, dated March 27, 2020, $1.034B
- **HHS/IHS Inter-Departmental Delegation of Authority:** Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020), $750M

Indian Health Service FY 2020 Coronavirus (COVID-19) Funding Allocations

- **COVID-19 Funding Guidance for Tribes, Tribal Organizations and Urban Indian Organizations: https://www.ihs.gov/coronavirus/resources/**
  - Guidance on Indian Health Service COVID-19 Funding Distribution for Tribes, Tribal Organizations, and Urban Indian Organizations
  - Fiscal Year 2020 Coronavirus (COVID-19) Funding Allocations

Division of Business Operations Purchase Referred Care

FY19 Catastrophic Health Emergency Fund (CHEF)
Status as of May 27, 2020

90 Total Cases
41 Total Amendments
$4,556,234.00 Reimbursed
$0 Pending Reimbursements
100% Total Reimbursed
FY19 CHEF Balance: $6,749,364

FY20 Catastrophic Health Emergency Fund (CHEF)
Status as of May 27, 2020

18 Total Cases
6 Total Amendments
$228,623.00 Reimbursed
$222,329.99 Pending Reimbursements
50% Total Reimbursed
FY20 CHEF Balance: $50,083,629

QUARTERLY FINANCE REPORT – EUGEN MOSTOFI, ACCOUNTING MANAGER

MOTION to except the Finance Report present: MOTION by Cassie Sellard-Reck, Cowlitz, 2nd by li Desautel, Kalispel, Question called for: **MOTION PASSES**

EXECUTIVE DIRECTOR REPORT, LAURA PLATERO, JD

Highlights

1. Office & Administration
2. Staff
3. Executive Committee
4. New Funding
5. Personnel
6. Recognitions
7. Looking Forward

Office & Administration

- Physical office closed on 3/16/20
    - All staff on telework status since 3/16/20
    - Essential staff in office on staggered schedule – Finance/IT
    - Calendar to manage visits other staff who visit the office
    - Closure of office anticipated through at least August.
- Security improvements due to theft on Sunday, 5/27/20
    - Alarm system being installed on 6/9/20
    - New door with push bar to be installed
- Finance
    - Audit completed
    - Electronic purchase order software (Microix) in implementation phase
    - Electronic payments to vendors – in process
    - MIPS consultant to generate additional financial statements/budget

Staff

- Communications with staff
    - Daily 30-minute coffee/tea check-ins
    - Monthly staff and project director meetings
    - Weekly management meetings
- Other staff activities
    - Wellness activities
    - Virtual 2020 Student Honoring and Blanketing Ceremony on 4/26/20
    - August picnic- virtual gathering will be scheduled

Executive Committee

- Since, 3/20/20, Executive Committee has met weekly (with a few cancelled meetings)
- Passed 8 resolutions– require ratification by the Board
    - 20-02-05 -- Approving and Authorizing Waiver of Sovereign Immunity for Purposes of Insurance Policies with Standard Insurance Company

- 20-02-06 -- Declaration of Public Health Emergency Related to COVID-19 and Recommendations to Shut Down Non-Essential Services and to Shelter in Place
- 20-02-07 – SAMHSA Tribal Opioid Response Grant
- 20-03-01 – NIH Northwest Native American Research Center for Health (NARCH) Grant
- 20-03-02 – HRSA Opioid-Impacted Family Support Program Grant to Support CHAP BHA
- 20-03-03 – Public Health Recommendations for Phased Approach to Reopening Tribal Non-Essential Businesses, Entities, and Public Spaces
- 20-03-04 – CDC BOLD PH Program to Address Alzheimer's Disease and Related Dementias-Native Elders Project Grant
- 20-03-05 – Opposition to Expansion of 100% FMAP to non-IHS/Tribal Medicaid Providers without a Care Coordination Agreement or Tribal FQHC Contract

New Funding

Funder	Start	End	Amount	Program
U of TexasHealth Center, sub NIH	2/1/20	11/30/21	37,960	Online decision support re: sexual health education in Tribal Communities
Native American Agricultural Fund	1/1/20	12/31/21	150,000	Needs of Native Farmers
Native American Agricultural Fund	1/1/20		45,000	COVID-19 Rapid Response Funding
CDC COVID-19 CARES Supplement	4/6/20		3,005,628	Funding for NPAIHB tribes
IHS COVID-19 CARES Special Provisions	4/9/20		97,616	Funding for NPAIHB to respond to COVID-19
CDC, NACCHO	5/1/20	2/1/21	199,997	Native-Serving Org. to Identify Legal Strategies - PH Data Sharing
ICF, sub CDC	4/1/20	12/31/21	25,000	Cancer prevention interventions in childhood, demonstration NCCCP
OHA - HOWTO	3/10/20	3/31/23	995,844	Development of diverse culturally competent healthcare workforce
OHSU - RISE (Indians Into Medicine)	4/1/2020*	6/30/24	54,150	Health Professionals Recruitment for Indians
IHS Diabetes Management Systems	3/11/20		35,768	Incorporates training and education sessions into program
			$ 4,646,963	
*OHSU RISE started in 9/2019, but not at NPAIHB				

Personnel

6 New Hires

- Barbara Gladue – OR Tribal Public Health Improvement Project Manager – 2-12-20
- Celeste Davis – Environmental PublPersonnel
- ic Health Director – 2-24-20
- Melino Gianotti – OR Tribal Public Health Improvement Project Analyst – 3-2-20
- Lael Tate – THRIVE Project Coordinator – 3-16-20
- Dr. Tom Becker - Medical Epidemiologist & Project Director 4-13-20
- Ashley Hoover – Communicable Disease Epidemiologist 4-14-20

5 PROMOTIONS/Transfer

- Nancy Bennett – WA Tribal Public Health Improvement Project Manager – 1-21-20
- Nora Frank-Buckner – Promotion to Food Sovereignty Initiatives Director & WEAVE-NW FS Project Manager – 1-27-20
- Ryan Sealy – Environmental Public Health Project Scientist – 2-24-20
- Antoinette Aguirre – Environmental Public Health Project Specialist – 2-24-20
- Mattie Tomeo-Palmanteer – Cancer Prevention Project Coordinator – 6-22-20

2 OPEN POSITIONS UPDATE

- ECHO Case Manager – closes June 15, 2020
- Part-time Asthma Project Coordinator – closes June 26, 2020

Recognitions

- Thank you Eugene Mostofi, Fund Accounting Manager, for 10 years at NPAIHB!

Looking Forward

- Ensure tribes are getting needs met as to COVID-19 response and on other NPAIHB programs
- Survey Staff on virtual work needs
- Revive my 60-Day Plan as Executive Director
- Continue contract work with Cindy Darcy in D.C.
- Work on organizational budget for FY 2021

NW TRIBAL EPICENTER COVID-19 AND TRIBAL EPICENTER UPDATE, VICTORIA WARREN-MEARS, NWTEC DIRECTOR

COVIC-19 Leadership Team

- Laura Platero
- Thomas Weiser, MD – Indian Health Service Medial Epidemiologist
- Alex Wu – CDC EIS Officer
- Celeste Davis – Director Environmental Public Health Program (NWTEC)
- Tam Lutz – MCH Project Director (NWTEC)
- Jessica Leston – Community Clinical Learning (NWTEC)
- Stephanie Craig Rushing – Social Media and Digital Expertise (NWTEC)
- Victoria Warren-Mears – Director NWTEC Triage of Questions (NWTEC)

Service Areas for Local TECs

- NWTEC serves all northwest tribes: Idaho, Oregon and Washington
    - Have extensive data sharing and use agreements with tribes, state health departments and other regional partners. We have well over 22 data agreements which allow us to provide health profiles for the region.

  - UIHI serves Urban Indian Health Programs nationwide
  - For data surveillance for COVID-19, specifically with have a DSA with the Native Project and one pending for NARA.
- Currently conducting COVID-19 surveillance in partnership with Tribes and Indian Health Service – Portland Area Office

NPAIHB and the NWTEC began response ~ 2/24/2020

- Activated our 8 member response team.
- Established web site information www.npaihb.org/covid-19
- COVID-19 Weekly Call with tribal and state partners.
- Educational materials.
- Adjusted surveillance with Orpheus and Essence systems in OR and WA states
- Began data collection for Portland Area Office of Indian Health Service

Further NPAIHB and NWTEC Response

- COVID-19 Clinical ECHO established
  - Held twice weekly
  - Over 150 participants on each weekly call since it's inception
- Continue Development of Media Materials – youth focus
- Ongoing training and technical assistance
  - Current topics Outbreak Investigation and Contact tracing
  - 90 individuals trained to date.

Developed a COVID-19 Data Dashboard

- **http://www.npaihb.org/covid-19-data-dashboard/**
- **Emergency Department Surveillance for OR and WA**

Additional Responses

- Environmental Public Health Guidance for reopening of tribal enterprise.
- Continuing partnership with Columbia River Inter Tribal Fishing Commission (CRITFC) to ensure fisherman contact in isolated villages for testing and education.
- Stay home public health kits for patients with diabetes.
- FIT Testing capacity and kits for tribes
- Additional social media coming: future topics include; safe sweats, maternal child health, battling depression
- On-going tribal clinic revenue study
- Advocacy
- Contract Tracing staffing (5) in partnership with CDC foundation
- Tribal Grant Writer
- PHN and Social Work Case Manager

Other Major Accomplishments

- Hired an Environmental Health Department
  - Provided guidance on reopening of programs
- Dental
  - On-line CDE training
  - Assisted with teledentristry training/application
- NARCH
  - Large Grant submitted
  - Cancer Fellowship Training is now on-line
- Data/Epidemiology
  - Leveraged existing DSAs with states to obtain COVID-19 data
  - On-line data dashboard developed
- Diabetes Program
  - Achieved all annual goals
  - 100% diabetes audit submission for the Area
- **Cancer project**
  - **Submitted major grants**
  - **Cancer screening infographics developed**
  - **Tobacco Training**
- Public Health Modernization
  - Oregon and Washington Staff Hired
  - OR kick off meetings held with ½ of tribes
- Washington working on development of public health communicable disease data report cards.
- Expanded Clinical Support
  - LGBTQ+ support groups
  - Supporting 4 new ECHO series focused on Harm Reduction,
    - Peer Specialists,
    - Dental, and
    - COVID-19.

Starting March 18, the NPAIHB hosted twice weekly COVID-19 Indian Country ECHO telehealth clinics. From March 18 to May 27, the NPAIHB telehealth program had over 2,760 attendees from 24 states. While the majority of participants have been from the Pacific Northwest, the wide reach of pre-existing networks has brought in participants from 24 states, all 12 areas in the US covering Indian Country, Guam, Mexico and Canada

Right now, in this time of uncertainty, it is important for all of our Tribes to issue orders for community members to stay home, take a little time to look ahead, and continue to ask the federal government to honor treaty and trust obligations.
……. Tribes should reach out and help one another whenever possible. In this difficult time, we need each other to get through this pandemic.

Nickolaus Lewis, Chair, Northwest Portland Area Indian Health Board

LEGISLATIVE & POLICY UPDATE, SARAH SULLIVAN, HEALTH POLICY ANALYST

Report Overview

1. General News
2. Appropriations & Budget Formulation
3. COVID-19 Legislation
4. COVID-19 New Federal Policies
5. U.S. v. Texas Litigation
6. DHAT State Legislative Update

General News

- Rear Admiral (RADM) Michael D. Weahkee Confirmation as IHS Director
  - –4/21/20: RADM Weahkee was confirmed as the Director of the IHS for a four-year term. Director Weahkee has served as the interim head of the agency for the past 3 years.
- **Re-establishment of the White House Council on Native American Affairs**
  –4/28/20: White House and Department of the Interior announced the re-establishment of the White House Council on Native American Affairs, which was originally established by President Obama in 2013. The Council will continue to lead the Administration's coVID-19 inter-agency response coordination with Indian country, as well as lead other Administration policy priorities.

Appropriations & Budget Formulation

- FY 2021 Appropriations:
  - No markup hearings have been scheduled yet.
  - NPAIHB submitted IHS and HHS House and Senate testimony.
- FY 2022 Budget Requests:
  - NPAIHB submitted HHS/IHS testimony on 5/1/20.
  - National Tribal Budget Formulation Workgroup submitted testimony for IHS Funding on 5/1/20 https://www.nihb.org/legislative/budget_formulation.php
- FY 2022 IHS Budget Formulation Evaluation/FY 2023 Planning Meeting
  - Virtual meeting being scheduled.

COVID-19 Response Legislative Packages

- **Stimulus #1: H.R. 6074** (Public Law No. 116-123) Coronavirus Preparedness and Response Supplemental Appropriations Act 2020
  - –Signed into law on March 6. Provided $8.3B in emergency response funding with a focus on vaccine research, medical supplies procurement, and support for public health agencies and small businesses.
  - –IHS: Provided $30M to IHS Federal health programs and $40M to purchase PPE and medical supplies through IHS National Supply Service Center and for all IHS programs.
  - –CDC: Provided no less than $40M in CDC funding for Indian Country, CDC increased it to $80M.
- **Stimulus #2: H.R. 6201** (Public Law No. 116-127) – Families First Coronavirus Response Act
  - –Signed into law on March 18. Provided $3.5B in funding.
  - – IHS: $61M to IHS and Tribal health programs for program increases in Hospitals & Health Centers sub-account
- **Stimulus #3: H.R. 748** (Public Law No. 116-136) – Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
  - – Signed into law on March 27. Provided $2.2 trillion in overall funding.
  - – IHS: $1.032B including mandatory set asides: at least $450M to tribes, EHR stabilization and support ($65M) and facility needs ($125M). There was a short term reauthorization of SDPI at the current level of $150M per year through 11/2020.
  - – CDC: $125M for grants or cooperative agreements with tribes and urban Indian organizations to carry out preparedness and response activities.
  - – SAMHSA: $15M for SAMHSA mental and behavioral health services for tribes.
  - – HRSA: $15M for health surveillance and other needs under the HRSA Rural Health program.
- **Stimulus #3.5: H.R. 266** (Public Law No. 116-139)– Paycheck Protection Program and Health Care Enhancement Act
  - –Signed into law on April 21. Provided $75B for eligible health care providers, $25B for coronavirus testing ($750M dedicated to Indian Country).

COVID-19 Relief Package #4: HEROES Act (H.R. 6800)

- IHS: $2.1 billion to address health care needs
  - $1 billion to account for lost third party revenue
  - $64 million to assist urban Indian organizations
  - $10 million to assist with sanitation, hydration and hygiene needs
  - $500 million to provide health care, including telehealth services and to purchase medical supplies and PPE
  - $140 million to expand broadband infrastructure and IT for telehealth and EHR system purposes.
  - $20 million to provide health care, housing and isolation units for domestic violence victims and homeless Native Americans

  - No les than $366 million to provide isolation or quarantine space
- SAMHSA: no less than $150 million for tribes, tribal organizations urban Indian organizations, or health service providers to tribes across a variety of programs.
- CMS: extends 100% FMAP to urban Indian programs from July 1, 2020 to June 30, 2021 and allows services with a referral from an IHCP outside of the "four walls" of a clinic from July 1, 2020 to June 30, 2021.
- VA: clarification for the VA and DOD to reimburse IHS and Tribes for PRC services, regardless of where services are obtained.
- Guarantees IHS and Tribal health organizations direct access to the Strategic National Stockpile, just like all 50 other states.

HEROES Act Tribal-specific Provisions

- Eliminate the sunset provisions under Section 30106 of the HEROES Act so that removal of the "four walls" Medicaid billing restriction and extension of 100% FMAP to urban Indian organizations are made permanent.
- Authorize IHCPs to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs.
- Permanently extend waivers under Medicare for use of telehealth.
- Include Pharmacists, Licensed Marriage and Family Therapists, Licensed Professional Counselors, and other providers as eligible under Medicare for reimbursement to IHCPs.
- Ensure parity in Medicare reimbursement for IHCPs.
- Permanently reauthorize the Special Diabetes Program for Indians (SDPI)

CMS COVID-19 1135 Waivers and CMCS Informational Bulletin

- CMS Section 1135 Waiver Authorities:
  - CMS has waived certain conditions of participation and provider-based requirements to allow temporary expansion of hospitals, waived certain requirements for clinics to screen patients off-site, and have added over 80 additional services that can be reimbursed.
- 4/2/20 CMCS Informational Bulletin on Medicaid Telehealth Flexibilities:
  - Medicare program specifically addresses telehealth delivery methods and criteria for implementing those methods, but States have a lot more latitude to design telehealth delivery methods for Medicaid.
  - MAT can be delivered via telehealth delivery methods due to the high rates of SUD and behavioral health conditions in AI/AN populations.
  - States can elect to cover SUD treatment services via telehealth provided by School Based Health Centers (i.e. assessments, counseling, MAT, and medication management.

CMS Interim Final Rule: Medicare & Medicaid Policy and Regulatory Changes in Response COVID-19

- Issued 11/18/19; **Comments Submitted 6/1/20**
- Waived limitations on the types of practitioners that can furnish Medicare telehealth services.
- Expanded telehealth modalities to allow reimbursement for audio-only telehealth visits and to use smart phones and platforms like FaceTime/Skype.
- Extended telephone assessment and management services which extended virtual check-ins and e-visits that do not usually involve face-to-face visits.
- Allow direct physician supervision of non-physician providers to be furnished via interactive telecommunications technology during the pandemic.
- Allow use of two-way telephonic devices to provide opioid treatment services that are furnished via audio-only telephone calls.
- **Portland Area Recommendations:**
  – CMS must work with the Indian health system to authorize continued use of telehealth capabilities in delivery of health care services during and after the public health emergency.
  – Reimbursement rates for IHCPs are drastically different for onsite physician services and distant site telehealth services. NPAIHB requested permanent implementation of the OMB all-inclusive rate (AIR) for Medicare services for the in-person visit and the virtual or telephone visit.

IHS Recent DTLLS

- 5/22/20: Request for assistance in identifying priority health professions for inclusion into categories eligible for the 2021-2022 IHS Scholarship Program and the FY 2021 IHS Loan Repayment Program (Comments Due 6/15)
- 5/20/20: Updates on the Special Diabetes Program for Indians (SDPI) authorizing all current SDPI grants to their full annual grant amounts and ability to switch to a continuation application process for FY 2021.
- 4/3/20: Announces the creation of a new IHS Opioid Grant Pilot Program (OGPP)
- 3/4/20: Update on IHS SDPI for the current fiscal year and provide decisions regarding the next SDPI grant cycle.

Litigation: U.S. v. Texas Update

- 3/2/20: U.S. Supreme Court announced that it will hear consolidated cases addressing the validity of the Affordable Care Act's (ACA) individual mandate provision (granting petition for certiorari).
- **Amicus Brief Argument:** District Court's finding that the entirety of the ACA, including the IHCIA, was unconstitutional was flawed with respect to the IHCIA and other Indian-specific health provisions of the ACA. The IHCIA has an entirely separate genesis and

purpose, and therefore, should remain in effect even if the individual mandate is unconstitutional.

- NPAIHB joined the national coalition of tribes and tribal organization amicus brief, which will be filed with the Supreme Court in California v. Texas.
- Likely that the Court's review ill come during its next term that begins October 2020.

Dental Therapy Legislative Update Oregon

- A statewide dental therapy bill was introduced and had one hearing in Senate Health Care and did not move forward. In a short 35-day session (that resulted in virtually no bills passing because of legislators walking out early) we knew going in this would likely be the year we introduced bill for further work next legislative session.
- Senator Monnes Anderson (retiring Senate Health Care committee chair) convened an interim work group that is currently meeting to attempt to resolve questions that came up. Miranda Davis, NPAIHB; Kelle Little, Coquille; and Vicki Faciane, CTCLUSI are seated on the workgroup, as well as other members of the Oregon Dental Access Campaign, the coalition working to authorize dental therapy in Oregon.
- Representative Tawna Sanchez (Shoshone-Bannock, Ute, and Carrizo) and Director of Family Services at NAYA will be sponsoring the bill in the 2021 session.

Dental Therapy Legislative Update Washington

- The statewide licensing bill did not move out of the House again this session, so we will start over in Washington as well. NPAIBH and Washington Tribes continue to play a leadership role in the Washington Dental Access Campaign and will be helping to reshape the effort after exploring coalition strengths and weakness and how best to move resources into those strategic campaign areas that need it.
- Questions? Please contact Pam Johnson, Native Dental Therapy Initiative Project Manager, pjohnson@npaihb.org.

A call to ADJOURN at 3:33 pm, MOTION by Cassie Sellards-Reck, Cowlitz, 2nd by Marilyn Scott, Upper Skagit, MOTION PASSES

_____ _____

Prepared by Lisa Griggs, **Date**
Executive Administrative Assistant

_____ _____

Reviewed by Laura Platero, JD **Date**
NPAIHB Executive Director

_____ _____

Approved by Greg Abrahamson,
NPAIHB Secretary **Date**

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

QUARTERLY BOARD MEETING
ZOOM MEETING

June 5, 2020

AGENDA

FRIDAY JUNE 5, 2020

12:00 PM	Call to Order Invocation Welcome Roll Call	Cheryle Kennedy, NPAIHB Vice Chair Shawna Gavin, NPAIHB Treasurer
12:15 PM	1. Approve Agenda 2. Future Board Meeting Dates/Sites • July 13- 16, 2020 ~ Virtual • October 20 - 22, 2020 ~ Great Wolf Lodge, Chehalis, WA hosted by Chehalis Tribe • January 2021 ~ Portland, OR • April 2021, TBD 3. Review and Approve January QBM Minutes 4. Resolutions	
12:30 PM	Vice Chairman's Report **(1)**	Cheryle Kennedy, NPAIHB Vice Chair
12:45 PM	Executive Director Report **(2)**	Laura Platero, NPAIHB Executive Director
1:00 PM	Financial & Audit Report **(3)**	Eugene Mostofi, Account Manager Chris Tyhurst, REDW
1:45 PM	IHS Area Director Report **(4)**	Dean Seyler, Portland Area IHS Director
2:00 PM	COVID-19 Response & Epi Center Update **(5)**	Victoria Warren-Mears, NWTEC Director
2:30 PM	Legislative & Policy Update **(6)**	Sarah Sullivan, Health Policy Analyst
3:00 PM	Adjourn	

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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June 5, 2020

Re: In Solidarity with Black Lives Matter

The Northwest Portland Area Indian Health Board (NPAIHB)[1] stands with our Black relatives, many of whom are also Native. We know well the pain and agony of the current and historical systemic racism on Black people, Native people, and people of color. We grieve with you for George Floyd and the countless loved ones who are victims of racism and police brutality.

We send our deepest pride to each and every person who is part of the Black Lives Matter (BLM) movement to create change. Despite the risks in this pandemic, so many have been out on the streets to bring the roar of justice to all our ears because complacency is a matter of life or death. Racial disparities, white supremacy, violence against indigenous people impact us all in the same ways. This movement has once again grown into a strong and hopeful movement in the fight against oppression.

We are unified with you and demand nationwide systematic change. Addressing the injustices and disparities, bringing fairness to the criminal justice system and reparations will go a long way to healing. We honor and respect the work of BLM and everyone who is fighting for change. We offer you our love, support and prayers in this movement.

In Solidarity,

NPAIHB Delegates

[1]The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization, established in 1972, under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638 that advocates on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues. The Board's mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives (AI/AN) by supporting Northwest Tribes in the delivery of culturally appropriate, high quality health care.

Northwest Portland Area Indian Health Board
Balance Sheet
As of 3/31/2020

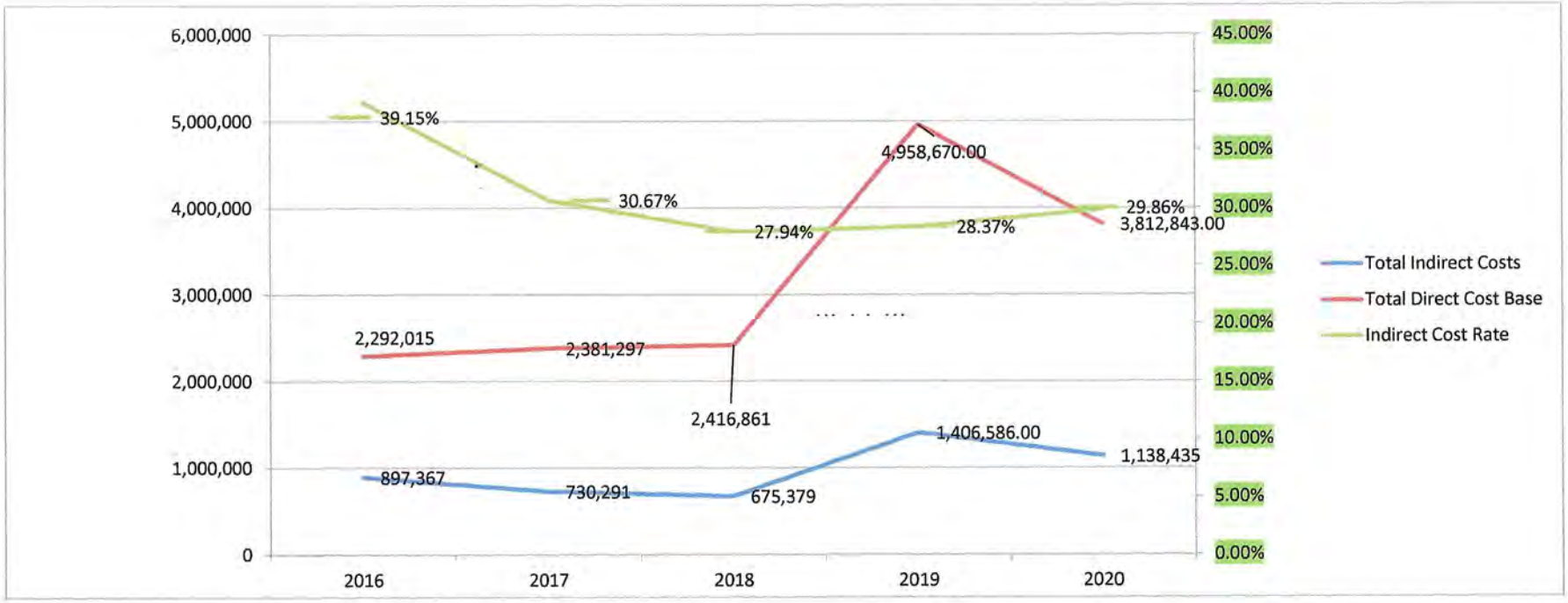
	Balance as of 3/31/2020	Balance as of 10/1/2019	Current Period Change	YTD % Change
Assets				
Current Assets				
Payroll, Petty Cash & Sec...	125.00	125.00	0.00	0.00
Operating Checking	6,922,958.25	6,902,827.12	20,131.13	0.29
Brokerage Account -Well...	1,404,590.23	1,492,766.41	(88,176.18)	(5.91)
Scholarship Account-Um...	527,715.79	527,328.63	387.16	0.07
Donated Funds	39,456.65	37,126.37	2,330.28	6.28
Travel Advance & Misc Rec	8,188.17	1,479.62	6,708.55	453.40
Contract & Grant Advances	(6,644,412.15)	(6,571,918.28)	(72,493.87)	1.10
Total Current Assets	2,258,621.94	2,389,734.87	(131,112.93)	(5.49)
Fixed Assets				
Computers	24,898.35	24,898.35	0.00	0.00
Furniture	145,316.53	147,140.98	(1,824.45)	(1.24)
Artwork	17,250.00	17,250.00	0.00	0.00
Accumulated Depreciation	(156,159.73)	(156,159.73)	0.00	0.00
Total Fixed Assets	31,305.15	33,129.60	(1,824.45)	(5.51)
Total Assets	2,289,927.09	2,422,864.47	(132,937.38)	(5.49)
Liabilities and Fund Balance				
Current Liabilities				
Accounts Payable	245,984.21	352,988.57	(107,004.36)	(30.31)
Retirement	13,804.63	13,320.16	484.47	3.64
Accrued Payroll	790.83	1,084.73	(293.90)	(27.09)
Accrued Annual Leave	193,906.02	168,555.88	25,350.14	15.04
Federal, State and Other ...	7,386.43	6,063.47	1,322.96	21.82
Flex Plan	28,149.86	17,277.99	10,871.87	62.92
Other Payroll Liabilities	1,312.78	1,462.98	(150.20)	(10.27)
Total Current Liabilities	491,334.76	560,753.78	(69,419.02)	(12.38)
Fund Balance				
	1,798,592.33	1,862,110.69	(63,518.36)	(3.41)
Total Liabilities and Fund Ba...	2,289,927.09	2,422,864.47	(132,937.38)	(5.49)

Northwest Portland Area Indian Health Board
Statement of Revenues and Expenditures - Board -R&E
From 10/1/2019 Through 3/31/2020

	Grants	Unrestricted	Indirect	Total
Revenues				
Program Revenue	8,918,535.84	0.00	0.00	8,918,535.84
Indirect Revenue	0.00	0.00	1,138,437.45	1,138,437.45
Other Revenue	0.00	(84,154.57)	0.00	(84,154.57)
Total Revenues	8,918,535.84	(84,154.57)	1,138,437.45	9,972,818.72
Expenditures				
Operating Expenditures				
Salaries & Wages	1,672,248.86	0.00	494,512.82	2,166,761.68
Payroll Taxes & Fringe Benefits	605,265.67	0.00	178,698.03	783,963.70
Prof. Fees & Contract Services	4,645,118.27	600.00	70,126.26	4,715,844.53
Rent & Facility Maint.	7,269.00	0.00	188,933.53	196,202.53
Equipment Lease & Maint.	0.00	0.00	31,371.09	31,371.09
Telephone	14,624.97	0.00	9,154.40	23,779.37
Insurance	0.00	0.00	6,665.35	6,665.35
Travel	548,633.56	2,788.99	64,549.94	615,972.49
Supplies and Equipment	210,637.64	2,714.83	67,485.63	280,838.10
Postage & Printing	60,298.84	0.00	6,673.22	66,972.06
Other Direct Expenses	16,003.63	(8,447.06)	1,974.21	9,530.78
Indirect Cost	1,138,435.40	0.00	0.00	1,138,435.40
Total Operating Expenditures	8,918,535.84	(2,343.24)	1,120,144.48	10,036,337.08
Total Expenditures	8,918,535.84	(2,343.24)	1,120,144.48	10,036,337.08
Revenue Over (Under) Expenditures	0.00	(81,811.33)	18,292.97	(63,518.36)

Indirect March for last 5 Years: Total Indirect Costs divided by Direct Cost Base

Year	2016	2017	2018	2019	2020
Total Indirect Costs	897,367	730,291	675,379	1,406,586.00	1,138,435
Total Direct Cost Base	2,292,015	2,381,297	2,416,861	4,958,670.00	3,812,843.00
Final Indirect Cost Rate	39.15%	30.67%	27.94%	28.37%	29.86%



March 2020 Over/Under Recovery		
TOTAL BASE EXPEND		3,812,843.00
TOTAL INDIRECT EXPENDED	999-00-00	1,138,435.40
Calculated Rate		29.86%
Provisional under-recovery		-85,487.14

Northwest Portland Area Indian Health Board
Statement of Revenues and Expenditures - NPAIHB - Unposted Transactions Included In Report
From 10/1/2019 Through 3/31/2020

Program Revenue/Expenses	Budget: October 2019 - Sept. 2020	Current Yr. Actual 2019-2020	Budget Remaining	Prior Year Actual 2018-2019	% Budget Remaining
Revenues					
Program Revenue					
Program Revenue	16,071,641	8,918,536	7,153,105	7,400,056	0.00%
Total Program Revenue	16,071,641	8,918,536	7,153,105	7,400,056	0.00%
Total Revenues	16,071,641	8,918,536	7,153,105	7,400,056	0.00%
Expenditures					
Operating Expenditures					
Salaries & Benefits	4,283,399	2,277,515	2,005,884	1,900,788	47%
Travel	1,108,769	548,634	560,135	522,377	51%
Supplies	158,765	120,817	37,948	86,918	24%
Minor Equipment	122,347	88,859	33,488	136,106	27%
Publications	119,136	61,260	57,875	29,167	49%
Telephone & Communication	37,780	14,625	23,155	17,244	61%
Lease & Maintenance	7,269	7,269	0	0	0%
Professional Services	1,378,179	678,111	700,068	692,145	51%
Other	549,176	16,004	533,172	9,515	97%
Total Operating Expenditures	7,764,820	3,813,093	3,951,727	3,394,260	51%
Pass Through Expend					
Contracts	5,850,466	3,906,728	1,943,738	2,698,599	33%
Education Stipends	60,280	60,280	0	209,120	0%
Indirect Allocated	2,396,075	1,138,435	1,257,640	1,098,077	52%
Total Pass Through Expend	8,306,821	5,105,443	3,201,378	4,005,796	39%
Total Expenditures	16,071,641	8,918,536	7,153,105	7,400,056	45%
			0		
Revenue Over (Under) Expenditures	0	0	0	0	

Northwest Portland Area Indian Health Board
Statement of Revenues and Expenditures-Detail - NPAIHB BOARD BUDGET - Unposted Transactions Included In Report
From 10/1/2019 Through 3/31/2020

Cost center	Title	Budget	Actual 10-1-2019 through 3-31-2020	Encumbrances	Remaining from Budget	Percent Total Budget Remaining - Original
100	IHS 638 Contract -9/30	3,453,508.00	1,209,770.83	712,923.00	1,530,814.17	44%
110	IHS-Epidemiology Center-9/15	1,039,893.00	349,347.11		690,545.89	66%
111	IHS-NW Special Diabetes-9/30	246,900.00	156,680.07		90,219.93	37%
117	WEAVE-Northwest	1,277,625.00	303,816.92		973,808.08	76%
122	CDC-Natl Cancer Preventi-6/29	287,575.00	119,305.63		168,269.37	59%
123	Thrive Purpose Area 4	103,331.45	37,197.84		66,133.61	64%
124	Thrive Purpose Area 2	111,267.68	28,427.31		82,840.37	74%
127	Narch 9 Promoting AI/AN Health	703,417.00	245,002.01	47,718.00	410,696.99	58%
129	We R Native Youth Development	310,249.00	133,448.64	13,306.00	163,494.36	53%
132	OMH Youth Spirit Project	51,800.00	27,306.94	24,493.06	0.00	0%
133	NW Tribal EPI Infrastructure	877,411.00	413,719.28	13,776.00	449,915.72	51%
134	OHSU-Sexual Health Messaging	60,679.00	0.00		60,679.00	100%
135	Injury Prevention Program	25,000.00	0.00		25,000.00	100%
136	HRSA-Pathways into Health	105,204.00	11,577.32		93,626.68	89%
137	Response Circles	85,281.05	35,192.30		50,088.75	59%
139	CDC Umbrella Public Health	447,847.00	203,930.47	30,600.00	213,316.53	48%
143	N.W. Tribal Dental Center	266,657.00	102,746.16	89,851.00	74,059.84	28%
145	Disseminating Effective Adoles	70,000.00	0.00	4,510.00	65,490.00	94%
146	NARCH X - Empowering AI/AN Hea	1,064,700.00	145,518.75	106,818.00	812,363.25	76%
147	Improve Use Motor Vehicle Data	490,470.00	195,808.94	182,456.00	112,205.06	23%
154	SAMHSA-Opioid Echo	534,200.26	133,145.49	51,107.00	349,947.77	66%
155	NW Juvenile Justice Alliance	64,145.00	30,045.42	7,920.00	26,179.58	41%
156	SAMHSA-Tribal Opioid Response	2,654,505.70	1,907,764.91	34,427.00	712,313.79	27%
157	OMH Opioid Response	349,999.00	157,750.57	34,550.00	157,698.43	45%
158	THRIVE-Tribal Health : Reachi	733,538.00	409,474.05	249,506.00	74,557.95	10%

Northwest Portland Area Indian Health Board
Statement of Revenues and Expenditures-Detail - NPAIHB BOARD BUDGET - Unposted Transactions Included In Report
From 10/1/2019 Through 3/31/2020

159	NIH-NIDA Investigating Opioid	230,275.00	58,376.54		171,898.46	75%
160	Environmental Health Tracking	44,880.00	0.00		44,880.00	100%
163	OHSU-Assessment of Cancer Burd	25,000.00	0.00		25,000.00	100%
164	SAMHSA TOR2	674,260.00	520,853.00		153,407.00	23%
211	Or. Preparedness & Response	0.00	0.00		0.00	#DIV/0!
213	WA DOH Parenting teens	126,404.00	80,547.17		45,856.83	36%
215	Yellowhawk Behavioral Health A	310,356.76	51,722.09		258,634.67	83%
216	State of Oregon TROCD	84,671.00	57,993.54	5,295.00	21,382.46	25%
217	State of Wa. HCA -CHAP	174,109.00	22,321.21		151,787.79	87%
218	Swinomish Behavioral Aid Progr	114,109.00	53,008.14	6,009.00	55,091.86	48%
219	TAM-WRN Mental Health	244,430.00	100,443.78	43,188.00	100,798.22	41%
223	WA. State Foundational Public	250,000.00	23,855.54		226,144.46	90%
224	Oregon Tribal PH Improvement	172,182.75	27,572.31		144,610.44	84%
225	NW Indian Health Board-BHA Cur	275,000.00	21,645.67		253,354.33	92%
306	Emerg. Prep. (EP) Conference	20,000.00	4,535.86		15,464.14	77%
911	Yellowhawk Cancer Data Project	8,664.58	1,714.67		6,949.91	80%
937	Kellogg-Dental Hlth Therapists	894,783.00	445,972.24	448,810.76	0.00	0%
943	BHA Training Scholarship	14,574.00	6,925.47		7,648.53	52%
948	Wa. Dental Therapy (WDTEP)	1,000,000.00	891,661.73	61,803.00	46,535.27	5%
950	Second Muse- Youth Wellbeing	6,705.00	3,963.00		2,742.00	41%
951	Ford Fndt-Or. Trib Denta Thera	175,010.00	66,564.84		108,445.16	62%
952	NW Hlth Fndtn Or Dental Access	25,000.00	9,977.32		15,022.68	60%
953	GHF DHAT Campaign Funds	300,000.00	105,007.02		194,992.98	65%
954	Navajo SMS	6,800.00	0.00		6,800.00	100%
955	NAAF-Food Sovereignty Project	105,000.00	0.00		105,000.00	100%
Total Expenditures		16,071,640.95	8,918,535.84	2,169,066.82	4,984,038.29	31%

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz Indians
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Band of Umpqua
Cowlitz Indian Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Nation
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribes
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Indian Nation

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RESOLUTION # 20-02-05

APPROVING AND AUTHORIZING WAIVER OF SOVEREIGN IMMUNITY FOR PURPOSES OF INSURANCE POLICIES WITH STANDARD INSURANCE COMPANY

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the NPAIHB wishes to enter into certain insurance policy agreements with Standard Insurance Company ("Standard"); and

WHEREAS, the NPAIHB wishes to waive its sovereign immunity from suit with respect to any claims brought by Standard in federal or state court arising from or relating to any group insurance policies issued to it by Standard;

NOW THEREFORE BE IT RESOLVED, that the NPAIHB hereby authorizes its Executive Director to execute a limited waiver of sovereign immunity from suit for claims arising from or relating to group insurance policies issued to NPAIHB by Standard.

CERTIFICATION

NO. 20-02-05

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; __5__ for, __0__ against, __0__ abstain on __January 31, 2020.

Chairman

January 31, 2020
Date

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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RESOLUTION # 20-02-06

DECLARATION OF PUBLIC HEALTH EMERGENCY RELATED TO COVID-19 AND RECOMMENDATIONS TO SHUT DOWN NON-ESSENTIAL SERVICES AND TO SHELTER IN PLACE

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; **AND**

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; **AND**

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes 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; **AND**

WHEREAS, the Northwest Tribal Epidemiology Center is a Public Health Authority, as defined in the Affordable Care Act, Indian Health Care Improvement Act Authorization of 2010, 25 USCS § 1621m(e)(1); **AND**

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; **AND**

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member tribes and American Indians/Alaska Natives (AI/AN); **AND**

WHEREAS, beginning in November 2019, the novel (new) coronavirus known as SARS-CoV-2 ("COVID-19") began to spread from China to other countries and has spread worldwide, including the United States; **AND**

WHEREAS, on March 11, 2020**,** a novel (new) coronavirus known as SARS-CoV-2 ("COVID-19") was declared a pandemic by the World Health Organization; **AND**

WHEREAS, on March 13, 2020, the President declared a National emergency due to the coronavirus**,** and Idaho, Oregon and Washington have declared states of emergency due to the coronavirus; **AND**

WHEREAS, many of our member tribes have declared states of emergency; **AND**

WHEREAS, hundreds of thousands of individuals have tested positive for COVID-19 and it is rapidly growing around the world, the United States, and in the Northwest; **AND**

WHEREAS, numbers of diagnoses will continue to increase as testing becomes more available; **AND**

WHEREAS, without intentional community-level preparation and response many more AI/AN will be diagnosed with COVID-19; **AND**

WHEREAS, sheltering in place (means finding a safe location indoors and staying there, unless performing essential activities) has been shown to slow the spread of diseases and protect vulnerable people and communities; **AND**

WHEREAS, the NPAIHB has a responsibility to protect our communities and is deeply concerned for the health and wellbeing of our member tribes, tribes nationwide, AI/AN people, and all people.

THEREFORE BE IT RESOLVED that the NPAIHB will prepare for the possibility of a COVID-19 pandemic that could last up to 18 months and include multiple waves of illness; **AND**

BE IT FURTHER RESOLVED that the NPAIHB is declaring a public health emergency; **AND**

BE IT FURTHER RESOLVED that the NPAIHB strongly recommends that our member tribes, and tribes nationwide, mitigate the COVID-19 pandemic by taking necessary steps to stop the spread of COVID-19 by closing non-essential services within their tribal communities; **AND**

BE IT FURTHER RESOLVED that NPAIHB supports each tribe define essential services and that essential services be limited to those necessary for public health and safety; **AND**

BE IT FURTHER RESOLVED that NPAIHB recommends tribes immediately enact shelter in place for their communities and people and cancel all social gatherings to stop the spread of COVID-19 and that all AI/AN people and those in their homes and communities shelter in place; **AND**

BE IT FINALLY RESOLVED, that NPAIHB recommends that all tribes, AI/AN people, and all people practice social distancing when out of the home accessing or providing essential services/needs.

CERTIFICATION

NO: 20-02-06

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 5 for, 0 against, 0 abstain on March 20, 2020.

Chairman

Secretary

March 20, 2020
Date

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
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Kalispell Tribe
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Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
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Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
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Stillaguamish Tribe
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RESOLUTION # 20-02-07

Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response (TOR) Grant

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board"} was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; **and**

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; **and**

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS §450b, a tribal organization is recognized as a governing body of any Indian tribe and includes 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; **and**

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; **and**

WHEREAS, since 1997, Northwest American Indian/Alaska Native (Al/AN) people have had consistently higher drug and opioid overdose mortality rates compared to non-Hispanic Whites (NHW) in the Northwest region; **and**

WHEREAS, from 2012-2016, the Al/AN age-adjusted death rate for drug overdose was more than twice the rate of non-AI/AN in the region, and the rate of opioid overdose was 2.7 times higher; **and**

WHEREAS, our member tribes are in need of additional resources directly from the federal government for funding to combat the multitude of problems related to opioid use through best practices for their tribal members; **and**

WHEREAS, the Department of Health and Human Services (HHS} Substance

Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response (TOR), FOA No. Tl-20-011, provides up to 200 awards to tribes across Indian country, including all of our member tribes; **and**

WHEREAS, the NPAIHB's Northwest Tribal Epidemiology Center (EpiCenter) is authorized to operate nationally to carry out the goals and objectives of SAMHSA's TOR grant and to coordinate a NPAIHB TOR Consortium on behalf of our interested member tribes; **and**

WHEREAS, the NPAIHB has deeply rooted partnerships with our member tribes, and has a successful track record of administering public health programs that are sensitive to the concerns and needs of tribal communities, including prior iterations of TOR funding (H79TI081812, H79TI082598); **and**

WHEREAS, our member tribes have provided NPAIHB with the authority to apply for the SAMHSA TOR grant on their behalf as part of the NPAIHB TOR Consortium; **and**

WHEREAS, NPAIHB is not competing with member tribes applying for this funding directly, but rather, ensuring that those tribes that do not apply directly receive funding for grant activities through the NPAIHB TOR Consortium; **and**

WHEREAS, NPAIHB EpiCenter would provide leadership, coordination, data management and analytic support, and training and technical assistance to member tribes participating in the NPAIHB TOR Consortium to ensure successful completion of grant activities; **and**

WHEREAS, the goals of this initiative are consistent with the goals and objectives of both the NPAIHB and the NW Tribal EpiCenter strategic plan; **and**

THEREFORE BE IT RESOLVED that the NPAIHB endorses and supports efforts by staff of the NPAIHB/NW Tribal EpiCenter, under the guidance of the Executive Director, to pursue funding through the Tl-20-011 SAMHSA TOR grant on behalf of member tribes who participate in the NPAIHB TOR Consortium.

CERTIFICATION

NO. 20-02-07

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; _____5___ for, ___0_____ against, ____0____ abstain on __March 27, 2020.

_____

Chairman

March 27, 2020
Date

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, & Lower Umpqua Tribe
Coquille Tribe
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RESOLUTION NO.: 20-03-01

RESOLUTION IN SUPPORT OF NORTHWEST NATIVE AMERICAN RESEARCH CENTER FOR HEALTH GRANT APPLICATION

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of American Indian/Alaska Native (AI/AN) people; and

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes 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; and

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of AI/AN people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, the Northwest Native American Research Centers for Health (NARCH) is one of the NPAIHB programs working toward health promotion of regional tribes;

WHEREAS, the NARCH program proposes to further health promotion education programs for tribal people in the areas of cancer prevention, applied biostatistics, and via a variety of summer training classes;

WHEREAS, the NARCH program also proposes to address fall prevention among elderly tribal members, as an important public health concern;

NOW, THEREFORE BE IT RESOLVED that the Northwest Portland Area Indian Health Board supports the NW NARCH application for funding from the National Institutes of Health and Indian Health Service.

CERTIFICATION

NO. 20-03-01

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 5 for, 0 against, 0 abstain on April 7,2020.

Chairman

April 7, 2020
Date

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

2121 S.W. Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

RESOLUTION # 20-03-02

HEALTH RESOURCES SERVICES ADMINISTRATION OPIOID-IMPACTED FAMILY SUPPORT PROGRAM GRANT TO SUPPORT CHAP BHA PROJECT - FUNDING OPPORTUNITY NUMBER: HRSA-20-014

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a non-governmental "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes 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; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, American Indians/Alaska Natives (AI/AN) have very limited access to health care services and are disproportionately affected by behavioral health disparities and these disparities are directly attributed to the lack of health professionals in AI/AN communities, which has caused a serious access issue and backlog of health services for AI/AN people; and

WHEREAS, many of our member tribes have great difficulty and face significant challenges in recruiting health professionals to have in their communities that results in further challenges in ensuring continuity and comprehensive healthcare for AI/AN people; and

WHEREAS, this specific funding opportunity supports developing the behavioral health workforce for AI/AN people in Idaho, Oregon and Washington to deliver sustainable, culturally relevant behavioral health services in AI/AN communities; and

WHEREAS, the Alaska Community Health Aide Program (CHAP) has been in existence since 1964 as a program of the Indian Health Service (IHS) and has a successful Behavioral Health Aide (BHA) Program; and

WHEREAS, CHAP grows providers from within Tribal communities who provide patient-centered quality care that comes from providers that understand the history, culture, and language of their patients, and

WHEREAS, CHAP workforce is contingent upon the development of CHAP education programs and training centers; and

WHEREAS, our member tribes would benefit from BHA education programs in Washington; and

WHEREAS, NPAIHB has a Tribal Community Health Provider Program that has been working towards CHAP Expansion in the Northwest with establishing a Dental Health Aide Therapist program and BHA program; and

WHEREAS, NPAIHB has a longstanding relationship with Northwest Indian College, Swinomish, Didgwalic, Yakama Nation, Heritage University and Alaska Native Tribal Health Consortium and these entities have agreed to work with NPAIHB to establish a BHA education program in the Northwest.

THEREFORE, BE IT RESOLVED that the NPAIHB endorses and supports efforts by NPAIHB Tribal Community Health Provider Program staff to create the Northwest *Tribal Behavioral Health Aide Education Program,* under the guidance of the NPAIHB Executive Director, to pursue funding through Health Resources & Services Administration ***– Opioid-Impacted Family Support Program funding to support Washington BHA Education Programs.***

CERTIFICATION

NO. 20-03-02

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 5 for, 0 against, 0 abstain on April 17, 2020.

Chairman

April 17, 2020
Date

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
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Makah Tribe
Muckleshoot Tribe
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Nooksack Tribe
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Skokomish Tribe
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Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
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RESOLUTION NO.: 20-03-04

"SUPPORT GRANT SUBMISSION TO CENTERS FOR DISEASE CONTROL AND PREVENTION BOLD PUBLIC HEALTH PROGRAMS TO ADDRESS ALZHEIMER'S DISEASE AND RELATED DEMENTIAS", NATIVE ELDERS PROJECT

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the NPAIHB is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes 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; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, AI/AN elders are at a higher threat for Alzheimer's / Dementia and between 2012 and 2050, the number of AI/ANs aged ≥ 65 years will increase by nearly four-times,

WHEREAS, AI/ANs have a disproportionate burden of many established modifiable risk factors for dementia, including diabetes, obesity, depression, tobacco use, binge drinking, and traumatic brain injuries; and

WHEREAS, studies have reported that cardiovascular risk factors are associated with 50-60% higher risk of dementia in US; and

WHEREAS, once diagnosed with dementia, these same risk factors may influence its progression

WHEREAS, the Centers for Disease Control and Prevention have issued a request for applications for CDC-RFA-DP20-2004 and is titled: BOLD Public Health Programs to Address Alzheimer's Disease and Related Dementias; and

WHEREAS, identifying and addressing modifiable risk factors could substantially reduce the burden of dementia on the health care systems serving AI/AN's.

WHEREAS, The Western Tribal Diabetes Project and the Northwest Tribal Comprehensive Cancer Project currently address resources and prevention in chronic disease risk factors in our tribal communities, and has the experience and capacity to carry out activities of the proposed BOLD Public Health project: work with the NPAIHB elders committee to establish and support an advisory committee, develop a strategic plan; build on partnerships; promote capacity building at the tribal level;

WHEREAS, the NPAIHB to support the development and implementation of resources, training and dissemination for Alzheimer's and dementia awareness,

NOW, THERFORE BE IT RESOLVED that the NPAIHB approves a submission of a grant application to the CDC to request funding for Public Health Programs to Address Alzheimer's Disease and Related Dementias.

NO. 20-03-04

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; ____5___ for, ___0____ against, ____0____ abstain on __May 22, 2020.

Chairman

___May 22, 2020_____
Date

Secretary

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
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RESOLUTION # 20-03-05

OPPOSITION TO EXPANSION OF 100% FMAP TO NON-IHS/TRIBAL MEDICAID PROVIDERS WITHOUT A CARE COORDINATION AGREEMENT OR TRIBAL FQHC CONTRACT

WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist tribal governments to improve the health status and quality of life of American Indian/Alaska Native (AI/AN) people; and

WHEREAS, the NPAIHB is a tribal organization as defined by the Indian Self-Determination and Education Assistance Act, P.L. 93-638 seq. et al., (ISDEAA) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the ISDEAA at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian Tribe and includes 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; and

WHEREAS, the NPAIHB is dedicated to assisting and promoting the health needs and concerns of AI/AN people; and

WHEREAS, tribes have a unique government-to-government relationship with the federal government, and it is required that the federal government consult with tribes on any policy or action that will significantly impact tribal governments; and

WHEREAS, tribal nations are political, sovereign entities whose status stems from the inherent sovereignty they possess as self-governing people predating the founding of the United States, and since its founding the United States has recognized them as such and entered into treaties with them on that basis; and

WHEREAS, the federal government's trust responsibility includes ensuring access to federal health programs like Medicaid; and

WHEREAS, 42 U.S.C. § 1396d(b) provides that the federal government will pay 100% Federal Medical Assistance Percentage (FMAP) for services "received through" an IHS or tribal facility; and

WHEREAS, the Centers for Medicare & Medicaid Services (CMS) State Health Official Letter (dated February 26, 2016) (SHO #16-002) and Frequently Asked Questions (FAQ) (dated January 18, 2017) expanded the 100% FMAP policy to allow for IHS and tribal facilities to enter into written care coordination agreements or Tribal Federal Qualified Health Center (FQHC) contracts with non-IHS/Tribal providers to furnish certain services for

their patients who are AI/AN Medicaid beneficiaries and the amounts paid by the state for services requested by the facility under such agreements would be eligible for 100% FMAP under section 1905(b) of the Social Security Act; and

WHEREAS, the 100% FMAP for services "received through" an IHS or tribal facility is intended to benefit the IHS or tribal facility and the Indian Health System; and

WHEREAS, there has been a legislative proposal that would expand 100% FMAP to all Medicaid providers who provide services to AI/AN without a care coordination agreement or Tribal FQHC contract thereby increasing significant Medicaid reimbursement funding to states and non-Indian providers with no guarantee that additional funding will support the Indian Health System or provide better care to individual AI/AN; and

WHEREAS, the legislative proposal would change over 40 years of established Indian Medicaid policy without tribal consultation and potentially impact the coordination of care for AI/AN patients that IHS and tribal healthcare facilities provide; and

WHEREAS, changes to Medicaid and 100% FMAP for services "received through" an IHS or tribal facility must move forward in a manner that respects tribal sovereignty and upholds federal treaty and trust responsibilities.

NOW THEREFORE BE IT RESOLVED, that the Northwest Portland Area Indian Health Board opposes efforts to expand the one hundred percent Federal Medical Assistance Percentage (100% FMAP) to a non-IHS/Tribal Medicaid provider without a care coordination agreement or Tribal Federally Qualified Health Center (FQHC) contract as described in the CMS State Official Health dated February 26, 2016 (SHO #16-002) or CMS Frequently Asked Questions (FAQ) on Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid Eligible American Indians and Alaska Natives dated January 18, 2017 as it would drastically decrease a vital funding resource to a chronically underfunded Indian Health System, resulting in decreased health services to American Indians and Alaska Natives.

CERTIFICATION
NO. 20-03-05

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; ____5___ for, ___0____ against, ____0____ abstain on __May 22, 2020.

Chairman

May 22, 2020
Date

Secretary

Northwest Portland Area Indian Health Board

Audit Summary Presentation

Fiscal Year Ended

September 30, 2019

Organization and History

- Founded in 1953, REDW LLC is one of the largest CPA and business consulting firms based in the Southwestern U.S.
- Nearly 200 team members in Albuquerque and Phoenix
- Serve Tribes and healthcare organizations throughout the country

Audit Team

- Chris Tyhurst, CPA - Principal
- Alex Mercer – Senior Associate
- Victoria Spragg - Associate

Required Communications to Those Charged with Governance

- Required by our professional standards
- Discuss our views on:
  - NPAIHB's accounting practices and policies
  - Management's judgments and estimates
  - Financial statement disclosures
  - Financial statement and federal compliance
  - Other

Status of Our Audit — continued

- Our financial statement audit and federal awards audit is completed for the year ended September 30, 2019.
- Our audit was conducted in accordance with:
  - U.S. generally accepted auditing standards
  - Government Auditing Standards
  - Uniform Guidance
- Audit objective: Obtain ***reasonable*** – not absolute – assurance the financial statements are free from material misstatements, whether due to fraud or error.

Status of Our Audit — continued

- Scope of work performed was substantially the same as we discussed in our earlier audit planning communications meeting.
- We issued unmodified opinions on the financial statements and major federal programs compliance, and released our report on April 10, 2020.

Status of Our Audit — continued

- Our responsibility for other information contained in the financial statements.
- All records and information we requested were freely available for our inspection.
- Cooperation was excellent from management and all levels within the organization.

Results of Our Audit

- Accounting Practices and Policies
  - Significant accounting practices and policies are included in Note 1 to the financial statements
    - They are appropriate, comply with GAAP and industry standards, and were consistently applied
  - A summary of recently issued accounting pronouncements is included in Note 1
    - Leases
    - Revenue From Contracts With Customers
  - Implementation of new accounting standard
    - Presentation of Financial Statements of Not-for-Profit Entities
  - Aside from above, there were no significant changes in accounting policies and practices during the year

Results of Our Audit — continued

- Accounting Estimates
  - Significant accounting estimates include:
    - Depreciation expense
  - Management made no significant changes to the processes or assumptions used to develop significant accounting estimates during the fiscal year.

Results of Our Audit — continued

- Correcting Journal Entries
  - Management provided entry to reduce Indirect Revenue:

Account	Description	Debit	Credit
999-4035	Indirect Revenue	807.00	
999-6013	Minor Computer		807.00
Total		**807.00**	**807.00**

Internal Control Over Financial Reporting

- Professional standards require us to communicate to you, in writing, the following types of internal control over financial reporting items:

Category	Definition
Deficiency in Internal Control	A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.
Significant Deficiency	A deficiency or combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.
Material Weakness	A deficiency or combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of AHCH's financial statements will not be prevented, or detected and corrected on a timely basis.

Internal Control Over Financial Reporting — continued

- In conjunction with our audit of the financial statements, we noted no material weaknesses.
- No significant deficiencies were reported.

Single Audit (Uniform Guidance)

- The following major programs were tested in accordance with OMB Uniform Guidance provisions:

CFDA #	Program Name
93.228	Health Management Development Program
93.243	Substance Abuse and Mental Health
93.772	Public Health Improvement and Training
93.788	Tribal Opioid Response

Single Audit (Uniform Guidance)

Finding: Subrecipient Monitoring – CFDAs 93.228, 93.243 and 93.788

Criteria: The OMB Uniform Grant Guidance (2 CFR 200.331) requires that pass-through entities such as NPAIHB (1) evaluate each subrecipient's risk of noncompliance and (2) monitor the activities of the subrecipient as necessary to ensure compliance.

Condition: Risk assessments were not performed. Some monitoring procedures were performed, but not enough to meet the requirements of the Uniform Grant Guidance.

Other Required Communications

- No significant changes were made to our planned audit strategy or significant risks initially identified and discussed with you in our earlier audit planning communications meeting.
- No matters relevant to the audit regarding NPAIHB's financial reporting that we were made aware of as a result of our inquiries of those charged with.
- No specialized skills or knowledge were needed, outside our core engagement team, to perform the audit or evaluate results related to significant risks.

Other Required Communications — continued

- Since our earlier audit planning communication meeting, there were no significant changes in:
  - The basis for our determination that we can serve as principal auditor.

Other Required Communications — continued

- We are not aware of any consultations about accounting matters, auditing matters, or GAAP application between management and other CPA firms.
- No disagreements with management about matters, whether or not satisfactorily resolved, that could be significant to the NPAIHBs financial statements or our auditor's report.
- No significant difficulties we encountered during our audit.

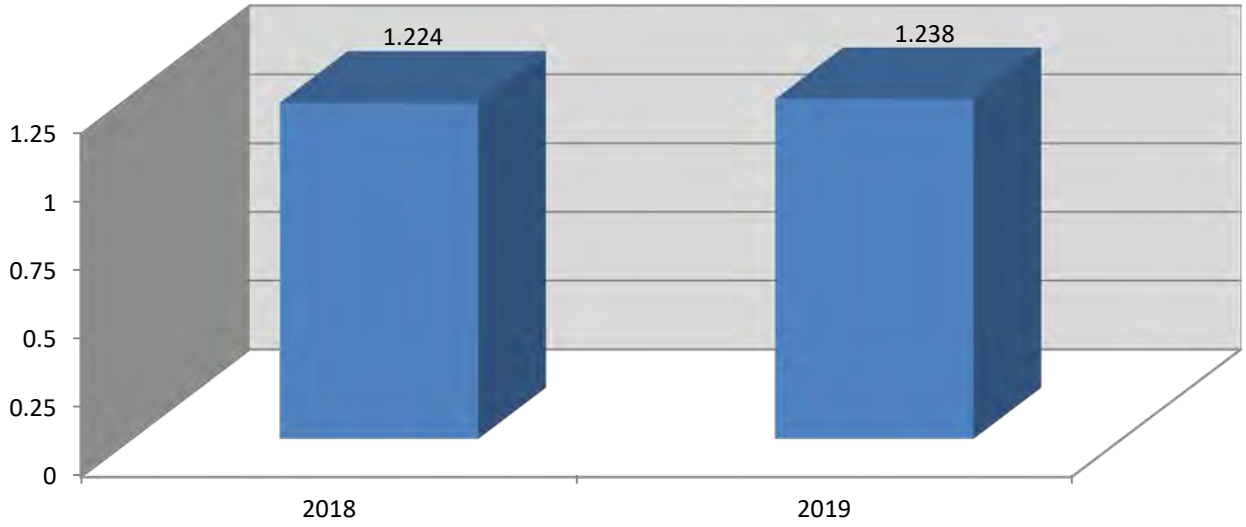
Other Required Communications — continued

- No other matters significant to the oversight of the NPAIHB's financial reporting process not previously communicated.
- Various representations were requested and obtained from management in the form of a written letter.
- Our engagement letter describes our responsibilities in accordance with professional standards and certain regulatory authorities with regard to independence and the performance of our services.

Financial Highlights

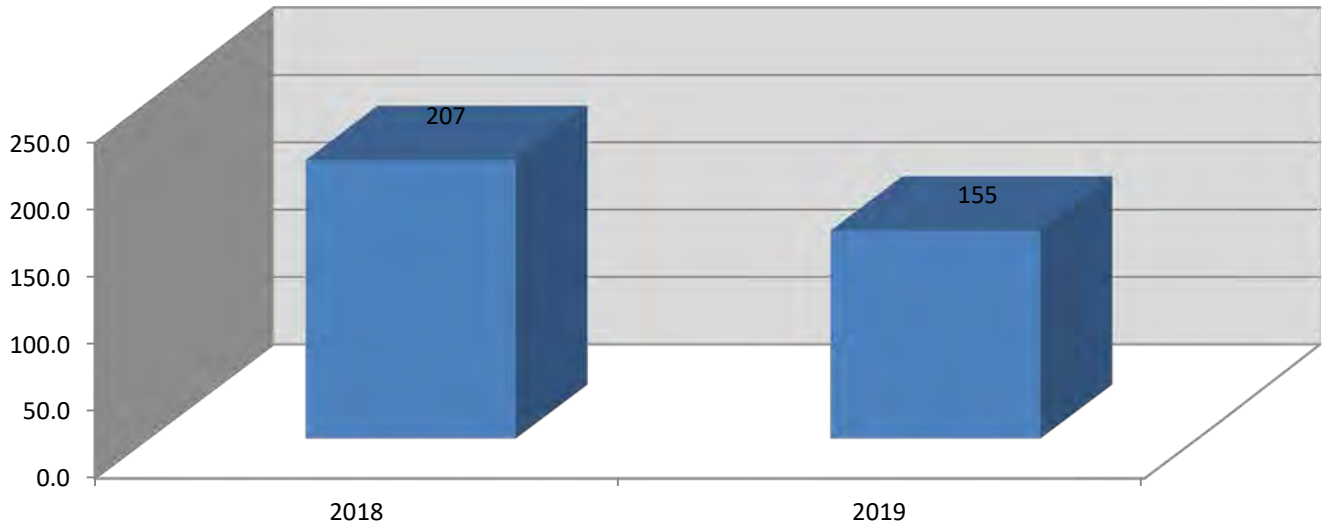
Current Ratio

- A financial ratio that measures whether or not an organization has enough resources to pay its debts for the next 12 months.
- Calculated by dividing current assets by current liabilities.

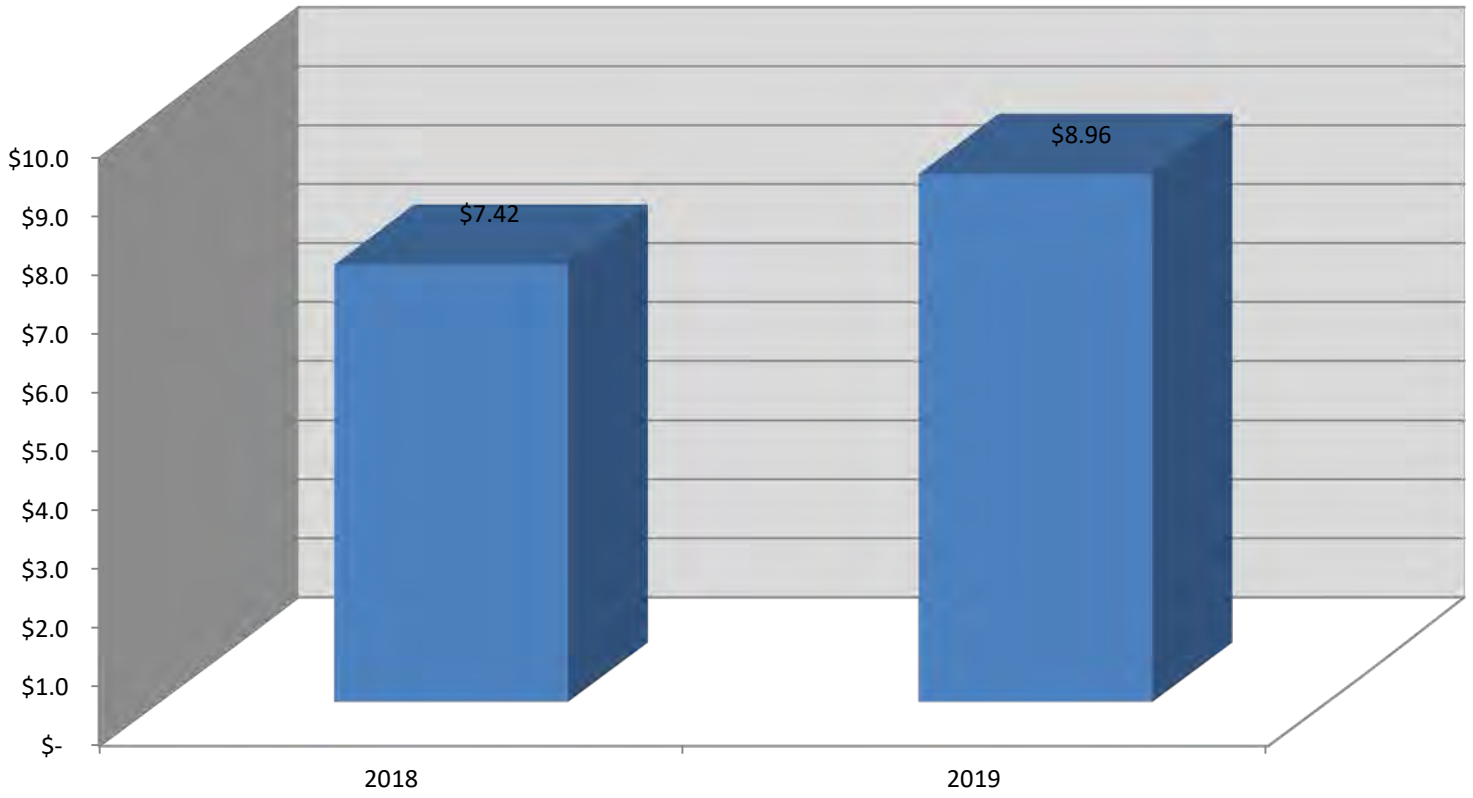


Days cash on hand

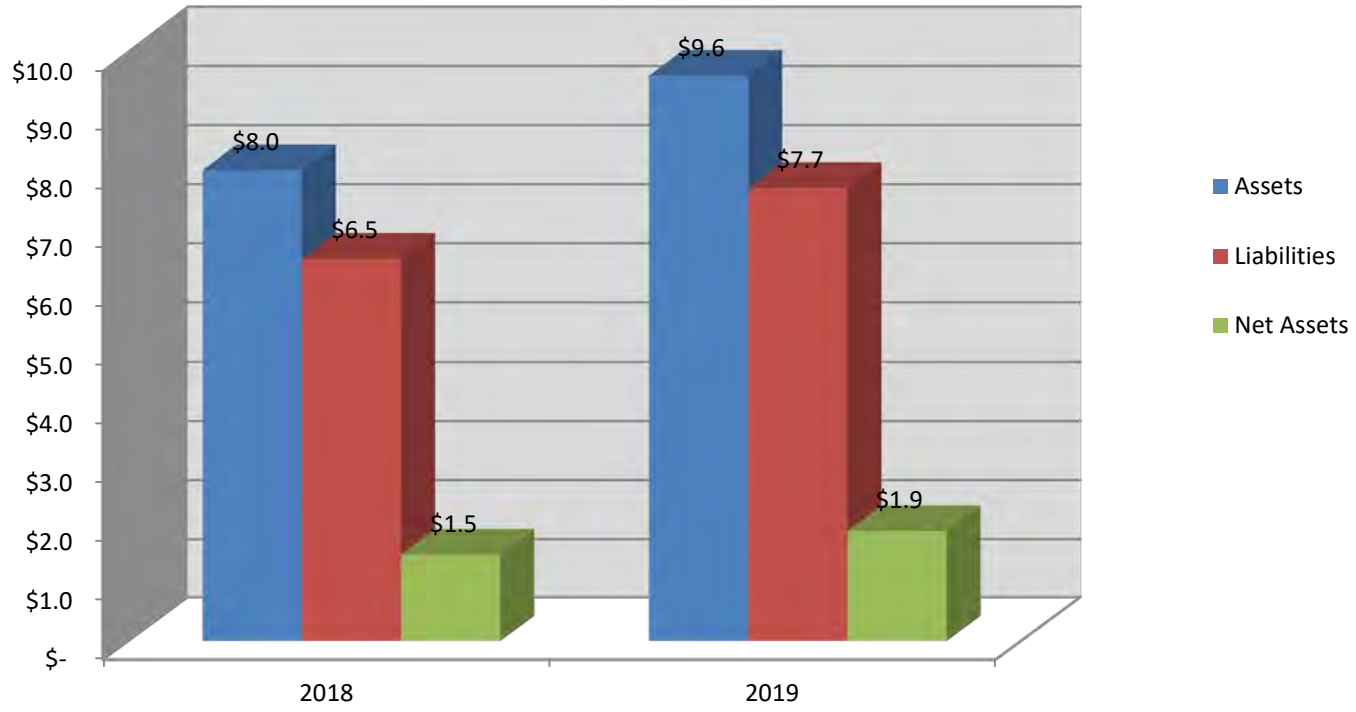
- Defined as the estimated number of days an organization can meet operating expenses if no additional revenues were received.
- Computed by dividing annual cash expenditures (excluding depreciation and bad debt) by 365 to obtain average daily expenditures. Then total cash on hand is divided by the average daily expenditures.



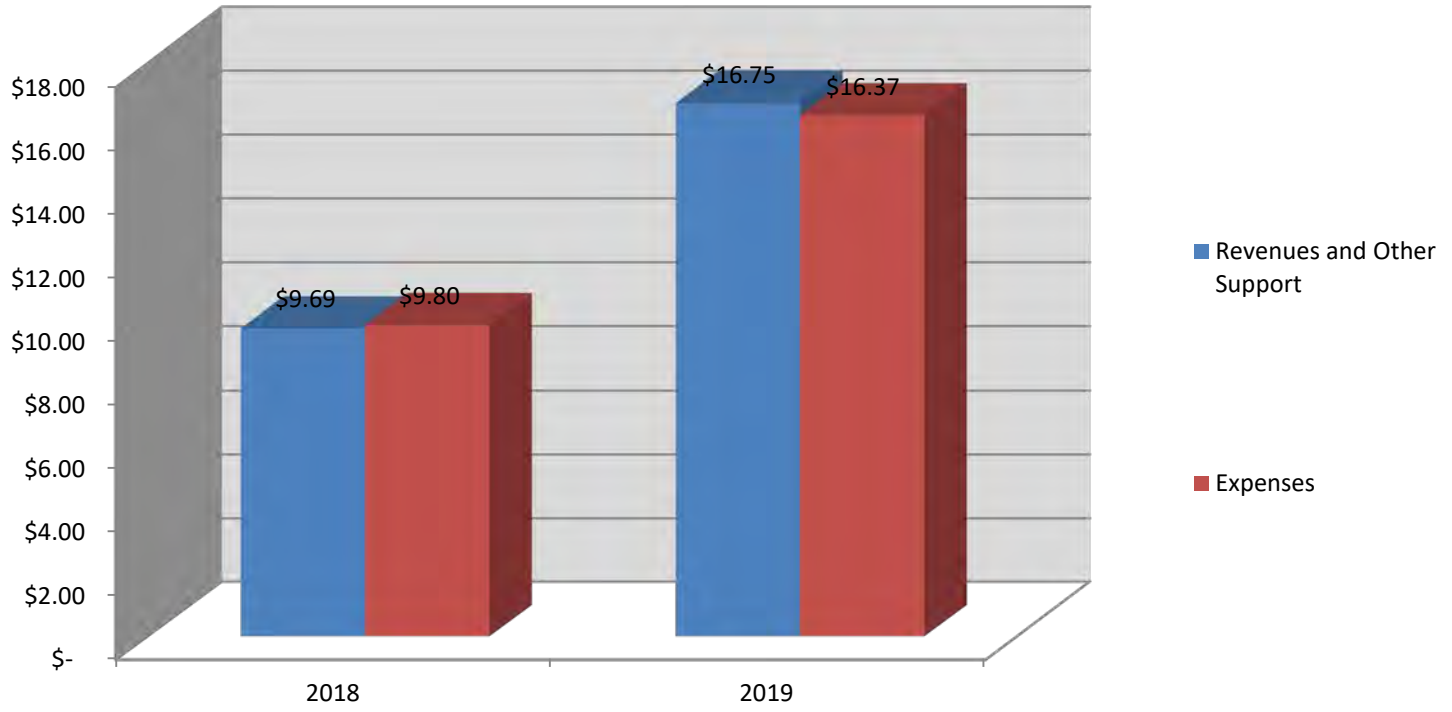
Cash and investments (in millions).



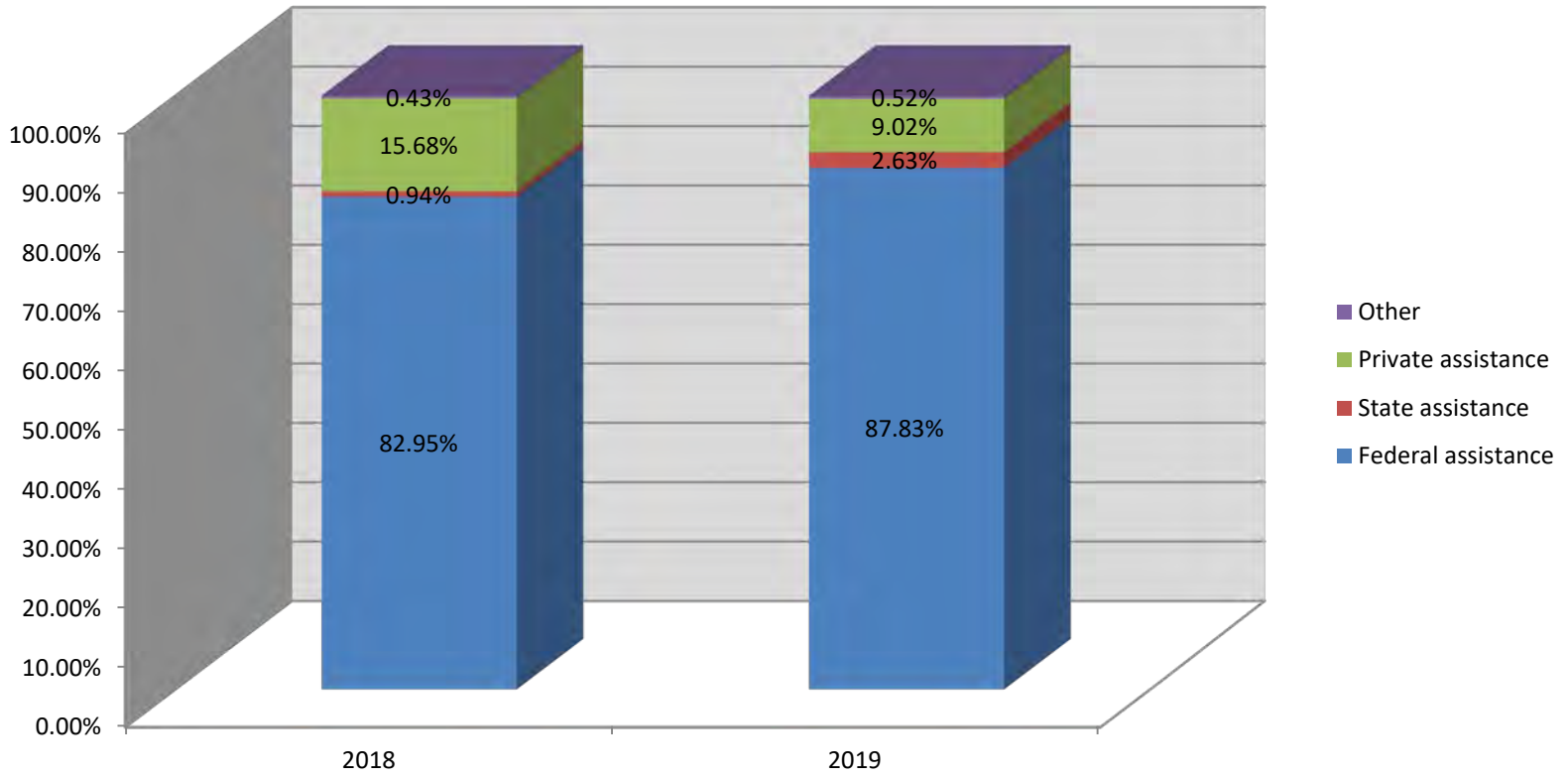
Statement of financial position (in millions).



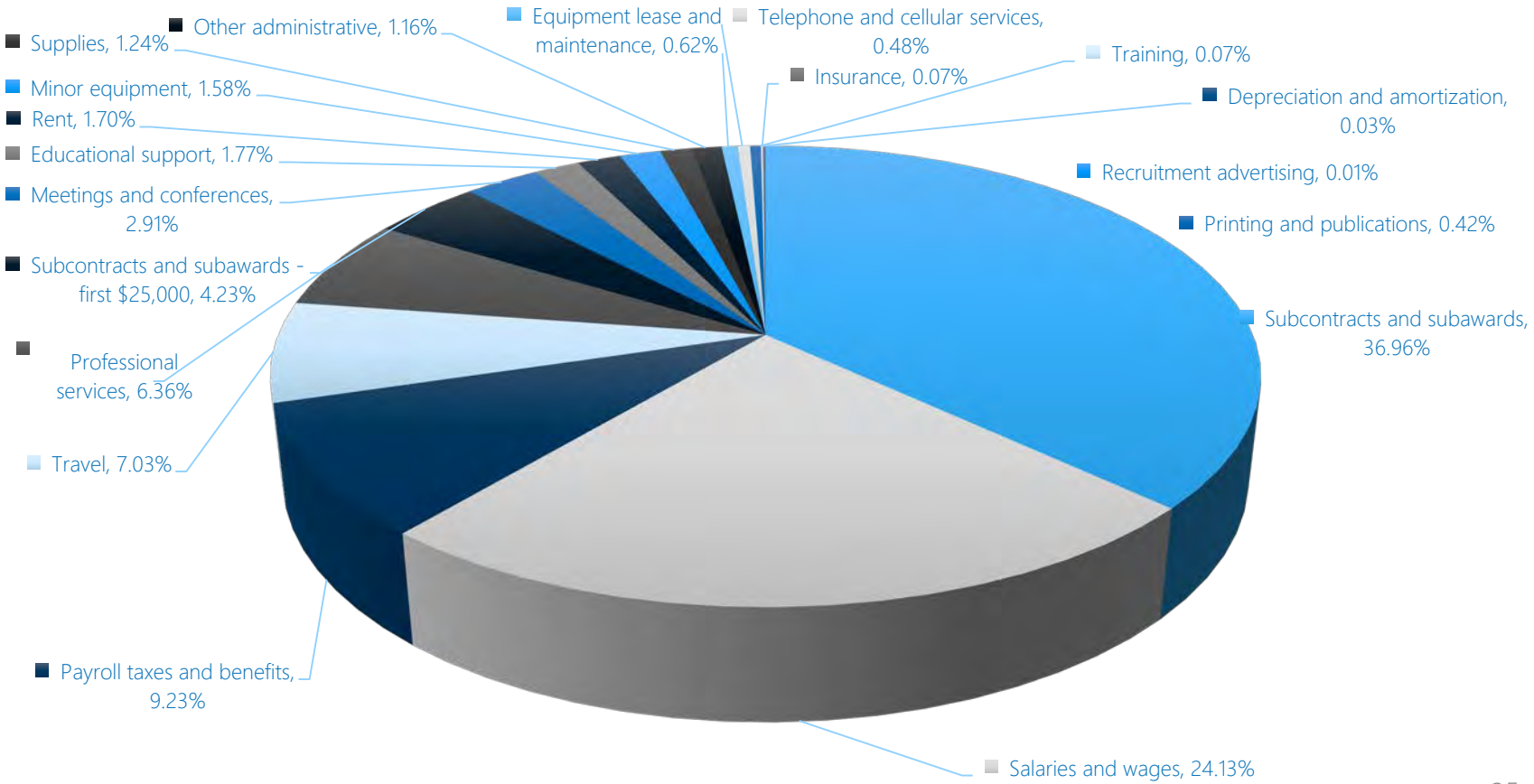
Statement of activities and changes in net assets (in millions).



Revenue sources



2019 operating expenses (total = $16,370,296)



Thank You !

- Chris Tyhurst, Principal
  (602) 730-3669
  ctyhurst@redw.com
- Alex Mercer, Senior
  (505) 998-3485
  amercer@redw.com

Indian Health Service

NPAIHB-QBM – ZOOM MEETING

DEAN M. SEYLER

DIRECTOR, PORTLAND AREA

JUNE 5, 2020

Division of Financial Management

Indian Health Service FY 2020 Coronavirus (COVID-19) Funding Allocations

- **Supplemental 1**: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (CPRSAA), PL 116-123, dated March 6, 2020, $70M
- **Supplemental 2**: Families First Coronavirus Response Act (FFCRA), PL 116-127, dated March 18, 2020, $64M
- **Supplemental 3**: Coronavirus Aid, Relief, and Economic Security (CARES) Act, PL 116-136, dated March 27, 2020, $1.034B
- **HHS/IHS Inter-Departmental Delegation of Authority:** Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020), $750M

Division of Financial Management

Indian Health Service FY 2020 Coronavirus (COVID-19) Funding Allocations

- **COVID-19 Funding Guidance for Tribes, Tribal Organizations and Urban Indian Organizations: https://www.ihs.gov/coronavirus/resources/**
  - Guidance on Indian Health Service COVID-19 Funding Distribution for Tribes, Tribal Organizations, and Urban Indian Organizations
  - Fiscal Year 2020 Coronavirus (COVID-19) Funding Allocations

Division of Business Operations
Purchase Referred Care

FY19 Catastrophic Health Emergency Fund (CHEF)

Status as of May 27, 2020

90 Total Cases

41 Total Amendments

$4,556,234.00 Reimbursed

$0 Pending Reimbursements

100% Total Reimbursed

FY19 CHEF Balance: $6,749,364

Division of Business Operations
Purchase Referred Care

FY20 Catastrophic Health Emergency Fund (CHEF)

Status as of May 27, 2020

18 Total Cases

6 Total Amendments

$228,623.00 Reimbursed

$222,329.99 Pending Reimbursements

50% Total Reimbursed

FY20 CHEF Balance: $50,083,629


INDIAN HEALTH SERVICE
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Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

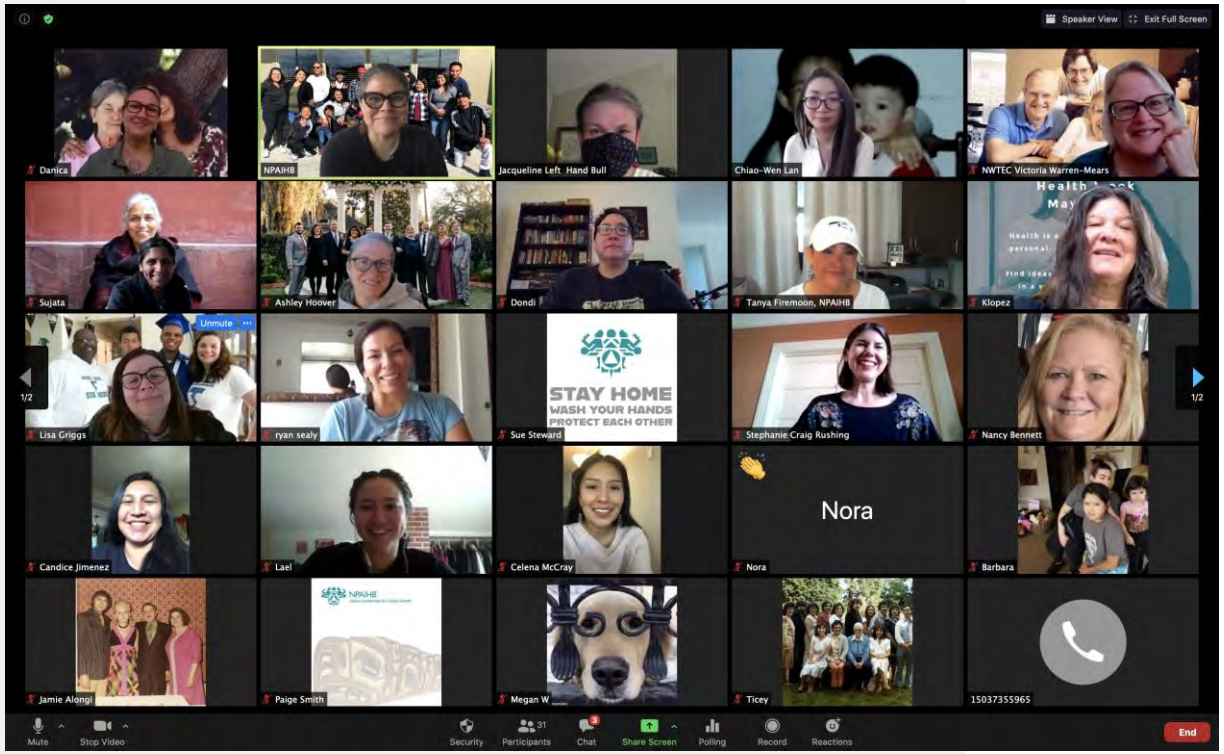
EXECUTIVE DIRECTOR REPORT

Virtual Quarterly Board Meeting
June 5, 2020

Laura Platero, JD

Highlights

1. Office & Administration
2. Staff
3. Executive Committee
4. New Funding
5. Personnel
6. Recognitions
7. Looking Forward



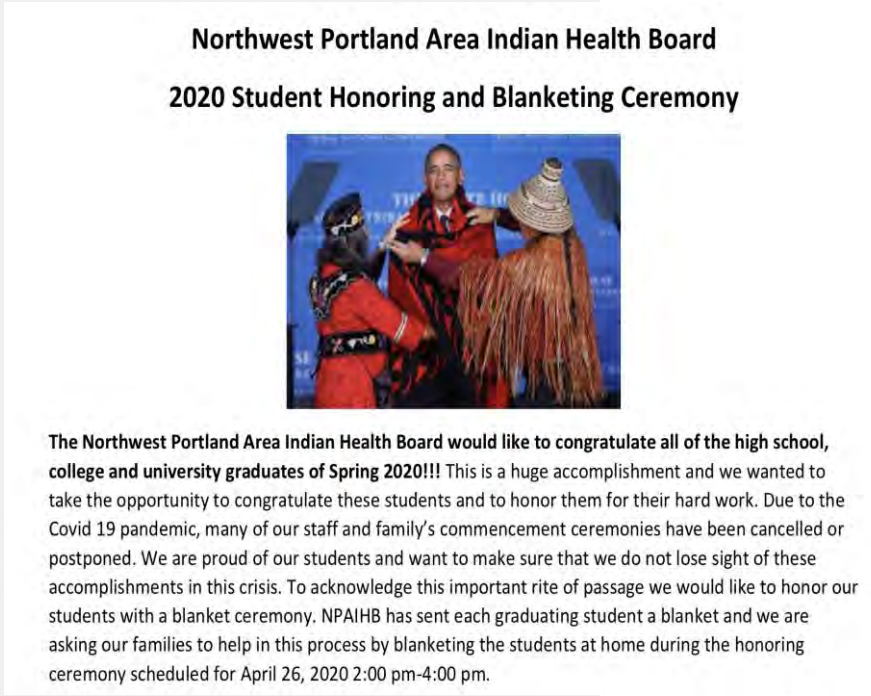
NPAIHB Staff Daily Morning Check-In

Office & Administration

- Physical office closed on 3/16/20
  - All staff on telework status since 3/16/20
  - Essential staff in office on staggered schedule – Finance/IT
  - Calendar to manage visits other staff who visit the office
  - Closure of office anticipated through at least August.
- Security improvements due to theft on Sunday, 5/27/20
  - Alarm system being installed on 6/9/20
  - New door with push bar to be installed
- Finance
  - Audit completed
  - Electronic purchase order software (Microix) in implementation phase
  - Electronic payments to vendors – in process
  - MIPS consultant to generate additional financial statements/budget

Staff

- Communications with staff
  - Daily 30 minute coffee/tea check-ins
  - Monthly staff and project director meetings
  - Weekly management meetings
- Other staff activities
  - Wellness activities
  - Virtual 2020 Student Honoring and Blanketing Ceremony on 4/26/20
  - August picnic- virtual gathering will be scheduled



Northwest Portland Area Indian Health Board

2020 Student Honoring and Blanketing Ceremony

The Northwest Portland Area Indian Health Board would like to congratulate all of the high school, college and university graduates of Spring 2020!!! This is a huge accomplishment and we wanted to take the opportunity to congratulate these students and to honor them for their hard work. Due to the Covid 19 pandemic, many of our staff and family's commencement ceremonies have been cancelled or postponed. We are proud of our students and want to make sure that we do not lose sight of these accomplishments in this crisis. To acknowledge this important rite of passage we would like to honor our students with a blanket ceremony. NPAIHB has sent each graduating student a blanket and we are asking our families to help in this process by blanketing the students at home during the honoring ceremony scheduled for April 26, 2020 2:00 pm-4:00 pm.

Executive Committee

- Since, 3/20/20, Executive Committee has met weekly (with a few cancelled meetings)
- Passed 8 resolutions– require ratification by the Board
  - 20-02-05 -- Approving and Authorizing Waiver of Sovereign Immunity for Purposes of Insurance Policies with Standard Insurance Company
  - 20-02-06 -- Declaration of Public Health Emergency Related to COVID-19 and Recommendations to Shut Down Non-Essential Services and to Shelter in Place
  - 20-02-07 – SAMHSA Tribal Opioid Response Grant
  - 20-03-01 – NIH Northwest Native American Research Center for Health (NARCH) Grant
  - 20-03-02 – HRSA Opioid-Impacted Family Support Program Grant to Support CHAP BHA
  - 20-03-03 – Public Health Recommendations for Phased Approach to Reopening Tribal Non-Essential Businesses, Entities, and Public Spaces
  - 20-03-04 – CDC BOLD PH Program to Address Alzheimer's Disease and Related Dementias-Native Elders Project Grant
  - 20-03-05 – Opposition to Expansion of 100% FMAP to non-IHS/Tribal Medicaid Providers without a Care Coordination Agreement or Tribal FQHC Contract

New Funding

Funder	Start	End	Amount	Program
U of TexasHealth Center, sub NIH	2/1/20	11/30/21	37,960	Online decision support re: sexual health education in Tribal Communities
Native American Agricultural Fund	1/1/20	12/31/21	150,000	Needs of Native Farmers
Native American Agricultural Fund	1/1/20		45,000	COVID-19 Rapid Response Funding
CDC COVID-19 CARES Supplement	4/6/20		3,005,628	Funding for NPAIHB tribes
IHS COVID-19 CARES Special Provisions	4/9/20		97,616	Funding for NPAIHB to respond to COVID-19
CDC, NACCHO	5/1/20	2/1/21	199,997	Native-Serving Org. to Identify Legal Strategies - PH Data Sharing
ICF, sub CDC	4/1/20	12/31/21	25,000	Cancer prevention interventions in childhood, demonstration NCCCP
OHA - HOWTO	3/10/20	3/31/23	995,844	Development of diverse culturally competent healthcare workforce
OHSU - RISE (Indians Into Medicine)	4/1/2020*	6/30/24	54,150	Health Professionals Recruitment for Indians
IHS Diabetes Management Systems	3/11/20		35,768	Incorporates training and education sessions into program
			$ 4,646,963	
*OHSU RISE started in 9/2019, but not at NPAIHB				

Personnel

6 NEW HIRES

- Barbara Gladue – OR Tribal Public Health Improvement Project Manager – 2-12-20
- Celeste Davis – Environmental Public Health Director – 2-24-20
- Melino Gianotti – OR Tribal Public Health Improvement Project Analyst – 3-2-20
- Lael Tate – THRIVE Project Coordinator – 3-16-20
- Dr. Tom Becker - Medical Epidemiologist & Project Director 4-13-20
- Ashley Hoover – Communicable Disease Epidemiologist 4-14-20

Personnel

5 PROMOTIONS/TRANSFER

- Nancy Bennett – WA Tribal Public Health Improvement Project Manager – 1-21-20
- Nora Frank-Buckner – Promotion to Food Sovereignty Initiatives Director & WEAVE-NW FS Project Manager – 1-27-20
- Ryan Sealy – Environmental Public Health Project Scientist – 2-24-20
- Antoinette Aguirre – Environmental Public Health Project Specialist – 2-24-20
- Mattie Tomeo-Palmanteer – Cancer Prevention Project Coordinator – 6-22-20

2 OPEN POSITIONS UPDATE

- ECHO Case Manager – closes June 15, 2020
- Part-time Asthma Project Coordinator – closes June 26, 2020

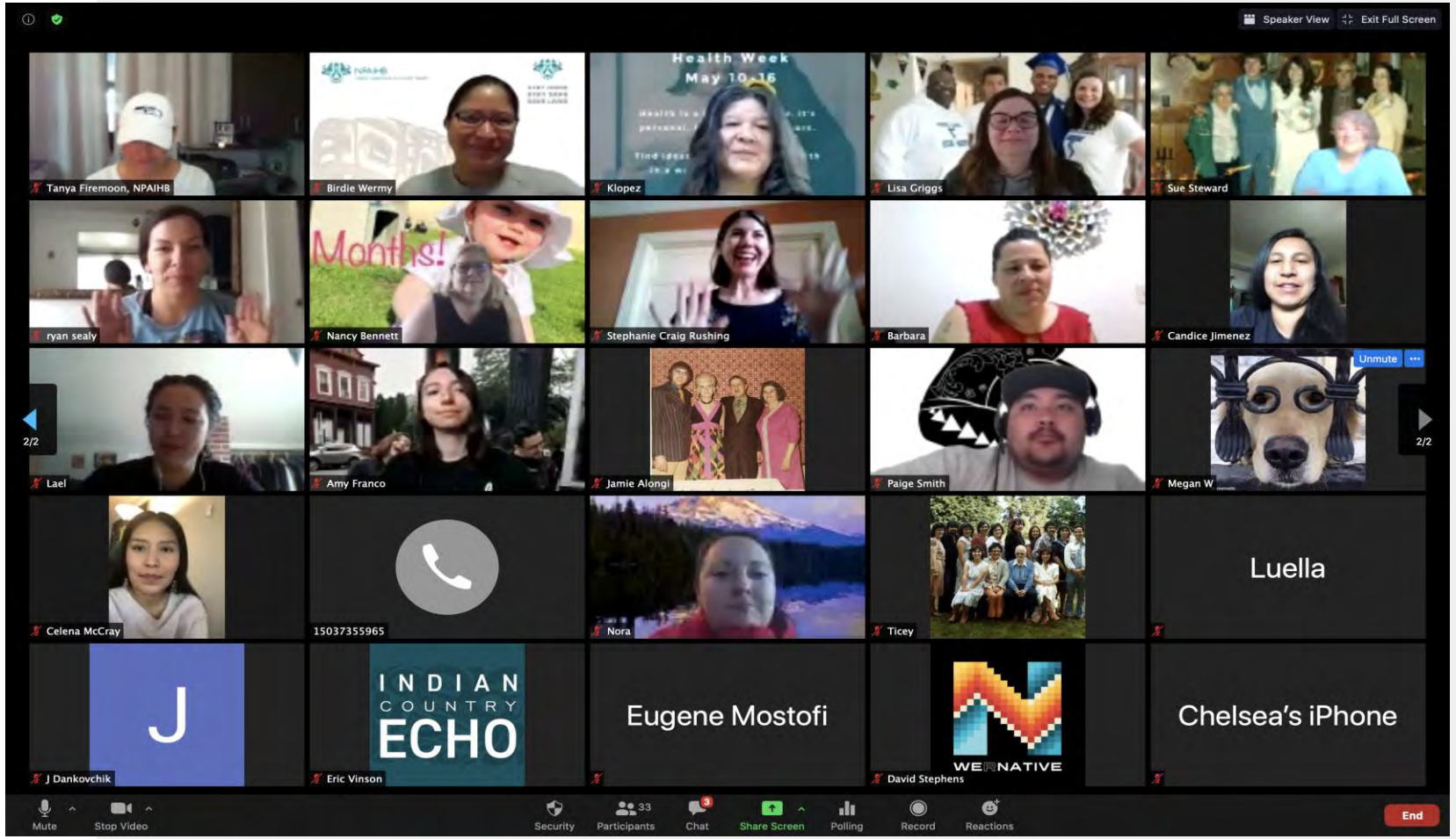
Recognitions

- Thank you Eugene Mostofi, Fund Accounting Manager, for 10 years at NPAIHB!

Looking Forward

- Ensure tribes are getting needs met as to COVID-19 response and on other NPAIHB programs
- Survey Staff on virtual work needs
- Revive my 60-Day Plan as Executive Director
- Continue contract work with Cindy Darcy in D.C.
- Work on organizational budget for FY 2021

Questions…?


Speaker View
Exit Full Screen
Tanya Firemoon, NPAIHB
Birdie Wermy
Health Week
May 10-16
Klopez
Lisa Griggs
Sue Steward
ryan sealy
Months!
Nancy Bennett
Stephanie Craig Rushing
Barbara
Candice Jimenez
2/2
Lael
Amy Franco
Jamie Alongi
Paige Smith
Unmute
Megan W
2/2
Celena McCray
15037355965
Nora
Ticey
Luella
J
J Dankovchik
INDIAN COUNTRY ECHO
Eric Vinson
Eugene Mostofi
WERNATIVE
David Stephens
Chelsea's iPhone
Mute
Stop Video
Security
Participants
33
Chat
Share Screen
Polling
Record
Reactions
End

Victoria Warren-Mears, PhD, RDN, FAND
Director, NWTEC
503-998-6063

NWTEC COVID-19 Response and TEC Update

COVID-19 Leadership Team

- Laura Platero
- Thomas Weiser, MD – Indian Health Service Medial Epidemiologist
- Alex Wu – CDC EIS Officer
- Celeste Davis – Director Environmental Public Health Program (NWTEC)
- Tam Lutz – MCH Project Director (NWTEC)
- Jessica Leston – Community Clinical Learning (NWTEC)
- Stephanie Craig Rushing – Social Media and Digital Expertise (NWTEC)
- Victoria Warren-Mears – Director NWTEC Triage of Questions (NWTEC)

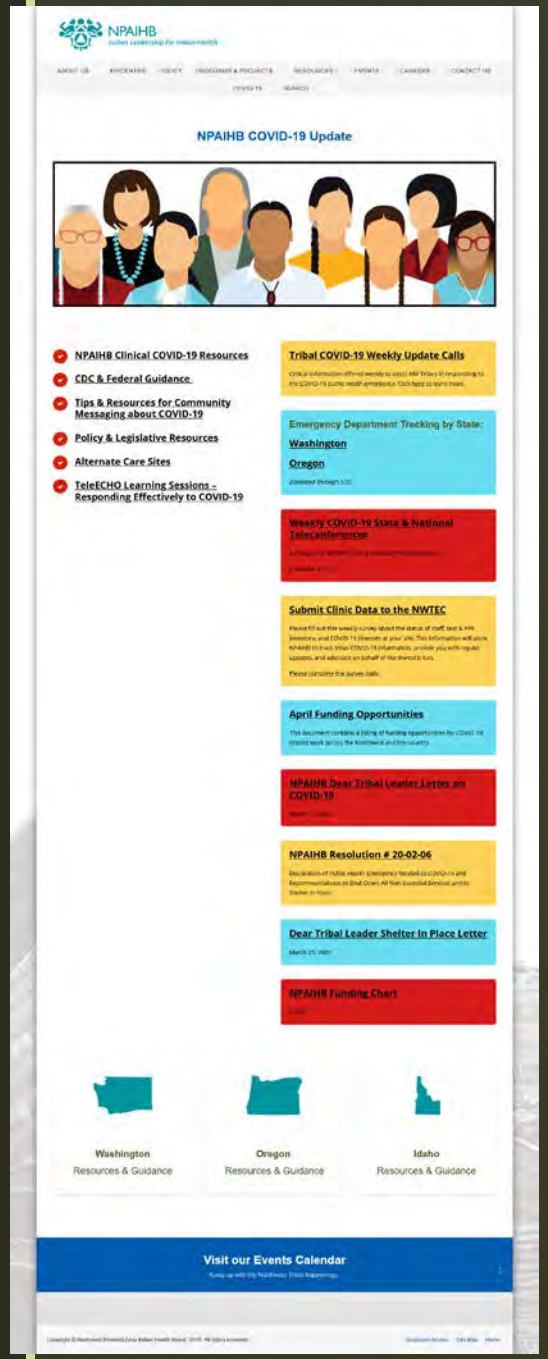
NWTEC

Specialties include: research, public health programs, data management, epidemiology and others

Approximately 56 staff members work in the NWTEC

Service Areas for Local TECs

- NWTEC serves all northwest tribes: Idaho, Oregon and Washington
  - Have extensive data sharing and use agreements with tribes, state health departments and other regional partners. We have well over 22 data agreements which allow us to provide health profiles for the region.
    - UIHI serves Urban Indian Health Programs nationwide
    - For data surveillance for COVID-19, specifically with have a DSA with the Native Project and one pending for NARA.
- Currently conducting COVID-19 surveillance in partnership with Tribes and Indian Health Service – Portland Area Office



NPAIHB and the NWTEC began response ~ 2/24/2020

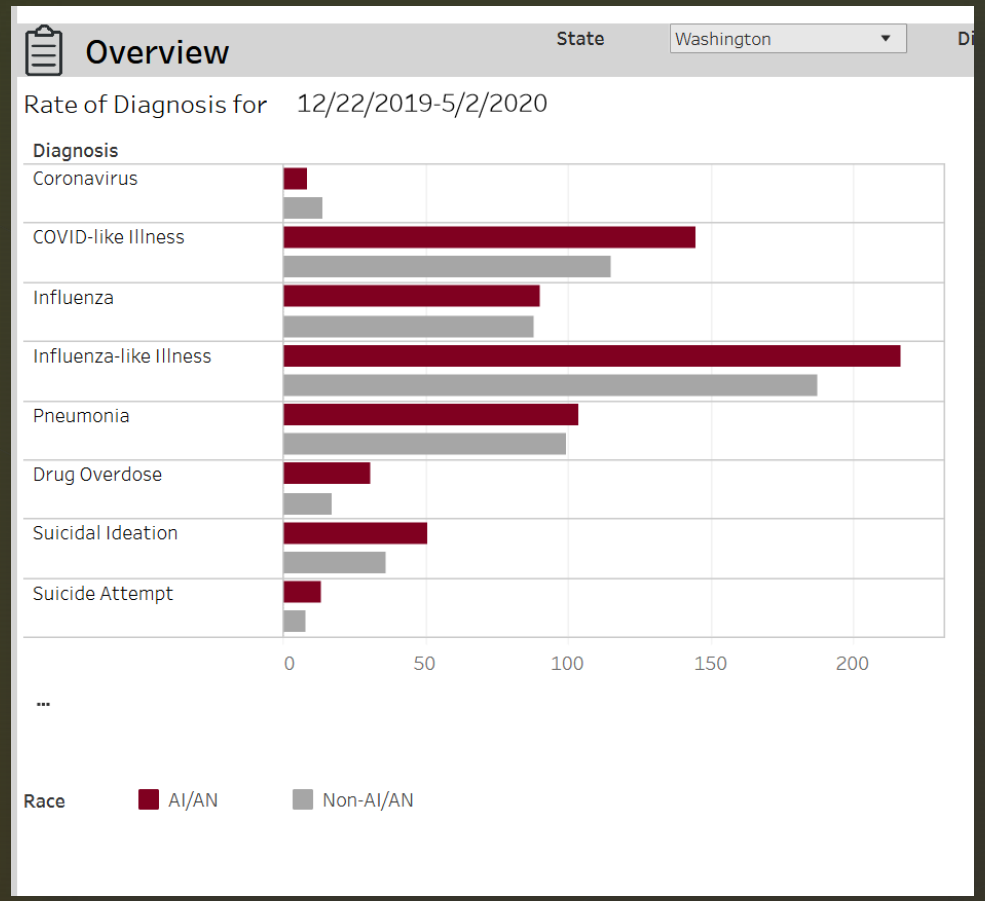
- Activated our 8 member response team.
- Established web site information www.npaihb.org/covid-19
- COVID-19 Weekly Call with tribal and state partners.
- Educational materials.
- Adjusted surveillance with Orpheus and Essence systems in OR and WA states
- Began data collection for Portland Area Office of Indian Health Service

Further NPAIHB and NWTEC Response

- COVID-19 Clinical ECHO established
  - Held twice weekly
  - Over 150 participants on each weekly call since it's inception
- Continue Development of Media Materials – youth focus
- Ongoing training and technical assistance
    - Current topics Outbreak Investigation and Contact tracing
    - 90 individuals trained to date.

Developed a COVID-19 Data Dashboard

- http://www.npaihb.org/covid-19-data-dashboard/
- Emergency Department Surveillance for OR and WA



Additional Responses

- Environmental Public Health Guidance for reopening of tribal enterprise.
- Continuing partnership with Columbia River Inter Tribal Fishing Commission (CRITFC) to ensure fisherman contact in isolated villages for testing and education.
- Stay home public health kits for patients with diabetes.
- FIT Testing capacity and kits for tribes
- Additional social media coming: future topics include; safe sweats, maternal child health, battling depression
- On-going tribal clinic revenue study
- Advocacy
- Contract Tracing staffing (5) in partnership with CDC foundation
- Tribal Grant Writer
- PHN and Social Work Case Manager

Other Major Accomplishments

- Hired an Environmental Health Department
  - Provided guidance on reopening of programs
- Dental
  - On-line CDE training
  - Assisted with tele-dentistry training/application
- NARCH
  - Large Grant submitted
  - Cancer Fellowship Training is now on-line
- Data/Epidemiology
  - Leveraged existing DSAs with states to obtain COVID-19 data
  - On-line data dashboard developed
- Diabetes Program
  - Achieved all annual goals
  - 100% diabetes audit submission for the Area

Other Major Accomplishments

- Cancer project
  - Submitted major grants
  - Cancer screening infographics developed
  - Tobacco Training
- Public Health Modernization
  - Oregon and Washington Staff Hired
  - OR kick off meetings held with ½ of tribes
- Washington working on development of pubic health communicable disease data report cards.

Other Major Accomplishments

- Expanded Clinical Support
  - LGBTQ+ support groups
  - Supporting 4 new ECHO series focused on Harm Reduction,
    - Peer Specialists,
    - Dental, and
    - COVID-19.

Starting March 18, the NPAIHB hosted twice weekly COVID-19 Indian Country ECHO telehealth clinics. From March 18 to May 27, the NPAIHB telehealth program had over 2,760 attendees from 24 states. While the majority of participants have been from the Pacific Northwest, the wide reach of pre-existing networks has brought in participants from 24 states, all 12 areas in the US covering Indian Country, Guam, Mexico and Canada.

Right now, in this time of uncertainty, it is important for all of our Tribes to issue orders for community members to stay home, take a little time to look ahead, and continue to ask the federal government to honor treaty and trust obligations.
……. Tribes should reach out and help one another whenever possible. In this difficult time, we need each other to get through this pandemic.

Nickolaus Lewis, Chair, Northwest Portland Area Indian Health Board

Questions for NWTEC? Call or Text Victoria Warren-Mears at 503-998-6063 or email to vwarrenmears@npaihb.org

Northwest Portland Area Indian Health Board

Indian Leadership for Indian Health

Legislative & Policy Update

Virtual Quarterly Board Meeting

June 5, 2020

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Report Overview

1. General News
2. Appropriations & Budget Formulation
3. COVID-19 Legislation
4. COVID-19 New Federal Policies
5. U.S. v. Texas Litigation
6. DHAT State Legislative Update

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

General News

- **Rear Admiral (RADM) Michael D. Weahkee Confirmation as IHS Director**
  - –4/21/20: RADM Weahkee was confirmed as the Director of the IHS for a four-year term. Director Weahkee has served as the interim head of the agency for the past 3 years.

- **Re-establishment of the White House Council on Native American Affairs**
  - –4/28/20: White House and Department of the Interior announced the re-establishment of the White House Council on Native American Affairs, which was originally established by President Obama in 2013. The Council will continue to lead the Administration's coVID-19 inter-agency response coordination with Indian country, as well as lead other Administration policy priorities.

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Appropriations & Budget Formulation

- **FY 2021 Appropriations:**
  - No markup hearings have been scheduled yet.
  - NPAIHB submitted IHS and HHS House and Senate testimony.
- **FY 2022 Budget Requests:**
  - NPAIHB submitted HHS/IHS testimony on 5/1/20.
  - National Tribal Budget Formulation Workgroup submitted testimony for IHS Funding on 5/1/20 https://www.nihb.org/legislative/budget_formulation.php
- FY 2022 IHS Budget Formulation Evaluation/FY 2023 Planning Meeting
  - Virtual meeting being scheduled.

Northwest Portland Area Indian Health Board
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COVID-19 Response Legislative Packages

- **<u>Stimulus #1:</u> H.R. 6074 (Public Law No. 116-123) Coronavirus Preparedness and Response Supplemental Appropriations Act 2020**
  - Signed into law on March 6. Provided $8.3B in emergency response funding with a focus on vaccine research, medical supplies procurement, and support for public health agencies and small businesses.
  - IHS: Provided $30M to IHS Federal health programs and $40M to purchase PPE and medical supplies through IHS National Supply Service Center and for all IHS programs.
  - CDC: Provided no less than $40M in CDC funding for Indian Country, CDC increased it to $80M.
- **<u>Stimulus #2:</u> H.R. 6201 (Public Law No. 116-127) – Families First Coronavirus Response Act**
  - Signed into law on March 18. Provided $3.5B in funding.
  - IHS: $61M to IHS and Tribal health programs for program increases in Hospitals & Health Centers sub-account

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

COVID-19 Response Legislative Packages Cont'd

- **<u>Stimulus #3:</u> H.R. 748 (Public Law No. 116-136) – Coronavirus Aid, Relief, and Economic Security Act (CARES Act)**
  - Signed into law on March 27. Provided $2.2 trillion in overall funding.
  - IHS: $1.032B including mandatory set asides: at least $450M to tribes, EHR stabilization and support ($65M) and facility needs ($125M). There was a short term reauthorization of SDPI at the current level of $150M per year through 11/2020.
  - CDC: $125M for grants or cooperative agreements with tribes and urban Indian organizations to carry out preparedness and response activities.
  - SAMHSA: $15M for SAMHSA mental and behavioral health services for tribes.
  - HRSA: $15M for health surveillance and other needs under the HRSA Rural Health program.
- **<u>Stimulus #3.5:</u> H.R. 266 (Public Law No. 116-139)– Paycheck Protection Program and Health Care Enhancement Act**
  - Signed into law on April 21. Provided $75B for eligible health care providers, $25B for coronavirus testing ($750M dedicated to Indian Country).

Northwest Portland Area Indian Health Board
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COVID-19 Relief Package #4: HEROES Act (H.R. 6800)

- **IHS:** $2.1 billion to address health care needs
  - $1 billion to account for lost third party revenue
  - $64 million to assist urban Indian organizations
  - $10 million to assist with sanitation, hydration and hygiene needs
  - $500 million to provide health care, including telehealth services and to purchase medical supplies and PPE
  - $140 million to expand broadband infrastructure and IT for telehealth and EHR system purposes.
  - $20 million to provide health care, housing and isolation units for domestic violence victims and homeless Native Americans
  - No les than $366 million to provide isolation or quarantine space
- **SAMHSA:** no less than $150 million for tribes, tribal organizations urban Indian organizations, or health service providers to tribes across a variety of programs.
- **CMS:** extends 100% FMAP to urban Indian programs from July 1, 2020 to June 30, 2021 and allows services with a referral from an IHCP outside of the ”four walls” of a clinic from July 1, 2020 to June 30, 2021.
- **VA:** clarification for the VA and DOD to reimburse IHS and Tribes for PRC services, regardless of where services are obtained.
- Guarantees IHS and Tribal health organizations direct access to the Strategic National Stockpile, just like all 50 other states.

HEROES Act Tribal-specific Provisions

- Eliminate the sunset provisions under Section 30106 of the HEROES Act so that removal of the “four walls” Medicaid billing restriction and extension of 100% FMAP to urban Indian organizations are made permanent.
- Authorize IHCPs to receive Medicaid reimbursement for all medical services authorized under the Indian Health Care Improvement Act when delivered to Medicaid-eligible AI/ANs.
- Permanently extend waivers under Medicare for use of telehealth.
- Include Pharmacists, Licensed Marriage and Family Therapists, Licensed Professional Counselors, and other providers as eligible under Medicare for reimbursement to IHCPs.
- Ensure parity in Medicare reimbursement for IHCPs.
- Permanently reauthorize the Special Diabetes Program for Indians (SDPI)

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

CMS COVID-19 1135 Waivers and CMCS Informational Bulletin

- **CMS Section 1135 Waiver Authorities:**
  - CMS has waived certain conditions of participation and provider-based requirements to allow temporary expansion of hospitals, waived certain requirements for clinics to screen patients off-site, and have added over 80 additional services that can be reimbursed.
- **4/2/20 CMCS Informational Bulletin on Medicaid Telehealth Flexibilities:**
  - Medicare program specifically addresses telehealth delivery methods and criteria for implementing those methods, but States have a lot more latitude to design telehealth delivery methods for Medicaid.
  - MAT can be delivered via telehealth delivery methods due to the high rates of SUD and behavioral health conditions in AI/AN populations.
  - States can elect to cover SUD treatment services via telehealth provided by School Based Health Centers (i.e. assessments, counseling, MAT, and medication management.

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

CMS Interim Final Rule: Medicare & Medicaid Policy and Regulatory Changes in Response COVID-19

- Issued 11/18/19; **Comments Submitted 6/1/20**
- Waived limitations on the types of practitioners that can furnish Medicare telehealth services.
- Expanded telehealth modalities to allow reimbursement for audio-only telehealth visits and to use smart phones and platforms like FaceTime/Skype.
- Extended telephone assessment and management services which extended virtual check-ins and e-visits that do not usually involve face-to-face visits.
- Allow direct physician supervision of non-physician providers to be furnished via interactive telecommunications technology during the pandemic.
- Allow use of two-way telephonic devices to provide opioid treatment services that are furnished via audio-only telephone calls.
- **Portland Area Recommendations:**
  - CMS must work with the Indian health system to authorize continued use of telehealth capabilities in delivery of health care services during and after the public health emergency.
  - Reimbursement rates for IHCPs are drastically different for onsite physician services and distant site telehealth services. NPAIHB requested permanent implementation of the OMB all-inclusive rate (AIR) for Medicare services for the in-person visit and the virtual or telephone visit.

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IHS COVID-19 Recent DTLLS

- **5/19/20:** Announces distribution decisions for the $750 million in new resources appropriated to HHS to support testing and testing related activities in AI/AN communities.
- **4/23/20:** Announce final allocation decisions of the remaining resources authorized by the CARES Act.
- **3/27/20:** Announce availability of an distribution decisions for $134 million in new resources ($64 million for testing and $70 million for COVID-19 response activities).

Northwest Portland Area Indian Health Board
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IHS Recent DTLLS

- **5/22/20:** Request for assistance in identifying priority health professions for inclusion into categories eligible for the 2021-2022 IHS Scholarship Program and the FY 2021 IHS Loan Repayment Program **(Comments Due 6/15)**
- **5/20/20:** Updates on the Special Diabetes Program for Indians (SDPI) authorizing all current SDPI grants to their full annual grant amounts and ability to switch to a continuation application process for FY 2021.
- **4/3/20:** Announces the creation of a new IHS Opioid Grant Pilot Program (OGPP)
- **3/4/20:** Update on IHS SDPI for the current fiscal year and provide decisions regarding the next SDPI grant cycle.

Northwest Portland Area Indian Health Board
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Litigation: U.S. v. Texas Update

- 3/2/20: U.S. Supreme Court announced that it will hear consolidated cases addressing the validity of the Affordable Care Act's (ACA) individual mandate provision (granting petition for certiorari).
- **Amicus Brief Argument:** District Court's finding that the entirety of the ACA, including the IHCIA, was unconstitutional was flawed with respect to the IHCIA and other Indian-specific health provisions of the ACA. The IHCIA has an entirely separate genesis and purpose, and therefore, should remain in effect even if the individual mandate is unconstitutional.
- NPAIHB joined the national coalition of tribes and tribal organization amicus brief, which will be filed with the Supreme Court in California v. Texas.
- Likely that the Court's review ill come during its next term that begins October 2020.

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Dental Therapy Legislative Update Oregon

- A statewide dental therapy bill was introduced and had one hearing in Senate Health Care and did not move forward. In a short 35-day session (that resulted in virtually no bills passing because of legislators walking out early) we knew going in this would likely be the year we introduced bill for further work next legislative session.
- Senator Monnes Anderson (retiring Senate Health Care committee chair) convened an interim work group that is currently meeting to attempt to resolve questions that came up. Miranda Davis, NPAIHB; Kelle Little, Coquille; and Vicki Faciane, CTCLUSI are seated on the workgroup, as well as other members of the Oregon Dental Access Campaign, the coalition working to authorize dental therapy in Oregon.
- Representative Tawna Sanchez (Shoshone-Bannock, Ute, and Carrizo) and Director of Family Services at NAYA will be sponsoring the bill in the 2021 session.

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Dental Therapy Legislative Update Washington

- The statewide licensing bill did not move out of the House again this session, so we will start over in Washington as well. NPAIBH and Washington Tribes continue to play a leadership role in the Washington Dental Access Campaign and will be helping to reshape the effort after exploring coalition strengths and weakness and how best to move resources into those strategic campaign areas that need it.

- Questions? Please contact Pam Johnson, Native Dental Therapy Initiative Project Manager, pjohnson@npaihb.org.

Northwest Portland Area Indian Health Board
Indian Leadership for Indian Health

Discussion and Questions

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: April 2, 2020

FROM: Calder Lynch, Deputy Administrator and Director

SUBJECT: Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth

This Center for Medicaid & CHIP Services Informational Bulletin (CIB) identifies opportunities for the utilization of telehealth delivery methods to increase access to Medicaid services and to comply with the requirement to publish guidance to states regarding federal reimbursement for furnishing services and treatment for substance use disorders under Medicaid using services delivered via telehealth, including in School-Based Health Centers. This requirement is set forth in section 1009(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. 115-271). This CIB provides state Medicaid agencies and other interested stakeholders information about options to facilitate access to services through the use of telehealth delivery methods as specifically outlined in 1009(b) of the SUPPORT Act, but these telehealth delivery methods could also be used in other circumstances, for example, to help respond to the COVID-19 public health emergency, as applicable. With this CIB, the Centers for Medicare & Medicaid Services (CMS) hopes to enhance our work with states to improve care for Medicaid beneficiaries through the use of telehealth delivery methods. This CIB is composed of the following two parts:

I. Rural Health Care and Medicaid Telehealth Flexibilities; and

II. Medicaid Substance Use Disorder Treatment Services Furnished via Telehealth

In addition, pursuant to section 1009(d) of the SUPPORT Act, CMS will submit a report to Congress identifying best practices and potential solutions for reducing barriers to using services delivered via telehealth to furnish services and treatment for substance use disorder (SUD) among pediatric populations under Medicaid, and the report will be made available online at www.medicaid.gov once it has been published. Section 1009(d)(1) of the SUPPORT Act specifies that the report must identify and analyze differences in the provision of care for SUD among pediatric populations under Medicaid using services delivered via telehealth, and for children with SUD using services delivered in-person regarding utilization rates; costs; avoidable inpatient admissions and readmissions; quality of care; and patient, family, and provider satisfaction.

Telehealth

Telehealth is the use of information technology by providers to deliver covered services. Historically, the term "telemedicine" meant the use of interactive telecommunication equipment that included, at a minimum, audio and video equipment between beneficiary and practitioner at a distant site.[1] Similarly, the term "telehealth" refers to the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, monitoring, supervision, and information across distance.[2] However, given the advances and varying uses of technology in healthcare, the term telehealth has generally emerged as the umbrella term that encompasses the full range of services furnished remotely.[2] Telehealth could include services such as those furnished with medical information exchanged from one site to another, through audio and video equipment permitting two-way, real time, interactive communication between the beneficiary and a clinician at different locations. Such services could also include, but are not limited to, beneficiary consultations, remotely controlled or directed surgery, remote observation or monitoring, services furnished by clinicians or other health professionals such as screening for health conditions, mental health or SUD assessment, smoking cessation counseling, individual psychotherapy, and family psychotherapy.

Telehealth can be utilized to deliver services in many forms such as live video-conferencing, store and forward, remote patient monitoring, and mobile health.[3] Live video-conferencing consists of two way, real time, video conferences between the patient and a healthcare provider; "store and forward" is when a patient's healthcare documents are stored and shared electronically for use and analysis by a healthcare provider; remote patient monitoring is the collection of a patient's healthcare data from one site that is electronically sent to healthcare providers at another site for monitoring and review; and mobile health is the utilization of smartphones and mobile applications to support the continued monitoring of a patient's health. While other telehealth delivery methods may exist, these four methods are generally the most frequently utilized.[3] Telehealth delivery methods, particularly the four primary telehealth methods of live video-conferencing, store and forward, remote patient monitoring, and mobile health, can address healthcare access barriers for beneficiaries in isolated geographic areas, such as rural areas.

The benefits of telehealth delivery methods are not limited to only rural areas, and telehealth delivery methods can be implemented more broadly in many communities. As part of an overall strategy, telehealth could increase access to services in underserved areas by increasing the availability of providers within a state. As a result, the use telehealth may help mitigate barriers to treatment through expanding access to a limited workforce.

[1] Telemedicine. CMS. Retrieved from: https://www.medicaid.gov/medicaid/benefits/telemed/index.html. Note that the federal Medicaid statute does not recognize telemedicine as a distinct service.
[2] Telehealth. Substance Abuse and Mental Health Services Administration. Retrieved from https://www.integration.samhsa.gov/hit/telehealthguide_final_0.pdf
[3] Telehealth. (2017). Mayo Clinic. Retrieved from https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/telehealth/art-20044878

I. Rural Health Care and Medicaid Telehealth Flexibilities

Background

Approximately 60 million people live in rural areas across the United States. Rural communities often face multiple unique barriers to accessing care.[4] These barriers can include distance and transportation, access to services, lower health literacy, social stigma, privacy issues, and workforce shortages.[5] As a result, rural communities need to find creative solutions to assist individuals who live in rural areas in mitigating barriers to accessing care. Traditionally, these solutions involved the physical (i.e., face-to-face) connection of beneficiaries to providers, which usually meant an additional transportation expense. Now, however, rural communities are increasingly expanding their strategies to include telehealth to deliver care and services.

Telehealth in Medicaid

In Medicaid specifically, telehealth can be a cost-effective service delivery method to furnish care and services to beneficiaries. Unlike in the Medicare program, federal Medicaid law and regulations do not specifically address telehealth delivery methods or the criteria for implementation of telehealth delivery methods. As a result, states have broad flexibility in designing the parameters of telehealth delivery methods to furnish services so long as the underlying services are consistent with the overarching provisions in section 1905(a) of the Social Security Act (the Act) and the state's plan and policy framework as a Medicaid benefit. For example, in geographic areas where specialty care is limited, states may fill gaps in coverage by incentivizing specialty care practitioners in one area of the state to visit remotely with beneficiaries in another area of the state. In this example, the specialty care practitioner must meet the existing provider qualifications to perform this service, as well as any other state-established criteria for furnishing services through telehealth delivery methods. States that use Medicaid managed care plans to deliver services also can include telehealth delivery methods within their managed care contracts to ensure the Medicaid managed care plans adhere to the improved access states are working to achieve. States may encourage managed care plans to explore telehealth delivery options during the contracting process and make use of the flexibilities that states already have in this area.

As is common with emerging technologies, accessibility of telehealth interventions may be problematic for some populations of beneficiaries with disabilities – particularly those with visual and hearing disabilities and those with limited or no use of their hands.[6] CMS recommends that states discuss accessibility needs and adaptations with their telehealth vendors. Please note that the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 apply to state's Medicaid programs and services.

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[4] CMS Rural Health Strategy. (2018). Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

[5] Healthcare Access in Rural Communities. (2019). Retrieved from https://www.ruralhealthinfo.org/topics/healthcare-access#population-health

[6] Frieden, L., Nguyen, V. & Powers, G., Southwest ADA Center, TELEMEDICINE: ACCESS TO HEALTH CARE FOR PEOPLE WITH DISABILITIES, 17 Hous J. Health L. & Policy (2017), available online at http://www.law.uh.edu/hjhlp/volumes/Vol_17/V17%20-%20Frieden-FinalPDF.pdf. This paper was funded in part by the National Institute on Disability, Independent Living, and Rehabilitation Research within the Administration for Community Living.

Payment for Services Furnished Through Telehealth

Federal requirements for efficiency, economy, and quality of care must be satisfied in order to receive federal financial participation (FFP) for Medicaid covered services. Using telehealth delivery methods as part of a comprehensive strategy to increase the availability of Medicaid covered services can be taken into account as the state determines appropriate payment methodologies. In Medicaid, states are allowed to set different rates for services provided through telehealth delivery methods. As an example, states may reimburse providers at the distant site and reimburse a facility fee to the originating site. Additional costs such as technical support, transmission charges, and equipment can also be incorporated into the payment methodology. A state may also reimburse providers for medically necessary Medicaid services, and recognize the varied costs of providing care based on the setting(s) in which the services are provided or the severity of need. States may also pay for individually covered services or, if determined as a more efficient payment method, may develop bundled rates to reimburse for services. In addition, states may develop payment methodologies that offer incentives for improved outcomes and quality care.

Generally, a State Plan Amendment (SPA) is not necessary to incorporate telehealth delivery methods if there are no changes to the 1905(a) benefit descriptions, limitations, or payment methodologies. However, a SPA would generally be necessary when states add specific distinctions for coverage or different reimbursement methodologies for services furnished through telehealth delivery methods.

When using a managed care delivery system, Medicaid managed care plans are not limited by the payment arrangements outlined in the state plan and could pay alternate fees for additional provider types or for other telehealth modalities in order to improve access and increase provider capacity. In addition, States may implement delivery system and provider payment initiatives under Medicaid managed care contracts, including for providers furnishing services through telehealth delivery methods, consistent with 42 CFR section 438.6(c).

Nationwide Telehealth Trends

The use of telehealth delivery methods is growing nationwide as providers and payers seek to improve access to services and better manage patient care, while reducing health care spending.[7] State laws and policies related to reimbursement, licensure, and practice standards are changing in response to the development of new technology and the growing evidence base demonstrating the impact of telehealth on access, quality, and cost of care.[7]

A Fall 2019 examination of laws and Medicaid policies in all 50 states and the District of Columbia found that all Medicaid agencies in the states and the District have some form of reimbursement for services delivered by telehealth.[7] The predominant form of telehealth that is being reimbursed in all 50 states is live video, while 14 states reimburse for store-and-forward.[7] Additionally, 22 states have some form of reimbursement for remote patient monitoring in their Medicaid programs.[7] Finally, 19 state Medicaid programs explicitly allow the home and schools to serve as originating sites, although there are often additional restrictions on these sites such as geographic or specialty restrictions.[7]

[7] State Telehealth Laws and Medicaid Policies: 50-State Survey Findings. (2019). *Manatt*. Retrieved from https://www.cchpca.org/sites/default/files/2019-10/50%20State%20Telehealth%20Laws%20and%20Reibmursement%20Policies%20Report%20Fall%202019%20FINAL.pdf

II. Medicaid Substance Use Disorder Treatment via Telehealth

Section 1009(b)(1) of the SUPPORT Act requires CMS to issue guidance on state options for Federal reimbursement for services and treatment for SUD under Medicaid delivered via telehealth, including assessment, medication-assisted treatment, counseling, medication management, and medication adherence with prescribed medication regimes. Section 1009(b)(1) also requires that such guidance include information on furnishing services and treatments that address the needs of high-risk individuals, including at least the following groups: American Indians and Alaska Natives (AI/AN), adults under the age of 40, individuals with a history of non-fatal overdose, individuals with a co-occurring mental illness and a SUD, and pregnant women with a SUD.

Section 1009(b)(2) of the SUPPORT Act further requires CMS to address in guidance state options for federal reimbursement of expenditures under Medicaid for education directed to providers serving Medicaid beneficiaries with substance use disorders using the hub and spoke model, through contracts with managed care entities, through administrative claiming for disease management activities, and under Delivery System Reform Incentive Payment ("DSRIP") programs. Historically, DSRIP programs provided states with resources to catalyze significant reforms through the development of infrastructure, workforce enhancements, redesign of systems and processes, and provider incentives to promote positive health outcomes. CMS has not approved a state to use a DSRIP program to support provider education. CMS anticipates that approving such a request to support provider education under DSRIP programs in the future is unlikely. DSRIP awards were time limited investments in system transformation.

Section 1009(b)(3) of the SUPPORT Act requires CMS to address in guidance state options for federal reimbursement of expenditures under Medicaid for furnishing services and treatment for SUD for individuals enrolled in Medicaid in a school-based health center using services delivered via telehealth.

This section of this CIB addresses the requirements listed above.

Substance Use Disorder Treatments and Application of Telehealth

The services described below are generally coverable under 1905(a) Medicaid benefits. In response to the national growing opioid epidemic, many states have implemented telehealth delivery methods to reach communities that have previously encountered barriers to accessing SUD treatment services.[7] States are uniquely positioned to identify SUD services that would be most beneficial to their populations. Beyond the federal Medicaid requirements of free choice of providers, statewide operation, and comparability of services for medically needy and categorically needy groups, states generally have flexibility in determining which services are most appropriate for their beneficiaries' needs. Appendix A sets forth some examples of how states are currently utilizing telehealth delivery methods to furnish services to Medicaid beneficiaries. Additionally, Appendix B identifies other existing Federal funding streams that may compliment Medicaid's federal financial participation.

Assessment

An assessment is the evaluation of the health status of an individual along the health continuum, which is a concept that guides and tracks patients over time through a comprehensive array of

health services spanning all levels and intensity of care.[8] The purpose of an assessment is to establish an individual's health needs, diagnosis, and treatment approaches in relationship to the health continuum.[8] Historically, assessment services required an individual to visit a practitioner's office, which may entail having to leave work during business hours and overcoming transportation barriers, but with the increase of telehealth delivery methods many of the challenges individuals faced in obtaining face to face assessment services may be alleviated. Several states are utilizing telehealth delivery methods to furnish assessments.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) is the use of certain drugs that are often generally prescribed as an adjunctive therapy to support treatment for SUD, along with counseling and behavioral health therapies. Whether or not telemedicine is used, when the medications prescribed for MAT are controlled substances, the prescriber must comply with the federal Controlled Substances Act (CSA). Among other requirements, a practitioner seeking to prescribe controlled substances must be registered with the U.S. Drug Enforcement Administration (DEA). If a narcotic controlled substance is being prescribed for MAT, the practitioner must also obtain a waiver pursuant to the Drug Abuse Treatment Act, comply with 21 U.S.C. § 823(g)(2), and the substance used must be in schedules III, IV, or V and approved by FDA for use in maintenance or detoxification treatment.

The CSA permits the prescribing of controlled substances via telemedicine in certain circumstances. In general, it is a per se violation of the CSA for a practitioner to issue a prescription for a controlled substance by means of telemedicine without having conducted at least one in-person medical evaluation. Nevertheless, a qualified practitioner who has previously conducted at least one in-person medical evaluation of the patient may thereafter prescribe controlled substances to the patient via telemedicine, including controlled substances for the purpose of MAT. In addition, a qualified practitioner may prescribe controlled substances to a patient, including for the purpose of MAT, without conducting an in-person medical evaluation when the practitioner is engaged in the practice of telemedicine as defined at 21 U.S.C. § 802(54).[9] The practice of telemedicine under the CSA is limited to communication using audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site practitioner. The practice of telemedicine under the CSA includes a practitioner communicating with a patient or healthcare professional while the patient is being treated by, and is physically located in, a DEA-registered hospital or clinic, or while the patient is being treated by, and is in the physical presence of, a DEA-registered practitioner. The practice of telemedicine under the CSA also includes telemedicine prescribing by a practitioner who is an employee or contractor of the Indian Health Service, or is working for an Indian tribe or tribal organization under its contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, acting within the scope of the employment, contract, or compact, and who is designated as an Internet Eligible Controlled Substances Provider by the Department of Health and Human Services (HHS). The CSA definition also permits telemedicine prescribing by a practitioner who has obtained a special registration for telemedicine from DEA and is operating within the scope of that registration. DEA intends to propose regulations in the near future outlining the circumstances under which a practitioner may obtain and use a special registration for telemedicine.

[8] Si, S., Moss, J., Sullivan, T., Newton, S., & Stocks, N. (2014). Effectiveness of general practice-based health checks: a systematic review and meta-analysis. *The British Journal of General Practice*. 64(618): 47–53.
[9] For more information about some of the ways to prescribe controlled substances for MAT via telemedicine, see DEA's Use of Telemedicine While Providing Medication Assisted Treatment guidance document, https://www.deadiversion.usdoj.gov/mtgs/pract_awareness/resources/Telemedicine_MAT.pdf.

Congress enacted these limitations on the prescribing of controlled substances via telemedicine in the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (RHA), to address the grave threat to public health and safety caused by physicians who prescribed controlled substances via the internet without establishing a valid doctor-patient relationship. The limitations in the RHA and in DEA's implementing regulations are designed to balance the need to address the use of the internet to divert prescription controlled substances with the need to preserve access to the valid practice of medicine via telemedicine.

State rules governing the prescribing of medications via telehealth vary, ranging from more to less specific to silent. Although each state's laws, regulations, and Medicaid program policies differ significantly, certain trends have emerged. Several states have begun incorporating specific documentation and/or confidentiality, privacy, and security guidelines within their manuals for telehealth. Laws and regulations allowing practitioners to prescribe medications through live video interactions have also increased, as well as a few states even allowing for the prescription of controlled substances over telehealth, within Federal limits.[10]

Barriers to states implementing medication-assisted treatment (MAT) that impact the delivery of MAT via telehealth include the limited number of providers that can prescribe certain MAT medications, funding barriers to implementing MAT, and lack of access to medical personnel with expertise in delivering MAT via telehealth. Some states have laws prohibiting prescribing via telehealth due to concerns that without meeting in person, providers may not have sufficient medical history or information to safely prescribe medication, and some states require at least one in-person visit before allowing a doctor to prescribe MAT via telehealth. In other states, clinicians are able to prescribe via telehealth just as they would prescribe during a face-to-face visit, provided that the provider-patient relationship has been established.[11]

Some states are actively changing their laws and rules in order to identify strategies to address the opioid epidemic. Six states have enacted laws that allow controlled substance prescribing through telehealth without a prior in-person examination (Delaware, Florida, Indiana, Michigan, Ohio, and West Virginia), provided that specific state requirements are met. For example, Indiana allows prescribing of buprenorphine via telehealth, while also attempting to address the opioid epidemic by limiting remote access to most prescription opioids.[12]

Counseling

Counseling is a professional relationship between patient and licensed or certified healthcare provider that empowers diverse individuals, families, and groups to attain mental health and wellness, and it can be used for individuals with SUD.[13] Telehealth delivery methods now often offer access to mental health specialists, including, but not limited to psychiatrists, psychologists, clinical social workers, substance use disorder counselors, and mental health counselors, as an

[10] Patient-centered interventions to improve medication management and adherence: a qualitative review of research findings. Patient Education Counsel. 2014 Dec; 97(3): 310–326.
[11] Telehealth in Medicaid, MAPAC. (2018). Retrieved from https://www.macpac.gov/wp-content/uploads/2018/03/Telehealth-in-Medicaid.pdf
[12] National Council for Behavioral Health Financing Reform and Innovation (2018). The Use of Telehealth to Treat Opioid Use Disorder: An Environmental Scan.
[13] Counseling. (2019). *American Counseling Association*. Retrieved from https://www.counseling.org/about-us/about-aca/20-20-a-vision-for-the-future-of-counseling/consensus-definition-of-counseling

avenue for extending counseling beyond the office and into communities where access to healthcare and substance use disorder services is limited.[14] Beyond using telehealth for individual treatment, specialists can use the platform for group counseling, family counseling, as well as various other counseling services that meet the requirements of 1905(a), which can give providers the opportunity to treat more people in several locations without the need for the provider to travel. Several states are utilizing telehealth delivery methods to furnish counseling services, such as Arizona, Delaware, Kentucky, Maryland, Michigan, Minnesota, New York, and Utah.[7]

Medication Management and Medication Adherence with Prescribed Medication Regimen

The term medication management encompasses services that focus on medication education, appropriateness, effectiveness, safety, monitoring, and adherence with the goal of improving health outcomes.[15] People fail to take their prescribed medications for many reasons, including, but not limited to, burdensome and complex adherence regimens, concerns about cost and side effects, doubts about the benefit of medications, and poor health literacy. Medication management aims to increase adherence through shared decision-making, use of methods that enhance effective prescribing, systems for eliciting and acting on patient feedback about medication use and treatment goals, and reinforcing medication-taking behavior.[16]

Medication management via telehealth can be as successful as face-to-face treatment.[17] Studies to date generally show high patient and provider satisfaction with care delivered via videoconferencing, although some providers express concern that telehealth may affect the therapeutic relationship between patient and provider. Telehealth and remote technologies may also be used to monitor clinical aspects of a patient, such as blood sugar levels for an individual with diabetes being reported to a clinician, despite distance, which could help ensure that monitoring is optimally convenient for the patient.[18]

Although medication management may be possible through texting or e-mail, live video conferencing is used most commonly to allow for a thorough collection of patient information, including medication-taking behaviors, adherence, and identification of medication-related problems. In addition, some states require real-time encounters in order for providers to receive compensation for services furnished via telehealth.[19]

High-Risk Populations

Section 1009(b)(1) of the SUPPORT Act requires CMS to issue guidance on furnishing services and treatments that address the needs of high-risk individuals, including at least the following groups: American Indians and Alaska Natives (AI/AN), adults under the age of 40, individuals with

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[14] Using Telehealth to Coordinate Care for Substance Abuse Disorders. (2018). *mHealth Intelligence*. Retrieved from https://mhealthintelligence.com/features/using-telehealth-to-coordinate-care-for-substance-abuse-disorders

[15] Joint Commission of Pharmacy Practitioners. (2018). https://jcpp.net/wp-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf

[16] Patient-centered interventions to improve medication management and adherence: a qualitative review of research findings. (2014). Patient Education Counsel. 97(3): 310–326.

[17] Mostafa et al., (2017). Telemental Health Care, an Effective Alternative to Conventional Mental Care: a Systematic Review. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723163/

[18] Telehealth Application Domains. Rural Health Information Hub. Retrieved from https://www.ruralhealthinfo.org/toolkits/telehealth/1/application-domains

[19] State Telehealth Laws and Reimbursement Policies. (2018). Center for Connected Health Policy. Retrieved from https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf

a history of non-fatal overdose, and individuals with a co-occurring mental illness and a SUD. CMS addresses each of these groups below, as well as pregnant women with a SUD, given that SUD during pregnancy has increased dramatically in the last two decades.[20] The telehealth delivery methods referenced above can assist high-risk populations in overcoming barriers to healthcare access and increasing access to needed providers.

American Indians and Alaska Natives

According to 2010 U.S. Census data, there are approximately 5.2 million AI/AN living in the United States.[21] Out of this number, approximately 2.6 million AI/AN receive services from health programs operated by the Indian Health Service (IHS), Tribes or tribal organizations, and Urban Indian Health Organizations.[22] Individuals living on reservations are often more severely affected than the rest of the AI/AN population due to rural isolation, poverty, and challenges accessing healthcare services. The combined effects of poverty, limited educational opportunities, and substance use disorders have led to a disproportionate risk of chronic disease and a lower life expectancy among AI/AN populations.[23] In many rural tribal communities, access to specialty providers continues to be a challenge in providing care for complex medical conditions.

One way IHS and Tribes address the need for access to specialty providers is through more robust services that can be delivered via telehealth. For example, the IHS Telebehavioral Health Center of Excellence (TBHCE) consists of a small team of IHS personnel who provide telebehavioral health services at 25 delivery sites located at IHS, tribal, or urban health programs in the contiguous 48 states and Alaska. In 2019, the Center provided over 4,627 hours of telebehavioral health services encounters covering culturally sensitive counselling, behavioral health therapy and medication assisted treatment to AI/ANs.

SAMHSA's 2018 National Survey on Drug Use and Health (NSDUH) noted that the prevalence of past-year illicit drug use among all AI/AN youth aged 12-17 was 18.1 percent as compared to 16.7 percent among all youth.[24, 25] In addition, the 2018 NSDUH indicated that the prevalence of past-year opioid misuse (either heroin use or prescription pain reliever misuse) was 0.9 percent as compared to 2.8 percent for all youth; the prevalence of past-year prescription tranquilizer or sedative misuse was 3.0 percent as compared to 1.8 percent for all youth; the prevalence of past-year substance use disorder was 3.9 percent as compared to 3.7 percent of all youth; and the

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[20] "Opioid Crisis in Medicaid: Saving Mothers and Babies." Health Affairs Blog. May 1, 2018.
[21] The American Indian and Alaska Native Population: 2010. (2012). *U.S. Census*. Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf
[22] In 1976, Congress amended titles XVIII and XIX of the Social Security Act to authorize IHS facilities (whether operated by the IHS or by an Indian Tribe or Tribal organization as defined in section 4 of the Indian Health Care Improvement Act (IHCIA)) to receive Medicare and Medicaid reimbursement for services covered under those programs and provided by these facilities, so long as the facilities meet generally applicable Medicare and Medicaid program conditions and requirements. Congress also amended section 1905(b) of the Act to establish a 100% Federal Medical Assistance Percentage (FMAP) for state expenditures on Medicaid-covered services provided to AI/AN Medicaid beneficiaries when those services are "received through" an IHS facility (whether operated by the IHS or by an Indian Tribe or Tribal organization as defined in section 4 of the IHCIA). In 2016, CMS updated its interpretation of when 100% FMAP under section 1905(b) of the Act is available for Medicaid services received through an IHS/Tribal facility. See State Health Official (SHO) Letter#16-002.
[23] Adakai, M., Sandoval-Rosario, M., Xu, F., Aseret-Manygoats, T., Allison, M., Greenlund, K., & Barbour, K. (2017). Health Disparities Among American Indians/Alaska Natives — Arizona, 2017. *Morbidity and Mortal Weekly Report*. (67):1314–1318.
[24] Substance Abuse and Mental Health Services Administration (SAMHSA). (2018). Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsqreports/NSDUHDetailedTabs2018R2/NSDUHDetTabsAppB2018.htm
[25] Information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children under the age of 21 can be found at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf and https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf

prevalence of past-year illicit drug use disorder was 3.7 percent as compared to 2.9 percent of all youth; and the prevalence of past-year illicit drug use was 18.1 percent as compared to 16.7 percent of all youth.[24] The prevalence rates are not statistically significant between AI/AN youth and all U.S. youth.[24]

SAMHSA's NSDUH also reports that 5.2 percent (72,000) of AI/AN aged 18 and older reported misusing a prescription drug in 2018 and 4.0 percent (56,000) of AI/ANs aged 18 and older reported misusing a prescription pain reliever in 2018.[26] In addition, the Centers for Disease Control and Prevention (CDC) reported that AI/ANs had the highest drug overdose death rates among adults in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015, compared to other racial and ethnic groups.[27] During that time, deaths rose more than 500 percent among the AI/AN adult population.[28]

Given the high rates of substance use disorders and behavioral health conditions in AI/AN populations, opioid treatment to AI/ANs could include MAT, which may be delivered via telehealth delivery methods.[29] Additionally, while not required by CMS, treatment that acknowledges the importance of AI/AN cultures in recovery can allow healthcare providers to take meaningful steps in attempting to curb the rates of AI/AN opioid use disorder.[30]

Telehealth can bridge the gap in service delivery created by the geographic isolation of the remote Indian communities and associated transportation limitations. While treatment centers in rural areas are less likely than their urban counterparts to provide buprenorphine and other evidence-based services, such as case management, furnishing counseling services via telehealth has helped to overcome these geographic limitations and yielded encouraging outcomes.[31] Additionally, specific attributes, such as having high rates of co-occurring conditions, high rates of co-occurring mental health diagnosis, and high rates of co-occurring SUD diagnosis, could be addressed further through the increased utilization of SUD services delivered via telehealth.

Adults under the Age of 40

Individuals under the age of 40 make up the majority of Americans with SUD in the United States.[32] Using 2016 Medicaid claims data, there is evidence of telehealth usage in service delivery to individuals in this age group: of those individuals who had an SUD diagnosis and a telehealth claim filed, 34.5 percent were age 18 to 24, 17.5 percent were age 25 to 34, and 29.8 percent were age 35 to 49.[33] Of these individuals, 18 to 24 year olds represent the highest percentage of telehealth use (34.5 percent), followed by those 35 to 49 years old (29.8 percent).[33]

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[26] Jones, C. (2018). Testimony from Christopher M. Jones, PharmD., M.P.H. on Opioids in Indian Country: Beyond the Crisis to Healing the Community before Committee on Indian Affairs. *Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.hhs.gov/about/agencies/asl/testimony/2018-03/opioids-indian-country-beyond-crisis.html

[27] Centers for Disease Control and Prevention. (2017). Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *Morbidity and Mortality Weekly Report*. 66(19): 5-11.

[28]The IHS Launches New Opioids Website. (2018). *Indian Health Service*. Retrieved from https://www.ihs.gov/newsroom/ihs-blog/july2018/the-ihs-launches-new-opioids-website/

[29] Crisis Response. (2019). *Indian Health Service*. Retrieved on February from https://www.ihs.gov/opioids/recovery/telemat/

[30] Substance Abuse and Mental Health Services Administration (SAMHSA). (2013). SAMHSA American Indian/Alaska Native Data. Retrieved from https://www.samhsa.gov/sites/default/files/topics/tribal_affairs/ai-an-data-handout.pdf

[31] Opioid Use Disorder: Challenges and Opportunities in Rural Communities. (2019). *The Pew Charitable Trusts*. Retrieved from https://www.pewtrusts.org/-/media/assets/2019/02/opioiduseruralcommunities_final.pdf

[32] Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. (2019). *Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm

[33] Utilization of Telehealth Services in the Treatment of People with Opioid Use Disorder. (2018). *IMB Watson Health*. Cambridge, MA.

Among those with an SUD diagnosis in 2016, adults under the age of 40 accessed telehealth services most frequently. The 2016 Medicaid claims data results also indicated that 68.4 percent of these individuals with an SUD diagnosis and telehealth claims were women, 64.4 percent lived in urban geographic locations, 83 percent identified as non-Hispanic whites, and many had co-occurring diagnostic conditions. Specifically, 56.1 percent of the individuals under the age of 40 had a co-occurring SUD diagnosis, 87 percent had a co-occurring mental illness diagnosis, and 39 percent had a co-occurring medical/non-SUD diagnosis.[33]

When developing treatments for adults under 40 with SUD, it is important to recognize the high rates of co-occurring conditions and to address these co-occurring conditions when possible during the course of SUD treatment. While there is a current gap in the literature as to what method of telehealth is most effective in providing SUD treatments, a study by the University of Michigan found that the most common type of telehealth in use, is direct video conferencing (40 percent of respondents), the most common type of behavioral health providers using telehealth are psychiatrists (78 percent of respondents), and the most common type of service telehealth is used for is medication management (54 percent of respondents).[34] As a result, telehealth can be further utilized in the Medicaid program to facilitate the delivery of medication management services to treat SUD, as well as address the co-occurring SUD and mental illness diagnosis specific to adults under 40 who are Medicaid beneficiaries.

Individuals with a history of non-fatal overdose

In general, there are approximately 30 non-fatal overdoses for every fatal overdose.[35] Those who survive an overdose remain at elevated risk for all-cause mortality in the year after the overdose. One study of adult Medicaid enrollees found that the one-year all-cause mortality rate after an overdose was more than 24 times higher than what would be expected for age, sex, and race/ethnicity-matched community controls. The one-year mortality was higher for a range of causes, including fatal overdose, suicide, chronic respiratory diseases, viral hepatitis, and HIV.[36] Because of this pronounced risk of all-cause mortality, it is especially important that people who survive an opioid overdose be linked to treatment for substance abuse, mental health disorders, and other health conditions. Research shows that medication treatments should be initiated before an individual leaves the emergency department (ED)[37] as there are demonstrated decreases in mortality in opioid overdose survivors who receive medication treatments in the ED. Despite this, one study found that only 30 percent of patients receive appropriate medications for opioid use disorder in the 12 months following a non-fatal overdose.[37, 38, 39]

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[34] Mace, S., Boccanelli, A. & Dormond, M. (2018). The Use of Telehealth Within Behavioral Health Settings: Utilization, Opportunities, and Challenges. *University of Michigan Behavioral Health Workforce Research Center*. Retrieved from http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/05/Telehealth-Full-Paper_5.17.18-clean.pdf

[35] Frazier, W., Cochran, G., Wi-Hsuan, L.C. et al. (2017). Medication Assisted Treatment and Opioid Use Before and After Overdose in Pennsylvania Medicaid, *Journal of the American Medical Association.* 318(8): 750-752. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/2649173

[36] Olfson M et al. (2018). Causes of death after nonfatal opioid overdose. *JAMA Psychiatry*. 1;75(8):820-7. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2685326

[37] Larochell, M.R., Benson, D., Land, T. et. al. (2018). Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study. *Annals of Internal Medicine.* 169(3): 137-145 Retrieved from https://annals.org/aim/fullarticle/2684924/medication-opioid-use-disorder-after-nonfatal-opioid-overdose-association-mortality

[38] Utilization of Telehealth Services in the Treatment of People with Opioid Use Disorder. (2018). *IMB Watson Health*. Cambridge, MA.

ED-based interventions alone are insufficient to improve longer-term outcomes for people who have overdosed.[39] To promote sustained treatment engagement and long-term recovery, SAMHSA recommends a "warm handoff" after a non-fatal overdose. These handoffs "comprise a range of interventions aimed at helping individuals…connect with the people, resources, and/or services they need to prevent future overdoses and other negative health outcomes." A warm handoff can include ED-based screening and referral, ED-based naloxone provision, and post-overdose outreach and follow-up.[40] In settings where face-to-face interactions with professional substance use disorder specialists are not possible, telehealth may be a viable alternative.[41]

Individuals with co-occurring mental illness and substance use disorder

Research indicates that individuals with a mental illness are more likely to have a co-occurring SUD when compared to individuals without a mental illness.[42] In 2018, among the 47.6 million adults who had any mental illness in the past year, 9.2 million (19.3 percent) also had a SUD.[43] In contrast, only 5.1 percent of adults who did not have a mental illness (10.2 million adults) in 2017 met the criteria for a SUD. Among the 11.2 million adults who had a mental illness[44] in the past year, 3.1 million (27.6 percent) had a SUD.[45] Conservative estimates in the adult population based on self-reports, excluding homeless and incarcerated individuals, suggest that among people with SUD, 64 percent have any mental illness and nearly 27 percent have a serious mental illness.[46] Data from the 2008 – 2014 NSDUH revealed that 47 percent of individuals with OUD and co-occurring mild/moderate mental illness did not receive any behavioral health treatment, and 21 percent of those with co-occurring serious mental illnesses did not receive any behavioral health treatment. Among those with OUD and co-occurring mild/moderate mental illness, 16 percent reported receiving both substance use disorder and mental health treatment; among those with co-occurring serious mental illness the rate was 32 percent.[47] Additionally, among 358,000 adolescents with co-occurring substance use disorders and a major depressive episode, only 5.4 percent received both mental health care and substance use treatment.[43] Despite the strong association between SUD and mental illness, most people with co-occurring SUD and mental illness do not receive treatment for more than one disorder.

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[39] D'Onofria, G., Chawarski, M.C., O'Connor, P.G., et. al. (2017). Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. Journal of General Internal Medicine. 32(6)660-666. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/28194688

[40] Substance Abuse and Mental Health Services Administration. (2019). Retrieved from https://www.integration.samhsa.gov/clinicalpractice/sbirt/referral-to-treatment

[41] Boudreaux, E.D., Haskins, B. Harralson, T., et al. (2015). The Remote Brief Intervention and Referral to Treatment Model: Development, Functionality, Acceptability, and Feasibility *Drug and Alcohol Dependence.* Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4624210/

[42] Why is there comorbidity between substance use disorder and mental illness. National Institute of Drug Abuse. Retrieved from https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/why-there-comorbidity-between-substance-use-disorders-mental-illnesses

[43] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[44] Defined as having at any time during the past year, a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment and that substantially interferes with or limits one or more major life activities.

[45] Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Retrieved from https://www.samhsa.gov/data/

[46] Jones, C.M., McCance-Katz, E.F. (2019). Co-Occurring Substance Use and Mental Disorders Among Adults with Opioid Use Disorder, *Drug and Alcohol Dependency,* 197, 78-82. Retrieved from https://reader.elsevier.com/reader/sd/pii/S0376871618305209?token=8EE2E410C307B89E8B81EB2B5C210B1D265D6FCDB80AF87C14A94603AFF367AC4B131B5F752A140D517DA91C8B9CC8E4].

[47] Novak, P., Feder, K.A., Ali, M.M., et al. (2019). Behavioral health treatment utilization among individuals with co-occurring opioid use disorder and mental illness: Evidence from a national survey. *Journal of Substance Abuse Treatment*. 98:47-52. Retrieved from https://www.sciencedirect.com/science/article/pii/S0740547218304781?via%3Dihub

In addition to counseling and MAT to treat SUDs, people with mental illnesses are likely to need medication management for drugs to treat mental illness, and compared to those without a mental illness, may need more intensive services such as case management and psychotherapy or behavioral treatment. Telehealth can be a means to connect people with co-occurring mental illness and SUD with mental health services. Multiple studies have examined the outcomes of using telehealth to treat mental illness.

Pregnant Women with Substance Use Disorders

Access to comprehensive approaches to care are a critical barrier for pregnant and postpartum women with substance use disorder, who often have difficulty accessing care coordiation services. Increasing access to care coordination services through telehealth delivery methods may lead to a reduction in the number of babies born with neonatal abstinence syndrome and may result in beneficial health outcomes for both mother and child. The surge in substance use-related illness and death in recent years particularly affects pregnant women, and is now a leading cause of maternal death. SUD has been associated with increased risk of preterm labor, early onset delivery, poor fetal growth, and stillbirth. Additionally, women who used opioids during pregnancy were four times as likely to have a prolonged hospital stay, had babies with increased rates of neonatal abstinence syndrome, and were almost four times more likely to die before discharge.[48] Several barriers to SUD treatment exist for women who are pregnant, including but not limited to lack of access to SUD treatment, lack of available SUD treatment for pregnant women specifically, fear of the stigma associated with the use of opioids or other substances during pregnancy, as well as legal consequences in some states with statutes that sanction pregnant women with SUD.[49] In some instances, healthcare treatment for pregnant women with SUD may be delayed by fears that seeking prenatal care or addiction treatment will trigger child welfare involvement and possible loss of parental rights for their children.

Women diagnosed with SUDs, who are pregnant or in the 60 day postpartum period, require access not only to effective SUD treatment but also to the full array of mandatory and optional pregnancy and pregnancy-related services available through Medicaid, including treatment of conditions that may complicate pregnancy. Increasing the utilization of services delivered via telehealth could be effective in addressing the needs of pregnant women with SUD.

Medicaid Payment for Education to Providers Regarding Telehealth

The below options have been included pursuant to section 1009(b)(2) of the SUPPORT Act.

Medicaid Payment to Providers Serving Medicaid Beneficiaries with Substance Use Disorders

States have significant flexibility in how they elect to cover and reimburse for services rendered to Medicaid-eligible individuals who have been diagnosed with SUDs. A state may reimburse providers for medically necessary Medicaid services, and recognize the varied costs of providing care based on the setting(s) in which the services are provided or the severity of need. States may

[48] Whiteman, VE, Salemi, JL, Mogos, M F, et al. (2014). Maternal Opioid Drug Use during Pregnancy and Its Impact on Perinatal Morbidity, Mortality, and the Costs of Medical Care in the United States. *Journal of Pregnancy*, 906723. Retrieved from http://doi.org/10.1155/2014/906723.
[49] Substance Abuse and Mental Health Services Administration. (2018). Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054: Rockville, MD.

reimburse for individually covered services or, if determined as a more efficient payment method, may develop bundled rates[50] to pay for services. In addition, states may develop payment methodologies that offer incentives for improved outcomes and quality care. By utilizing service delivery mechanisms such as the Medicaid Health Home benefit or other benefits, states may create integrated care models (ICMs), which support value-driven strategies that emphasize person-centered, continuous, comprehensive care.[51] ICMs are characterized by organized and accountable care delivery and payment methodologies that are aligned across payers and providers to ensure effective, seamless, and coordinated care. ICMs include integration of various types of health care services such as primary, acute, specialty, dental, behavioral, long-term support services, and SUD-related services. States may use a variety of Medicaid authorities to implement ICMs, including section 1905(t) and 1932(a) primary care case management (and including coordinating, locating and monitoring activities under section 1905(t)(1), section 1945 health homes, and section 1115(a) demonstration authorities, and to create incentive payments for providers who demonstrate improved performance on quality and cost measures.[52]

Hub and Spoke Model

When utilizing telehealth delivery methods the predominant model of service delivery is the "hub and spoke" design. With regard to telehealth services, the hub site means the location of the telehealth consulting provider, which is considered the place of service, and spoke site means the location where the patient is receiving the telehealth service. The hub and spoke model is widely used throughout the United States for healthcare service delivery, and is the model many telehealth delivery methods are currently utilizing when delivering services through live video conferencing.[53] Education directed to providers serving Medicaid beneficiaries with SUDs on how to most effectively utilize the hub and spoke model could be built into the overhead component of a fee-for-service rate paid for the provision of a direct service, and can serve to increase provider knowledge on how to furnish services through telehealth delivery methods.

Medicaid Payment through Managed Care Contracts

States can use varying delivery systems when providing services to its Medicaid beneficiaries. Some states use a managed care plan to deliver a set of services to its enrollees in a risk-based arrangement where the managed care plan gets paid a set amount per enrollee, generally called a capitation payment, to provide all of the covered services under the contract. The capitation payment must be developed only on state plan services, but must also be an amount that is adequate to allow the managed care plan to efficiently deliver those covered services to its enrollees in a manner that is compliant with contractual requirements, including the requirements of the Mental Health Parity and Addiction Equity Act detailed at 42 CFR 438, Subpart K.[54]

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[50] CMS issued guidance for developing bundled payment rates, which can be found at https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf

[51] The Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects states' health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the whole person.

[52] CMS has several programs that encourage states to provide integrated care models, a concept that provides the full array of Medicaid and Medicare benefits through a single delivery system in order to provide quality care for dual eligible enrollees, improve care coordination, and reduce administrative burdens.

[53] Telehealth: The Big Picture. (2016). *National Organization of State Offices of Rural Health*. Retrieved from http://dhhs.ne.gov/publichealth/RuralHealth/Documents/NOSORH%20Telehealth%20Big%20Picture%20Fact%20Sheet%20FINAL.pdf

[54] See 42 CFR 438.3(c)(1)(ii) and 438.5(e).

States have the flexibility to define network adequacy standards for their managed care plans, including the delivery of SUD services, which could include such specificity as the SUD specialists that are required to be in the plan network as well as requiring the use of a hub and spoke telehealth delivery method. The managed care plan development of the network, education to providers on the use of the hub and spoke model, and additional technical assistance/training to providers, could be included under the non-benefit component of a capitation rate if the state were to contractually require such standards for the delivery of SUD services. Many managed care plans provide education and trainings to providers on a regular basis as part of network development and retention efforts, even if it is not explicitly identified in the capitation rate development process.

Medicaid Payment through Administrative Funds for Disease Management Services

Medicaid can cover disease management services, such as care coordination, counseling, behavior modification, collecting, recording, and reporting on health outcome measures, and analysis and determination of the effectiveness of current interventions and the individual's needs for future interventions.[55] Disease management programs that focus interventions on the beneficiary may qualify as medical services under Medicaid.

Disease management programs that are limited to administrative activities, furnished by the state and its designated contractors, would not constitute "medical assistance." Administrative activities, however, could be eligible for Federal matching funds for administration of the state plan at the standard administrative matching rate of 50 percent. For example, states or their contractors may work with providers within their state to promote adherence to evidence-based treatments and guidelines, improve provider-patient communication, and analyze the Medicaid-enrolled individual's utilization of services. Contact with Medicaid-enrolled individuals is indirect and the change in provider practice patterns should enhance beneficiary care. Additionally, targeted informational mailings to Medicaid-enrolled individuals may improve patient knowledge, but no face-to-face contact occurs. The examples described in this section are generally considered to be administrative functions, and may be eligible for Federal administrative match.[56] Medicaid state plan requirements, such as statewide operation and comparability of services for medically and categorically needy groups, are not applicable to services deemed to be administrative functions.

School Based Health Centers

The below information has been included pursuant to section 1009(b)(3) of the SUPPORT Act.

Background

Section 2110(c)(9) of the Act defines a school-based health center (SBHC) as a health clinic that: 1) is located in or near a school facility of a school district or board, or of an Indian tribe or tribal organization; 2) is organized through school, community, and health provider relationships; 3) is administered by a sponsoring authority; 4) provides through health professionals primary health services to children in accordance with state and local law, including laws relating to licensure and certification; and 5) satisfies such other requirements as a state may establish for the operation of such a clinic. Additionally, section 2110(c)(9) of the Act defines a sponsoring facility to include any

[55] CMS SMDL #04-002 https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd022504.pdf
[56] CMS SMDL #04-002 https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd022504.pdf

of the following: a hospital; a public health department; a community health center; a non-profit health care agency; a local educational agency; or a program administered by the IHS or the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization.[57]

Authorizing legislation at 42 U.S.C. § 280h-4 provided the requirements for SBHCs to receive construction-related grant funding from HRSA. From FY 2011-2013, HRSA administered the School Based Health Center Capital (SBHCC) awards to address significant and pressing capital needs, improve service delivery, and support the expansion of services at SBHCs. Organizations eligible to apply for SBHCC funding included SBHCs or a sponsoring facility of a SBHC. Nearly $200 million was available in FY 2011-2013, and funds remained available until expended. In February 2019, HRSA awarded $11 million in SBHCC funding to SBHCs to specifically increase access to mental health, substance use disorder, and childhood obesity-related services by funding minor alteration/renovation projects and/or the purchase of equipment, including telehealth equipment.

Frequently furnished services by SBHCs include immunizations, acute illness treatment, prescriptions, collection of blood or urine samples for lab analysis, substance use counseling, and health education on topics such as nutrition and reproductive health. Many health centers also manage students' chronic conditions, such as asthma or diabetes, and educate them on disease prevention and how to remain in good health. In addition, in 2012, mental health services such as baseline assessment and counseling were available in approximately 45 percent of SBHCs, and general dental care, such as fillings and basic cleanings, were available in about 10 percent of SBHCs.[57]

Medicaid Coverage

SBHCs are not a recognized Medicaid facility benefit. However, SBHCs may qualify as a Medicaid facility if they meet the requirements of the clinic benefit or the Federally Qualified Health Center (FQHC) benefit. In addition, Medicaid could cover services under 1905(a) of the Act furnished by an SBHC. States may elect to cover SUD treatment services such as assessments, counseling, MAT, and medication management under several Medicaid benefits. These benefits may include the Physicians' Services, Other Licensed Practitioner Services, or Rehabilitative Services benefits. Services provided by SBHCs vary since they are tailored to meet the needs of the communities which SBHCs serve.[58]

Medicaid Reimbursement and Telehealth Options

Some states have taken the step to enroll SBHCs as Medicaid providers that meet the state's Medicaid benefit provider qualification requirements. States may request technical assistance from CMS with regard to reimbursement of Medicaid covered services and treatment via telehealth for substance use disorders that are delivered by a SBHC.[58]

[57] School-Based Health Center Capital Program (SBHCCP). (2012). *Health Resources and Services Administration*. Retrieved from https://bphc.hrsa.gov/programopportunities/fundingopportunities/sbhcc/fy13sbhccappfaqs.pdf
[58] School Based Health Centers. (2011). *National Conference of State Legislatures*. Retrieved from http://www.ncsl.org/research/health/school-based-health-centers.aspx

State Readiness Assessment for Implementing Telehealth Delivery Methods

The above guidance has detailed coverage and reimbursement opportunities available to states for Medicaid services delivered via telehealth delivery methods. States may choose to examine several areas if implementing or expanding telehealth delivery methods are right for their state. In addition, during the period of public health crisis related to COVID-19, states may also use the following questions to assess telehealth in their state. The following questions should help a state determine which paths to pursue to align with the above telehealth coverage and reimbursement options for expansion of telehealth in their state under typical operations or in an emergency:

1. Assess the state operational environment by reviewing state policies and regulations governing services being delivered through telehealth delivery methods.

    a. Do state policies/regulations prohibit services from being delivered through telehealth delivery methods?

    b. Do state policies/regulations prohibit professionals from providing services delivered through telehealth delivery methods?

    c. Does the state need to establish new regulations or seek authority from its legislature to furnish services delivered through telehealth delivery methods?

    d. Does the state's provider scope of practice laws allow for practitioners to furnish services being delivered through telehealth delivery methods?

    e. Do the state's managed care contracts have requirements regarding services being delivered through telehealth delivery methods? Please refer to page 14 of this CIB for additional information regarding reimbursement under managed care contracts.

2. Assess the state's technological capabilities to implement or expand services being delivered through telehealth delivery methods.

    a. Do providers within the state have the technological capabilities to furnish services using telehealth delivery methods?

    b. Are there any barriers to implementing or expanding technology in the state to furnish services being delivered through telehealth delivery methods?

    c. Are there enough providers familiar with the technology used to furnish services using telehealth delivery methods?

3. Assess whether a state plan amendment is necessary for coverage and reimbursement of the proposed services.

    a. Does the state's existing Medicaid state plan indicate that specific services are being delivered through telehealth delivery methods? Please refer to page 3 of this CIB for additional information regarding Medicaid state plan coverage flexibilities.

b. Does the state's existing Medicaid state plan include language prohibiting services being delivered through telehealth delivery methods?

c. Does the state's existing Medicaid state plan include a reimbursement methodology that differs for services being delivered through telehealth delivery methods? Please refer to page 3 of this CIB for additional information regarding Medicaid state plan reimbursement flexibilities.

Conclusion

Delivering SUD services via telehealth yields many positive impacts for Medicaid beneficiaries and for states. Telehealth delivery methods, including the four primary telehealth methods of live video-conferencing, store and forward, remote patient monitoring, and mobile health, can address healthcare access barriers for beneficiaries in rural and isolated geographic areas. Multiple states are currently delivering Medicaid covered services using telehealth delivery methods and designing services to meet the needs of their state. In addition to Medicaid reimbursement for services, several other Federal agencies such as Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources & Services Administration (HRSA), the Administration for Children and Families (ACF), and IHS have grants and entitlement programs which can be utilized to cover SUD services delivered via telehealth. Many states are utilizing Federal funding authorities to deliver assessment, MAT, counseling, and medication management services via telehealth. Services are particularly needed for special populations such as AI/AN, adults under age 40, individuals with a history of non-fatal overdose, and individuals with co-occurring mental illness and SUD, who have been identified as having unique needs and challenges in obtaining SUD treatment services.

Under Medicaid, states have several options for receiving Federal financial participation to furnish SUD services delivered via telehealth. First, states may receive Federal financial participation for Medicaid services that meet the benefit requirements of the Act. Second, states may include SUD services delivered via telehealth in their managed care contracts and rates, creating some flexibility in determining adequacy standards for managed care plans. The state would then receive FFP for the whole capitation rate, including the services delivered via telehealth. Third, disease management services such as care coordination, collecting, recording, and reporting on health outcome measures, and analysis and determination of the effectiveness of current interventions and the individual's needs for future interventions, may be reimbursed by Medicaid as administrative activities at the 50 percent administrative rate. Fourth, states can receive Federal financial participation by utilizing service delivery mechanisms such as the Health Home benefit or other benefits to create ICMs, which support value-driven strategies that emphasize person-centered, continuous, comprehensive care, which can include SUD-related Medicaid services.[59] Fifth, some states have enrolled SBHCs as Medicaid providers to receive Federal financial participation for services delivered via telehealth that are coverable under Medicaid and included in a state's approved Medicaid state plan or waiver program. And, states may utilize the state readiness assessment questions to determine which paths to pursue in order to align with the telehealth coverage and reimbursement options previously referenced.

[59] CMS issued four State Medicaid Director Letters concerning ICMs, which can be located at the following URLs: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf, and https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf

States seeking Medicaid Federal financial participation for SUD services delivered via telehealth may request technical assistance from CMS. If you have questions or would like to request CMS technical assistance related to this guidance, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at Kirsten.Jensen@cms.hhs.gov.

Appendix A

State Model Examples

In response to the national growing opioid epidemic, many states have implemented telehealth models to reach communities that have previously encountered barriers to accessing SUD treatment services. As of 2017, live video conferencing was covered under fee-for-service Medicaid by all 50 states and the District of Columbia.[60] As of the Fall 2019, remote patient monitoring, defined as the secure transmission of patient health and medical data collected at the originating site to a provider who will assess them at a distant site, was reimbursed under Medicaid by 22 states (Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New York, Oregon, South Carolina, Texas, Utah, Vermont, Virginia, and Washington). Finally, store-and-forward services, which involve the secure transmission of data, images (e.g., X-rays, photos), sound, or video that are captured at the originating site and sent to specialists at a distant site for evaluation, were covered under Medicaid by 15 states (Alaska, Arizona, Connecticut, California, Georgia, Maryland, Minnesota, New Mexico, Nevada, New York, Tennessee, Texas, Virginia, and Washington). States structured their coverage and reimbursement of services furnished by telehealth delivery methods differently to account for the unique population needs within each state, but each program has integrated at least one telehealth service delivery mechanism.[60]

The following are some examples of how some states are currently utilizing certain telehealth service delivery mechanisms:

Idaho

Idaho Medicaid covers specific services delivered via telehealth technology to help ensure Idaho Medicaid beneficiaries receive the best possible care regardless of geographic location. Since 2003, Idaho's Medicaid program covers live video telehealth for mental health services, specifically pharmacological management counseling, psychiatric diagnostic interviews, psychiatric crisis interventions, and psychotherapy services. In addition, Idaho allows for behavioral health services delivered via telehealth methods under a managed care contract. Effective as of 2008, Idaho allows for mental health services provided via telehealth to be provided by physicians in mental health clinics, as well as to sites beyond mental health clinics. Crisis intervention services were added as covered services in 2011.[61]

Arizona

Arizona Medicaid covers many medically necessary services delivered via two telehealth delivery methods. The first method is "real time" telehealth, meaning interactive, live video conferencing in order for the patient and healthcare provider to engage directly by utilizing technology. Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication. The second method is "store-and-forward", meaning transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image

[60] State Telehealth Laws and Medicaid Policies: 50-State Survey Findings. (2019). *Manatt*. Retrieved from https://www.cchpca.org/sites/default/files/2020-01/Historical%20State%20Telehealth%20Medicaid%20Fee%20For%20Service%20Policy%20Report%20FINAL.pdf

[61] Idaho Medicaid Policy: Telehealth Services. (2018). *Idaho Department of Health and Welfare*. Retrieved from http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthPolicy.pdf

that is sent (forwarded) via telecommunication to another site for analysis. Arizona's Medicaid coverage of services via live video conferencing or "store-and-forward" is expansive and permits coverage of cardiology, dermatology, endocrinology, pediatric subspecialties, hematology-oncology, home health, infectious diseases, neurology, obstetrics and gynecology, oncology and radiation, ophthalmology, orthopedics, pain clinic, pathology, pediatrics, radiology, rheumatology, and surgery follow-up and consultation services.[62]

Kentucky

Kentucky Medicaid covers several classes of services provided via telehealth using live video: mental health evaluation and management services; individual psychotherapy; pharmacological management counseling; psychiatric, psychological, and mental health diagnostic interview examinations; individual medical nutrition counseling; individual diabetes self-management counseling; occupational, physical, or speech therapy evaluation or non-hands on treatment; neurobehavioral status examination; and end stage renal disease monitoring, assessment, or counseling services. Kentucky requires that the Department of Health requirements for coverage and reimbursement of services are equivalent for in-person services and services delivered via telehealth, unless the telehealth provider and the Medicaid program agree to a lower reimbursement rate for telehealth services, or the Kentucky Department of Health establishes a different reimbursement rate.[60]

Georgia

Georgia Medicaid covers office visits, pharmacological management, limited office psychiatric services, limited radiological services, and a limited number of other physician fee schedule services delivered via live video conference. Georgia Medicaid reimburses for mental health services for residents in nursing homes via telehealth for dually eligible Medicaid and Medicare beneficiaries.[63] In Georgia, store-and-forward is not reimbursable as interactive telecommunications; however, Georgia Medicaid reimburses for teleradiology and ultrasound services in which results are electronically sent to other practices for qualified providers to analyze and interpret the results, and which are then sent back to the originating hospital or directly to the patient depending on the method used. Georgia was one of the first states to reimburse store-and-forward teledentistry services.[63]

[62] Chapter 10: Individual Practitioner Services. (2018). *Arizona Health Care Cost Containment System*. Retrieved on February 26, 2019, from https://azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf

[63] Georgia. (2017). *Public Health Institute Center for Connected Health Policy*. Retrieved from http://www.mtelehealth.com/wp-content/uploads/2017/11/Georgia.pdf

Appendix B

Existing Federal Funding Opportunities for Substance Use Disorder Treatment Services and Services Delivered via Telehealth that May Compliment Medicaid Funding

Every day in the United States, 130 people die from opioid overdoses, and the number of overdose deaths involving opioids increased five-fold between 1999 and 2016.[64] The opioid epidemic is especially prevalent among children and families in specific regions and from specific racial and socioeconomic backgrounds. As of 2017, generally, states in New England and Appalachia have experienced higher overdose death rates than other regions.[65] Individuals living in rural areas are more likely to die from an opioid overdose, as are those individuals with lower education levels.[66] A 2016 study showed that in 31 states and the District of Columbia, deaths increased across all prescription and illegal opioid classifications, and that opioid use rates increased from the previous year across demographics, urbanization levels, and amongst all states participating in the study.[67]

The Federal government has enacted several programs to aid states in furnishing SUD services. In 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the State Targeted Response to the Opioid Crisis Grants program, which provides Federal grant funds to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for SUD.[68] In 2018, the Health Resources & Services Administration (HRSA) launched the Rural Communities Opioid Response Program to support treatment for and prevention of SUD, including opioid use disorder, in rural counties at the highest risk for SUD.[69] Also in 2018, SAMHSA launched the State Opioid Response Program, which supports a comprehensive response to the opioid epidemic through increasing access to medication assisted treatment (MAT), reducing unmet treatment needs, and reducing opioid overdose deaths through the provision of prevention, treatment and recovery services. SAMHSA also continued the funding of MAT for the Prescription Drug and Opioid Addiction Program, first begun in 2012, to expand and enhance access to services for persons with an SUD seeking or receiving MAT.[70]

In addition to new SUD specific funding opportunities being offered, existing Federal programs can also be leveraged to assist states in increasing SUD treatment and telehealth utilization. Existing funding opportunities include the Administration for Children and Families' (ACF) Regional Partnership Grants, which are grants for inter-agency collaboration and program integration between child welfare and other agencies to support families affected by SUD [71]; CMS' reimbursement for many SUD services through Medicaid; HRSA's Title V Maternal and Child

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[64] Understanding the Epidemic. (2018). *Centers for Disease Control and Prevention*. Retrieved from https://www.cdc.gov/drugoverdose/epidemic/index.html
[65] Drug Overdose Death Data. (2018). *Centers for Disease Control and Prevention*. Retrieved from https://www.cdc.gov/drugoverdose/data/statedeaths.html
[66] Rigg et al. (2018). Opioid-related Mortality in Rural America: Geographic Heterogeneity and Intervention Strategies. *International Journal of Drug Policy*. 57: 119-129.
[67] Seth et al. (2018). Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. *Morbidity and Mortality Weekly Report*. 67(12): 349–358.
[68] State Targeted Response to Opioid Crisis Grants. (2017). *Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.samhsa.gov/grants/grant-announcements/ti-17-014
[69] Rural Communities Opioid Response Program. (2018). *Health Resources & Services Administration*. Retrieved from https://www.hrsa.gov/grants/fundingopportunities/default.aspx?id=35ee358e-d42f-4c7a-ba6e-d71f228eb1a9
[70] Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction Program. (2018). *Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.samhsa.gov/grants/grant-announcements/ti-18-009
[71] Grants & Funding. (2016). *Administration for Children and Families*. Retrieved from https://www.acf.hhs.gov/grants

Health Block Grants, which are state block grants to support maternal and child health, in which states have significant flexibility in how to use the funds [72]; the IHS Alcohol and Substance Abuse Programs, which funds IHS alcohol and substance abuse treatment programs, including comprehensive care in IHS facilities [73]; SAMHSA's Substance Abuse Prevention and Treatment Block Grants, which are funds available to all states to implement and evaluate substance abuse prevention and treatment activities;[74] and the U.S. Department of Agriculture's Distance Learning and Telemedicine Grants, which help rural residents use telecommunications and the internet to access medical service providers.[75] Through the utilization of these new and existing Federal funding streams, states can implement and sustain telehealth delivery models.

[72] Title V Maternal and Child Health Block Grant Program. (2019). *Health Resources & Services Administration*. Retrieved from https://mchb.hrsa.gov/maternal-child-health-initiatives/title-v-maternal-and-child-health-services-block-grant-program
[73] Alcohol and Substance Abuse Program. (2019). *Indian Health Service*. Retrieved from https://www.ihs.gov/asap/about/
[74] Substance Abuse Prevention and Treatment Block Grant Fact Sheet, *Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.samhsa.gov/sites/default/files/sabg_fact_sheet_rev.pdf
[75] See https://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants

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v.

CALIFORNIA, *et al.*, *Respondents*.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF TRIBES AND TRIBAL ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS STATE OF CALIFORNIA, *ET AL.*

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici are federally recognized Tribal Nations, local and regional tribal organizations, and national tribal organizations as listed in Appendix A to this brief.[2] Individually or collectively, *amici* all either operate health care facilities and provide direct health care services to their citizens and other beneficiaries, or they advocate on health issues affecting American Indian and Alaska Native people, or both. For the reasons stated below, they will be directly and uniquely affected by the disposition of this case.

When Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA" or "Act"), it enacted along with it several provisions relating specifically to the Indian health system. In particular, Section 10221 amended and modernized the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §§ 1601–1680v, a stand-alone law first enacted in 1976 that provides the statutory framework for health care programs and services to American Indian and Alaska Native beneficiaries. Congress also enacted other Indian-specific provisions in the ACA to carry out the federal trust responsibility and further improve the status of Indian health through,

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[1] No counsel for any party to this case authored this brief in whole or in part, and no person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief. This brief is filed with the consent of all parties. Written consent from counsel of record for Petitioners State of California, *et al.*, is on file with the authors of this brief. All other parties have granted blanket consent to the filing of *amicus* briefs, as reflected on the docket.

[2] In total, 471 Tribal Nations are represented by *amici curiae*, either directly or indirectly through membership in an *amici* tribal organization.

inter alia, increasing access to federal funding and other resources to support the Indian health system.[3]

These Indian provisions of the ACA have nothing to do with health insurance or the individual mandate deemed unconstitutional by the District Court. Nevertheless, because the District Court held the individual mandate inseverable from the entire Act, its sweeping decision extended to them. The Fifth Circuit vacated the District Court's severability ruling, but agreed that the individual mandate is unconstitutional. If this Court likewise agrees, the *amici* have a vital and urgent interest in ensuring that a proper severability analysis is applied to sustain the separate and severable Indian-specific provisions.

Amici and the tribal health care programs they operate depend on a legal architecture that includes the IHCIA as a critical cornerstone. Many *amici*, for example, have entered into agreements with the Secretary of Health and Human Services, acting through the Indian Health Service (IHS) under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §§ 5301–5399, to provide health care services directly to Indian people in their geographic areas. In carrying out their ISDEAA agreements, *amici* directly implement various provisions of the IHCIA and rely on others (as well as other Indian-specific provisions of the ACA) for crucial legal rights and protections. Over the past decade, these provisions have allowed *amici* and the Indian health system as a whole to modernize in important ways and

[3] As used in this brief, the term "Indian" or "Indians" includes American Indians and Alaska Natives, and the term "Indian health system" refers collectively to Indian Health Service (IHS), tribally operated, and urban Indian health programs serving eligible American Indian and Alaska Native beneficiaries.

to ensure that health care services are delivered to Indian people in the most effective possible manner. Striking them down would be misguided and enormously disruptive—especially now, as Indian Country and the rest of the United States grapple with the deadly coronavirus pandemic.

SUMMARY OF THE ARGUMENT

Should this Court find that the ACA's individual mandate is unconstitutional, it should sever that provision from the remainder of the Act, in particular Section 10221 (the IHCIA amendments) and other Indian-specific provisions enacted by Congress to carry out the federal trust responsibility. These Indian-specific provisions of the ACA have a separate genesis and purpose from the remainder of the Act, and are neither related to nor dependent on the individual mandate specifically or health insurance reform more generally.

When a court finds a portion of a statute unconstitutional, surviving provisions that remain "fully operative as a law" should be left intact unless it is "evident" that Congress would have preferred otherwise. *See Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1490, 1482 (2018) (internal citations omitted). Applying this standard, Section 10221 and other Indian-specific provisions of the ACA must be preserved. Section 10221 represents only a single page of the ACA, but it incorporates by reference S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, 111th Cong. (2009), a 274-page bill that amended and updated the IHCIA. The IHCIA was first enacted as a standalone law in 1976, and although the 2010 amendments were ultimately enacted by way of the ACA, they have

a separate legislative history from the remainder of the Act.

More importantly, along with other Indian-specific provisions of the ACA, the IHCIA serves an entirely separate legislative purpose: It provides the foundation for an independent, freestanding Indian health care system that does not depend, in any measure, on operation of the ACA's individual mandate. These provisions include important programmatic authorities for the IHS and Tribal Nations carrying out health care programs and services under the ISDEAA, and expand access to resources to remedy historical underfunding and neglect of the system.

If a provision of a federal statute is unconstitutional but potentially severable, the "touchstone for any decision about remedy is legislative intent[.]" *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 586 (2012) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006)). In enacting S. 1790 by way of the ACA, Congress expressly affirmed a longstanding federal Indian health care policy "in fulfillment of [the federal government's] special trust responsibilities and legal obligations to Indians[.]" S. 1790, 111th Cong. § 103 (2009), as enacted by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221(a), 124 Stat. 935 (2010). Congress has continued to pursue that policy in subsequent legislation that builds on the IHCIA's programmatic provisions, including in its recent emergency response to the coronavirus pandemic.

Striking down the IHCIA amendments and other Indian-specific provisions on the ground that a wholly unrelated private insurance coverage mandate is constitutionally invalid would disregard the trust responsibilities espoused by Congress and subvert

federal Indian health care policy, without any indication that Congress had anticipated—let alone intended—such a result. Because the federal courts "cannot 'use [their] remedial powers to circumvent the intent of the legislature[,]'" the IHCIA amendments and other Indian-specific provisions of the ACA must be preserved. *Ayotte*, 546 U.S. at 330 (2006) (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring in part and dissenting in part)).

ARGUMENT

Once a portion of a statute is found unconstitutional, the purpose of the severability rule is to separate and save other portions of the legislation that are practically and legally independent and therefore valid. In *Free Enterprise Fund v. Public Company Accounting Oversight Board*, this Court stated: "Because the unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions, the normal rule is that partial, rather than facial, invalidation is the required course[.]" 561 U.S. 477, 508 (2010) (internal citations omitted); *see also Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) ("[A] court should refrain from invalidating more of the statute than is necessary.").

In conducting a severability analysis, a court must "ask whether the law remains 'fully operative' without the invalid provisions[.]" *Murphy*, 138 S. Ct. at 1482 (citing *Free Enter. Fund*, 561 U.S. at 509). If so, the invalid provision is "presumed severable," *Immigration & Naturalization Serv. v. Chadha*, 462 U.S. 919, 934 (1983), and what remains after severance should be sustained unless it is "evident" that Congress would have preferred the rest of the statute (or particular sections) to be invalidated along with the unconstitutional provision. *Free Enter. Fund*, 561 U.S. at 508–09; *Nat'l*

Fed'n of Indep. Bus., 567 U.S. at 587 ("The question here is whether Congress would have wanted the rest of the Act to stand, had it known that States would have a genuine choice whether to participate in the new Medicaid expansion [pursuant to the Court's ruling]. Unless it is 'evident' that the answer is no, we must leave the rest of the Act intact.").

I. The IHCIA Amendments and other Indian-specific provisions of the ACA are fully operative, independent provisions of law that are not related to or dependent on the individual mandate.

A. The Indian Health Care Improvement Act

The IHCIA is a primary and critical component of the statutory framework for the delivery of health care services to Indian people by the United States. Along with the Transfer Act of 1954, 42 U.S.C. § 2001, and the Snyder Act, 25 U.S.C. § 13, the IHCIA provides key legislative authority for the health care programs and facilities administered by the IHS, the agency housed within the Department of Health and Human Services that is responsible for providing health services to American Indians and Alaska Natives.[4]

The Indian health care system is unique and exists largely apart from the mainstream health care delivery system in the United States. Services to eligible beneficiaries are provided directly at IHS and tribal hospitals and clinics and urban Indian clinics,

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[4] *See, e.g.*, *Yankton Sioux Tribe v. U.S. Dep't of Health & Human Servs.*, 869 F. Supp. 760, 761 (D.S.D. 1994); Indian Health Service, *Agency Overview*, https://www.ihs.gov/aboutihs/overview/ (last visited Apr. 23, 2020).

supplemented by the purchase of health services from other providers where necessary. Funding to support those services is provided through annual appropriations from Congress. While the IHS and tribal health programs are authorized to collect reimbursements from Medicare, Medicaid, and private insurance when they serve Indian patients with such coverage, enrollment in an insurance plan is not a prerequisite for receiving direct services through Indian health care providers. Eligibility for IHCIA-authorized programs is defined in federal regulations, 42 C.F.R. § 136.12, and eligible American Indian and Alaska Native patients receive care at no cost to them even when they lack any form of health insurance coverage.[5]

The legislative history of the IHCIA, like its substantive purpose, is distinct from the remainder of the ACA. As originally enacted in 1976, the appropriations authority in the IHCIA required periodic reauthorization. It has been reauthorized and amended a number of times, with extensive substantive amendments enacted in 1992 to strengthen its programmatic provisions. Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526. In 1999, a new effort to reauthorize the expired provisions and make much needed improvements to the IHCIA began. In that year and throughout the ensuing decade, Congress continued to appropriate funds for IHCIA programs through annual appropriations under other authority, while considering legislation to update the law's

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[5] *See* 25 U.S.C. § 1680r(b). In the past, Congress has expressly prohibited the IHS from charging for services, *e.g.*, Pub. L. No. 104-134, 110 Stat. 1321 (1996), and that is still IHS policy today. Although tribal health programs are permitted to charge beneficiaries for services, 25 U.S.C. § 1680r(a), they almost never do.

provisions and make the expired appropriations authority permanent.[6]

On October 15, 2009, Senator Byron Dorgan and 15 co-sponsors introduced S. 1790, an independent bill to amend and reauthorize the IHCIA. 155 Cong. Rec. 24,957 (2009).[7] S. 1790 contained over 270 pages of amendments that modernized the IHCIA and made all of its provisions permanent federal law without an expiration date. The amendments further enhanced authorities to recruit and retain health care professionals to overcome high vacancy rates; expanded programs to address diseases such as diabetes that are at alarmingly high levels in Indian Country; augmented the ability of tribal epidemiology centers to devise strategies to address local health needs; provided more equitable and innovative procedures for construction of health care and sanitation facilities; expanded opportunities for third-party collections in order to maximize all revenue sources; established comprehensive behavioral health initiatives, with a particular focus on the Indian youth suicide crisis; and expressly authorized operation of modern methods of health care delivery such as long-term care and home- and community-based care, among other changes. Following its introduction, S. 1790 was referred to the Senate Committee on Indian Affairs, the panel with

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[6] *See* Cong. Research Serv., R.41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline* 2 (updated Jan. 3, 2014), https://crsreports.congress.gov/product/pdf/R/R41630.

[7] *See also* Nat'l Indian Health Bd., *Brief History of the Indian Health Care Improvement Act*, https://www.nihb.org/tribalhealthreform/ihcia-history/ (last visited Apr. 23, 2020).

primary jurisdiction over Indian health. It was then reported favorably out of that Committee.[8]

In the meantime, H.R. 3590—which would become the Senate's health care reform legislation and, eventually, the ACA—evolved as the product of the Majority Leader's reconciliation of health care reform measures considered and approved by the Senate Finance Committee and the Health, Education, Labor and Pensions (HELP) Committee. S. 1790 was added to H.R. 3590 later, as part of a Manager's package of amendments adopted by the Senate on December 22, 2009—two days before H.R. 3590 passed the Senate.[9] The relevant amendment added a new Part III to Title X of the ACA, titled "Indian Health Care Improvement." That Part consisted solely of Section 10221, a single page of legislation incorporating by reference and enacting into law S. 1790, and making four alterations to the text of that measure. *See* Appendix B.

When the President signed H.R. 3590 into law on March 23, 2010, S. 1790 (the IHCIA amendments) became law along with it. However, as the Fifth Circuit majority recognized, "[t]he ACA's framework of economic regulations and incentives spans over 900 pages of legislative text and is divided into ten titles. Most of the provisions directly regulating health insurance, including the one challenged in this case, are found in Titles I and II," and "the other titles

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[8] *See* S. Comm. on Indian Affairs, 111th Cong., *Rep. on History, Jurisdiction, and Summary of Legislative Activities of the United States Senate Committee on Indian Affairs During the One Hundred Eleventh Congress* 13 (Comm. Print 2013).

[9] H.R. 3590 was passed by the Senate on December 24, 2009 and adopted by the House of Representatives on March 21, 2010. It was signed into law by the President on March 23, 2010 as Pub. L. No. 111-148.

generally address" other topics, including "improv[ing] health care for Native Americans (Title X)." (footnotes omitted). *Texas v. United States,* 945 F.3d 355, 396 (5th Cir. 2019). Judge King's dissenting opinion similarly noted that "the ACA contains countless other provisions that are unrelated to the private insurance market—and many that are only tangentially related to health insurance at all[,]" including "Title III of Part X [sic], which reauthorizes and amends the Indian Health Care Improvement Act, a decades-old statute creating and maintaining the infrastructure for tribal healthcare services." *Id*. at 418 (King, J., dissenting). Thus, although S. 1790 was included in Title X of the massive and sprawling ACA, like many other discrete provisions of the law it is not tied to the individual mandate or other insurance market reform measures concentrated in Titles I and II of that Act.

B. Other Indian-specific Provisions of the ACA

The ACA contains several other beneficial Indian provisions that, like the IHCIA amendments, were added to the Senate's health care reform bill as a matter of legislative convenience and efficiency—not because they were part of or related to the insurance market reforms that include the individual mandate. Instead, like the IHCIA amendments, these provisions were designed to assist in implementation of the federal trust responsibility to provide health care services to American Indian and Alaska Native people by strengthening the Indian health system.

The need for these provisions was apparent at the time the ACA was enacted. Despite improvement in some health status measures over prior decades, Indian health disparities continued to invite comparisons with third-world countries. When introducing S. 1790 in

the fall of 2009, Senator Dorgan cited but a few examples: "Native Americans die of tuberculosis at a rate 600 percent higher than the general population, suicide rates are nearly double, alcoholism rates are 510 percent higher, and diabetes rates are 189 percent higher than the general population." 155 Cong. Rec. 24,957 (2009) (statement of Sen. Dorgan). Much of this ongoing crisis was attributable to a chronic lack of funding for Indian health programs: Senator Dorgan observed in 2009 that the health care system for Native Americans is "only funded at about half of its need." *Id.* Even now, funding for the Indian health system remains "inequitable and unequal," as the United States Commission on Civil Rights detailed in a recent report.[10]

Although no provision of the IHCIA or the ACA directly appropriates funding for the Indian health system,[11] several individual provisions included in the final law were designed, among other things, to increase that system's access to additional federal and other third-party resources to supplement annual appropriations. These provisions include the following:

- Section 2901 contains a critically important provision designed to protect scarce IHS resources. It affirms that the Indian health system is the payer of last resort, which means that all other forms of payment, including Medicare, Medicaid, the Department of Veterans Affairs,

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[10] U.S. Comm'n on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* 209 (2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.

[11] The IHCIA authorizes program funding, but does not require any expenditure, and is not "paid for" by any other provision of the ACA.

and private insurance must pay before the IHS will pay for a service to an eligible beneficiary.[12]

- Section 2902 amends Section 1880 of the Social Security Act, the statutory provision that authorizes IHS and tribally operated hospitals and clinics to receive reimbursements from Medicare. Section 2902 removed the "sunset" date for collection of reimbursements for Medicare Part B services that had been authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.[13]
- Section 3314 corrects a problem encountered by IHS, tribal, and urban Indian organization pharmacies that provide Medicare Part D prescription drugs to their Indian patients without charge, in order to improve access to catastrophic coverage.[14]
- Section 9021 amends the Internal Revenue Code to exclude from an individual tribal

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[12] This provision was included in the health care reform bill reported by the Finance Committee, and included in H.R. 3590 as approved by the Senate. S. Rep. No. 111-89, at 105 (2009).

[13] This provision was included in the health care reform bill reported by the Finance Committee, and included in H.R. 3590 as approved by the Senate. *Id.* at 106.

[14] Since the value of such drugs was not counted as out-of-pocket costs of the patient, the Indian patient was not able to qualify for the catastrophic coverage level under Part D. The Section 3314 amendment removed this barrier by directing that effective January 1, 2011, the cost of drugs borne or paid by an Indian pharmacy are to be considered out-of-pocket costs of the patient. It was added to the Finance Committee bill during mark-up, and was retained in the reconciled bill, H.R. 3590, as approved by the Senate. *Id.* at 260.

> member's gross income the value of health benefits, care or coverage provided by the IHS or by a Tribal Nation or tribal organization to its members.[15]

As with the IHCIA itself, none of these other Indian-specific provisions is related to or dependent upon the individual mandate. They are fully operative as stand-alone law, and therefore they must be preserved unless it is "evident" that Congress would not have enacted them without the individual mandate. *Chadha*, 462 U.S. at 934; *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586–87.

II. Congress enacted the Indian-specific provisions of the ACA to fulfill its unique trust obligations to Indians, and the Indian-specific provisions continue to serve that goal.

The IHCIA was crafted in response to the deplorable health status of Indian people and the shameful condition of health and sanitation facilities on and around Indian reservations. *See* H.R. Rep. No. 94-1026, pt. 1, at 1–17 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652–57. It is one of many distinct and specialized federal laws designed by Congress to address the unique needs of tribal communities. These laws carry out treaty obligations assumed by the United States in

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[15] This provision overrides the determination by the Internal Revenue Service that the value of health benefits provided by a Tribal Nation for its citizens constitutes taxable income to the citizen even when a Tribal Nation stepped in to provide such coverage to compensate for insufficient funding from the IHS. It was added to the Finance Committee's health care reform bill that was reported to the Senate and was retained in the reconciled bill, H.R. 3590, approved by the Senate. *Id.* at 356.

exchange for vast cessions of land and resources by Tribal Nations, and implement the federal trust responsibility to Indians that evolved from those and other historical dealings.[16]

In enacting the IHCIA in 1976, Congress expressed a firm commitment to carry out the trust responsibility to Indian people in its Declaration of Policy:

> The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

Indian Health Care Improvement Act, Pub. L. No. 94-437, Sec. 3, 90 Stat. 1401 (1976). Congress repeated this language and took it a step further in the text of the 2010 amendments to the IHCIA, declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians" to, among other things, "ensure the highest possible

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[16] *See generally* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW § 22.01[3], at 1384 (Nell Jessup Newton ed., 2012) ("Obligation to Provide Services"). Articulated in treaties, judicial decisions, laws, regulations and policies over more than two centuries, the federal trust responsibility has been repeatedly recognized by all branches of the federal government. *See, e.g.*, *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); ISDEAA, 25 U.S.C. §§ 5301, 5302, 5381, 5384(a), 5385(a), 5387(g); Exec. Order No. 13,175, 65 Fed. Reg. 67,249 (2000); Memorandum on Tribal Consultation, 2009 Daily Comp. Pres. Doc. 1 (Nov. 5, 2009); Dep't of Health and Human Services, *Tribal Consultation Policy* 1–2 (2010), https://www.hhs.gov/sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf.

health status for Indians and urban Indians and to provide all resources necessary to effect that policy[.]" Pub. L. No. 111-148, § 10221(a), 124 Stat. 935 (2010) (codified at 25 U.S.C. § 1602).[17]

A severability analysis requires the courts to "seek to determine what Congress would have intended in light of the Court's constitutional holding." *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586 (quoting *United States v. Booker*, 543 U.S. 220, 246 (2005)). It would be wrong to conclude that Congress—without ever saying so—intended the fulfillment of its "special trust responsibilities and legal obligations to Indians" to be contingent on otherwise unrelated private insurance market reforms. It is self-evident from Congress's declaration of purpose in enacting the IHCIA amendments that the 111th Congress, sitting in 2010, would have intended to preserve those and other Indian-specific provisions regardless of the individual mandate. Nothing in the text or the legislative history of the ACA suggests otherwise.

Nor is there anything in the text or legislative history of the Tax Cuts and Jobs Act of 2017, Pub. L. 115-97, 131 Stat. 2054 (TCJA), to indicate that the 115th Congress intended to abandon its federal trust commitments to Indians when it voted to eliminate the individual mandate tax penalty without altering any other provision of the Act. The Conference Report accompanying the TCJA correctly notes that Indians, among other groups, were never subject to the

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[17] When introducing S. 1790 in 2009, Senator Dorgan declared: "We face a bona fide crisis in health care in our Native American communities, and this bill is a first step toward fulfilling our treaty obligations and trust responsibility to provide quality health care in Indian Country." 155 Cong. Rec. 24,957 (2009) (statement of Sen. Dorgan).

individual mandate tax penalty to begin with. H.R. Rep. No. 115-466, at 324 (2017); 26 U.S.C. § 5000A(e)(3) (exempting members of Indian tribes). Congress's decision to reduce the amount of that penalty to $0, therefore, would have had no effect on them or on the operation of the distinct, Indian-specific provisions of the ACA. There is no other evidence in the legislative record that Congress in 2017 even *considered* the possibility that eliminating the individual mandate tax penalty could have any impact on the IHCIA amendments or other Indian-specific provisions, let alone that Congress *intended* to unravel them.

Although the individual mandate is now effectively gone, Congress has consistently demonstrated its intent to keep the Indian health system and the legal architecture that supports it fully intact. That intent is reflected in continued annual appropriations for IHCIA and related Indian health programs, *see, e.g.*, Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, 133 Stat. 2534, 2730–34 (2019), and in other legislation addressing public health. For example, less than a year after passing the TCJA, the very same Congress passed measures to increase access to supplemental funding for Tribal Nations and tribal health programs to respond to the national opioid epidemic in American Indian and Alaska Native communities.[18] Likewise, in the Coronavirus Aid,

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[18] *See* Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, § 7073, 132 Stat. 3894, 4031 (2018) (amending 42 U.S.C. § 294i to qualify tribes and tribal health programs, as defined in section 4 of the IHCIA, for grant funding for the education and training of health care professionals in pain care); *id.* § 7181(a), 132 Stat. 3894, 4068–69 (codified at 42 U.S.C. § 290ee-3, note) (amending the 21st Century Cures Act to

Relief, and Economic Security (CARES) Act enacted this past March 27, Pub. L. No. 116-136, tit. VII, 134 Stat. 281, 550–51 (2020), the current Congress authorized an appropriation of over $1 billion in additional resources to "prevent, prepare for, and respond to" coronavirus through the IHS and tribal health programs. Notably, the CARES Act appropriation specifically identifies several IHCIA-authorized programs that are to be included in the utilization of the emergency funds.[19]

Both the opioid crisis and the coronavirus pandemic have disproportionately ravaged American Indian and Alaska Native populations, which suffer high rates of pre-existing conditions and, in some cases, lack reliable access to basic necessities like clean water and

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establish a 5 percent set-aside for grants made available to Indian tribes to address the opioid crisis).

[19] The statutory language states, in relevant part:

> For an additional amount for "Indian Health Services", $1,032,000,000, to remain available until September 30, 2021, to prevent, prepare for, and respond to coronavirus, domestically or internationally, including for public health support, electronic health record modernization, telehealth and other information technology upgrades, Purchased/Referred Care, Catastrophic Health Emergency Fund, Urban Indian Organizations, Tribal Epidemiology Centers, Community Health Representatives, and other activities to protect the safety of patients and staff [.]

Pub. L. No. 116-136, tit. VII, 134 Stat. 281, 550–51 (2020). It also states that "of amounts provided under this heading in this Act, not less than $450,000,000 shall be distributed through IHS directly operated programs and to tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act and through contracts or grants with urban Indian organizations under title V of the Indian Health Care Improvement Act[.]" *Id.*

adequate shelter.[20] The IHCIA and related Indian health provisions, including those enacted as part of the ACA, are intended precisely to increase the capacity of the Indian health system to respond to and address these problems—whether in the context of ordinary primary and preventive care or in the case of public health emergencies.

Given that the "touchstone for any decision about remedy is legislative intent," *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586 (quoting *Ayotte*, 546 U.S. at 330), those provisions that can continue to carry out Congress's goal of implementing the federal trust responsibility to Indians should be left to do so, regardless of the impact of the constitutional ruling on *separate* legislative goals that may be reflected in other provisions of the ACA. The Indian-specific provisions still "function in a *manner* consistent with the intent of Congress[,]" *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), and they are needed now more than ever. It would be extraordinarily disruptive to the Indian health system, and thus to important congressional policy objectives, to upend those provisions simply because they were enacted alongside the ACA's individual mandate.

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[20] *See, e.g.*, Simon Romero, *Checkpoints, Curfews, Airlifts: Virus Rips Through Navajo Nation*, N.Y. TIMES (Apr. 9, 2020), www.nytimes.com/2020/04/09/us/coronavirus-navajo-nation.html; *Opioids in Indian Country: Beyond the Crisis to Healing the Community: Hearing Before the Senate Comm. On Indian Affairs*, 115th Cong. 3 (2018), https://www.indian.senate.gov/sites/default/files/upload/HHS%20IHS%20testimony%20Opioids%20Indian%20Country%20SCIA%203-14-18%20revised.pdf.

CONCLUSION

If this Court deems the ACA's individual mandate unconstitutional, it should sever that provision from, at a minimum, Section 10221 and other Indian-specific provisions enacted by Congress to carry out the federal trust responsibility to Indians. These Indian-specific provisions are not related to or dependent on the individual mandate specifically or health insurance reform more generally, and they implement a separate and distinct legislative purpose. A proper severability analysis thus compels that they remain intact.

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May 13, 2020

APPENDIX

APPENDIX A

LIST OF *AMICI CURIAE*

Amici Federally Recognized Tribal Nations

Absentee Shawnee Tribe of Indians of Oklahoma
Cabazon Band of Mission Indians
Chemehuevi Indian Tribe of the
Chemehuevi Reservation
Cherokee Nation
Cheyenne and Arapaho Tribes
Chickaloon Native Village
Chippewa Cree Tribe
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation
Confederated Salish and Kootenai Tribes
Confederated Tribes of the Colville Reservation
Confederated Tribes of the
Warm Springs Reservation of Oregon
Coquille Indian Tribe
Eastern Band of Cherokee Indians
Federated Indians of Graton Rancheria
Forest County Potawatomi Community
Fort Belknap Indian Community
Gila River Indian Community
Jamestown S'Klallam Tribe
The Klamath Tribes
Little River Band of Ottawa Indians
Lytton Rancheria of California
Mashantucket Pequot Indian Tribe
Menominee Indian Tribe of Wisconsin
Mille Lacs Band of Ojibwe
Mississippi Band of Choctaw Indians
Mohegan Tribe of Indians of Connecticut
Navajo Nation

Nisqually Indian Tribe
Northern Arapaho Tribe
Oglala Sioux Tribe
Oneida Nation
Pala Band of Mission Indians
Pascua Yaqui Tribe
Passamaquoddy Tribe at Indian Township
Pechanga Band of Luiseño Indians
Ponca Tribe of Nebraska
Puyallup Tribe of Indians
Quinault Indian Nation
Red Lake Band of Chippewa Indians
Saint Regis Mohawk Tribe
Salt River Pima-Maricopa Indian Community
Seminole Tribe of Florida
Seneca Nation
Shoalwater Bay Indian Tribe
Suquamish Tribe
Swinomish Indian Tribal Community
The Viejas Band of Kumeyaay Indians
Wampanoag Tribe of Gay Head (Aquinnah)
Wichita and Affiliated Tribes of Oklahoma
Yurok Tribe

Amici National Tribal Organizations

National Indian Health Board
National Council of Urban Indian Health
National Congress of American Indians

Amici Local and Regional Tribal Organizations[1]

Alaska Native Health Board and the **Alaska Native Tribal Health Consortium**, whose members include all 227 federally recognized Tribal Nations in Alaska.

All Pueblo Council of Governors, whose members include:

Kewa Pueblo, New Mexico
Ohkay Owingeh, New Mexico
Pueblo of Acoma, New Mexico
Pueblo of Cochiti, New Mexico
Pueblo of Isleta, New Mexico
Pueblo of Jemez, New Mexico
Pueblo of Laguna, New Mexico
Pueblo of Nambe, New Mexico
Pueblo of Picuris, New Mexico
Pueblo of Pojoaque, New Mexico
Pueblo of San Felipe, New Mexico
Pueblo of San Ildefonso, New Mexico
Pueblo of Sandia, New Mexico
Pueblo of Santa Ana, New Mexico
Pueblo of Santa Clara, New Mexico
Pueblo of Taos, New Mexico
Pueblo of Tesuque, New Mexico
Pueblo of Zia, New Mexico
Ysleta del Sur Pueblo
Zuni Tribe of the Zuni Reservation, New Mexico

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[1] Tribal Nations listed with an asterisk are not on the Bureau of Indian Affairs list of federally recognized tribal entities. *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 85 Fed. Reg. 5462 (January 30, 2020).

Arctic Slope Native Association, whose members include:

Atqasuk Village (Atkasook)
Kaktovik Village (Barter Island)
Native Village of Barrow Inupiat Traditional Government
Native Village of Nuiqsut (Nooiksut)
Native Village of Point Hope
Native Village of Point Lay
Village of Anaktuvuk Pass
Village of Wainwright

Bristol Bay Area Health Corporation, whose members include:

Chignik Bay Tribal Council
Chignik Lake Village
Curyung Tribal Council
Egegik Village
Ivanof Bay Tribe
King Salmon Tribe
Knugank*
Levelock Village
Manokotak Village
Naknek Native Village
Native Village of Aleknagik
Native Village of Chignik Lagoon
Native Village of Ekuk
Native Village of Ekwok
Native Village of Goodnews Bay
Native Village of Kanatak
Native Village of Perryville
Native Village of Port Heiden
New Koliganek Village Council
New Stuyahok Village
Pilot Station Traditional Village
Platinum Traditional Village

Portage Creek Village (Ohgsenakale)
South Naknek Village
Traditional Village of Togiak
Twin Hills Village
Ugashik Village
Village of Clarks Point

California Tribal Families Coalition, whose members include:

Bear River Band of the Rohnerville Rancheria
Big Lagoon Rancheria
Big Sandy Rancheria of Western Mono Indians of California
Bishop Paiute Tribe
Cher-Ae Heights Indian Community of the Trinidad Rancheria
Coyote Valley Band of Pomo Indians of California
Dry Creek Rancheria Band of Pomo Indians
Enterprise Rancheria of Maidu Indians of California
Federated Indians of Graton Rancheria
Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation
Habematolel Pomo of Upper Lake
Hopland Band of Pomo Indians
Ione Band of Miwok Indians of California
Jamul Indian Village of California
Karuk Tribe
Mechoopda Indian Tribe of Chico Rancheria
Morongo Band of Mission Indians
North Fork Rancheria of Mono Indians of California
Pala Band of Mission Indians
Paskenta Band of Nomlaki Indians of California
Pechanga Band of Luiseño Indians

Pit River Tribe (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)
Redding Rancheria
Redwood Valley or Little River Band of Pomo Indians of the Redwood Valley Rancheria California
Resighini Rancheria
Robinson Rancheria
Round Valley Indian Tribes, Round Valley Reservation
Shingle Springs Band of Miwok Indians, Shingle Springs Rancheria (Verona Tract)
Soboba Band of Luiseño Indians
Susanville Indian Rancheria
Tolowa Dee-ni' Nation
Wilton Rancheria
Yurok Tribe of the Yurok Reservation

Chapa De Indian Health, whose members include:

United Auburn Indian Community of the Auburn Rancheria of California

Chugachmiut, whose members include:

Native Village of Chenega (Chanega)
Native Village of Nanwalek (English Bay)
Native Village of Port Graham
Qutekcak Native Tribe (Seward)*
Native Village of Tatitlek

Copper River Native Association, whose members include:

Gulkana Village
Native Village of Cantwell
Native Village of Gakona
Native Village of Kluti Kaah (Copper Center)
Native Village of Tazlina

Council of Athabascan Tribal Governments, whose members include:

Arctic Village
Beaver Village
Native Village of Fort Yukon
Canyon Village*
Native Village of Stevens
Chalkyitsik Village
Birch Creek Tribe
Native Village of Venetie Tribal Government
Circle Native Community

Eastern Aleutian Tribes, whose members include:

Agdaagux Tribal Council (from King Cove)
Akutan Tribal Council
False Pass Tribal Council
Nelson Lagoon Tribal Council
Qagan Tayagungin Tribal Council (From Sand Point)
Unga Tribal Council (From Sand Point)
Pauloff Harbor Tribal Council (From Sand Point)

Great Plains Tribal Chairmen's Health Board, whose members include:

Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota
Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota
Flandreau Santee Sioux Tribe of South Dakota
Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota
Oglala Sioux Tribe
Omaha Tribe of Nebraska
Ponca Tribe of Nebraska
Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota

Sac & Fox Tribe of the Mississippi in Iowa
Santee Sioux Nation, Nebraska
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota
Spirit Lake Tribe, North Dakota
Standing Rock Sioux Tribe of North & South Dakota
Trenton Indian Service Area*
Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota
Turtle Mountain Band of Chippewa Indians of North Dakota
Winnebago Tribe of Nebraska
Yankton Sioux Tribe of South Dakota

Indian Health Council, whose members include:

Iipay Nation of Santa Ysabel
Inaja Band of Diegueño Mission Indians of the Inaja and Cosmit Reservation
La Jolla Band of Luiseño Indians
Los Coyotes Band of Cahuilla and Cupeño Indians
Mesa Grande Band of Diegueño Mission Indians of the Mesa Grande Reservation
Pala Band of Mission Indians
Pauma Band of Luiseño Mission Indians of the Pauma & Yuima Reservation
Rincon Band of Luiseño Indians
San Pasqual Band of Diegueño Mission Indians of California

Kodiak Area Native Association, whose members include:

Alutiiq Tribe of Old Harbor
Native Village of Afognak
Native Village of Akhiok
Native Village of Larsen Bay

Native Village of Ouzinkie
Native Village of Port Lions
Sun'aq Tribe of Kodiak
Kaguyak Village
Tangirnaq Native Village (aka Woody Island)

Maniilaq Association, whose members include:

Native Village of Ambler
Native Village of Buckland
Native Village of Deering
Native Village of Kiana
Native Village of Kivalina
Native Village of Kobuk
Native Village of Kotzebue
Native Village of Noatak
Native Village of Point Hope
Native Village of Selawik
Native Village of Shungnak
Noorvik Native Community

Mount Sanford Tribal Consortium, whose members include:

Cheesh-Na Tribe
Mentasta Traditional Council

Northern Valley Indian Health, whose members include:

Grindstone Indian Rancheria of Wintun-Wailaki Indians of California
Kletsel Dehe Band of Wintun Indians
Mechoopda Indian Tribe of Chico Rancheria
Yocha Dehe Wintun Nation

Northwest Portland Area Indian Health Board, whose members include:

Burns Paiute Tribe
Coeur d'Alene Tribe

Confederated Tribes and Bands of the Yakama Nation
Confederated Tribes of Siletz Indians of Oregon
Confederated Tribes of the Chehalis Reservation
Confederated Tribes of the Colville Reservation
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians
Confederated Tribes of the Grand Ronde Community of Oregon
Confederated Tribes of the Umatilla Indian Reservation
Confederated Tribes of the Warm Springs Reservation of Oregon
Coquille Indian Tribe
Cow Creek Band of Umpqua Tribe of Indians
Cowlitz Indian Tribe
Hoh Indian Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe of Indians
The Klamath Tribes
Kootenai Tribe of Idaho
Lower Elwha Tribal Community
Lummi Tribe of the Lummi Reservation
Makah Indian Tribe of the Makah Indian Reservation
Muckleshoot Indian Tribe
Nez Perce Tribe
Nisqually Indian Tribe
Nooksack Indian Tribe
Northwestern Band of the Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe of Indians
Quileute Tribe of the Quileute Reservation
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Tribe

Shoalwater Bay Indian Tribe of the Shoalwater Bay Indian Reservation
Shoshone-Bannock Tribes of the Fort Hall Reservation
Skokomish Indian Tribe
Snoqualmie Tribe
Spokane Tribe of the Spokane Reservation
Squaxin Island Tribe of the Squaxin Island Reservation
Stillaguamish Tribe of Indians of Washington
Suquamish Tribe
Swinomish Indian Tribal Community
Tulalip Tribes of Washington
Upper Skagit Indian Tribe

Norton Sound Health Corporation, whose members include:

Chinik Eskimo Community (Golovin)
Native Village of Brevig Mission
Native Village of Diomede (Inalik)
Native Village of Elim
Native Village of Gambell
Native Village of Koyuk
Native Village of Saint Michael
Native Village of Savoonga
Native Village of Shaktoolik
Native Village of Shishmaref
Native Village of Teller
Native Village of Unalakleet
Native Village of Wales
Native Village of White Mountain
Nome Eskimo Community
Stebbins Community Association

Riverside San-Bernardino County Indian Health, Inc., whose members include:

Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation
Cahuilla Band of Indians
Morongo Band of Mission Indians
Pechanga Band of Luiseño Indians
Ramona Band of Cahuilla
San Manuel Band of Mission Indians
Santa Rosa Band of Cahuilla Indians
Soboba Band of Luiseño Indians
Torres Martinez Desert Cahuilla Indians

Southcentral Foundation, whose members include:

Igiugig Village
Kokhanok Village
McGrath Native Village
Newhalen Village
Nikolai Village
Nondalton Village
Pedro Bay Village
Pribilof Islands Aleut Communities of St. Paul & St. George Islands
Takotna Village
Telida Village
Village of Iliamna

Southeast Alaska Regional Health Consortium, whose members include:

Angoon Community Association
Chilkat Indian Village (Klukwan)
Chilkoot Indian Association (Haines)
Craig Tribal Association
Douglas Indian Association
Hoonah Indian Association
Hydaburg Cooperative Association

Juneau Tlingit & Haida Community Council*
Klawock Cooperative Association
Organized Village of Kake
Organized Village of Kasaan
Petersburg Indian Association
Sitka Tribe of Alaska
Skagway Traditional Council
Wrangell Cooperative Association

Tanana Chiefs Conference, whose members include:

Alatna Village
Allakaket Village
Anvik Village
Arctic Village
Beaver Village
Birch Creek Tribe
Canyon Village Traditional Council*
Chalkyitsik Village
Circle Native Community
Evansville Village (Bettles Field)
Galena Village (Louden Village)
Healy Lake Village
Holy Cross Village
Hughes Village
Huslia Village
Kaktovik Village (Barter Island)
Koyukuk Native Village
Manley Hot Springs Village
McGrath Native Village
Medfra Traditional Council*
Native Village of Eagle
Native Village of Fort Yukon
Native Village of Minto
Native Village of Ruby
Native Village of Stevens

Native Village of Tanacross
Native Village of Tanana
Native Village of Tetlin
Nenana Native Association
Nikolai Village
Northway Village
Nulato Village
Organized Village of Grayling (Holikachuk)
Qawalangin Tribe of Unalaska Rampart Village
Shageluk Native Village
Takotna Village
Telida Village
Tok Native Association*
Village of Dot Lake
Village of Kaltag
Village of Venetie

United South and Eastern Tribes, Inc., whose members include:

Alabama-Coushatta Tribe of Texas
Aroostook Band of Micmacs
Catawba Indian Nation (Catawba Tribe of South Carolina)
Cayuga Nation
Chickahominy Indian Tribe
Chickahominy Indian Tribe – Eastern Division
Chitimacha Tribe of Louisiana
Coushatta Tribe of Louisiana
Eastern Band of Cherokee Indians
Houlton Band of Maliseet Indians
Jena Band of Choctaw Indians
Mashantucket Pequot Indian Tribe
Mashpee Wampanoag Tribe
Miccosukee Tribe of Indians of Florida
Mississippi Band of Choctaw Indians
Mohegan Tribe of Connecticut

Narragansett Indian Tribe
Oneida Indian Nation
Pamunkey Indian Tribe
Passamaquoddy Tribe
Penobscot Nation
Poarch Band of Creeks
Rappahannock Tribe, Inc.
Saint Regis Mohawk Tribe
Seminole Tribe of Florida
Seneca Nation of Indians
Shinnecock Indian Nation
Tunica-Biloxi Indian Tribe
Wampanoag Tribe of Gay Head (Aquinnah)

Yukon-Kuskokwim Health Corporation, whose members include:

Akiachak Native Community
Akiak Native Community
Algaaciq Native Village (St. Mary's)
Anvik Village
Asa'carsarmiut Tribe
Chevak Native Village
Chuloonawick Native Village
Emmonak Village
Holy Cross Village
Iqurmuit Traditional Council
Kasigluk Traditional Elders Council
Lime Village
Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
Native Village of Eek
Native Village of Georgetown
Native Village of Hamilton
Native Village of Hooper Bay
Native Village of Kipnuk
Native Village of Kongiganak

Native Village of Kwigillingok
Native Village of Kwinhagak (Quinhagak)
Native Village of Marshall (Fortuna Ledge)
Native Village of Mekoryuk
Native Village of Napaimute
Native Village of Napakiak
Native Village of Napaskiak
Native Village of Nightmute
Native Village of Nunam Iqua
Native Village of Nunapitchuk
Native Village of Paimiut
Native Village of Pitka's Point
Native Village of Scammon Bay
Native Village of Tuntutuliak
Native Village of Tununak
Newtok Village
Nunakauyarmiut Tribe
Organized Village of Grayling (Holikachuk)
Organized Village of Kwethluk
Orutsararmiut Traditional Native Council
Oscarville Traditional Village
Pilot Station Traditional Village
Shageluk Native Village
Tuluksak Native Community
Umkumiut Native Village
Village of Alakanuk
Village of Aniak
Village of Atmautluak
Village of Bill Moore's Slough
Village of Chefornak
Village of Crooked Creek
Village of Kalskag
Village of Kotlik
Village of Lower Kalskag
Village of Ohogamiut
Village of Red Devil

Village of Sleetmute
Village of Stony River
Yupiit of Andreafski

APPENDIX B

PART III-INDIAN HEALTH CARE IMPROVEMENT

Sec. 10221. Indian Health Care Improvement.

Incorporation by reference.
25 USC 1601 *et seq*.

(a) IN GENERAL.—Except as provided in subsection (b), S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.", as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law.

(b) AMENDMENTS.—

(1) Section 119 of the Indian Health Care Improvement Act (as amended by section 111 of the bill referred to in subsection (a)) is amended—
25 USC 1616*l*.

(A) in subsection (d)—

(i) in paragraph (2), by striking "In establishing" and inserting "Subject to paragraphs (3) and (4), in establishing"; and

(ii) by adding at the end the following:

"(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

"(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or mid-level dental health provider services is authorized under State law to supply such services in accordance with State law.

"(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

"(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist."; and

(B) by adding at the end the following:

"(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to

provide any service authorized by any other Federal law.".

25 USC 1616r.

(2) The Indian Health Care Improvement Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by striking section 125 (relating to treatment of scholarships for certain purposes).

(3) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676) is amended—

(A) by striking "Any limitation" and inserting the following:

"(a) HHS APPROPRIATIONS.—Any limitation"; and

(B) by adding at the end the following:

Applicability.
Abortions.

"(b) LIMITATIONS PURSUANT TO OTHER FEDERAL LAW. Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions.".

42 USC 1395*l*, 1395qq.

(4) The bill referred to in subsection (a) is amended by striking section 201.

HEROES ACT Summary of Indian Provisions

House Dems' COVID-19 relief package, the HEROES Act-H.R. 6800, includes the following:

Tribal Fiscal Relief – $20 billion in funding to assist Tribal governments with the fiscal impacts from the public health emergency caused by the coronavirus. $500 billion for states, $375 billion for local governments and $20 billion for territories.

Community Development Financial Institutions (CDFI) – $1 billion for economic support and recovery in distressed communities by providing financial and technical assistance to CDFIs.

Assistance to Homeowners--$75 billion to states, territories, and tribes to address the ongoing needs of homeowners struggling to afford their housing due directly or indirectly to the impacts of the pandemic by providing direct assistance with mortgage payments, property taxes, property insurance, utilities, and other housing related costs.

$50 million for grants through the State and Tribal Wildlife grant program.

Bureau of Indian Affairs – $900 million to meet Tribal government needs necessary to prevent, prepare for, and respond to coronavirus, including:

- $780 million to continue Tribal government operations and programs and to clean Tribal facilities.
- $100 million to address overcrowded housing which is prohibiting social isolation.

Indian Health Service – $2.1 billion to address health care needs related to coronavirus for Native Americans, including:

- $1 billion to account for lost third party revenues as a result of reduced medical care.
- $64 million to assist Urban Indian Organizations.
- $10 million to assist with sanitation, hydration and hygiene needs in Indian Country necessary to prevent, prepare for, and respond to coronavirus.
- $500 million to provide health care, including telehealth services to Native Americans, and to purchase medical supplies and personal protective equipment.
- $140 million to expand broadband infrastructure and information technology for telehealth and electronic health records system purposes.
- $20 million to provide health care, housing and isolation units for domestic violence victims and homeless Native Americans.
- No less than $366 million to provide isolation or quarantine space.

Within SAMHSA, not less $150 million for tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes across a variety of programs.

Within CMS, extends 100% FMAP to urban Indian programs from July 1, 2020 to June 30, 2021 and allows services with a referral from an Indian health provider outside of the four walls of a clinic from July 1, 2020 to June 30, 2021.

Division C – Health Provisions

Section 30106. Temporary extension of 100 percent FMAP to Indian health providers. Clarifies that services received through urban Indian providers are matched at 100 percent FMAP through June 30, 2021.

Section 30575. Tribal funding to research health inequities, including COVID-19. Requires the Indian Health Service (IHS), in coordination with CDC and NIH, to conduct research and field studies to improve understanding of tribal health inequities.

Section 30641. Improving State, local, and Tribal public health security. Extends eligibility for the CDC's Public Health Emergency Preparedness (PHEP) program to Tribes.

Section 30642. Provision of items to Indian programs and facilities. Guarantees IHS and other Tribal health organizations direct access to the Strategic National Stockpile, just like all 50 other states.

Section 30643. Ensure parity for urban Native veterans. Allows the Urban Indian Health Organizations (UIHO) to bill VA for care provided to qualified urban native veterans.

Section 30644. Ensure coverage for Native veterans. Clarifies VA coverage for Native Veterans who qualify for both VA benefits and HIS services.

Northwest Portland Area Indian Health Board
Indian Health Legislation: 116th Congress
Dated: June 4, 2020

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
H.R. 195 Introduced: 1/3/19	Pay our Doctors Act of 2019	Provides full-year appropriations for the Indian Health Service in the event of a partial lapse in appropriations, and for other purposes.	Mullin (R-OK)/ *Simpson (R-ID), Bonamici (D-OR), Kilmer (D-WA)*	Appropriations	In Committee
		SDPI BILLS			
S. 192 Introduced: 1/18/19	Community and Public Health Programs Extension Act	Provides extensions for community health centers, the National Health Service Corps., teaching health centers that operate GME programs, and special diabetes programs	Lamar (R-TN)/ *Murray (D-WA)*	HELP	In Committee
H.R. 2328 Introduced: 4/14/19	Special Diabetes Programs for Indians Reauthorization Act of 2019	Funds SDPI at $150 million per year for four years.	O'Halleran (D-AZ)/ *Smith (D-WA), Jayapal (D-WA), Kilmer (D-WA), Larsen (D-WA), Schrader (D-OR), Heck (D-WA), DeFazio (D-OR), Newhouse (R-WA)*	Energy and Commerce, Health Subcommittee	7/17/19- Ordered reported by House E&C
H.R. 2680 Introduced: 5/10/19	Community Health Investment, Modernization, and Excellence Act of 2019	Reauthorizes SDPI at $200m for 5 years	O'Halleran (D-AZ)	Energy and Commerce	6/4/19- Subcommittee Hearing
H.R. 2668 Introduced: 5/10/19	Special Diabetes Program Reauthorization Act of 2019	Reauthorizes special programs for diabetes for 5 years	DeGette (D-CO)/ *Schrier (D-WA)*	Energy and Commerce	6/4/19- Subcommittee Hearing
H.R. 2700 Introduced: 5/14/19	Lowering Prescription Drug Costs an Extending Community Health Centers and Other Health Priorities Act	Incentives low-cost drug options and general competition, and provides extensions to community health centers, NHSC, and special diabetes program for 4 years at $150m	Burgess (R-TX)/ *Walden (R-OR), McMorris Rodgers (R-WA), Herrera Beutler, (R-WA)*	Energy and Commerce, Judiciary	In Committee & Subcommittees
S. 1895 Introduced: 6/19/19	Lower Health Care Costs Act	Lowers healthcare costs and includes funding for SDPI at $150 million per year.	Lamar (R-TN)/ *Murray (D-WA)*	HELP	7/8/19- Placed on Senate Legislative Calendar

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S. 209 Introduced: 1/24/19	PROGRESS for Indian Tribes Act	Amends the Indian Self-Determination and Education Assistance Act (ISDEAA) to establish and further self-governance by Indian Tribes under DOI.	Hoeven (R-ND)/ *Cantwell (D-WA)*	House Natural Resources	5/22/20- Reported by the Committee on Natural Resources: H. Report 116-422. Placed on the Union Calendar, Cal no 338.
H.R. 2031 Introduced: 4/2/19			Haaland (D-NM)/ *Heck (D-WA), Kilmer (D-WA); Delbene (D-WA)*	Natural Resources	7/16/19- Indigenous Peoples of the US Subcommittee hearing.
		ADVANCE APPROPRIATIONS BILLS			
S. 229 Introduced: 1/25/19	Indian Programs Advance Appropriations Act (BIA & IHS)	Provides advance appropriations authority for certain accounts of the BIA and BIE of the DOI and the IHS of HHS.	Udall (D-NM)/ *Merkley (D-OR), Wyden (D-OR)*	Budget	1/25/19- Read twice and referred to the Committee on Budget Action by Senate
H.R. 1128 Introduced: 2/8/19	Indian Health Service Advance Appropriations Act of 2019	Amends ICHIA to authorize advance appropriations for IHS by providing 2-fiscal years budget authority	McCollum (D-MN)/ *Kilmer (D-WA), Herrera Beutler (R-WA), Simpson (R-ID), Heck (D-WA), McMorris Rodgers (D-WA)*	Budget, Energy and Commerce and Natural Resources	9/25/19- Subcommittee hearings held
H.R. 1135 Introduced: 2/8/19			Young (R-AK)/ *Kilmer (D-WA), Heck (D-WA)*	Budget, Energy and Commerce and Natural Resources	9/25/19- Subcommittee hearings held
S. 2541 Introduced: 9/24/19			Murkowski (R-AK)/ *Wyden (D-OR), Merkley (D-OR)*	SCIA	In Committee
S. 257 Introduced: 1/29/19	Tribal HUD-VASH Act of 2019	Provides rental assistance for homeless or at-risk Indian veterans, and for other purposes.	Tester (D-MT)/ *Cantwell (D-WA)*	Indian Affairs	6/27/19- Passed Senate 6/28/19- House Referred Committee on Financial Services
H.R. 2999 Introduced: 5/23/19			Lujan (D-NM)/ *Delbene (D-WA), Heck (D-WA), Kilmer (D-WA)*	Financial Services	In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S. 336 Introduced: 2/5/19 H.R. 2029 Introduced: 4/2/19	Studying the Missing and Murdered Indian Crisis Act of 2019	Directs the Comptroller General of the United States to submit a report on the response of law enforcement agencies to report on missing or murdered Indians.	Tester (D-MT) Gallego (D-AZ)/ *Bonamici (D-OR)*	Indian Affairs Judiciary, Natural Resources	2/5/19- Referred to Committee on Indian Affairs 5/15/19- Referred to Subcommittee on Crime, Terrorism and Homeland Security
S. 450 Introduced: 2/12/19	Veterans Improved Access and Care Act of 201	Requires the Secretary of Veterans Affairs to carry out a pilot program to expedite the onboarding process for new medical providers of the Department of Veterans Affairs and to reduce the duration of the hiring process for such medical provider.	Gardner (R-CO)	Veterans' Affairs	2/5/2020- Place on Senate Leg Calendar under General Orders Cal no 412.
S. 467 Introduced: 2/13/19 H.R. 1191 Introduced: 2/13/19	Native American Suicide Prevention Act of 2019	Amends section 520E of the Public Health Service Act to require States and their designees receiving grants for development and implementation of statewide suicide early intervention and prevention strategies to collaborate with each Federally recognized Indian tribe, tribal organization, urban Indian organization, and Native Hawaiian health care system in the State.	Warren (D-MA)/ *Merkley (D-OR)* Grijalva (D-AZ)/ *Blumenauer (D-OR), Jayapal (D-WA), Heck (D-WA), McMorris Rodgers (D-WA), Larsen (D-WA)*	HELP Energy and Commerce	2/13/19- In Committee 2/12/19- In Subcommittee on Health
H.R. 1158 Introduced: 2/13/19	Consolidated Appropriations Act, 2020	Makes consolidated appropriations for the fiscal year ending September 30, 2020.	McCaul (R-TX)	Homeland Security	12/20/19 – Signed into law
S. 498 Introduced: 2/14/19	Assessment of the Indian Health Service Act of 2019	Calls for the Secretary of HHS to contract an assessment of IHS' health care delivery systems and financial management process of IHS facilities to improve care for patients.	Rounds (R-SD)	Indian Affairs	2/14/19-In Committee of Indian Affairs
H.R. 1303 Introduced: 2/15/19	Examining Opioid Treatment Infrastructure Act of 2019	Requires Comptroller General of the United States to examine, among other things, the availability of residential and outpatient treatment programs to AI/AN.	Foster (D-IL)/ *Walden (R-OR)*	Energy and Commerce, Natural Resources	3/8/19-In Committee and Subcommittee for Indigenous Peoples of the United States

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S. 524 Introduced: 2/24/19	Department of Veterans Affairs Tribal Advisory Committee Act of 2019.	Establishes a VA Tribal Advisory Committee to provide advice and guidance to the Secretary on matters relating to Indian tribes, tribal organizations and Native American veterans.	Tester (D-MT)/	Veterans Affairs	1/29/20- Ordered to be reported without amendment favorably.
H.R. 1585 Introduced: 3/7/19	Violence Against Women Reauthorization Act of 2019	Reauthorizes Violence Against Women's Act of 1994	Bass (D-CA)/	Whole House	4/4/19- Passed House 4/10/19- Senate: On Legislative Calendar
H.R. 5323 Introduced: 3/9/19	Tribal Elder Care Improvement Act of 2019	Amends the Older Americans Act of 1965 to expand supportive services for Native American aging programs, and for other purposes.	O'Halleran (D-AZ)	Education and Labor	12/5/19- In Committee
S. 785 Introduced: 3/31/19	Commander John Scott Hannon Veterans Mental Health Improvement Act of 2019	Improves mental health care, eases transition from recently separated veterans, increases community engagement through grants.	Tester (D-MT)/ *Murray (D-WA), Merkley (D-OR)*	Veterans' Affairs	1/29/20-Ordered to be reported with an amendment in the nature of a substitute favorably
S. 982 Introduced: 4/2/2019 H.R. 2438 Introduced: 5/1/19	Not Invisible Act	Establishes an advisory committee on violent crimes and would establish best practices for law enforcement on combatting the missing and murdered AI/ANs epidemic.	Cortez Masto (D-NV) Haaland (D-NM)/ *Kilmer (D-WA), Smith (D-WA), Heck (D-WA), DelBene (D-WA), Larsen (D-WA), Bonamici (D-OR), DeFazio (D-OR)* *Blumenauer (D-Or)*	Indian Affairs Natural Resources, Judiciary	3/12/20- Held at the desk 3/11/20- Ordered to be reported (amended) by voice vote.
S. 1001 Introduced: 4/3/19	Tribal Veterans Health Care Enhancement Act	Amends the Indian Health Care Improvement Act to allow the Indian Health Service to cover the cost of a copayment of an Indian or Alaska Native veteran receiving medical care or services from the Department of Veterans Affairs, and for other purposes.	Thune (R-SD)/	Indian Affairs	11/20/19- In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
H.R. 2062 Introduced: 4/3/19	Overdose Prevention and Patient Safety Act	Aligns 42 CFR Part 2 with HIPAA to protect the privacy of patients with substance use disorders. Prevents discrimination based on medical records and provides penalties for violations.	Blumenauer (D-OR)/ *Bonamici (D-OR), DelBene (D-WA), Larsen (D-WA), Walden (R-OR), DeFazio (D-OR), Kilmer (D-WA)*	Energy and Commerce	4/4/19-In Committee on Health
S. 1012 Introduced: 4/3/19	Protecting Jessica Grub's Legacy Act		Manchin (D-WV)/ *Merkley (D-OR)*	HELP	4/3/19-In Committee
S. 1180 Introduced: 4/11/19	Urban Indian Health Parity Act	Extends the full Federal medical assistance percentage to urban Indian organizations.	Udall (D-NM)/ *Cantwell (D-WA), Merkley (D-OR), Murray (D-WA)*	Finance	4/11/19-In Committee
H.R. 2316 Introduced: 4/12/19	Amend Title XIX of the SS Act		Lujan (D-NM)/ *Blumenauer (D-OR), DelBene (D-WA), Jayapal (D-WA), Smith (D-WA), Heck (D-WA), Bonamici (D-OR)*	Energy and Commerce	4/15/19-In Committee on Health
S. 1213 Introduced: 4/11/19	Consumer Health Insurance Protection Act of 2019	Introduces consumer protections on par with Medicare and Medicaid requirements for private insurers. Protects against high premiums and limits insurance company profits.	Warren (D-MA)	Finance	4/11/19- In Committee
H.R. 2482 Introduced: 5/2/19	Mainstreaming Addiction Treatment At of 2019	Repeals the DATA waiver requirement to prescribe buprenorphine. S. 2074 would allow CHAs to prescribe MAT	Tonko (D-NY)/ *Schrader (D-OR), Jayapal (D-WA), Heck (D-WA), Newhouse (R-WA), Blumenauer (D-OR)*	Energy and Commerce, Judiciary, Ways and Means	5/21/19- In Committee and Subcommittee on Crime, Terrorism and Homeland Security In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S. 1329 Introduced: 5/6/19 H.R. 2549 Introduced: 5/7/19	AI/AN CAPTA	Requires that equitable distribution of assistance include equitable distribution in Indian tribes and tribal organizations and to increase amounts reserved for allotment to Indian tribes and tribal organizations under certain circumstances, and to provide for a Government Accountability Office report on child abuse and neglect in American Indian tribal communities.	Warren (D-MA)/ *Merkley (D-OR)* Grijalva (D-AZ)	Indian Affairs Education and Labor, Natural Resources	5/6/19- In Committee 5/16/19-In Committee and Subcommittee for Indigenous Peoples of the United States
S. 1365 Introduced: 5/8/19 H.R. 2569 Introduced: 5/8/19	Comprehensive Addiction Resources Emergency Act of 2019 (CARE)	Provides emergency assistance to States, territories, Tribal nations, and local areas affected by the opioid epidemic and to make financial assistance available to States, territories, Tribal nations, local areas, and public or private nonprofit entities to provide for the development, organization, coordination, and operation of more effective and cost efficient systems for the delivery of essential services to individuals with substance use disorder and their families	Warren (D-MA) Maloney (D-NY) Cummings (D-MD)/ *Bonamici (D-OR), Blumenauer (D-OR), Jayapal (D-WA), Kilmer (D-WA)*	HELP Energy and Commerce, Natural Resources, Judiciary	5/8/19- In Committee 1/13/20- Sponsorship change to Carolyn Maloney (NY)
H.R. 3055 Introduced: 6/3/19	Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019	Provides continuing FY2020 appropriations to federal agencies through December 20, 2019, and extends several expiring health programs.	Serrano (D-NY)	Appropriations	11/21/19 - Became Public Law 116-69
H.R. 3340 Introduced: 6/19/19	Tribal Healthcare Careers Act	Provides a set-aside of funds for Indian populations under the health profession opportunity grant program under section 2008 of the Social Security Act.	Gomez (D-CA)	Ways and Means	6/19/19- In Committee
H.R. 3343 Introduced: 6/19/19	Technical Assistance for Health Grants Act	Provides for technical assistance under the health profession opportunity grant program under section 2008 of the Social Security Act.	Kildee (D-MI)	Ways and Means	6/19/19-In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S. 1926 Introduced: 6/20/2019 H.R. 3815 Introduced: 7/17/2019	PrEP Access and Coverage Act	Increases access to pre-exposure prophylaxis to reduce the transmission of HIV	Harris (D-CA) Schiff (D-CA)/ *Blumenauer (D-OR)*	HELP Energy & Commerce; Oversight and Reform; Veterans Affairs; Ways and Means; Natural Resources, Armed Services, Financial Services	6/20/19- In Committee 8/14/19-In Committee and Subcommittees
H.R. 3630 Introduced: 7/11/2019	No Surprises Act	Amends title XXVII of the Public Health Service Act to protect health care consumers from surprise billing practices, and for other purposes.	Palone (D-NJ)/ *Walden (R-OR)*	Energy & Commerce; Education and Labor	7/11/19- Forwarded by E&C Health Subcommittee to Full Committee by Voice Vote
H.R. 3877 Introduced: 7/23/19	Bipartisan Budget Act of 2019	Increases spending caps, suspending debt limit and, ending sequestration for all discretionary spending including IHS.	Yarmuth (D-KY)	Budget, Rules, Ways and Means	8/2/19- Signed by President 8/1/19- Passed Senate 7/25/19- Passed House 7/23/19- Rules Committee Reported to House
S. 2365 Introduced: 7/31/19	**Health Care Access for Urban Native Veterans Act of 2019**	Allows the VA to reimburse urban Indian health centers for services they provide to Native Veterans.	Udall (D-NM)	Indian Affairs	12/18/19- Placed on Senate Legislative Calendar
H.R. 4378 Introduced: 9/18/19	Continuing Appropriations Act, 2020, and Health Extenders Act of 2019	Provides FY 2020 continuing appropriations to federal agencies through November 21, 2019	Lowey (D-NY)	Appropriations, Budget	9/19/19-Passed House 9/26/19- Passed Senate 9/27/19- Signed into Law
H.R. 4530 Introduced: 9/26/19	Native American Health Savings Improvement Act	Amends the Internal Revenue Code of 1986 to permit individuals eligible for	Moolenaar (R-MI)	Ways and Means	9/26/19-In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
		Indian Health Service assistance to qualify for health savings accounts.			
H.R. 4532 Introduced: 9/26/19 S. 2558 Introduced: 9/26/19	Nursing Home Care for Native Veterans Act	Amends title 38, United States Code, to authorize the Secretary of Veterans Affairs to make certain grants to assist nursing homes for veterans located on tribal lands.	O'Halleran (D-AZ) Sinema (D-AZ)	Veterans Affairs Veterans Affairs	10/8/19- In Subcommittee on Health 9/26/19-In Committee
H.R. 4533 Introduced: 9/26/19	Native Health Access Improvement Act	Amends the Public Health Service Act to improve behavioral health outcomes for American Indians and Alaska Natives and for other purposes.	Pallone (D-NJ)	E&C, Ways and Means, Natural Resources	10/7/19- In Subcommittee
H.R. 4534 Introduced: 9/26/19	Native Health and Wellness Act	Amends the Public Health Service Act to improve the public health system in tribal communities and increase the number of American Indians and Alaska Natives pursuing careers and for other purposes.	Ruiz (D-CA)	E&C	7/27/19-In Committee
H.R. 4908 Introduced: 10/29/19	Native American Veteran Parity in Access to Care Today Act	**Amends title 38, U.S. Code, to prohibit the collection of health care copayment by the Secretary of Veterans Affairs from a veteran who is a member of an Indian tribe.**	Gallego (D-AZ)	Veterans Affairs	11/8/19-In Subcommittee on Health
S. 2871 Introduced: 11/14/19	Indian Health Service Health Professions Tax Fairness Act of 2019	Amends the Internal Revenue Code of 1986 to exclude from gross income payments under the Indian Health Service Loan Repayment Program and certain amounts received under the Indian Health Professions Scholarships Program.	Udall (D-NM)	Finance	In Committee
S 1001 Introduced: 11/20/19	Tribal Veterans Health Care Enhancement Act	Amends the Indian Health Care Improvement Act to allow the Indian Health Service to cover the cost of a copayment of an Indian or Alaska Native veteran receiving medical care or services from the Department of Veterans Affairs, and for other purposes.	John Thune (R-SD)	Indian Affairs	8/12/19- In Committee
H.R. 4957 Introduced: 12/5/19	**Native American Child Protection Act**	Amends the Indian Child Protection and Family Violence Prevention Act.	Gallego (D-AZ)	Natural Resources	12/5/19- Ordered to be reported

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S. 3126 Introduced: 12/19/19	Native Behavioral Health Access Improvement Act of 2019	**Amends the Public Health Service Act to authorize a special behavioral health program for Indians.**	Smith (D-MN)	Indian Affairs	12/19/19-In Committee
S. 3264 Introduced: 2/11/20 HR 5850 Introduced: 2/11/20	Bridging the Tribal Digital Divide Act of 2020	Expedites and streamline the deployment of affordable broadband services on Tribal land and for other purposes.	Tom Udall (D-NM) Gallego (D-AZ)	Senate Indian Affairs Energy and Commerce, Agriculture, Natural Resources	2/11/20- In Committee 2/25/20- In Subcommittee: Commodity Exchange and Credit
H.R. 6074 Introduced: 3/4/20	Coronavirus Preparedness and Response Supplemental Appropriations Act 2020	Provides $8.3B in emergency response funding with a focus on vaccine research, medical supplies procurement, and support for public health agencies and small businesses. –IHS: Provided $30M to IHS Federal health programs and $40M to purchase PPE and medical supplies through IHS National Supply Service Center and for all IHS programs. –CDC: Provided no less than $40M in CDC funding for Indian Country, CDC increased it to $80M.	Nita Lowey (D-NY)		3/18/20—Signed into law
H.R. 6201 Introduced: 3/11/2020	Families First Coronavirus Response Act	Signed into law on March 18. Provides $3.5B in funding. IHS: $61M to IHS and Tribal health programs for program increases in Hospitals & Health Centers sub-account	Nita Lowey (D-NY)		3/18/20 – Signed into law
HR 6274 Introduced: 3/13/20	CDC Tribal Public Health Security and Preparedness Act	Allows tribes and tribal organizations to apply directly to the Centers for Disease Control and Prevention (CDC) for Public Health Emergency Preparedness (PHEP) program funds. Currently, only	Debra Haaland (D-NM)	House, Energy, Commerce	3/3/20- In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
S 3486		states and certain local entities may apply for PHEP funds to respond to public health emergencies, such as COVID-19 (i.e., coronavirus disease 2019). Additionally, the CDC must consult with tribes and tribal organizations to ensure the PHEP program enables such entities to respond to public health emergencies. The CDC may make modifications to the program after such consultation. The CDC must award at least 10 cooperative agreements to tribal applicants.	Tom Udall (D-NM)	HELP	3/12/20- In Committee
S 3514 Introduced: 3/17/20	Tribal Medical Supplies Stockpile Access Act of 2020	HHS deploys drugs, vaccines, biological products, medical devices, and other supplies from the Strategic National Stockpile directly to health programs or facilities operated by the Indian Health Service (IHS), tribes, or tribal organizations. Such supplies from the stockpile are used to respond to public health emergencies.	Elizabeth Warren (D-MA)	HELP	3/17/20- In Committee
H.R. 6352 Introduced: 3/23/20	Tribal Medical Supplies Stockpile Access Act of 2020	Ensures that facilities of the Indian Health Service operated by an urban Indian organization receive items from the strategic national stockpile directly from the Dept of Health and Human Services	Kendra Horn (D-OK)	Energy and Commerce	3/23/20-In Committee
H.R. 748	Coronavirus Aid, Relief and Economic Security	Signed into law on March 27. Provides $2.2 trillion in overall funding. – IHS: $1.032B including mandatory set asides: at least $450M to tribes, EHR stabilization and support ($65M) and facility needs ($125M). There was a short term reauthorization of SDPI at the current level of $150M per year through 11/2020. – CDC: $125M for grants or cooperative agreements with tribes and urban Indian organizations to carry out preparedness and response activities.	Joe Courtney (D-CT)		3/27/20- Signed into law

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
		– SAMHSA: $15M for SAMHSA mental and behavioral health services for tribes. – HRSA: $15M for health surveillance and other needs under the HRSA Rural Health program.			
H.R. 6448 Introduced: 4/3/20	Indian Health Service Health Professions Tax Fairness Act of 2020	Amends the Internal Revenue Code of 1986 to exclude from gross income payments under the Indian Health Service Loan Repayment Program and certain amounts received under the Indian Health Professions Scholarship Program	Gwen Moore (D-Wisconsin)	House Ways and Means	4/3/20- In Committee
H.R. 6468 Introduced: 4/7/20	Coronavirus Assistance for States Act	Provides $332 billion to states and tribal governments affected by the COVID-19 (i.e., coronavirus disease 2019) pandemic for FY2020. Such funds shall be paid to each state and tribal government within 30 days of this bill's enactment. The amount of the payment is proportional to population.	Ed Perlmutter (D-CO) Joseph Morelle (D NY) Paul Tonko (D-NY) Jerrold Nadler (D-NY)	Oversight and Reform	4/7/20- In Committee
H.R. 266 Introduced	Paycheck Protection Program and Health Care Enhancement Act	Signed into law on April 21. Provided $75B for eligible health care providers, $25B for coronavirus testing ($750M dedicated to Indian Country).	Betty McCollum (D-MINN)		4/24/20- Signed into law
S.3622 Introduced: 5/6/20	Indian Tribal Government Coronavirus Disaster Assistance Cost Share Relief Act	Waives the cost share requirements for Indian Tribes receiving disaster assistance relating to COVID-19 and for other purposes	Martin Heinrich (D-NM)	Senate Homeland Security and Government Affairs	In Committee
S. 3666 Introduced: 5/7/20 HR 6819	Covid-19 Disaster in Indian Country Act.	Funds grants for the immediate deployment of temporary wireless broadband service on Tribal lands and Hawaiian Home Lands, to provide emergency special temporary authority to use electromagnetic spectrum for the	Martin Heinrich (D-NM) Debra Haaland (D-NM)	Indian Affairs Energy and Commerce	5/7/20- In Committee 5/20/20-In Committee

Bill No.	Title	Bill Description and Related Bills	Sponsor(s)/*NW*	Committee(s)	Status
		provision of wireless broadband service on Tribal lands and Hawaiian Home Lands, and for other purposes.			
S. 3650 Introduced 5/7/20	Coverage for Urban Indian Health Providers Act	Amends the Indian Health Care Improvement Act to deem employees of urban Indian organizations as part of the Public Health Service	Tina Smith (D-MN)	Senate Indian Affairs	In Committee
H.R. 6772 Introduced 5/8/20	Tribal Covid-19 Disaster Assistance Cost Share Relief Act	Waives cost share requirement for Indian Tribes receiving disaster assistance relating to COVID-19, and for other purposes.	Ben Luján (D- NM)	Economic Development, Public Buildings and Emergency Management	5/11/20- In Committee
S. 3672 Introduced 5/11/20	Pandemic TANF Assistance Act	Provides States and Indian Tribes with flexibility in administering the temporary assistance for families program due to the public health emergency with respect to the Coronavirus Disease to make emergency grants to States and Indian Tribes t provide financial support	Ron Wyden (D- OR)	Senate Finance	In Committee
H.R. 6836 Introduced 5/12/20	Tribal Health Care Protection Fund Act	Amends the CARES Act to provide for payments to Indian Health Service, Indian Tribes, Tribal Organizations and Urban Organizations from the Public Health and Social Services Emergency Fund and for other purposes.	Raul Ruiz (D-CA)	Appropriations	In Committee
H.R. 6800 Introduced 5/12/20	The Heroes Act	Makes emergency supplemental appropriations for the fiscal year ending September 30, 2020, and for other purposes.	Nita Lowey (D-NY)	Appropriations, Budget Ways and Means	6/01/20 -Placed on Senate Legislative General Orders. Calendar No. 455.
H.R. 7010 Introduced 5/26/20	Paycheck Protection Program Flexibility Act	Amends the Small Business Act and the CARES Act to modify certain provisions related to the forgiveness of loans under the paycheck protection program, to allow recipients of loan forgiveness under the paycheck protection program to defer payroll taxes, and for other purposes.	Dean Phillips (D-MN)	Small Business, Ways and Means	5/28/20- Passed House 6/3/20- Passed Senate

SUBMITTED VIA EMAIL

April 21, 2020

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: HHS Public Health & Social Emergency $100 Billion Funding Distribution

Dear Administrator Verma:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I write to provide recommendations on the $100 billion in funding provided through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) for the U.S. Department of Health and Human Services (HHS) Public Health and Social Services Emergency Fund. Established in 1972, the NPAIHB is tribal organization formed 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 health care issues.[1]

CARES Act funding is targeted to support healthcare-related expenses or lost revenue attributable to the novel coronavirus (COVID-19) and to ensure uninsured Americans can get the testing and treatment they need. The initial funding distribution by HHS and CMS of $30 billion to Medicare providers did not benefit many tribes in the Portland Area. Only a few tribes in the Portland Area are Medicare providers.

The second distribution of $70 billion, we understand, will be for providers that have been significantly impacted by the COVID-19 outbreak. Some of the first COVID-19 cases were among American Indians/Alaska Natives (AI/AN) in our area so our IHS and tribal facilities have been impacted longer than many other areas. In addition, as COVID-19 cases continue to increase and medical operations have been cut back, third-party revenue continues to decline. This is compounded by the fact that AI/ANs are at extremely high risk for serious COVID-19 illness, because they are disproportionately impacted by health conditions such as heart and lung disease, diabetes, respiratory illnesses, and other chronic health conditions that plague our communities. This will only further financially burden the Indian health system as cases increase across Indian country.

For these reasons, we make the following recommendations:

1 A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.I. 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."

Recommendations on the Distribution of $70 Billion of COVID-19 Funding

CMS guidance from April 10, 2020 states that the intent of the next round of funding is to address providers who do not have a large base of Medicare patients, are rural, and who serve a large number of Medicaid and/or uninsured patients. [2]

The Portland Area has no IHS or tribal hospitals and relies on purchased and referred (PRC) and Medicaid funding to provide critical services to AI/AN people in the area. During this pandemic, Medicaid third party revenue has decreased for IHS and tribal health programs substantially and is a serious concern as to continuity of some programs or operations. Therefore, NPAIHB urges CMS to ensure that the majority of the next round of funding be directed to Medicaid providers.

Further, NPAIHB opposes the use of Disproportionate Share Hospital (DSH) allotments used for the $30 billion of Medicare provider payments for the distribution of the $70 billion. The Medicare DSH allotment did not favor the Indian health system, especially the IHS and tribal health programs in the Portland Area, because there are no IHS or tribal hospitals in our area.

Conclusion

NPAIHB requests that CMS honor trust and treaty obligations by taking into account the unique needs of the Indian health system and providers during the COVID-19 pandemic. Thank you for consideration of our comments and recommendations. If you have any questions about the information discussed above, please contact Sarah Sullivan, Health Policy Analyst at (503) 228-4185 or by email to ssullivan@npaihb.org.

Sincerely,

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

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS

2 U.S. Department of Health and Human Services (HHS). CARES Act Provider Relief Fund. April 10, 2020. https://www.hhs.gov/provider-relief/index.html

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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SUBMITTED VIA: www.regulations.gov

June 1, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTENTION: CMS-1744-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC)

Dear Administrator Verma:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I write to provide comments on the Centers for Medicare & Medicaid Services (CMS) interim final rule, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE)". Established in 1972, the NPAIHB is tribal organization formed 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 health care issues.[1]

GENERAL COMMENT

NPAIHB is appreciative and supportive for many of the regulatory changes made in response to the COVID-19 pandemic. CMS' expansion of telehealth services during the PHE have benefited American Indian and Alaska Native (AI/AN) Medicare and Medicaid beneficiaries. Telehealth expansion recognizes the everyday barriers to care for AI/AN, and provides sustainable solutions to improve health care access and improve health outcomes for AI/ANs. There has been a reduction in no-shows and cancellations for routine visits and follow-up care. Health care delivery through telecommunications has provided greater protection and safety for our most vulnerable patients. Therefore, CMS must work with the Indian health system to authorize continued use of telehealth capabilities in delivery of health care services during and after the PHE.

[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."

SPECIFIC COMMENTS

NPAIHB provides the following recommendations on CMS' changes to Medicare payment rules for practitioners to furnish services using remote communications technology:

Reimbursement Rates for Indian Health Care Providers

CMS explains in the interim final rule that "it would be appropriate to assume that the relative resource costs of services furnished through telehealth should be reflected in the payment to the furnishing physician or practitioner as if they furnished the services in person, and to assign the payment rate that ordinarily would have been paid … were the services furnished in-person." (Fed. Reg. 85 at 19233). However, there are dramatically different rates for onsite physician services and distant site telehealth services. In-person services covered under Part B, including physician services, are paid at the OMB/IHS All Inclusive Rate (AIR), currently $479 per encounter for facilities in the lower-48 states.[2] The AIR is a flat daily cost-based average rate that is established annually by CMS and IHS and approved by OMB, based upon a review of yearly cost reports prepared by IHS's contractor.[3] The AIR reflects the cost of all services and supplies furnished by a tribal facility to a patient in a single day, and are not adjusted for the complexity of the patient's health care needs, the length of the visit, or the number or type of practitioners involved in the patient's care.

CMS currently pays only the assigned physician fee to the distant site tribal provider-based clinic, and nothing for the facility's associated costs - a $479 per visit differential for lower-48 Tribal facilities.[4] Tribal FQHCs are paid far less for those services during the PHE than they would be for the same service furnished in person. An in-person service would be paid at the $479 AIR, but a telehealth service will be at only $92.03.[5] In addition, not only is Medicare reimbursement less for Indian health providers, but IHS and tribal clinics have had to incur significant expenses to build the infrastructure for the extension of telehealth, which is not reflected in the current Medicare reimbursement rates for telehealth services.

These payment differences, and unanticipated costs, place a majority of the cost of telehealth services onto tribes and tribal health programs that are significantly underfunded. NPAIHB recommends that IHS and tribal clinics be paid at the same rate for telehealth services (virtual or telephonic) in alignment with services furnished during an in-person visit at the OMB/IHS All Inclusive Rate (AIR).

Payment for Medicare Telehealth Services under Section 1834(m) of the Social Security Act

[2] AIRs are published annually in the federal register. The 2020 rates were published at 85 Fed. Reg. 21864 (April 20, 2020), https://www.govinfo.gov/content/pkg/FR-2020-04-20/pdf/2020-08247.pdf. The higher rate for Alaska facilities reflects their much higher operational costs.
[3] CMS Medicare Claims Processing Manual Section (Publication 104), sec. 100.5.
[4] The originating site is paid the same $26.65 nominal originating site facility fee as for non-Tribal sites.
[5] CMS "MLN Matters" SE 20016, updated April 30, 2020, https://www.cms.gov/files/document/se20016.pdf.

Telehealth is a key component to ensuring AI/AN Medicaid and Medicare beneficiaries have access to health care when they do not have transportation to get to a provider or, as with COVID-19, someone is in a high-risk group for serious illness and should not visit a medical facility. IHS and tribal facilities have demonstrated that telehealth visits are safe and just as effective as an in-person visit to provide services to AI/AN Medicaid and Medicare beneficiaries during COVID-19.

NPAIHB is grateful for CMS' decision to waive limitations on the types of practitioners that can furnish Medicare telehealth services (Fed. Reg 85 at 19239). Prior to the change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Due to the pandemic, CMS has authorized other practitioners to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

Telehealth Modalities Recommendations

NPAIHB is grateful to CMS for the expansion in modalities which telehealth can be delivered. We concur with CMS expanding the definition of "telehealth services" at 42 CFR 410.78(a)(3)(i) to include communication via smart phones and similar devices using platforms like FaceTime or Skype.

NPAIHB strongly supports the CMS decision to cover a range of "telephone assessment and management services," as well as the extended coverage for virtual check-ins and e-visits that do not ordinarily involve a face-to-face visit and thus do not qualify as telehealth services (Fed. Reg. 85 at 19265). As highlighted by CMS, these services have become an important part of overall physician care of Medicaid beneficiaries. These services are especially important during the current PHE and in the underserved areas served by the IHS and tribal health facilities.

Some of our AI/AN Medicare beneficiaries do not have access to interactive audio-visual technology that is required for Medicare telehealth services, or beneficiaries choose not to use it even if offered by their practitioner. This is particularly important for Medicare beneficiaries who lack access to broadband technologies in tribal communities and do not have equal access to care.

Direct Supervision by Interactive Telecommunications Technology Recommendations

NPAIHB strongly supports the amendments to allow direct physician supervision of non-physician providers to be furnished via interactive telecommunications technology during the pandemic (Fed. Reg. 85 at 19245). Remote supervision of non-physician clinical staff is crucial within the Indian health system because of our reliance on non-physician providers to furnish services due to the health care workforce shortage in our communities. The ability for non-physician providers to provide care under supervision of a remote physician expands the capacity of Indian health providers. We urge CMS to permanently adopt the supervision change after the PHE to address health care provider shortages in the Indian health system.

Recommendations on § 410.67 Requirements for Opioid Treatment Programs (OTP)

NPAIHB is supportive of the expansion of the use of two-way telephonic devices in providing opioid treatment services that are furnished via audio-only telephone calls "where audio/video technology is not available to the beneficiary" (85 Fed. Reg. at 19258). The opioid epidemic has devastated our communities and this is a much needed expansion to increase access to treatment and ensure continuity of treatment during the PHE.

CONCLUSION

NPAIHB requests that CMS honor trust and treaty obligations by taking into account the unique telehealth needs of Indian health providers and AI/AN Medicare and Medicaid beneficiaries. Thank you for consideration of our comments and recommendations. If you have any questions, please contact Sarah Sullivan, Health Policy Analyst at (503) 228-4185 or by email to ssullivan@npaihb.org.

Sincerely,

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

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS

Northwest Portland Area Indian Health Board

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Federal Novel Coronavirus 2019(COVID-19) Funding for Tribes
June 3, 2020

KEY	Funding Application Available Now	New Funding Opportunity

HEALTHCARE

AGENCY	*AMOUNT*	*PURPOSE*	*Funding Opportunity & Distribution Information*
IHS	**$1.032 billion** PHASE 3- S.3548 CARES Act	COVID-19 response efforts may include treatment, supplies, education, electronic health records improvement, telehealth, etc. $125 million will be transferred to the Facilities Account to support COVID-19 facilities-type activities at IHS and Tribal health programs. $172 million will be allocated and managed centrally by IHS. Negotiations of Contract Support Costs will be made after the first award has been made. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_CARES_04232020.pdf	• **Should be distributed by 5/8.** • *$570 million to federal health programs and Tribal Health Programs* • *$30 million to UIOs* • *$65 million for RPMS electronic health record support* • *Distributed through Funding Agreements using existing distribution methodologies for program increases in hospitals and health clinics, PRC, alcohol and substance abuse, and mental health funding.* • *$74 million will support medical equipment needs* • *$41 million will support maintenance and improvement needs* • *$10 million will support sanitation and potable water needs.* • *$50 million to IHS health programs and THPs for CHR program increases.* • *$95 million to support the expansion of telehealth activities* • *$6 million for public health support activities* • *$5 million to provide additional test kits and materials*

			• *$10 million to non-clinical federal staff support* • *$30 million to address unanticipated needs* • *$26 million to Tribal Epi Centers*
	$750 million PHASE 3.5 – H.R. 266 Paycheck Protection Program and Health Care Enhancement Act	Set aside for tribes, tribal organizations, UIOs, and Indian health care providers to the Public Health and Social Services Emergency Fund. **The purpose is for use to purchase, administer, and expand capacity for COVID-19 testing; to procure and distribute COVID-19 tests and PPE for administering COVID-19 tests; to support surveillance and contact tracing; and to support other COVID-19 related activities.** Recipients must submit a plan for COVID-19 funding to the HHS Secretary. The plan must include the number of tests needed month to month as well as the description of how the recipient intends to use support for testing and how it will relate to COVID-19 community mitigation policy. • $550 million will be allocated to IHS federal health programs and THPs using existing distribution methodologies for program increases in Hospitals and Health Clinics, PRC, Alcohol and Substance Abuse, Mental Health, Community Health Representatives, and Public Health Nursing. • $50 million is allocated using the PRC distribution formula for new PRC funds. • $50 million for Urban Indian Organizations. • $100 million is allocated to purchase tests, test kits, testing supplies, and related PPE through the IHS National Supply Service Center • $50 million for nation-wide coordination, epidemiological, surveillance, and public health support to bolster the expansion of testing across Indian Country. IHS DTLL: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/docume	• ***5/28 COVID-19 Testing Plan template was circulated by IHS*** • **The IHS Area Office will be reaching out to you to initiate actions necessary for transferring resources, and may have already been in contact with you.** • **Tribal Health Programs will receive these one-time, non-recurring funds through bilateral modifications/amendments to your existing ISDEAA agreements.** • **Tribal Health Programs will be required to provide the statutorily-required COVID-19 Testing Plan, and an all-inclusive budget, as a condition of receiving these funds.** • **Budget submitted by Tribes must be all inclusive with Direct and Indirect costs for the activity. There will be no additional CSC costs calculated on these funds.** • **Executed amendment will include terms that they provide a "Testing Plan" within 30-days of award to fully describe the activities that will be under taken.**

		nts/2020_Letters/DTLL_DUIOLL_05192020.pdf	
	$64 million PHASE 2- H.R. 6201 Families First Coronavirus Response Act	Funds to be utilized to cover the costs of COVID-19 diagnostic testing supplies and services (including PPE for testing staff). https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_03272020.pdf	• $3 million will support UIOS • $61 million will be allocated to IHS federal health programs, and THPs • Uses the existing distribution methodology. • Distributed through existing funding agreements using methodology for hospitals and health clinic program increases.
	$70 million PHASE 2- H.R. 6201 Families First Coronavirus Response Act	To prevent prepare for, and respond to the spread of COVID-19 in AI/AN communities. May include medical supplies, treatment costs, patient transport, etc. PPE /supplies provided to IHS facilities, Tribal Health Programs, and UIOs at no cost. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_DUIOLL_03272020.pdf	• $40 million to purchase PPE and medical supplies through the IHS National Supply Service Center. • $30 million to direct service tribes (DSTs) • Funds distributed through existing methodology that use recurring federal hospitals and health clinics base funding levels.
CDC	**$40 million** PHASE 1- HR. 6074 Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020	Tribal set-aside to support preventing, preparing for, and responding to the coronavirus. Non-competitive funding opportunity to Title I and Title V tribes to strengthen the tribal public health system to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities. Expenses will be reimbursed dating back to January 20.	**CDC-RFA-OT20-2004** https://www.grants.gov/web/grants/view-opportunity.html?oppId=325942 **CDC FAQs for this announcement:** https://www.cdc.gov/tribal/documents/cooperative-agreements/OT20-2004-FAQs-508.pdf **Posted: April 1** ***NEW Closing Date: June 3*** **Awards: 574** • CDC Calls: 4/2 and 4/8
	$30 million PHASE 1- HR. 6074 Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020	Supplemental funding to the existing OT18-1803: Tribal Public Health Capacity Building and Quality Improvement Umbrella cooperative agreement to directly fund the three largest tribal nation recipients. The nine regionally designated tribal organizations recipients (NPAIHB) will receive funding which includes resources for sub-awards to tribal nations with the greatest burden and needs in their region.	• NPAIHB application form for the 1803 subawards (the $61,062-$63,000 available now). • Applications are rolling, due ASAP. http://www.npaihb.org/wpfb-file/fy2020-npaihb-funding-application-covid-19-docx/ • CDC Listening Session: 3/31
	$125 million minimum PHASE 3- S.3548 CARES Act	Established under the CDC-wide Activities and Program Support account, which is used to carry out the agency's public health service authorities like surveillance, epidemiology, diagnostics, laboratory support, infection control, mitigation,	TBD • May be same mechanism used to distribute $40 million in non-competitive grants.

		communications, guidance, and other preparedness and response activities. It can also be used to reimburse expenditures during a public health emergency like the current pandemic.	
HHS	**$100 billion** ***(includes $500 million to IHS and Tribal facilities)*** PHASE 3- S.3548 CARES Act	https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html HHS is now requiring providers to apply for the next $20 billion in funding for Medicare providers using a new General Distribution Portal. In order to be eligible, you must have received funding from the first $30 billion, and report that amount to HRSA. You must also report estimated lost revenues from March and April of this year. You will also have to submit your tax identification number and tax returns, and agree to meet the following terms and conditions: https://www.hhs.gov/sites/default/files/terms-and-conditions-provider-relief-20-b.pdf CARES Provider Relief Fund Payment Portal: https://covid19.linkhealth.com/#/step/1 Application Guide: https://chameleoncloud.io/review/2977-5ea0af98f0fd0/prod General Distribution Portal FAQs: https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf • $30 billion proportional to providers' share of 2018 Medicare net patient revenue (distributed April 10 and April 17) • $20 billion will be dispersed to providers to build on the initial $30B. distribution based on CMS cost reports or incurred losses on April 24. • $50 billion to areas particularly impacted by COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population.	• **5/22 Update: https://www.hhs.gov/about/news/2020/05/22/hhs-announces-500-million-distribution-to-tribal-hospitals-clinics-and-urban-health-centers.html** • ***The payments can be used to prevent, prepare for, and respond to coronavirus, and shall reimburse only for health care related expenses or lost revenues that are attributable to coronavirus.*** • ***Payments cannot be used for expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.*** • **Distribution: IHS and tribal clinics and programs will receive a $187,000 base payment plus 5% of the estimated service population multiplied by the average cost per user.** • IHS and tribal hospitals will receive a $2.81 million base payment plus 3% of their total operating expenses. • IHs urban programs will receive a $181,000 base payment plus 6% of the estimated service population multiplied by the average cost per user. • Provider Relief Fund: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html • ***In order to qualify for the additional $20 billion based on Medicare Reimbursements from 2018, HHS is requiring providers who received funding from the Provide Relief Fund before April 24th to submit their EIN and***

		• $10 billion to hospitals in areas hit hard by the outbreak • $10 billion to rural hospitals (non-tribal) • $500 million to IHS, Tribes, and urban Indian Health Centers based on operating expenses. • $12 billion to 395 hospitals who provided inpatient care for 100 or more COVID-19 patients through April 10. • $4.9 billion to skilled nursing facilities (SNFs)	***financial information to a portal by June 3.*** ***https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html*** • Providers will be paid via Automated Clearing House account information on file with UHG, UnitedHealthcare, or Optum Bank, or used for reimbursements from CMS. • **Within 30 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment. The portal for signing the attestation will be open the week of April 13, 2020 and will be linked from hhs.gov/providerrelief.**
	$15 million minimum PHASE 3- S.3548 CARES Act	Public Health Service and Social Services Emergency Fund can be used for essential preparedness and health center needs, as well as reimbursements of expenses incurred in response to the pandemic prior to the CARES Act enactment date.	TBD
SAMHSA	**$40 million**	FY 2020 COVID-19 Emergency Response for Suicide Prevention (COVID-19 ERSP) The purpose of this program is to support states and communities during the COVID-19 pandemic in advancing efforts to prevent suicide and suicide attempts among adults age 25 and older in order to reduce the overall suicide rate and number of suicides in the U.S. SAMHSA is requiring that a minimum of 25 percent of direct services funding for this program be used to support domestic violence victims	**FG-20-007** https://www.grants.gov/web/grants/view-opportunity.html?oppId=327024 **Posted: May 12** **Closing Date: May 22** **Awards: 50** **Award Ceiling: $800,000** https://www.samhsa.gov/newsroom/press-announcements/202005131138
	$110 million $500,000 for territories and tribes in total costs (direct and indirect) for the proposed project	FY 2020 Emergency Grants to Address Mental and Substance Use Disorders. The purpose of this program is to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults impacted by the COVID-19 pandemic.	**FG-20-006** https://www.grants.gov/web/grants/view-opportunity.html?oppId=325993 **Posted: April 2** **Closing Date: April 10** **Awards: 60**
	$15 million	Health Surveillance and Program Support Resources funding for mental and behavioral	• Announcement: https://www.samhsa.gov/newsroo

	PHASE 3- S.3548 CARES Act	health services, as well as the systematic collection and analysis of public health related data for community wellness planning.	m/press-announcements/202005011645 • DTLL: https://files.constantcontact.com/c2394f27001/765dac03-4a52-4e0f-bf54-91321b089eab.pdf • **SAMHSA is releasing supplemental grant awards to 154 current Tribal Behavioral Health (TBH) grant recipients in the amount of $97,402 each to meet the increased mental and substance use disorders needs among tribes.** • The purpose of the TBH program is to prevent suicide and substance misuse to reduce the impact of trauma, and to promote mental health among AI/AN youths up to 24 years old. • SAMHSA Listening Session: 4/1
	$50 million PHASE 3- S.3548 CARES Act	Build national capacity for preventing suicide by providing technical assistance, training, and resources to assist states, tribes, communities, providers, and members of the public on suicide prevention strategies and best practices to address the issue of suicide.	TBD • Updates: https://www.samhsa.gov/coronavirus • Program information: https://www.samhsa.gov/grants/grant-announcements/sm-20-011
	$250 million PHASE 3- S.3548 CARES Act	Certified Community Behavioral Health Clinics (CCBHCs) to increase access to and improve the quality of community mental health and substance use disorder treatment services through the expansion of CCBHCs.	• Update: grants awarded:https://www.samhsa.gov/newsroom/press-announcements/202004271200 • Program information: https://www.samhsa.gov/grants/grant-announcements/sm-20-012
HRSA	**$15 million minimum** PHASE 3- S.3548 CARES Act	Telehealth and rural health activities set-aside funding for Tribes, Tribal organizations, and urban Indian health organizations, or health service providers under HRSA. Funding is for health surveillance and other needs under the HRSA Rural Health program. The purpose is to provide maximum flexibility to assist tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes to prevent, prepare for, and	**HRSA-20-135** https://www.grants.gov/web/grants/search-grants.html?keywords=hrsa-20-135 **Posted: 4/21** **Closing Date: 5/6** **Awards: 50** **Award Ceiling: $300,000** • HRSA Consultation: 4/14 & 4/17

		respond to the coronavirus and the evolving needs in rural communities.	
	Reimbursement for Testing and Treatment of Uninsured Individuals	HRSA will begin to provide claims reimbursement to health care providers for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis at Medicare rates. Includes providing treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020 can electronically request claims.	**Submit patient information and claims beginning 5/6:** **https://coviduninsuredclaim.linkhealth.com**
FEMA	**COVID-19 National Emergency Declaration**	Emergency protective measures, such as medical care, medial sheltering, operation costs, etc.	• Details on how to apply: https://www.fema.gov/newsrelease/2020/03/23/coronavirus-covid-19-pandemic-public-assistance-simplifiedapplication • Tribal specific information: https://www.fema.gov/newsrelease/2020/03/26/coronavirus-covid-19-femaassistance-tribal-governments • ISSUE: 25% cost sharing, even if Tribe is sub-awardee with the state.
EPA	**$1,000,000**	This notice announces EPA re-opening the State Environmental Justice Cooperative Agreement Program (SEJCA) and the availability of funds for US States, Territories, Tribal Governments, and local governments to propose projects focusing on COVID-19 and other areas.	**EPA-OP-OEJ-20-02** https://www.grants.gov/web/grants/view-opportunity.html?oppId=326650 ***Posted: 04/30/20*** ***Closing Date: 06/30/20*** ***Awards: 5*** ***Award Ceiling: $200,000***

COMMUNITY SUPPORT SERVICES (NUTRITION, CHILDCARE, AFFORDABLE HOUSING)

AGENCY	*AMOUNT*	*PURPOSE*	*Funding Opportunity & Distribution Information*
ACL	**$10 million** PHASE 2- H.R. 6201 Families First Coronavirus Response Act	Supplemental funding for nutrition and related services for Native American Programs to help tribes and tribal organizations provide meals and supportive services directly to Native American elders.	• Eligibility: Existing tribal grantees. • Idaho OAA Title VI Tribes: $232,080 • Oregon OAA Title VI Tribes: $509,250 • Washington OAA Title VI Tribes: $1,871,860 • ACL connecting services for older adults and their families: https://eldercare.acl.gov

	$20 million PHASE 3- S.3548 CARES Act		• $10 million has already been disbursed • More information: https://acl.gov/about-acl/older-americans-act-oaa
	$250 million	Senior Nutrition Program to provide additional home-delivered and pre-packaged meals to low-income seniors. Funding has been provided to states, territories, and tribes for subsequent allocation to local meal providers. Grant amounts are determined based on the population-based formulas defined in the Older Americans Act	Funding Allocation Tables https://acl.gov/about-acl/older-americans-act-oaa
USDA	**$500 million** PHASE 2- H.R. 6201 Families First Coronavirus Response Act	Special Supplemental Nutrition Program for low-income pregnant women or mothers with young children (WIC) who lose their jobs or are laid off due to COVID-19. Funding "…to remain available through Sept. 30, 2021 for increases in program participation. FNS will work with state to ensure funding is available to state agencies that require additional funds based on enrollment"	• Intended to cover increases in program participants. • For more information: https://www.fns.usda.gov/disaster/pandemic/covid-19
	$100 million PHASE 3- S.3548 CARES Act	Funding for the Food Distribution Program for Indians Reservations (FDPIR).	TBD • $50 million shall be for facility improvements and equipment upgrades. • $50 million shall be for the costs relating to additional food purchases.
	$25 million PHASE 3- S.3548 CARES Act	Telemedicine and distance learning services in rural areas	**RUS-20-02-DLT** https://www.grants.gov/web/grants/search-grants.html ***Posted: 04/15/20*** ***Closing Date: 07/13/20*** ***Awards: 200*** ***Award Ceiling: $1,000,000*** https://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants Round 2 – Applications accepted beginning April 14, due no later than July 13 at grants.gov
ACF	**$4.5 million** *Family Violence and Prevention Services*	Family Violence and Prevention Services formula grants to provide temporary housing and in-person assistance to victims of family, domestic, and dating violence	• Eligible: Existing FVPSA Tribal formula grantees. • Should be automatically awarded via existing formula grant.

	PHASE 3- S.3548 CARES Act		
	$900 million PHASE 3- S.3548 CARES Act	Low Income Home Energy Assistance	TBD • For tribes and tribal organizations
	$96.25 million PHASE 3- S.3548 CARES Act	Supplemental Child Care and Development Block Grant (CCDBG) funding for tribes to provide immediate assistance to child care providers to prevent them from going out of business and to otherwise support child care for families, including for healthcare workers, first responders, and other essential workers.	• For existing Tribal Child Care and Development Fund (CCDF) Lead Agencies. • Allocation will most likely be based on current percentage share of funding with some adjustments. • More information: https://www.acf.hhs.gov/occ/resource/summary-of-child-care-provisions-of-cares-act
	$750 million PHASE 3- S.3548 CARES Act	Head Start funding to meet emergency staffing needs, address added operational costs, and provide summer learning opportunities.	• Eligible: Existing Head Start programs. • Up to $500 million for summer Head Start programs. • More information: https://eclkc.ohs.acf.hhs.gov/about-us/coronavirus/responding-covid-19
	$45 million PHASE 3- S.3548 CARES Act	Supplemental Title VI-B Child Welfare Services Grant funding to support the child welfare needs of families during the COVID-19 crisis and to help keep families together.	TBD • Eligible: Existing tribal grantees. • Should be automatically awarded via existing formula grant
	$1 billion Supplemental Community Services Block Grant PHASE 3- S.3548 CARES Act	Funding for wide range of social services and emergency assistance to serve individuals up to 200% of the federal poverty line	• Supplemental funding to existing block grant recipients. • More information: https://www.acf.hhs.gov/ocs/resource/state-officials-and-program-contacts
HUD	**$300 minimum** Native American Block Grants program PHASE 3- S.3548 CARES Act	Funds will be allocated using the same formula used for the FY 2020 Indian Housing Block Grants. Funds shall be used by recipients to "prevent, prepare for, and respond to coronavirus, including to maintain normal operations and fund eligible affordable housing activities under NAHASDA during the period that the program is impacted by coronavirus. May be "used to cover or reimburse allowable costs to prevent, prepare for, and respond to coronavirus that are incurred by a recipient, including	• **ICDBG-CARES Implementation** • **May 15 Update:** https://www.hud.gov/sites/dfiles/OCHCO/documents/2020-11pihn.pdf?utm_medium=email&utm_source=govdelivery • **The Office of Native American Programs will begin accepting applications on Monday June 1 at 3PM.** • **Purpose: for activities, projects, or programs tied to preventing, preparing for, and/or responding to COVID-19.** • $200 million for Indian Housing Block Grants (IHBG)

		for costs incurred prior to the date of enactment of this Act.	• $100 million Indian Community Development Block Grants (ICDBG) • Indian Housing Block Grant distributed to tribes and tribally-designated housing entities via same formula for FY 2020 awards. • Statutory and Regulatory Waiver Notice 2020-05 – issued 4/10/20, defines the authority provided under the CARES Act, to waive and establish alternative requirements.
FCC	**Rural Tribal Priority Window**	The Federal Communications Commission (FCC) began accepting applications as part of the Rural Tribal Priority Window to obtain spectrum licenses in the 2.5GHz band. As part of the Rural Tribal Priority Window, eligible applicants may obtain available licenses in the 2.5GHz band free of any auction bidding costs. The window will allow federally recognized tribal nations, a consortium of federally recognized tribal nations, or an entity majority owned and controlled by a federally recognized tribal nation or consortium of tribal nations to apply for unlicensed portions of the 2.5GHz band.	Public Notice: https://docs.fcc.gov/public/attachments/DA-20-18A1.pdf Additional Information: https://www.fcc.gov/25-ghz-rural-tribal-window **The Rural Tribal Priority Window for 2.5Ghz band licenses will close on Monday, August 3, 2020, at 6:00 p.m. EST.**

ECONOMIC ASSISTANCE

AGENCY	*AMOUNT*	*PURPOSE*	*FUNDING OPPORTUNITY & DISTRIBUTION INFORMATION*
BIA	**$453 million** PHASE 3- S.3548 CARES Act	Aid to tribal governments; welfare assistance and social service programs; public safety and emergency response.	• $380 million for aid to Tribal Governments (ATG/OATG) • $20 million to welfare assistance. • $20 million held until end of April for unexpected needs. • $33 million for purchasing PPE for law enforcement/detention center staff, overtime for law enforcement and essential workers, inmate quarantine, cleaning facilities, and telework. • Funding will go under existing funding agreements, unless an amendment is needed.

			• Title I Tribes can spend funds now but will have to work with BIA on a budget later. • Consultation: 4/15
Treasury	**$8 billion** PHASE 3- S.3548 CARES Act	Coronavirus Relief Fund for tribes for increased expenditures related to the COVID-19 public health emergency. For increased expenditures related to COVID-19 public health emergency incurred between march 1-December 20, 2020. Treasury will distribute **60% of the $8 billion** reserved for Tribal governments immediately **based on population**. • Treasury will refer to the Tribal population data used by HUD in connection with the Indian Housing Block Grant (IHBG) program. Treasury will distribute the remaining **40 percent of the $8 billion reserved for Tribal governments based on employment and expenditures data of Tribes and tribally-owned entities**. • The use of employment data is expected to correlate reasonably well with expenditures related to effects of the emergency, such as the provision of economic support to those experiencing unemployment or business interruptions due to COVID-19-related business closures.	• ***5/19 Update:*** **Department of Treasury should be posting a tribal employment/expenditures form up on their website today and the deadline to submit will be 5/26.** • **Treasury Secretary Mnuchin told a D.C. federal judge that they plan to send out the $3.2 billion it still owe tribal governments under the CARES Act by June 5.** • **Methodology:** ***https://home.treasury.gov/system/files/136/Coronavirus-Relief-Fund-Tribal-Allocation-Methodology.pdf*** • ***5/5 Update:*** ***https://www.indianz.com/covid19/?p=4247*** • ***https://www.quarles.com/publications/treasury-issues-guidelines-for-use-of-cares-act-title-v-funding-how-tribes-can-prepare-to-spend-these-funds/*** • Chehalis, et.al. v. Mnuchin litigation: Judge preliminarily enjoined the Treasury from disbursing to ANCs any of the $8 billion **Population-based component of allocation formula**: • Step 1. Calculate the pro-rata payment for each Tribal government based on single-race and then multi-race data for each Tribe's IHBG formula area, and use the larger result for each Tribal government. • Step 2. Assign a minimum payment of $100,000 to those Tribal government that would otherwise receive less than that amount under step 1. • Step 3. For Tribal governments that would receive a payment greater than the minimum, a

			pro-rata reduction is made for those amounts above the minimum for each Tribe so that the total amount for all Tribes does not exceed $4.8 billion.
	$474 billion For loans, loan guarantees, and other investments PHASE 3- S.3548 CARES Act	For loans, loan guarantees, and other investments to eligible businesses, municipalities, and states – the definition expressly includes Indian tribes. This fund includes the ability of the Secretary of Treasury to make direct loans to tribes and other governments.	TBD
SBA	**$100 billion** eligible health care providers	For eligible health care providers to respond to coronavirus, including facilities construction.	TBD • Guidance forthcoming. Tribes are working to clarify Indian health care providers qualify.
	$2 million each Emergency Income Disaster Loans (EIDL) PHASE 2- H.R. 6201 Families First Coronavirus Response Act	Tribal small business concerns, non-profits (under IRS code sections 501(c), 501(d), and 501(e)0 and non-profit veterans' organizations) are eligible for EIDL loans up to $2 million, with up to $10,000 immediate advance. May be coupled with Paycheck Protection Program, but may reduce forgiveness amount. Small dollar loans available.	Ongoing Application: https://covid19relief.sba.gov/#/ More information https://www.sba.gov/disaster-assistance/coronavirus-covid-19
DOL	**$345 million**	Grants to provide employment-related services for dislocated workers, including funding to create temporary employment opportunities and funding to meet the increased demand for employment and training services.	• Eligible applicants for Disaster Recovery grants include Indian tribal governments. • Eligible applicants for Employment Recovery grants are entities eligible for funding through the Indian and Native American program in WIOA Section 166(c) • https://www.dol.gov/newsroom/releases/eta/eta20200415-0
EDA	**$1.5 billion** PHASE 3- S.3548 CARES Act	Economic Adjustment Assistance (EAA) program grants to plan and implement economic recovery strategies in response to the coronavirus pandemic.	• For tribes and tribal organizations. • Application: https://www.grants.gov/web/grants/view-opportunity.html?oppId=321695 • More information: https://www.eda.gov/pdf/about/Economic-Adjustment-Assistance-Program-1-Pager.pdf

IRS	PHASE 3- S.3548 CARES Act	Refundable payroll tax credit of 50% of qualifying wages paid by employers. Tribes and other employers whose operations were suspended due to shutdown order or whose gross receipts declined by more than 50%. FAQs: Employee Retention Credit https://www.irs.gov/newsroom/faqs-employee-retention-credit-under-the-cares-act	• Request Form 7200 in advance: https://www.irs.gov/forms-pubs/about-form-7200 • More information: https://www.irs.gov/newsroom/irs-employee-retention-credit-available-for-many-businesses-financially-impacted-by-covid-19
DOJ	**$850 million** PHASE 3- S.3548 CARES Act	Must be used for PPE, inmates' medical needs, hire personnel, overtime costs, distribution of resources. Solicitation: https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/bja-2020-18553.pdf?utm_medium=email&utm_source=govdelivery	• **Application Deadline: 5/29** • Eligible applicants of the Byrne-Justice Assistance Grant Program eligible agencies State and Local Allocations: https://bja.ojp.gov/program/cesf/state-and-local-allocations

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Siuslaw, &
Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
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Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispell Tribe
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Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
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SUBMITTED VIA: consultation@ihs.gov

May 10, 2020

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RE: COVID-19 Provider Relief Fund and Paycheck Protection Program and Health Care Enhancement Act Funding Distribution Comments

Dear Director Weahkee and Dr. Moore:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I write to provide recommendations on the $400 million in funding provided through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) Provider Relief Fund, as well as the $750 million set aside for tribes, tribal organizations, urban Indian organizations, and Indian health care providers through the Paycheck Protection Program and Health Care Enhancement Act.

Established in 1972, the NPAIHB is a tribal organization formed 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 health care issues.[1]

We thank the Indian Health Service (IHS) and the Health Resources and Services Administration (HRSA) for holding a joint consultation on April 29 regarding allocations of these funds. IHS is requesting comments on the core principles the agency should consider when distributing the funding as well as suggestions on how to account for the various facility types within the IHS, tribal, and urban Indian (I/T/U) healthcare system.

NPAIHB makes these recommendations on the funds:

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."

$400 Million Provider Relief Fund

The purpose of the CARES Act Provider Relief Fund is to aid healthcare providers on the front lines of the coronavirus response and support healthcare-related expenses or loss of revenue accredited to COVID-19. The $400 million allocation for IHS acknowledges the American Indian and Alaska Native (AI/AN) disparities and damage caused by COVID-19 to the IHS, tribal and urban Indian facilities (I/T/U) healthcare system. We appreciate the acknowledgment by IHS and HRSA that the intent of these funds is to support health related expenses and lost revenue attributed to COVID-19.

NPAIHB recommends that this funding:

- Be flexible and not burdensome for IHS and tribal facilities to access and use. COVID-19 has already caused drastic economic harm to our IHS and tribal clinics due to loss of revenue and third-party collections.
- Be allocated using the existing IHS Hospital and Health Clinics (H&HC) and Purchased and Referred Care distribution formulas and FY 2019 data sets. This will result in an equitable distribution that has already been utilized by IHS for other COVID-19 funding.
- Be included in ISDEAA Title I and Title V contracts and compacts.
- Not be subject to extensive auditing. Attestation by IHS and tribal facilities should be considered sufficient.

$750 Million Public Health and Social Services Emergency Fund

The Paycheck Protection Program and Health Care Expansion Act provides $750 million to the Department of Health and Human Services (HHS) Public Health and Social Services Emergency Fund and will be distributed in consultation with the IHS Director. The purpose of the $750 million is to purchase, dispense, and expand capacity for COVID-19 testing, including procurement of Personal Protective Equipment (PPE) and support for related activities such as surveillance and contact tracing. IHS is seeking comments on the factors the agency should consider in developing a funding distribution methodology and implementation of reporting requirements.

NPAIHB recommends that:

- The funding be flexible and not burdensome for IHS and tribal facilities to access and use.
- The funding be used by IHS to purchase Rapid Point-of-Care analyzers for all I/T/Us. We thank IHS for the analyzers that were distributed to the Portland Area but we need analyzers at all facilities not just the ones in designated as being in rural areas.
- A portion of the funding be transferred to IHS via interagency transfer agreement (less the amount of analyzers).
- The funding be distributed to IHS and tribal facilities using IHS distribution formulas and FY 2019 data sets it sub-accounts, including but not limited to, H&C, PRC, Alcohol and Substance Use, Mental Health, Community Health Representatives and Public Health Nursing.
- The funding included in ISDEAA Title I and Title V contracts and compacts.

- A portion should also be allocated to Tribal Epidemiology Centers to assist IHS and tribal facilities with surveillance and contact tracing activities.

In addition, there is a requirement that awardees must submit a plan for COVID-19 funding to the HHS Secretary within 30 days of the Paycheck Protection Program and Health Care Expansion Act, which became law on April 24, 2020. For this requirement, NPAIHB recommends that IHS coordinate with the Centers for Disease Control and Prevention (CDC) to create a template for the COVID-19 testing plan since tribes have already developed similar plans for the CDC funding requirements.

Conclusion

Thank you for consideration of our comments and recommendations. If you have any questions about the information discussed above, please contact Sarah Sullivan, Health Policy Analyst, at ssullivan@npaihb.org.

Sincerely,

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

cc: Dean Seyler, IHS Portland Area Director