National Indian Health Board

TESTIMONY OF NATIONAL INDIAN HEALTH BOARD – WILLIAM SMITH
LEGISLATIVE HEARING ON H.R. 6237
NATURAL RESOURCES COMMITTEE, SUBCOMMITTEE FOR INDIGENOUS PEOPLES OF THE UNITED STATES
WEDNESDAY JULY 22, 2020

Chairman Gallego, Ranking Member Cook, and Members of the Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally-recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, thank you for the opportunity to submit testimony on H.R. 6237 – PRC for Native Veterans Act. The federal trust obligations to Tribes and AI/AN People extends to every agency and department of the United States federal government, including the Department of Veterans Affairs. **NIHB strongly supports H.R. 6237 and urges Congress to enact this legislation under the next pandemic relief package**.

Background: Federal Obligations to AI/AN Veterans

The United States federal government has a dual obligation to AI/AN Veterans – one obligation specific to their political status as citizens of sovereign Tribal Nations, and one obligation specific to their courageous service in our Armed Forces. By current estimates, there are over 140,000 Native Veterans, with AI/ANs enlisting to serve at nearly five times the national average, and at higher rates per capita than any other ethnicity.[1] Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services, among all Americans. These enduring challenges have left Native Veterans at significantly higher risk of COVID-19.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the federal government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at $3,779 in Fiscal Year (FY) 2018 compared to $9,574 in VHA per capita medical spending that same year[2]; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.[3] Moreover, while the VHA service population is only three times the size of the Indian health system, its discretionary appropriations are *approximately thirteen times higher* than for IHS.

Similarly, Congress has not provided comparable emergency funding to IHS compared to VHA in response to the COVID-19 pandemic. For instance, the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act invested $15.85 billion into medical care at the VHA, including $3.1 billion specifically for health information technology (HIT) and telemedicine; but only $1.032 billion for IHS, of which only $65 million was allocated for HIT support. **One way Congress can close the gap between VHA and IHS is by passing H.R. 6237, which will ensure that the VHA**

[1] Veterans Administration. 2017. American Indian and Alaska Native Veterans. https://www.va.gov/vetdata/docs/SpecialReports/AIAN.pdf
[2] The full FY 2022 IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf
[3] *See* 38 U.S.C. 117; P.L. 111-81

fully reimburses IHS and Tribes for healthcare services authorized under Purchased/Referred Care (PRC). Because of chronic underfunding of IHS, PRC is integral to the overall stability of the Indian health system. Yet because the VHA has taken the position that it does not have the statutory obligation to reimburse for PRC services, the program has even fewer resources to cover essential healthcare services.

Lack of VA Data on COVID-19 Cases among AI/AN Veterans

As of July 19, 2020, the VA has confirmed 6,208 active COVID-19 cases and 1,874 known deaths. An interactive map on the VA website illustrates COVID-19 clusters across 140 VA facilities nationwide, with the largest cluster of cases concentrated in the Northeast stretching from Washington D.C. to Boston. Nevertheless, there are multiple positive case reports from many VA facilities in close proximity to Tribal lands and reservations, including in Arizona, Montana, Utah, eastern Washington State, South Dakota, Wyoming, and Oklahoma. To date, however, the VA has yet to release breakdowns of COVID-19 case rates by race or ethnicity, yielding zero insight into population-specific disparities in COVID-19 health outcomes.

Like most healthcare systems, the VHA has transitioned to virtual care delivery via telehealth, reporting a 1,140% increase in telehealth visits since March 1, 2020 with an average of 138,766 weekly telehealth visits.[4] Yet VHA also has yet to release any demographic-based breakdowns of use of telehealth-based care delivery, thereby yielding zero insight into any population-specific disparities in access to virtual health services. However, COVID-19 data reporting from IHS and state health departments demonstrates that AI/ANs are, yet again, being disproportionately impacted by this public health crisis.

COVID-19 Impact on AI/AN Population

As of July 17, 2020, the Indian Health Service (IHS) reported 26,727 positive cases of COVID-19, with over 61% of positive cases reported out of the Phoenix and Navajo IHS Areas. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribal health programs, which constitute roughly two-thirds of the Indian health system, is voluntary. According to data analysis by APM Research Lab, **AI/Ns are experiencing the second highest aggregated COVID-19 death rate at 36 deaths per 100,000**.[5] The Centers for Disease Control and Prevention (CDC) reported on July 11, 2020 that **age-adjusted COVID-19 hospitalization rates among AI/ANs are higher than any other ethnicity, at 273 per 100,000**.[6] Reporting by state health departments has further highlighted disparities among AI/ANs. In a data visualization of COVID-19 case rates per 100,000 by Tribal Nation created by the American Indian Studies Center at the University of California Los Angeles, **it was found that if Tribes were states, the top five infection rates nationwide would all be Tribal Nations**.[7]

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[4] U.S. Department of Veterans Affairs. COVID-19 Pandemic Response Weekly Report. https://www.va.gov/health/docs/VA_COVID_Response.pdf

[5] APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. https://www.apmresearchlab.org/covid/deaths-by-race

[6] Centers for Disease Control and Prevention. COVID-19 Data Visualization. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/data-visualization.htm

[7] University of California Los Angeles. American Indian Studies Center. Coronavirus in Indian Country: Latest Case Counts. Retrieved from https://www.aisc.ucla.edu/progression_charts.aspx

The COVID-19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID-19, the Indian health system was beset by an average 25% clinician vacancy rate[8], and a hospital system that remains over four times older than the national hospital system.[9] Limited intensive care unit (ICU) capacity to address a surge of COVID cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services. Unfortunately, the adverse impacts of COVID-19 in Indian Country extend far beyond these sobering public health statistics. Tribal economies have been shuttered by social distancing guidelines that have also severely strained Tribal healthcare budgets. Because of the chronic underfunding of IHS[10], Tribal governments have innovatively found ways of maximizing third party reimbursements from payers like Medicare, Medicaid, and private insurance. For many self-governance Tribes, third party collections can constitute up to 60% of their healthcare operating budgets. However, because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have experienced third party reimbursement shortfalls ranging from $800,000 to $5 million per Tribe, per month.

These funding shortfalls have forced Tribes across the lower 48 and Alaska to furlough hundreds of workers, curtail available healthcare services, or close down clinics entirely. For example, Tribes in the Bemidji Area reported that nearly 20% of their healthcare system and 35% of their government services staff were forced to be furloughed due to revenue shortfalls. Meanwhile, Tribal business closures have compounded the devastation of the COVID pandemic in Indian Country.

According to the Harvard Project on American Indian Economic Development (HPAIED), before COVID-19 hit, Tribal governments and businesses employed 1.1 million people and supported over $49.5 billion in wages, with Tribal gaming enterprises alone responsible for injecting $12.5 billion annually into Tribal programs. **During the six week period (through May 4, 2020) whereby all 500 Tribal casinos were closed in response to COVID-19 guidelines, Tribal communities lost $4.4 billion in economic activity, with 296,000 individuals out of work and nearly $1 billion in lost wages.**[11]

Extrapolated across the entire U.S. economy, collectively $13.1 billion in economic activity was lost during the same time period, in addition to $1.9 billion in lost tax revenue across federal, state and local governments. In a new visualization created by NIHB, over 193,000 AI/ANs have become uninsured as a result of COVID-19 job losses, with the vast majority of these individuals (72%) lacking access to IHS as well.[12] Such astronomical losses in Tribal healthcare and business

[8] Government Accountability Office (GAO-18-580). https://www.gao.gov/products/GAO-18-580
[9] Indian Health Service. 2016. IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf
[10] Per capita spending at IHS in FY 2018 equaled $3,779 compared to $9,409 in national health spending per capita; $9,574 in Veterans Health Administration spending per capita; and $13,257 per capita spending under Medicare.
[11] Meister Economic Consulting. Coronavirus Impact on Tribal Gaming. Retrieved from http://www.meistereconomics.com/coronavirus-impact-on-tribal-gaming
[12] National Indian Health Board. Estimating Covid-19 caused increases in Uninsured AIANs due to job loss. https://public.tableau.com/profile/edward.fox#!/vizhome/EstimatingCovid-19causedincreasesinUninsuredAIANsduetojobloss/EstimatingIncreaseinAIANUninsureddduetoCOVID-19JobLoss_

revenue are exacerbating the already disproportionate impact of COVID-19 infections in Indian Country, and are further reducing available resources for Tribes to stabilize their health systems and provide critical COVID-19 and related health services to their communities.

Significance of PRC

The PRC system is designed for IHS and Tribes to purchase care from external providers to help make up for the paucity of primary and specialty care providers within the Indian health system. However, it is limited to only circumstances where the patient has first exhausted all other available forms of health coverage include private insurance, Medicare and Medicaid. In other words, the PRC program is the payer of last resort. PRC is funded under IHS annual discretionary appropriations; but has only received minimal increases over the last several years that barely keep track with medical inflation. In addition, chronic underfunding has forced IHS and Tribes to largely restrict use of PRC to the most critical "life or limb" situations. Limited funds for PRC resulted in nearly 80,000 PRC services (an estimated total of $371 million) being denied in FY 2016 alone.

As discussed in the 2019 Government Accountability Office (GAO) report (GAO-19-291), VA officials have repeatedly stated that they do not have a statutory authority to include the PRC program in reimbursement agreements with Tribal health programs (THPs). This interpretation translates to even higher PRC expenditures for an already underfunded and depleted program. According to the GAO report, since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally-operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113%.

VA reimbursements to IHS and THPs overall during that same time period increased by 75%, reaching $84.3 million in total. Yet these increased reimbursements still represent just a fraction of one percent of the VA's annual budget. While recent increases in the quantity of agreements and reimbursements demonstrates a positive trend, there continue to be significant challenges in care coordination between the VHA and IHS.

These issues are worsened by VHA claims that no statutory obligation exists for reimbursement of specialty and referral services provided *through* IHS or THPs. To clarify, the VHA currently reimburses IHS and THPs for care that they provide *directly* under the MOU. Despite repeated requests from Tribes, the VA has not provided reimbursement for PRC specialty and referral care provided through IHS/THPs. This is highly problematic, as AI/AN Veterans should have the freedom to obtain care from either the VA or an Indian health program. If a Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.

But because that doesn't happen, it creates greater care coordination issues and burdensome requirements for Native Veterans. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must be seen within the VA system *before* a referral

can be secured. This means the VHA is paying for the same services twice, first for those primary care services provided to the Veteran in the IHS or THP facility, and then again when the patient goes back to the VHA for the same primary care service to then receive a VHA referral. This is neither a good use of federal funding, nor is it navigable for veterans. In order to provide the care that Native Veterans need, many THPs are treating Veterans or referring them out for specialty care and paying for it themselves so that they can be treated in a timely and competent manner. For those Veterans that do go back to the VHA for referrals, there is often delayed treatment and a significantly different standard of care provided.

To that end, NIHB strong urges Congress to pass the bipartisan H.R. 6237, as it would simply clarify in federal statute the requirement that VHA reimburse IHS and Tribes for the full scope of services authorized under PRC.

Substandard Care for AI/AN Veterans Before and During COVID-19 Pandemic

In a 2018 VHA Survey of Veteran Enrollees' Health and Use of Health Care, the VHA reported having 217,580 patients who self-identified as AI/AN – representing 2.5% of the agency's enrolled patient population.[13] Yet across the board, AI/AN Veterans report higher rates of issues around quality of care and accessibility that have undermined trust in the VHA system and left AI/AN Veterans significantly more vulnerable to adverse health outcomes, including for COVID-19. For instance, the 2018 survey found that only 66.9% of AI/AN Veterans reported that it was easy to schedule medical appointments in a reasonable time, compared to 78.7% of White Veterans. The same report found that only 67.2% of AI/AN Veterans reported easy access to the local VA or VA-approved facility (compared to 82.7% of White Veterans); and only 65.7% of AI/AN Veterans reported short wait times after arriving for an appointment (compared to 80.6% of White Veterans). Even more alarmingly, only 79% of AI/AN Veterans reported receiving respect from VHA employees, and only 78.2% reported that VHA employees accepted them for who they are – percentages lower than any other ethnicity.

AI/AN Veterans also reported the least satisfaction with three out of four indicators related to their healthcare decision-making process – reporting the least satisfaction with how healthcare problems were explained to them (72.4% compared to 84% among White Veterans); their personal level of participation in decisions about their healthcare (65.7% compared to 81.8% among White Veterans); and with explanations of their options for care (65.2 percent compared to 80.5% among White Veterans). A whopping 45.2% of AI/AN Veterans reported prior dissatisfaction with the level of VA care received – nearly double the rate for White Veterans.

These experiences of substandard care at VHA facilities have not miraculously disappear under the current COVID-19 crisis. In fact, it is much more likely that the negative experiences reported by AI/AN Veterans are contributing to even greater challenges in receiving sufficient, patient-centered care from VHA facilities during the COVID-19 pandemic. Moreover, while race-specific data on Veteran use of telehealth services during COVID-19 is unavailable, it is, unfortunately, safe to assume that the same experiences of inferior and inadequate care persist. These issues are likely exacerbated by pervasive gaps in broadband access in Indian Country. In a 2019 Federal

[13] Veterans Health Administration. 2018 Survey of Veteran Enrollees' Health and Use of Health Care. https://www.va.gov/HEALTHPOLICYPLANNING/SOE2018/2018EnrolleeDataFindingsReport_9January2019Final508Compliant.pdf

Communications Commission (FCC) report, only 46.6% of housing units on Tribal lands were reported to have a fixed terrestrial provider of 25/3 Mbps broadband service – a roughly 27 point gap compared to homes on non-Tribal lands.[14] In addition, roughly 3% of people living on Tribal lands lack mobile LTE coverage, compared to only 0.2% of the total U.S. population.[15] These sobering statistics indicate that AI/AN Veterans are, once again, experiencing higher healthcare accessibility challenges than the general Veteran population as the COVID-19 pandemic continues.

COVID-19: Lack of Adequate VA and IHS Care Coordination

AI/AN Veterans are entitled to healthcare services from both the Veterans Health Administration (VHA) and the IHS. In Fiscal Year (FY) 2017, IHS reported that 48,169 active IHS users self-identified as Veterans.[16] According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[17] In instances where an AI/AN Veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the "I/T/U" system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCIA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (EHRs); engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements; simplifying referral processes; and increasing coordination of specialty services such as for mental and behavioral health.

Of the twelve strategic goals of the 2010 MOU, four are directly or exclusively related to health information technology (HIT). Goal 2 is centered on improving care coordination, including through the establishment of standardized EHR mechanisms; Goal 3 is focused on improving care through the development and sharing of HIT to improve interoperability and joint development of applications and technologies; Goal 4 is specific to the development of implementation of new care technologies including and especially telehealth, tele-psychiatry, and tele-pharmacy; and Goal 6 revolves around improving availability of services through development of payment and reimbursement mechanisms, including as they relate to sharing and development of HIT. Yet in a 2019 Government Accountability Office (GAO) report on the VA-IHS MOU, **66% of VA, IHS and Tribal facilities surveyed in the report indicated significant challenges in accessing each other's HIT systems, citing lack of EHR interoperability. In fact, the same report found that**

[14] Federal Communications Commission. 2019. Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018. https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf

[15] U.S. Department of the Interior. 2020. Expanding Broadband in Indian Country. https://www.indianaffairs.gov/sites/bia.gov/files/assets/as-ia/ieed/pdf/Expanding%20Broadband%20in%20Indian%20Country%20Primer%20Final%203.17.20.pdf

[16] Government Accountability Office. GAO-19-291. Retrieved from https://www.gao.gov/assets/700/697736.pdf

[17] VA/IHS listening session held on May 15, 2019

none of the fifteen performance measures created under the VA-IHS MOU have established targets to measure progress.

Since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally-operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113%. **Unfortunately, the VHA has largely failed during the COVID-19 pandemic to act on these existing partnerships and MOUs with IHS and Tribal programs to deliver resources, improve care coordination, and increase access to telehealth based delivery systems. According to the VHA COVID website, Navajo Nation is the only recipient of technical and personnel assistance, receiving a handful of respiratory therapists and nurses. The VHA also reported delivering 100 masks to AI/AN Veterans on the Cheyenne and Standing Rock lands. That is it. There is no further information on VHA efforts to act on its MOUs with IHS and Tribal Nations**.

Conclusion

The federal government has a dual responsibility to AI/AN Veterans that continues to be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. **We applaud the Subcommittee for holding this important legislative hearing on H.R. 6237, and stand ready to work with Congress in a bipartisan manner to enact this legislation** that will strengthen the government-government relationship, improves access to care for AI/AN Veterans, and raises health outcomes.