Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

December 23, 2020
The Honorable Alex Azar, Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C., 20201

Re: Effective and Innovative Approaches/Best Practices in Health Care in Response to the COVID-19 Pandemic

Dear Secretary Azar,

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Department of Health and Human Services' (HHS) request for information, listed as "Effective and Innovative Approaches/Best Practices in Health Care in Response to the COVID-19 Pandemic". The TTAG believes that the Indian health care system has done a remarkable job of responding to this pandemic, especially as many of our providers face a shortage of resources, brought on by both the continued underfunding of the Indian Health Service and the economic fallout of the pandemic. We think that this comment illustrates the resiliency of our system and our ability to effectively and efficiently respond to this pandemic.

Background: The Trust Responsibility

The United States owes a special duty of care to Tribal Nations, which shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations has been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[1] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people." This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022: Importantly, the Federal Government has a unique legal and political government to government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[2]

The trust responsibility establishes a clear relationship between the Tribes and the federal government.[3] This unique obligation supplies the legal justification and foundation for distinct health policy and regulatory making when dealing with American Indians and Alaska Natives

[1] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).
[2] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html
[3] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third-party actors.

(AI/ANs) and the Indian health system that provides their care. The federal government is responsible for ensuring the health of the Indian health system and its ability to provide health care to AI/ANs.

Best Practices

HHS is collecting best practices from health care systems and providers to guide federal response to COVID-19 in the future. Even though the Indian health care system is chronically underfunded, our providers have been able to leverage their assets to provide care for their patients. Indian Health Service has never been funded at its level of need and we believe that its full funding is essential for improving our capacity to respond to these types of disasters. We believe that the federal government has yet to wholly live up to its part of the trust responsibility with Tribes, which has required our providers to be creative in their usage of limited resources to serve their patients. Because of limited funds, the IHS / Tribal / and Urban (I/T/U) system struggles to sufficiently serve AI/ANs during normal times, and yet these facilities and their staff have managed to innovate during a pandemic. In this comment, we highlight how the Indian health care system increased access to care and safety through telehealth and the usage of Alternate Care Sites (ACS).

Telehealth

Since the COVID-19 public health emergency began, the TTAG has written to both CMS and HHS advocating for greater flexibility in telehealth CMS issued waivers to temporarily expanded telehealth through the Medicare program and published a toolkit to assist states with using pre-existing authority to expand telehealth in their Medicaid programs. Most recently, they issued a proposed rule (CMS-1734-P) and suggested making some of the telehealth services permanent. Telehealth has offered numerous benefits for the I/T/U system – it allowed patients in rural or remote areas to see their providers without leaving home. It has enabled AI/ANs to continue preventative care or to manage chronic illnesses.

For patients without their own means of transportation, it removed barriers to service. We know from hearing from our providers that it has ensured continuity of care in areas such as substance abuse treatment. It has reduced the rate at which people miss appointments, ensuring that people are receiving follow up treatments when it is needed and that doctors are remained informed on the status of their patients. There are financial benefits to using telehealth as well—telehealth encounters enabled I/T/U providers to recuperate some of the third-party revenue that was lost when hospitals and clinics could not perform elective procedures.

However, the I/T/U system would see even greater benefits if telehealth were further expanded. CMS's waivers increased the types of reimbursable telehealth services under Medicare. TTAG understands that since Medicaid is jointly administered by state and federal governments, that expanding Medicaid services is not as simple. We encourage the federal government to work with states to broaden the number of reimbursable telehealth services for Medicaid beneficiaries, and

to establish parity between Medicare and Medicaid reimbursement. Although, for example, an originating site is not required during the PHE, clinics and hospitals must still maintain information technology systems to support telehealth encounters. Once the PHE ends, those systems will require continued maintenance and upkeep – which is why reimbursement for both the provider fee and the facility fee is necessary.

Since most of Tribal land is rural, telehealth is not accessible for all of Indian Country. In some areas, audio-only is the only mode for providers to reach patients. TTAG recommends that HHS work across agencies with the Federal Communications Commission (FCC) and other partners to invest in a rural broadband program that is inclusive of Tribal lands. But until these investments are made, it is important that audio-only modalities like two-way radio are reimbursable (at levels comparable to audio-visual modality) for those without broadband access.

Alternate Care Sites (ACS)

Through 1135 waivers, CMS provided flexibility for hospitals and health systems to set up alternate care sites (ACS). ACSs have emerged in various COVID-19 hot spots, including several Tribal ACSs in Arizona. For example, the White Mountain Apache Tribe re-purposed its substance abuse treatment center as an ACS. This Tribe saw that COVID-19 was disproportionately affecting AI/ANs and decided that standing up an ACS was part of the solution to slow community spread. By using and ACS along with robust contact tracing, the White Mountain Apache Tribe kept its mortality rate significantly below (1.3 percent in August 2020) the death rate for Arizonans (2.1 percent in August 2020).[4]

These efforts have been successful in preventing hospitals from reaching capacity, isolating COVID-19 patients from non-COVID patients, protecting providers from the virus, and more. Regarding reimbursement, AZ's ACS rates that were equal to the rates at traditional facilities, which provided much-needed funding for the hospital system. In addition to foresight and coordination that helped AZ Tribes respond to the pandemic, Tribes with the best chances of standing up ACS are those with the capacity – are those that own hotels, casinos, or other places that can be used to convert into an ACS. Even with the physical space, it took a large, multi-agency investment from the federal government to convert the treatment center to an ACS. TTAG recommends that funding sources for ACSs are streamlined in the future so that creating an ACS is a feasible option for more Tribes. Additionally, so long as the organization meets attestation requirements, the federal government should permit Tribes to use these funds in the way they best see fit.

Conclusion

Despite entering the COVID-19 pandemic without full funding, Tribes found best practices in their use of telehealth and ACSs. Looking forward, we hope that these recommendations for expanding

[4] Retrieved from the *New York Times* https://www.nytimes.com/2020/08/13/health/coronavirus-contact-tracing-apaches.html

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telehealth and streamlining ACS capacity are considered seriously. The TTAG thanks HHS for the opportunity to comment on this RFI, and we are available to answer any questions HHS may have for us.

Sincerely,

W. Ron Allen

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Chair, CMS Tribal Technical Advisory Group

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