

# National Indian Health Board



April 16, 2020

The Honorable Alex M. Azar, II  
Secretary  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

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

## ***Re: \$100 Billion HHS Public Health & Social Services Emergency Fund Distribution***

Dear Secretary Azar and Administrator Verma:

On behalf of the National Indian Health Board (NIHB), I am responding to the Trump Administration's announcement of the eminent delivery of \$70 billion in relief funds from the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act to support hospitals and other health care providers impacted by the COVID-19 crisis.

The escalation of the pandemic, the rapid increase in virus "hot spots" across the country, and the resulting health care systems disruptions make it critical to get the stimulus funds to hospitals and providers as quickly as possible. This is especially true for Indian health system providers which serve as lifelines to Tribal populations, and even before the COVID 19 crisis, operated in a severely underfunded environment.

While some Indian health system providers benefited from Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services' (CMS) initial distribution of \$30 billion in stimulus payments, because those payments were tied to Medicare participation, the Indian health system did not see as much relief from that distribution as it would have under a distribution tied to Medicaid participation, or another index which would account for the disparities and vulnerabilities in Tribal populations and the Indian health system. In the next distribution, Indian health system providers must be given an opportunity to more fully benefit from the stimulus package.

## **Design the 70 Billion Dollar Distribution to Fully Support Indian Health System Providers**

The Administration has announced a targeted distribution of the remaining \$70 billion in stimulus to those most affected by the COVID-19 outbreak, rural hospital and ambulatory health providers, and to providers serving primarily the Medicaid population. Tribal advocates are unclear how payments will be made, but we urge the administration to design the distribution to more fully support Indian health system providers, as a segment of the American health care system which is incredibly vulnerable to systems disruptions and as the only segment of the overall health care

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system dedicated to serving Tribal populations. The federal government has a trust and treaty obligation to Tribal Nations and any allocation of provider relief should honor and fulfill this Trust Responsibility.

### **The Federal Government's Trust Responsibility to Tribal Nations and Citizens**

The federal government has a Trust Responsibility to Tribal Nations. The responsibility of the federal government to protect Native peoples, first articulated in treaties, has been reaffirmed repeatedly through statutes, regulations, executive orders and Supreme Court decisions. This solemn duty to Tribes includes the duty to provide health care and public health services for American Indians and Alaska Natives (AI/AN). Because of this special obligation, we urge the Administration to support the Indian Health Service (IHS) and Tribal health system in this time of need. There is perhaps no greater urgency to fulfill the Trust Responsibility than during a global pandemic.

### **COVID-19 Impacts on Indian Country**

Due to historical inequities, the Indian health system needs significantly more resources to protect Tribal citizens, Indian health system providers, and our system overall, as we work to address the impact of the COVID-19 crisis.

COVID 19 is harming the financial viability of our system, placing a strain on our provider's ability to deliver needed care when hot spots arise, and posing higher risks to the health of our people compared with the general public. These factors taken together, along with other detrimental effects of COVID 19<sup>1</sup>, are creating an acute crisis in the Indian health system – one that requires immediate and robust federal intervention and assistance.

As of April 7, the IHS has reported conducting 8,934 COVID-19 tests across IHS, Tribal, and urban Indian (collectively "I/T/U") sites, of which 661 have been confirmed positive and 5,713 remain pending final results. The number of confirmed cases in Indian Country is likely underreported given a significant shortage of available testing kits, but also because of a critical shortage of medical supplies like respiratory swabs used to collect the COVID-19 specimen.

On top of these resource disparities, AI/ANs are disproportionately impacted by the health conditions that the Centers for Disease Control and Prevention (CDC) categorize as extremely high risk for serious COVID-19 illness. This includes respiratory illnesses, diabetes, heart disease, and other chronic health conditions. In light of this, and federal trust and treaty obligations, we urge you to consider the issues we present in our letter when allocating the next distribution for the HHS Public Health and Social Services Emergency Fund.

### **Balance of the Emergency Fund Should Target Medicaid Providers**

We appreciate the recent federal distribution of the \$30 billion in emergency relief, some of which has already reached Indian health care providers. However, the Indian health system serves many more Medicaid recipients, as compared with Medicare recipients. For this reason, the first

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<sup>1</sup> For example, as of this writing approximately 1,800 commissioned corps officers have been deployed to address COVID 19, with many of those officers getting reassigned from the Indian health system.

allocation – distributed to providers proportionately based on their 2019 Medicare fee for service disbursements<sup>2</sup> – was not as helpful and impactful to the Indian health system as it could have been if other factors were considered. We are hopeful that this can be taken into consideration in the next allocation and we urge the Administration to use Medicaid participation or payments to target the remaining allocation.

### **Medicaid and the Indian Health System**

The importance of Medicaid to the financial health of the Indian health system cannot be overstated. According to the Indian Health Service 2020 Congressional Justification, between Fiscal Year 2013 and Fiscal Year 2018, third party collections at IHS and Tribal facilities increased by \$360 million, of which 65% came from Medicaid, a substantial portion by any measure.<sup>3</sup> Moreover, data show that the number of AI/ANs with Medicaid increased from 1,458,746 in 2012 to 1,793,339 in 2018.<sup>4</sup> The 334,593 increase in Medicaid coverage is a 22.94% increase over 2012. In 2018, 33.55% of all AI/ANs had Medicaid compared to 29.55% in 2012. Despite these figures, we know that there limited information and *underreporting* on health status, service utilization, and Medicaid payments for IHS-eligible AI/ANs enrolled in Medicaid.

We emphasize that directing the funding toward Medicaid providers will help ensure that funding reaches Indian Country, where it is critically needed.

### **The Administration Must Use a Measure other than Disproportionate Share Hospital (DSH)**

With the Administration’s announcement of a second stimulus payment to providers, Tribal advocates are unclear how payments will be made or the basis for the payments. It is not clear how HHS/CMS will calculate the volume of Medicaid patients served by hospitals and health providers. We are concerned that using the Medicaid DSH allotments for states and providers as a proxy is unwise since Medicaid enrollment or Medicaid payments are available, and superior measures to use in the formula. There are additional reasons a DSH-based formula will hurt our health programs.

The DSH formula artificially disadvantages Indian health system hospitals. 75 percent of the DSH formula is based on bad debt and charity care reported on the S-10 form. IHS and Tribal hospitals do not use the S-10 form because they do not have any bad debt or charity care. IHS and Tribal hospitals do not count bad debt because they do not charge the IHS beneficiaries they serve, and they do not count the care they provide to IHS beneficiaries as charity care even when those patients have no other form of coverage. As a result, DSH payments are disproportionately low for IHS and Tribal hospitals compared to the large number of Medicaid and uninsured beneficiaries they serve.

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<sup>2</sup> CARES Act Provider Relief Fund, United States Department of Health and Human Services (2020), <https://www.hhs.gov/provider-relief/index.html>

<sup>3</sup> Data show that the number of AI/ANs with Medicaid increased from 1,458,746 in 2012 to 1,793,339 in 2018. In 2018, 33.55% of all AI/ANs had Medicaid. National Indian Health Board Date Brief (2020).

<sup>4</sup> NIHB Date Brief (2020).

A distribution based on DSH payments would not be fair to the Indian health system. In addition, states like Alaska with a very large AI/AN population that also comprise a large percentage of the Medicaid population, do not draw down all of their Medicaid DHS allotments. Basing the next distribution on state DSH allotments, or the amount of the allotment that a state might draw down, would negatively impact the share of this funding that would be available to the Indian health system.

HHS' April 10, 2020 press release<sup>5</sup> indicates that the intent of this next round of funding is to address areas "particularly impacted by the COVID-19 outbreak, rural providers, and providers of services with lower shares of Medicare [fee for service] FFS reimbursement or who predominantly serve the Medicaid population" and the uninsured.<sup>6</sup> The Indian health system is within these parameters and a formula that results in any distribution of funds should be proportional to participation in the overall Medicaid program, not just a *segment* of it.

### **In conclusion**

As HHS and CMS deliver the relief funding, we urge you to take into consideration the unique needs of the Indian health system, the population we serve, as well as well as the unique trust obligations that federal agencies have to Indian Country. AI/ANs have long experienced lower health status, have lower life expectancy, and a disproportionate disease burden compared to the general population. These factors make the AI/AN population at risk and extremely vulnerable to COVID-19. Tribal communities do not have the same economic supports as non-Tribal communities and do not have the resources to help address the COVID-19 crisis.

We thank you in advance for consideration of our comments and recommendations. Should you have any questions, please contact Carolyn Hornbuckle, Chief Operations Officer, at the National Indian Health Board, at [chornbuckle@nihb.org](mailto:chornbuckle@nihb.org).

Sincerely,



Stacy Bohlen  
CEO, National Indian Health Board

cc: Calder Lynch, Deputy Administrator & Director, CMS  
Kitty Marx, Director, Division of Tribal Affairs, CMS  
Stacey Ecoffey, Director for Tribal Affairs, Office of the Secretary, Intergovernmental and External Affairs, HHS

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<sup>5</sup> HHS to Begin Immediate Delivery of Initial \$30 Billion of CARES Act Provider Relief Funding, <https://www.hhs.gov/about/news/2020/04/10/hhs-to-begin-immediate-delivery-of-initial-30-billion-of-cares-act-provider-relief-funding.html>

<sup>6</sup> American Indians and Alaska Natives who are patients of Indian Health Care Programs have an uninsured rate of 34.5% (US Census, American Community Survey, 2018).

Devin Delrow, Associate Director for Tribal Affairs, Office of the Secretary,  
Intergovernmental and External Affairs, HHS