

National Indian Health Board

April 23, 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

Re: CARES Act Provider Relief Fund - Notice of Remaining Funding Distribution and Required Data Submission

Dear Secretary Azar:

On behalf of the National Indian Health Board (NIHB),¹ I write to express concern about the lack of notice given to Tribal leaders about the eminent distribution of \$10 billion through the Department of Health and Human Services (HHS) from the CARES Act Provider Relief Fund. This \$10 billion portion, also being referred to as the Targeted Relief Funding, is intended to help alleviate the financial burdens faced by hospitals and other providers around the country in areas highly impacted by COVID 19. We are also extremely concerned by the expedited data collection process that HHS is requiring for providers to be considered for a funding allocation. Many Tribes and Tribal providers were only made aware of the distribution and data portal yesterday², and the due date to submit data is today. Many more Tribes and Tribal providers remain unaware of this pending distribution and data requirement.

As such, NIHB urges HHS to grant an extension to submit facility data to the designated HHS portal so that Indian Country can have adequate opportunity to respond.

Notice was not sufficient

Despite the deadline for the opportunity to seek targeted relief being set for today at 11:59PM, NIHB has heard that some Tribal health administrators were not directly informed of the relief opportunity until April 21. While there may have been other notices about the target relief opportunity sent out, they were either difficult to find or Tribal leaders were not made aware of them. National organizations such as the National Indian Health Board, who often help to amplify

¹ Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

² Please see attached HHS letter for reference.

these notices throughout Indian Country, were also not made aware of this deadline and were unable to inform our Tribal partners of the brief application window and opportunity. We feel that expecting Tribes to compile this information in only two days represents an undue burden that will make applying for targeted relief, which is meant to help facilities like ours, prohibitively difficult for many Tribes.

Funding Need: Indian Country has been severely impacted, in multiple ways by COVID 19

Tribal communities have been dealt a severe blow by the COVID-19 pandemic, even in relation to surrounding communities. For example, the Navajo Nation has an infection rate that is *ten times higher* than the state of Arizona.³ In fact, the Tribe's infection rate is higher than 48 states.⁴ Our research also shows that only 25 states have fewer COVID-19 deaths than the Navajo Nation.⁵ In Oklahoma, our preliminary research is even showing a higher than average increase in cases in Caddo and Adair Counties, which have American Indian/Alaska Native (AI/AN) populations that are significantly higher than the state as a whole.

For many Tribes, the COVID-19 crisis has virtually halted all incoming revenue. With economies based on tourism and hospitality, the closing of these industries has forced Tribes to scramble to make use of a dwindling amount of funding and to prioritize immediate needs, such as food and shelter for citizens, over long-term needs. As a result, Tribes simply do not have the required funding to adequately support their hospitals and facilities. Access to the targeted relief fund would be a significant boost to Tribal facilities and their ability to combat the disease and slow its spread throughout their communities. For many Tribes, it could also mean the difference between staying open and ultimately closing their doors. We have already seen hospitals around the country laying off and furloughing employees, some even closing their doors entirely during this crisis. Without access to additional funding, Tribal hospitals may grapple with this same fate.

The Trust Responsibility

Federal intervention in this matter is even more pressing because of the Trust Responsibility between Tribes and the federal government: a trust responsibility which has been codified by treaties and affirmed by the United States Supreme Court.⁶ 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

³ Business Insider, The Navajo Nation's coronavirus infection and death rates are 10 times higher than the neighboring state of Arizona (Apr. 2020) <https://www.businessinsider.com/coronavirus-navajo-nations-infection-rate-10-times-higher-than-arizonas-2020-4>

⁴ New York Daily News, Navajo Nation coronavirus rate higher than 48 states: records (Apr. 14, 2020) <https://www.msn.com/en-us/lifestyle/lifestyle-buzz/navajo-nation-coronavirus-rate-higher-than-48-states-records/ar-BB12D1rZ>

⁵ See National Indian Health Board COVID-19 Tribal Resource Center https://public.tableau.com/profile/edward.fox#!/vizhome/April16COVID-19ConfirmedCasesAllRacesat5min_withAIANPopulation_/April192020COVID-19

⁶ 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).

responsibility is highlighted most 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 governments⁷.

This creates a unique relationship between Tribes and the federal government, which has been recognized by Congress through the implementation of the 100% Federal Medical Assistance Percentage (FMAP),⁸ which provides that the federal government is solely responsible for paying for the care of AI/ANs who visit IHS and Tribal clinics.

The impact of COVID-19 on Tribal nations necessitates that the federal government take special care to ensure that Tribal nations have access to the resources that they need in order to combat this disease. The financial impacts of this disease on Tribes also creates a duty on the federal government to ensure that Tribes are aware of funding opportunities. Failure to ensure that the Tribes have notice and access to these important resources is a dereliction of that duty.

Tribal Consultation Policy

The HHS Tribal Consultation Policy (TCP),⁹ calls on the HHS operating staff and divisions, to have an accountable process to ensure meaningful and timely input by Indian Tribes in the development of policies that have Tribal implications. According to the policy, true and effective consultation shall result in “information exchange, mutual understanding, and informed decision-making on behalf of the Tribal governments involved and the federal government.” In practice, this means that once Tribes identify a “critical event,” HHS must communicate clear and explicit information on the means and time frames for Tribal Nations to engage in consultation.

Under the Consultation Policy, the extent of consultation depends on Tribes or the federal government identifying a critical event. It is obvious that targeted relief for funds to allow hospitals to address the COVID-19 global pandemic is a critical event which at minimum required ample notice. Tribal clinics, hospitals and health care providers are an extension of Tribal governments – to whom the federal trust responsibility is owed and to whom the policy applies. Tribal leaders, Tribal clinics, and the organizations advocating on their behalf should thus have been made aware of this opportunity. There is no question that Tribal political leadership should have been given proper notice. According to the HHS Tribal Consultation Policy, “proper notice of the critical event and the consultation mechanism utilized shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods including mailing, broadcast e-mail, FR,

⁷ Introduction, “Cross-Agency Collaborations”, <https://www.hhs.gov/about/strategic-plan/introduction/index.html>

⁸ The FMAP refers to the share of the payment to the provider that the federal government pays when services are rendered.

⁹ HHS, Tribal Consultation Policy (2010), <https://www.hhs.gov/sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf>

and other outlets.” **This did not take place here and for reasons we outline further below, an extension of the application process is warranted for Tribes.**

Why an Extension is Warranted

Given what is at stake here, the amount of notice provided is insufficient. With such a substantial amount of funding at issue, which may determine whether or not hospitals and providers can continue to operate in Indian Country, we would have anticipated a full complement of notices going out. These notices should have included letters to the political leadership of Tribes and information sharing with organizations like NIHB that have helped to fill in the gap with regards to communications to Indian Country during this COVID 19 crisis.

The government has the right to create arbitrary deadlines, especially in an exigent situation such as a global pandemic. We recognize that the federal government is facing an unprecedented strain on resources and staff. However, if HHS is going to set such stringent deadlines, it must provide sufficient resources in order to allow Tribes to participate in these processes, which they have the right to participate. Under HHS’s Tribal Consultation Policy, a critical event is triggered and consultation warranted, when an agency event would have an impact on Tribes. We recognize that the urgency of responding to the pandemic has created a need to abbreviate that timeline. However, we feel that the extent to which this timeline was shortened is disadvantaging Tribes and their staff and making it prohibitively difficult to secure resources needed for Tribal populations.

This is not the first time that a failure of the federal government has resulted in adverse consequences for marginalized groups. This is reminiscent of food stamp system failures in Georgia, which caused households to forgo medicine and critical supplies in order to cover food expenses,¹⁰ or instances when the marketplace exchange has crashed because the technology systems are overwhelmed.¹¹ In the case of the Healthcare.gov marketplace exchange crash, “websites were slow or crashed altogether.”¹² The amount of people flooding the federal website caused it to briefly break under the strain. In all of these instances, people were told to simply wait. In this situation, with the administration’s intent to rapidly distribute the provider relief funds, Tribes have no time to wait. We have asked HHS about the consequences of having to apply late for the funding, and here we demand to know the same. Specifically, **we would like clarity as to whether late registration will automatically disqualify otherwise proper payments under whatever specific formula or distribution is being used.** Also, **NIHB would like to better understand what notices were provided beyond the email to administrators.**

At the end of last year, when the marketplace again became overwhelmed, “CMS allowed consumers an extra two days to enroll after some people could not get onto the website on the final, busy day, and others left phone numbers for callbacks.” Even in Georgia, in 2019, during a natural disaster, the federal government (US Department of Agriculture) allowed the state to

¹⁰ Atlanta Journal Constitution, Food stamp lawsuit settlement: Feds to pay Georgians \$22M (Jan. 11, 2016), <https://www.ajc.com/news/food-stamp-lawsuit-settlement-feds-pay-georgians-22m/Hr19rD7RtTWzniOi2KDqdM/> (“many food stamp applications and renewals were not processed in time and were therefore denied”).

¹¹ Healthcare.gov plagued by crashes on 1st day (Oct. 1, 2013), <https://www.cbsnews.com/news/healthcaregov-plagued-by-crashes-on-1st-day/>

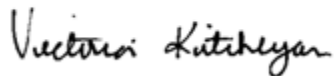
¹² *Id.*

extend the application period for food stamps.¹³ In each instance, the government recognized its missteps, and worked to remedy the problem – which included extending the deadline. Here, the situation is even more dire, and Tribes demand an extended time period to complete the required documentation to qualify for funding. Tribal members are literally battling for their lives and watching their family and friends perish from this terrible disease. This is not the time to create such stringent policies which will have the effect of excluding Tribal providers.

In Conclusion

We urge you to take into consideration the unique needs of the Indian health system, the population we serve, as well as the unique trust obligations that federal agencies have to Indian Country. We hope that HHS, in the spirit of continuing our partnership, will take heed 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.

Sincerely,



Victoria Kitcheyan
Chair, National Indian Health Board

cc: Stacey Ecoffey
Principal Advisor for Tribal Affairs
HHS Office of Intergovernmental and External Affairs

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

¹³ <https://dfcs.georgia.gov/press-releases/2019-09-09/georgia-extends-deadline-snap-recipients-report-food-lost-hurricane>