National Indian Health Board

Submitted via email to administrator@hrsa.gov

August 6, 2020

The Honorable Thomas Engels
Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Provider Relief Fund Tribal Consultation

Dear Administrator Engels:

On behalf of the National Indian Health Board (NIHB),[1] I write to request a formal Tribal consultation in regards to the distribution of the remaining funds in the Provider Relief Fund. A Tribal consultation would allow Tribes to engage directly with the agency, share concerns and recommendations, and in so doing, assist the agency in developing a distribution methodology that supports and protects the Indian health system and Tribal citizens.

Trust Responsibility

Engaging in Tribal consultation is important because the United States owes a special duty of care to Tribal Nations, which animates and 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.[2] 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 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

[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] 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).

services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[3]

NIHB believes that consultation is appropriate because of the link between Tribes and the Indian health system. Many Tribes operate their own health systems, utilizing funding and resources from IHS and supplementing them with their own resources. When decisions are made that impact the Indian health system, they also impact Tribal governments. Without access to adequate funding, Tribes will have to draw upon their own resources to remedy the issues caused by the COVID-19 pandemic, which will result in the underfunding of other critical areas of Tribal administration. In order to uphold the trust responsibility and ensure that these resources are distributed in a manner that satisfies the needs of Tribes, a consultation must happen.

Why This Is Important

NIHB has previously contacted the agency to voice its concerns regarding the distribution of the Provider Relief Fund. On April 16th, we expressed its concern about the usage of Medicare receipts to determine allocations from an early distribution of the Fund. In the letter, we noted that the Indian health system sees more Medicaid than Medicare recipients and that basing distributions on Medicaid receipts would more fairly reflect the needs of the Indian health system. We acknowledge that HRSA is planning to release payments that will be distributed based on Medicaid receipts, however we were disappointed to learn that providers who received funding from the Medicare tranche were ineligible for this new tranche. Given that many of our providers benefited from the first tranche of funding, this is highly concerning. We do acknowledge the July 31st announcement that certain Medicare providers can apply for a second round of funding and thank the agency for this opportunity[4]. However, the delay in making this announcement caused confusion among Tribes and we believe that a Tribal consultation would have identified this issue much sooner.

The Indian health system, unlike virtually every other health system in the country, is entirely dependent on both governmental appropriations and third party revenue. They cannot charge for their services and if a person does not have insurance, they are expected to absorb the cost of care. Unlike private providers, they also cannot accept co-pays that Medicare or a private insurer may require a patient to pay. When an insurer requires a co-pay of any kind, the Indian health system also absorbs that loss. This is further complicated by the fact that, even when we are not experiencing a global pandemic, the Indian Health Service (IHS) is chronically underfunded and perpetually pushing to provide high quality care with minimal resources. This lack of funding when combined with the dependency on third party revenue and governmental appropriations raises the importance of ensuring that the Provider Relief Fund is distributed to Tribes in a manner that is both responsive to their needs and appropriate for the circumstances that they are facing.

Ensuring that this aid reaches Indian Country in an appropriate manner is also important because of the impact COVID-19 is having on our people. The Navajo Nation made front-page news

[3] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html
[4] *See* https://www.hhs.gov/about/news/2020/07/31/hhs-extends-application-deadline-for-medicaid-providers-and-plans-to-reopen-portal-to-certain-medicare-providers.html

because of their struggles with the disease, but COVID-19's devastation extends throughout Indian Country. According to NIHB's data[5], 5.5% of Arizona's population is AI/AN, yet AI/ANs are 13% of their COVID-19 deaths. An even more dire story is told in New Mexico where 10.7% of the state is AI/AN, but 52% of their deaths have been AI/AN. We can look outside of the Southwest and towards Wyoming where 3.7% of their state is AI/AN, but AI/ANs comprise 48% of their deaths from COVID. In Mississippi, AI/ANs are only 0.8% of the state's population, but 3.9% of their COVID deaths. Many Tribal communities are dealing with disease and need access to the resources to fight it, including relief funds for Indian health system providers.

Conclusion

We urge HRSA to hold a Tribal consultation in order to ensure that the agency distributes the remainder of the Provider Relief Fund in a manner that best supports the Indian health system, which, in turn, will protect the health of our communities and citizens. Tribal nations share a government to government relationship with the federal government and we believe a consultation provides the appropriate venue to voice our concerns. We thank you in advance for your consideration of our request and look forward to hearing back from you.

Sincerely,

Stacy A. Bohlen
CEO
National Indian Health Board

CC:
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[5] *See* https://public.tableau.com/profile/edward.fox#!/vizhome/JULY262020COVID-19FundingConfirmedCasesandDeathswithAIANPopulation/NIHBBiweeklyUpdateCOVID-19AllRacesDatawithState-reportedAIANData