

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

April 11, 2020

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

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

Dear Administrator Verma:

On behalf of the CMS Tribal Technical Advisory Group (CMS-TTAG), I am writing to you about the \$100 billion in funding provided through the CARES Act for the HHS Public Health and Social Services Emergency Fund. This funding was provided by Congress to support hospitals and other health care providers who are on the front lines of the COVID-19 response. We want to acknowledge HHS and CMS for the initial distribution of \$30 billion that was made this week. This funding has already begun to hit the accounts of Indian health providers and I thank you for this first infusion of badly needed resources.

As the urgency, infection rate, and death toll of the COVID-19 pandemic intensifies, it has become increasingly clear that the Indian health system needs significantly more resources to protect tribal citizens, our non-tribal community, and address health effects of the COVID-19 crisis. As you are aware, American Indian and Alaska Native (AI/AN) communities are disproportionately impacted by the health conditions that the Centers for Disease Control and Prevention (CDC) notes 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.

We understand that HHS and CMS are considering a rapid and targeted distribution of the remaining \$70 billion to providers that have been greatly affected by the COVID-19 outbreak, rural hospital and ambulatory health providers, and those providers that predominately serve the Medicaid population. As an advisory body to the CMS Administrator, it is important that the CMS-TTAG provide CMS with our recommendations on factors it should consider on distribution of resources for the Indian health system.

Balance of the Fund Should Target Medicaid Providers

The recent distribution from the \$30 billion is very much appreciated. It is important to note, that although the Medicare population is a high priority, it is not the largest population that we are serving. For this reason, this first allocation was not as high as it could have been if other factors were considered. Additionally, Medicare payments made to Indian health providers are reduced

by the 20 percent co-insurance requirement in Medicare. Unfortunately, unlike other Medicare providers in the private sector, Indian health providers do not charge this cost-sharing back to Medicare patients. We are hopeful that this can be taken into consideration in the next allocation.

We understand that CMS may be considering weighting the next distribution for those providers that predominately serve the Medicaid population. We want to underscore the Indian health system's patient mix includes a very high percentage of Medicaid patients, and we urge the Administration to use Medicaid payments to target the remaining allocation.

According to a 2019 GAO report, 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 measure¹. We emphasize that directing the funding toward Medicaid providers will help ensure that funding reaches Indian Country, where it is critically needed.

Tribal Leaders Ask the Administration to Use a Measure other than Disproportionate Share Hospital (DSH)

We are not sure what the measure will be for calculating the volume of Medicaid patients served by hospitals or other health providers and are concerned that using the Medicaid DSH allotments for states and providers might be used as a proxy.

The Medicare DSH formula artificially disadvantages IHS 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.

A distribution based on DSH payments, like the Medicare formula used in the first round, would not favor the Indian health system. In addition, states like Alaska with a very large Alaska Native and American Indian Population (AN/AI) 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 be problematic for the Indian health system.

Your April 10, 2020 guidance states that the intent of this next round of funding is to address providers who do not have a large base of Medicare patients, who are rural, and who serve a large number of Medicaid and/or uninsured patients². The Indian health system does this and should be included in any distribution of funds.

¹ 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).

² 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).

We recommend that CMS take into consideration the unique needs of the Indian health system and the population that it serves, as well as its unique obligations to Indian Country. AN/AIs have long experienced lower health status, have lower life expectancy, and a disproportionate disease burden compared to the general population. These factors make the AN/AI population at risk and extremely vulnerable to COVID-19. Tribal communities do not have the same economic prospects as non-tribal communities and do not have the resources to help address the COVID-19 crisis.

Thank you in advance for consideration of our comments and recommendations.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive style with a large, sweeping initial "W" and a long, horizontal flourish at the end.

W. Ron Allen, CMS-TTAG Chair

Chairman, Jamestown S'Klallam Tribe

CC:

Calder Lynch, Deputy Administrator & Director, CMS

Kitty Marx, Director, Division of Tribal Affairs, CMS