

National Indian Health Board



Submitted via email

June 15, 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 and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

The Honorable Thomas J. Engels
Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857

Re: Provider Relief Fund Payments for Safety Net Hospitals, Medicaid & CHIP Providers

Dear Secretary Azar, Administrator Verma and Administrator Engels:

On behalf of the National Indian Health Board (NIHB),¹ I write to comment on the Administration's June 9 announcement of a \$25 billion distribution of the Provider Relief Fund and to reiterate the guidance, perspective and expectations from Tribal leaders across Indian Country. Specifically, I ask you to include Indian health providers in this most recent allocation of funding targeting Medicaid providers and future allocations from the Provider Relief Fund.

Background

As you know, an initial \$100 billion fund was established by the Congress in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to support health care providers impacted by the

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.

COVID-19 crisis. The Congress added an additional \$75 billion to the fund in the Paycheck Protection Program and Health Care Enhancement Act for a total fund of \$175 billion.

HHS, working through its designated lead agency -- the Health Resources and Services Administration (HRSA) -- made a number of distributions from this fund, from the time of its creation to now. HRSA designated an initial funding tranche of \$30 billion dollars, and directed that funding to Medicare fee-for-service providers. Shortly thereafter, HRSA designated an additional \$20 billion for Medicare providers, for a total of \$50 billion that the agency has referred to as the "General Distribution."² Targeted allocations followed. HRSA designated \$12 billion for providers experiencing high-impact from COVID 19, \$10 billion for rural providers, and \$4.9 billion for skilled nursing facilities. HRSA also set up a portal where providers could make claims for payment for services to uninsured patients. In addition to these tranches, HRSA designated \$400 million for Tribal Hospitals, Clinics, and Urban Health Centers. Several weeks ago, Tribal leaders were pleased to hear that HHS/HRSA increased that amount by an additional \$100 million for a total of \$500 million specifically for Indian health providers.

While Tribal leaders greatly appreciate this Tribal specific funding, we have shared in a number of letters and Tribal testimony that additional funding *must* be directed to Indian health providers to financially stabilize the overall Indian health system and to protect the health of our Tribal citizens, many of whom experience conditions that put them at special risk from COVID 19.

The Indian Health System Needs Additional Support

Although the Tribal specific funding provides helpful base level funds for COVID relief, Indian health providers need additional funding to support a system that is both woefully underfunded³ and desperately needed by Tribal citizens across Indian Country. The Tribal specific set aside only amounts to ~0.28 percent of the total Provider Relief Fund. This is wholly inadequate to address the financial damage COVID has caused to Indian health providers. COVID-19 dealt a crippling blow to Indian Country on many levels, and it threatens to destroy the viability of the Indian health system which literally serves as a lifeline for some of the most vulnerable citizens in the United States.

While Tribal leaders had hoped that the non-Tribal tranches of funding would reach Indian health providers, we regretfully report that very little of this funding benefits our system or patients. Most of these funding tranches contained categorical requirements that automatically excluded our providers. Even where eligibility existed, other barriers prevented a majority of Indian health system providers from benefitting from the fund. For example, very few Indian health system providers benefited from HHS/HRSA's general distribution of \$50 billion because those payments were tied to Medicare participation. While some Indian health providers participate in the

² On the Provider Relief website HHS/HRSA provide the following information regarding the \$50 billion, explaining that this funding "is allocated proportional to providers' share of 2018 net patient revenue. The allocation methodology is designed to provide relief to providers, who bill Medicare fee-for-service, with at least 2% of that provider's net patient revenue regardless of the provider's payer mix. Payments are determined based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April." <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html>

³ Historically, the federal government has funded the Indian health system at approximately 50% of need. Tribal estimates suggest even greater levels of disparity.

Medicare program, the Indian health system includes many more *Medicaid* recipients, as compared with Medicare recipients.⁴ It was for this reason that Tribal leaders and advocates urged the Administration to target a portion of the relief funds to Medicaid participation after HHS/HRSA announced the first tranche of funds would go out to Medicare providers (\$30 billion).

Likewise, HRSA required providers to demonstrate at least 100 COVID-19 admissions to be eligible for the initial High Impact payment. According to the Indian Health Service (IHS), only one hospital in the Indian health system (IHS and Tribal hospitals) has over 100 beds. This fact suggests that IHS and/or Tribal hospitals possess reduced ability to demonstrate the utilization required for HRSA to consider those providers for the high impact funds, despite the actual, and frequently devastating, impact of a COVID-19 outbreak on a hospital and community.

Despite these disappointments, Tribal leaders held out fervent hopes that HRSA would award funds to Indian health providers as part of the rural tranche of funding. They had good reason to believe this relief was on the way. On April 29, as part of a rapid joint consultation with IHS and HRSA, HRSA shared that the rural tranche *would* support Indian health system providers. As you can imagine, Tribal leaders across Indian Country felt dismay when just days later, we learned that the rural funding would not come to Indian health providers, even though most Indian health providers are in rural areas.

Indian Health Providers Must Benefit from Funds Targeting Medicaid Providers

On June 9, the Administration announced additional distributions from the Provider Relief Fund:

“to eligible Medicaid and Children's Health Insurance Program (CHIP) providers that participate in state Medicaid and CHIP programs. HHS expects to distribute approximately \$15 billion to eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Allocation. HHS is also announcing the distribution of \$10 billion in Provider Relief Funds to safety net hospitals that serve our most vulnerable citizens.”⁵

Indian health providers serve some of the nation's most vulnerable citizens, especially in relation to COVID-19. Additionally, according to the language in the announcement, Indian health providers that 1) participate in Medicaid and CHIP, and 2) did not receive a payment as part of the general \$50 billion distribution *should* qualify for this tranche of funding.

Despite this clear language and unambiguous intent, we heard on June 10, on the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory (TTAG) call, that this \$25 billion tranche would *not* include Indian health providers. In response to this information, Tribal leaders requested that federal representatives bring these Tribal concerns back to HHS and her operating divisions so that this issue might be examined and addressed. Funding from this

⁴ The American Community Survey (ACS) estimates that 183,000 American Indians/Alaska Natives (AI/AN) had access to Medicare and Indian Health Service (IHS) in 2018,. In comparison, ACS estimates that 516,158 AI/AN had access to Medicaid and IHS in 2018.

⁵ See <https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicare-chip-providers.html>

Medicaid tranche must include Indian health providers, for the health of the system and our patients.

Equity and Fairness Instruct Inclusion

Non- Indian health system providers have qualified for Provider Relief Payments under multiple tranches of funding. Providers receiving the general distribution have also qualified for the high impact funding; providers receiving the general distribution have also qualified for the rural funding. The distribution scheme demonstrates HRSA's astute observation that a provider may have multiple and varied reasons for requiring support, and that these reasons may occur simultaneously. In such a case, addressing one gap *only* would not provide needed relief. For example, a provider that has canceled procedures that are essential to its financial stability may be going without 3rd party revenue that makes up 90 percent of its operating budget, and that same provider might be providing care to a community experiencing a devastating outbreak which requires a tremendous outlay of funding to equip the facility. HRSA recognized the varied layers of impact, and accounted for them in its different tranches of relief funds. This careful consideration should not stop at our reservations' borders. Indian health providers have multiple and varied reasons to seek provider relief, and we urge HHS, HRSA and any involved HHS operating division to consider the multiple ways that COVID-19 damaged and continues to harm Indian Country.

Indian Country is Uniquely Vulnerable to the Impact of COVID-19

COVID 19 disproportionately impacts Tribal populations. Our people suffer from health conditions that place us at greater risk such as diabetes, asthma, heart disease, and other chronic health conditions. In addition, many of our people cope with overcrowded housing and lack access to modern sanitation systems and running water. These factors taken individually would lead to much higher rates of serious disease and death. Together, they combine to disastrous effect – as we see in the Tribal Nations currently battling outbreaks. Exacerbating these issues, COVID-19 has harmed the financial viability of our already fragile system, placing a strain on our provider's ability to deliver needed care when hot spots arise, which, in turn, increases the risk to the health of our people compared with the general public. COVID-19 has created an acute crisis in the Indian health system – one that requires additional and continued federal intervention and assistance.

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). In light of this special obligation, and for all of the reasons stated above, 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.

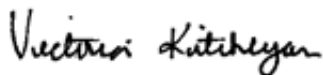
Tribal Request and Conclusion

While we appreciate the funding set aside for the Indian health system in the Provider Relief Fund, we do not believe that funding in any way answers a fraction of the shortfalls in the Indian health system, nor does it provide a legitimate basis for excluding Indian health providers from other tranches in the fund.

HRSA has allocated multiple streams of funding to non-Indian providers; to exclude Indian health providers from accessing funding that they would otherwise qualify for raises issues of disparate impacts, if not disparate treatment under the law. Congress intended Indian health providers to benefit from the relief they provided, and we urge the Administration to consider this Congressional intent along with the solemn responsibilities flowing from the federal government's trust responsibility to Tribal Nations.

We appreciate your consideration of this letter, and we look forward to your response.

Sincerely,



Victoria Kitcheyan
Chair
National Indian Health Board

CC:

Devin Delrow, Associate Director of Tribal Affairs, HHS-IEA
Stacey Ecoffey, Principal Advisor for Tribal Affairs, HHS-IEA
Kitty Marx, Director, Division of Tribal Affairs, CMS