

# 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

*Submitted via email*

May 27, 2020

The Honorable Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8013  
Baltimore, MD 21244-1850

**RE: Tribal Recommendations/Requests from May 13 TTAG Meeting - Dissemination of Provider Relief Fund to Indian Country, Four Walls, Extension of 100% FMAP**

Dear Administrator Verma,

On behalf of the Tribal Technical Advisory Group (TTAG)<sup>1</sup> to the Centers for Medicare & Medicaid Services (CMS), I write in response to the TTAG conference call discussion on May 13 with the CMS Division of Tribal Affairs. During that call, Tribal leaders shared requests and recommendations and we renew those requests in this letter. Part I outlines TTAG's request for CMS Tribal technical assistance on COVID-19 legislation and Part II outlines TTAG's request for CMS technical assistance on the Provider Relief Fund.

## **I. Request for CMS Tribal Technical Assistance on COVID-19 Legislation**

With recent multiple legislative packages passed in response to COVID-19, lawmakers are looking to address certain longstanding issues in health care and public health for American Indian and Alaska Native (AI/AN) people. Lawmakers cannot do this, however, without technical assistance from the Department of Health and Human Services (HHS), and specifically CMS. Unlike other federal agencies, CMS' Division of Tribal Affairs (DTA) has a unique and direct perspective into the health care challenges faced by AI/ANs, which predates the current public health emergency and will continue thereafter. While Tribal Nations appreciate that CMS has held webinars on new waiver flexibilities available

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<sup>1</sup> TTAG advises CMS on Indian health policy issues concerning Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and any other health care program funded in whole or in part by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives (AI/ANs) under these federal health care programs, including through providers operating in the Indian Health Service (IHS), Indian Tribes, Tribal organizations, and Urban Indian Organizations (collectively I/T/Us).

under Medicaid and Medicare that pertain to telehealth, and has provided information on many other COVID-19 issues, CMS – because of its special knowledge of Tribe specific issues – must do more to guide federal law and policymakers.

Many of the Tribal legislative priorities involve changes to the Medicaid and Medicare programs, which together provide more than 16% of average total health care funding for Indian health programs.<sup>2</sup> **We request that the CMS Division of Tribal Affairs provide technical assistance to Congress on the Tribal Medicaid and Medicare priorities discussed in the attached document,<sup>3</sup> and that the CMS Office of Legislation defer to the recommendations of Tribes and the CMS Division of Tribal Affairs on Tribal legislative priorities for the Medicaid and Medicare programs.**

## **II. Request for CMS Technical Assistance on the Provider Relief Fund**

The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided \$100 billion in relief funds to hospitals and other health care providers on the front lines of the COVID-19 response. The Paycheck Protection Program and Health Care Enhancement Act added an additional \$75 billion to the fund. During the May 13 conference call, TTAG asked CMS to ensure that remaining distributions take into consideration the pressing needs of Indian health providers, and design allocations to provide relief specifically to those providers. In response, CMS advised TTAG to contact the Health Resources and Services Administration (HRSA) with any recommendations concerning disbursement of the funding, since HRSA is the lead agency responsible for distributing the funding. While we appreciate this guidance, we understand that CMS may be able to provide technical assistance to the Administration. In light of CMS' ability to interact directly with the administration, we believe that CMS can and should share and amplify Tribal perspectives. In our comments below, we seek to provide CMS with concrete recommendations and requests for the remainder of the Provider Relief Fund and for any legislative package to follow that addresses provider relief.

### **A. Increase Tribal Nations' Access to the Provider Relief Fund.**

The COVID-19 pandemic is causing Tribal Nations to face a substantial decline in third party revenue, which is essential to the survival of Tribal health care operations. HHS

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<sup>2</sup> Government Accountability Office (GAO), *Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections*, Published Sept. 3, 2019. Publicly released Oct. 1, 2019, <https://www.gao.gov/products/GAO-19-612> (“Federally operated IHS facilities’ third-party collections—that is, payments for enrollees’ medical care from public programs such as Medicaid & Medicare, or from private insurers—totaled \$1.07 billion in fiscal year 2018, increasing 51% from fiscal year 2013.”).

<sup>3</sup> Also see the National Indian Health Board and joint organizational letter to Senate leadership, which encapsulates the priorities of the TTAG (April 8, 2020), [https://www.nihb.org/covid-19/wp-content/uploads/2020/04/FINAL\\_SENATE\\_ATTACHMENT-2\\_NIHB\\_Phase-4-Tribal-Healthcare\\_Public-Health-Priorities.pdf](https://www.nihb.org/covid-19/wp-content/uploads/2020/04/FINAL_SENATE_ATTACHMENT-2_NIHB_Phase-4-Tribal-Healthcare_Public-Health-Priorities.pdf)

allocated \$400 million in CARES Act funding to IHS to assist Tribal Nations through the Provider Relief Fund. Tribes were pleased to receive a direct allocation from the CARES Act funding, but disappointed that the amount was insufficient to meet their needs. Tribal Nations were also disappointed to find out that rural Tribal facilities had been completely left out of the funding allocations that HHS designated for rural health care providers despite HRSA officials assuring Tribal leaders in a joint HRSA/IHS Tribal Consultation call that Tribal Nations would be eligible for that funding.

We were glad to hear on Friday, May 22, that HHS increased the allocation of CARES Act funding from \$400 to \$500 million in response to Tribal concerns. We appreciate this additional allocation, which together with the IHS Tribal set-aside will assist Tribal Nations in covering some COVID-19 related expenses. However, some of these monies are just beginning to reach Indian Country, and still more funds are needed to make up for revenue shortfalls that Tribal Nations are facing during the pandemic. Congress allocated an additional \$75 billion in funding to the Provider Relief Fund in the Paycheck Protection Program and Health Care Enhancement Act (PPHCEA). **TTAG requests that HHS allocate at least the same amount to Indian country from the PPHCEA Provider Relief Funds as it did from the CARES Act funding.** Research from the Kaiser Family Foundation shows that AI/ANs are at a high risk of serious illness if they contract the coronavirus because of the health disparities they experience.<sup>4</sup> Health and economic disparities, coupled with an under-funded Indian Health System, illustrates why more funding is needed in order to level the playing field.

## **B. Honor the Federal Trust Obligation to Tribes.**

The United States has a unique trust responsibility toward Tribal Nations and Indian people regarding health care, and unique Constitutional authority to fulfill that responsibility that is recognized by the courts. The federal government has affirmed and reaffirmed the trust obligation through treaties, Supreme Court precedent, and Executive decrees. Congress itself has declared that it is “the policy of [the U.S.], in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”<sup>5</sup> In accordance with the trust obligation to Tribes, Congress must take into account the disproportionate impact that COVID-19 is having on vulnerable American Indian and Alaska Native people, and work to remedy it through legislation. HHS, with CMS offering technical assistance on behalf of Tribal Nations, must work to vastly increase the amount of provider relief resources flowing to Indian Country, as the remaining funds are distributed and as Congress negotiates future relief-related efforts. The substantial decline in third party revenue as a result of the pandemic, and the

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<sup>4</sup> Kaiser Family Foundation “COVID-19 Presents Significant Risks for American Indian and Alaska Native People” (May 14, 2020) <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-presents-significant-risks-for-american-indian-and-alaska-native-people/>

<sup>5</sup> 25 U.S.C. § 1602(a)(1).

federal government's failure to live up to its trust responsibility means that Tribal Nations are managing their already fragile but reliable health care systems, with resources that are vastly diminishing by the day. **TTAG urges CMS to advocate on behalf of Indian health system providers, and provide technical assistance to HHS leadership to help target future distributions to those providers.**

**C. Advocate for Targeted Funding Distribution.**

Tribal Nations were left out of the Rural Provider Relief funding (\$10 billion) even though most Tribes are in rural communities and HRSA officials promised Tribal leaders that they would be eligible to receive such funding. The requirements to receive hot spot funding unduly favored large metropolitan area hospitals that had a high number of COVID patients, with little regard to the actual impact of COVID-19 patients on the system treating them. Tribal Nations expected some of this inequity to be addressed in the rural funding allocation, and in fact discussed this with both IHS and HRSA in the joint rapid Tribal consultation session. Unfortunately, days later Tribal Nations were disappointed to learn that Indian health providers were excluded from this distribution that would have provided a needed lifeline to the Indian health system.

While it is not entirely clear why Tribal Nations were excluded, in past policy, HRSA has rightly recognized the extraordinary challenges that Tribes/Tribal clinics face, and that they serve an inherently rural population, regardless of where services are rendered. As such, and in example, HRSA has automatically classified IHS/Tribal/urban Indian (I/T/U) facilities as Health Professional Shortage Areas (HPSAs)<sup>6</sup>.

**TTAG asks that CMS provide technical assistance to HRSA and HHS to ensure that targeted funding, along with general Provider Relief Fund allocations, reach Indian Country and benefit one of the nation's health systems in greatest need, as intended by lawmakers.**

**D. Extend Flexibility in Requirements to Attest to Receipt of Federal Relief Payments.**

HHS and CMS must assist Tribal Nations with respect to attestation requirements under the Provider Relief Fund, so that IHS and Tribal Medicare fee-for-service providers do not encounter barriers to accessing relief funds. In addition, I/T/U providers are already subject to an excessive amount of federal oversight, such as auditing requirements. With this in mind, we urge the reduction of, and where possible, exemption from, any application, attestation, and reporting requirements associated with this funding. Further, access to the Tribal set-aside in particular should not be contingent on burdensome

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<sup>6</sup> Health Professional Shortage Areas (HPSAs), Health Resources and Services Administration, <https://bhwh.hrsa.gov/shortage-designation/hpsas>

paperwork and reporting requirements. Even requiring Tribal health entities to provide a Tax Identification Number (TIN) is laborious and should be eliminated, most urgently for those that do not currently have a TIN. The funds should be distributed in an equitable manner and, where appropriate, using existing funding mechanisms, such as through Indian Self-Determination and Education Assistance Act contracts and compacts.

**III. Conclusion**

The TTAG appreciates the opportunity share these recommendations and requests. We invite CMS and HHS to consult with the TTAG concerning strategies for encouraging patient access to care. Please feel free to contact us with any questions or comments or if you would like any additional information.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive, flowing style.

W. Ron Allen, Chair, Tribal Technical Advisory Group  
Chair/CEO, Jamestown S'Klallam Tribe

Enclosure

Cc: Kitty Marx, Division of Tribal Affairs, CMCS  
Calder Lynch, Director and Deputy Administrator, CMCS