NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
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Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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***Transmitted via email**: secretary@hhs.gov*

July 22, 2020

Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
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Thomas Engels
Administrator
Health Resources and Services Administration
5600 Fishers Lane
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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 2244-8016

Re: COVID-19 Provider Relief Funds for IHS and Tribal Programs Recommendations

Dear Secretary Azar, Administrator Engels, and Administrator Verma:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), we write to the U.S. Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) regarding our concerns on the distribution of the Provider Relief Fund (PRF) established under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L. 116-136.

NPAIHB respectfully requests that HHS and its agencies consider the following recommendations when allocating COVID-19 relief funding:

1. Ensure Indian Health Care Providers have access to all COVID-19 funding, especially funding specific to rural, Medicare, and Medicaid providers;
2. Ensure prompt and meaningful tribal consultations regarding COVID-19 funding;
3. Streamline and simplify all application and reporting requirements;
4. Provide flexibility in the use of COVID-19 funding to ensure tribes are able to use funds beyond any deadlines and for the purposes most beneficial for tribes; and
5. Allow for attestation as to use of funds rather than a complex auditing process.

Established in 1972, NPAIHB is a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, advocating on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington

on specific healthcare issues. NPAIHB operates a variety of important health programs on behalf of its member tribes, including the Northwest Tribal Epidemiology Center[1] and works closely with the IHS Portland Area Office.

I. BACKGROUND

The COVID-19 pandemic disproportionately impacts American Indian and Alaska Natives (AI/ANs) and tribes.[2] Tribes have closed businesses to protect their people, and those closures have eliminated financial resources. AI/ANs are also disproportionatly impacted by COVID-19 due to the higher rate of chronic disease.[3] As noted in The Broken Promises Report, the federal government chronicly underfunds the Indian healthcare system and tribes depend on third party insurance reimbursements and tribal enterprise revenue to fill the gaps left by the unmet obligations of the federal government.[4]

Federal Government's Treaty and Trust Obligations

The Federal Government's trust responsibility, based in treaties and federal law, should protect the interests of Indian Tribes and communities, and provide healthcare services to all AI/ANs. Tribes are political, sovereign entities whose status stems from their inherent sovereignty as self-governing people predating the founding of the United States. Our treaties are the Supreme Law of this land; therefore, fulfillment of trust and treaty obligations should be without debate and the U.S. should honor its obligations to tribes. Tribes are the only providers to which the federal government has a trust obligation, therefore tribes must have substantially greater access to resources and relief.

II. SPECIFIC RECOMMENDATIONS

Recommendation One: Ensure Indian Health Care Providers have access to all COVID-19 funding

The CARES Act and the Paycheck Protection Program and Health Care Enhancement Act provided $175 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response.[5]

HRSA distributed $50 billion to providers who bill the Medicare fee-for-service system. HHS expects to distribute an additional $15 billion to eligible providers that participate in state Medicaid/Children's Health Insurance Program (CHIP) programs or Medicaid managed care plans. Providers who received a share of the funds tied to Medicare services are ineligible to receive funds tied to Medicaid services. This restriction negatively impacts providers and clinics in the Indian healthcare delivery system as a disproportionate percentage of AI/ANs are covered by Medicaid, and many of the Medicare patients are also dual-eligible. Medicaid provides coverage to more than one in four (27%) nonelderly AI/AN adults and half of AI/AN children.[6] In 2018, the

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.5.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

[2] Mineo, Liz. For Native Americans, COVID-19 is the 'worst of both worlds at the same time' (2020).

[3] Mineo, Liz. For Native Americans, COVID-19 is the 'worst of both worlds at the same time' (2020).

[4] U.S Commission on Civil Rights.The Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans (2018).

[5] Department of Health and Human Services.CARES Act Provider Relief Fund.

[6] Kaiser Family Foundation, Medicaid and American Indians and Alaska Natives Issue Brief (2017).

American Community Survey estimated that 183,000 AI/ANs had access to Medicare and IHS, while 516,158 AI/ANs had access to Medicaid and IHS.[7]

For many of self-governance tribes, third party insurance reimbursements from Medicare, Medicaid, and private insurance constitutes up to 60% of their healthcare operating budget. During a June 11, 2020 hearing before the House Interior Appropriations Committee, IHS Director Rear Admiral (RADM) Weahkee stated that third party reimbursements have plummeted 30-80% below 2019 levels, and that it would likely take years to recoup these losses.

Many of the tribes and tribal organizations who bill both Medicare and Medicaid received a significantly small amount of funding from the general distribution (i.e. less than $10,000) because of the low number of Medicare beneficiaries and annual Medicare third party insurance reimbursement. As sovereign nations, tribes should have been eligible for all funding opportunities. In order to provide a clear picture of the gap in funding based on eligibility for Medicare Provider Relief Funds compared to Medicaid Provider Relief Funds we have included three examples:

- Tribe A received $1,600 from the Medicare Provider Relief Funds, while they could have received $450,000 from the Medicaid Provider Relief Funds.
- Tribe B received $4,465 from the Medicare Provider Relief Funds. Of Tribe A's total 3rd party insurance reimbursement collected, Medicare only represents 1%, while Medicaid reimbursement represents 96%.
- Tribe C received $10,000 from the Medicare Provider Relief Funds, however could have received $278,000 from the Medicaid Provider Relief Funds.

***Recommendation Two*:** Ensure prompt and meaningful tribal consultations re. COVID-19 funding

HHS designated HRSA as the lead agency for distribution of the COVID-19 Provider Relief Funds. By assigning HRSA as the lead agency, HHS failed to take into consideration the needs of the Indian healthcare system, and impeded the ability of tribes to fully respond to COVID-19. Consultation attempts by HRSA included non-tribal providers, and did not follow government to government consultation protocols.

Recommendation Three: Streamline and simplify any application and reporting requirements

The COVID-19 pandemic highlights the systemic barriers that tribes regularly encounter when receiving resources from the federal government. The Chair of the U.S. Broken Promises Report stated in the Letter of Transmittal to the President that "The federal government should provide steady, equitable, and non-discretionary funding directly to tribes to support the public safety, health care, education, housing, and economic development of Native tribes and people."[8]

HHS and HRSA COVID-19 funding made available through grants or grant-like applications have made the process complex and burdensome for tribes and IHS/Tribal healthcare facilities who have been understaffed and overwhelmed during this public health emergency. Multiple disjointed funding opportunities, a lack of streamlined funding, funding restrictions, and complex applications processes with limited time for application submission creates an inhospitable application process for tribes. Tribal applications must be simplified, funding distribution

[7] American Community Survey, Health Insurance Coverage in the United States (2018).

[8] U.S Commission on Civil Rights.The Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans (2018).

formulas and requirements must be more clearly defined, and consultation with tribal leaders is a statutory requirement.

Recommendation Four: Provide flexibility in use of COVID-19 funding to ensure tribes are able to use funds beyond any deadlines and for the purposes most beneficial for Tribes

NPAIHB recommends flexibility in use of COVID-19 funding to ensure tribes are able to use funds beyond any deadlines and for the purposes most beneficial for tribes of IHS/tribal health facilities, including small construction projects. Future funding for tribes and IHS/tribal health care programs for COVID-19 must allow flexibility to meet the specific needs of tribal communities and clinics, including trailer purchases, modification of buildings or other small construction project needs in this pandemic.

Recommendation Five: Allow for attestation as to use of funds rather than a complex auditing

The complexity of reporting and auditing for multiple and overlapping funding resources is an onerous and unnecessary administrative burden for tribes. HHS and HRSA must relieve and reduce duplicative, complex reporting and application requirements. HHS and its agencies must allow for attestation as to use of funds rather than a complex auditing process.

III. CONCLUSION

Indian Country is severely under resourced, and the the COVID-19 pandemic exacerbates the lack of investment in the health of AI/AN by the federal government. COVID-19 is far from over, Indian Country's crisis during this public health emergency should be a call to action for the federal government to meet its trust and treaty obligations, HHS and HRSA must provide for increased emergency funds. For questions or additional information please contact NPAIHB's Health Policy Analyst, Sarah Sullivan at (703) 203-6460 or ssullivan@npaihb.org.

Sincerely,

Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Indian Business Council

cc: Tyler Fish, Executive Director, White House Council on Native American Affairs
Stacy Ecoffey, Office of the Secretary, Intergovernmental and External Affairs, HHS
Elijah Martin, CAPT, USPHS, Tribal Health Affairs, HRSA Office of Equity