

National Indian
Health Board



National
Congress of
American
Indians



August 31, 2020

Submitted via email

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

Re: HRSA Relief Funding Disbursement

Dear Administrator Engels:

On behalf of the undersigned national organizations, I am writing in regards to Health Resources and Services Administration's (HRSA) distribution of the Provider Relief Fund, which was established under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and other monies that were allocated for the use of Tribes and Indian health care providers. We appreciate the recent presentation by HRSA staff to the CMS Tribal Technical Advisory Group (TTAG) during the July 2020 Face-to-Face virtual meeting, held virtually on July 22, 2020. We are also appreciative of the opportunity to discuss the Provider Relief Fund with HRSA staff members during a call on August 12, 2020 and the opportunity to have a consultation with HRSA leadership on August 31, 2020. This letter serves as a reiteration of the points that Tribal leaders made during the Tribal consultation on August 31st.

We have concerns about the manner in which the funds have been distributed thus far. The root of our concerns is the inconsistent manner in which Tribes have been able to access the funds and the barriers that they have encountered in attempting to do so. We believe that the required reporting mechanisms to receive funding were incompatible with the capacity of the Indian health system. We acknowledge and thank HRSA for the re-opening of Phase Two of the General Distribution of the Provider Relief Fund. However, there is more that could be done. HRSA should partner with the Indian Health Service (IHS), Tribes, and urban Indian organizations (UIOs) to ensure that the funding provided is accessible to the Indian health system in a manner consistent with the needs and capacity of the system; this includes Tribal recommendations, which were restated on the August 12th call, to increase the PRF Tribally Targeted Distribution by \$1.7 billion and to send those funds through the IHS. We are looking forward to having another discussion with HRSA in our upcoming Tribal consultation.

Trust Responsibility

We kindly remind the agency that the United States has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is the Federal Government’s trust responsibility to protect the interests of Indian Tribes and communities, including the provision of health care to American Indians and Alaska Natives. Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and permanently enacting the Indian Health Care Improvement Act (IHCIA).¹ In the IHCIA, for instance, Congress found that “Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”² Title V of the IHCIA authorized federal funding for urban Indian organizations to provide health services to American Indian/Alaska Natives (AI/ANs), many of whom had been relocated to urban areas by federal relocation programs. Congress also enacted the Indian Self-Determination and Education Assistance Act of 1975 to enable Tribes and Tribal Organizations to directly operate health programs that would otherwise be operated by the IHS, thereby empowering Tribes to design and operate health programs that are responsive to community needs. Together, this complex health care system makes up the “I/T/U” or Indian health system (hereinafter referred to as “Indian health care providers”).

Increased Vulnerability

The COVID-19 pandemic has been a perfect storm for the inequalities impacting AI/AN people and Indian health care providers. AI/AN populations have disproportionately higher rates of heart disease, diabetes, and other conditions that exacerbate the impact of this disease. The effects of this are already visible. AI/ANs have the highest rate of hospitalization at 281 per 100,000.³ They also have the second highest COVID-19 death rate, at 60.5 deaths per 100,000⁴ and are 3.5 times more likely to test positive for COVID-19 than non-Hispanic whites.⁵ The Indian health system is working to reduce these adverse outcomes and using an increasingly diminished slate of resources in order to do so. As outlined in the U.S. Commission on Civil Rights’ “Broken Promises” report, the federal government has chronically underfunded the Indian health system, making it incredibly reliant on third party insurance reimbursements and government aid.⁶ Tribes are also struggling with the decline in revenue from Tribal businesses. Unlike a state or local government, Tribes do not have a local tax base from which to draw. When the fortunes of Tribal businesses decline, as do the coffers of Tribes.

¹ 25 U.S.C. § 1601 et seq.

² Id. § 1601(1)

³ Centers for Disease Control and Prevention. COVID-19 Data Visualization. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

⁴ APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. <https://www.apmresearchlab.org/covid/deaths-by-race>

⁵ Centers for Disease Control and Prevention. COVID-19 Among American Indian and Alaska Native Persons (Aug. 19, 2020). https://www.cdc.gov/mmwr/volumes/69/wr/mm6934e1.htm?s_cid=mm6934e1_w

⁶ U.S. Commission on Civil Rights. The Broken Promises Report: Continuing Federal Funding Shortfall for Native Americans (2018).

When an unexpected catastrophe, such as a pandemic, occurs, the Indian health system is ill equipped to absorb the impact. This pandemic has also caused a drastic decline in third party insurance reimbursements. During a June 11, 2020 hearing before the House Interior Appropriations Committee, IHS Director Rear Admiral (RADM) Michael Weahkee stated that third party reimbursements have decreased 30-80% below 2019 levels. The decline in both third party insurance reimbursements and Tribal enterprise revenue have left Indian health care providers with fewer resources to combat the pandemic. This is essentially a perfect storm as the Indian health system is a vulnerable network serving a vulnerable population.

I. Provider Relief Fund

Eligibility for Funding Distributions

The trust responsibility creates an enhanced duty for the federal government to provide funding to the Indian health system and the Provider Relief Fund is an opportunity to deliver on that promise. We have concerns about how the Provider Relief Fund has been handled thus far, particularly around the Indian health system's eligibility for tranches of funding and the timeliness of communication between the agency and the Indian health system. Our recommendation is that HRSA work to expand the pots of funding that the Indian health system is eligible for, preferably including Indian health care providers, and AI/AN individuals where applicable, in all available funding under the PRF. Perhaps the best example of the harmful impacts of not being eligible for all funding and the confusion brought about by a delay in communication comes from the way that HRSA decided to handle the distribution of funds for Medicare and Medicaid providers. The initial tranche of funding was distributed based on providers who bill the Medicare fee-for-service system. HRSA initially made the decision to deem providers ineligible for the Medicaid targeted distribution fund if providers received funds from the Medicare general distribution funds. This is an extremely disproportionate restriction for Indian health providers, for whom Medicare beneficiaries are a smaller percentage of the patient population compared to Medicaid beneficiaries. We feel that timely communication would have prevented the agency from creating a situation that disadvantaged Indian health care providers.

Indian health care providers did attempt to reach out to HRSA to voice these concerns. In a letter to CMS on April 11th, the Tribal Technical Advisory Group (TTAG) voiced opposition to this distribution and a desire for a distribution based on Medicaid claims.⁷ TTAG noted in that letter that AI/AN patients are predominantly using Medicaid and that basing the amount of funds received on Medicaid receipts would yield more aid for the Indian health system. Indian health providers were still included and limited in the General Distribution based on Medicare claims despite TTAG's recommendation. Once HRSA announced that it would distribute money based on Medicaid receipts, we learned that Indian health providers were ineligible for the Medicaid and CHIP Targeted Distribution if they were merely eligible for the earlier Medicare funding, even if they rejected such funding. While we appreciate the opening of the second tranche of funding, we are concerned about the lack of communication with Indian health providers throughout this

⁷ See <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2020/04/TTAG-Covid-relief-letter-4.11.2020-FINAL.pdf>

process and want to make sure that the agency is aware that, given the reliance of the Indian health system on programs such as Medicare and Medicaid, two percent of annual revenue is insufficient as a means of adequately compensating for the losses that the system has faced – and will continue to face – during this pandemic.

Ambiguity around Available Funding

Tribes are also deeply concerned about the ambiguity around what funding is available, the methodology of the allocation, and the labels that are applied to them when that funding is allocated to recipients. Many of our leaders have indicated that they are not informed of funding opportunities in a timely manner, which impacts their ability to apply for and receive the funding. We have heard from Tribes that they still have not received funds from the Tribal Hospitals, Clinics, and Urban Health Center Targeted Distribution which is *specifically* targeted to the Indian health system. Even when Tribes receive funding, Tribal leaders have told us that there is ambiguity as to which pots of funding the funds came from. We have found that Tribes have had difficulty in reaching HRSA in order to receive more information or assistance, and often they are redirected to the HHS contractor, UnitedHealth Care, who lacks knowledge in assisting Indian health system representatives and how to address their questions. When HRSA has responded, the responses have failed to answer inquiries about missing payments or under payments based on publicly available formulas. The lack of expertise on the Indian health system seems to have hampered the accurate delivery of these funds. This extended to the presentation of Provider Relief Fund (PRF) payments data already sent out to providers posted by HHS. When all payment information is aggregated from the PRF in the HHS reported data, it makes it difficult for Tribal programs to understand and track these pots of funding.

We believe that HRSA should work with IHS, Tribes, and UIOs to clarify ambiguities around this process and ensure that they are aware of all funding opportunities and the source of any funds that they are receiving. We also recommend that HRSA work with IHS and Indian health providers through Tribal Consultation before funding eligibility and methodology decisions are finalized to prevent unintended consequences in future distributions from the PRF.

Lack of Knowledge of the Indian Health System

As we mentioned above, we are deeply concerned about the communication issues between HRSA, their contractor UnitedHealth Care, and the Tribes. The Indian health system is unique and is markedly distinct from private and non-profit health systems. From accounting measures to tax filing status, there are aspects of the Indian health system that would look completely alien to someone without any experience working within the system. We believe that a lot of the communication lapses are rooted in a lack of knowledge of the Indian health system. While we appreciate HRSA holding a Tribal consultation and opening a line of communication to Tribes, we feel that United HealthCare would also benefit from speaking to those within the Indian health system and learning more about it. We encourage HRSA to either invite UnitedHealth Care to its upcoming consultation or ask them to hold a separate discussion with Tribal leaders. We believe that knowledge of the Indian health system is imperative for the fair and equitable administration of the Provider Relief Fund.

II. Forms of Funding

Competitive Grants and Reporting Requirements

We are also concerned about the mechanisms used to award other CARES Act funding for Tribes and Tribal programs which were not part of the Provider Relief Fund, particularly the use of competitive grants. The shutdowns that resulted from COVID-19 have devastated many Tribal economies, particularly those which rely heavily on the hospitality industry. The impacts of the shutdowns have resulted in Tribes laying off staff and as a result many are now operating with limited staff. For self-governance Tribes, this severely impairs their ability to compete for grants and essentially creates a situation where Tribes that are struggling are at a substantial disadvantage. We believe that it would be in the spirit of the nation to nation relationship that Tribes have with the federal government for this funding to be distributed based on a Tribally consulted formula. The current methods of distribution create a situation where a Tribe may not be able to apply for funding, even if they urgently need it and we believe that this is not in the spirit of the trust responsibility.

Tribes are also concerned about the complex reporting requirements associated with many of these grant or grant-like funding applications. In some cases, it is difficult for Indian health providers to provide this information and it creates an additional administrative burden on a system that is already understaffed and overwhelmed to deal with the impacts of COVID-19. 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. Indian health providers are encountering numerous funding opportunities that come with onerous reporting requirements and restrictions that serve to both restrict what they can do with the funding and create additional burdens for reporting on it. We believe that Indian health providers, owing to the uniqueness of our system, should be able to use funding based on the needs of our patients and to strengthen the system. We also believe that the reporting requirements should be streamlined and simplified in order to ensure that Indian health providers are able to dedicate their limited resources to providing care to our people and not complying with burdensome paperwork requirements.

Conclusion

The manner in which Provider Relief funds have been distributed and the requirements that have been associated with accepting them is deeply troubling to Indian country. We believe that this process could be greatly improved and made easier for the Indian health system. These federal relief funds are needed for the continued protection and stabilities of our communities. We would hope the Federal Government could also work together with Tribal Governments and ensure there is a clear, streamlined processes for these funds to get to where they were meant. Thank you in advance for your consideration of these points and we look forward to your response.

Sincerely,



Stacy A. Bohlen, CEO, National Indian Health Board



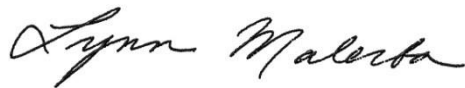
Kevin J. Allis, CEO, National Congress of American Indians



Francys Crevier, Executive Director, National Council of Urban Indian Health



W. Ron Allen, Tribal Chairman/CEO, Jamestown S'Klallam Tribe and Board President, Self-Governance Communication and Education Tribal Consortium



Chief Lynn Malerba, Mohegan Tribe of Connecticut, and Chairwoman, IHS Tribal Self-Governance Advisory Committee

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