HOBBS STRAUS DEAN & WALKER

1899 L Street, NW, Suite 1200
Washington, DC 20036

T 202.822.8282
F 202.296.8834

HOBBSSTRAUS.COM

MEMORANDUM

March 11, 2021

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker, LLP

RE: ***President Biden Signs American Rescue Plan into Law***

On March 11, 2021, President Biden signed the American Rescue Plan (ARP) into law. The bill was passed on a party-line vote in both chambers. The legislation contains $1.9 billion in federal funding to provide COVID-19 relief.

The legislation includes a historic $31.2 billion investment in Native communities. It provides $20 billion in direct funding for Tribal governments through the Coronavirus Relief Fund; over $6 billion for the Indian health system; $1.2 billion for tribal and Native Hawaiian housing programs; $1 billion for Native education programs; $1 billion for Tribal child care programs and Tribal TANF; $900 million for the Bureau of Indian Affairs; $500 million for economic infrastructure investments in Native communities; $20 million for Native languages and $419 million for Native communities to address domestic violence.

The ARP also includes extension of the enhanced unemployment benefits to September 6, 2021; $1,400 direct stimulus checks to American households; expansion of the child tax credit in 2021 from $2,000 to $3,600 for children under 6 years old and $3,000 for older children; and expansion of the earned income tax credit. Other highlights include additional funding for LIHEAP; water assistance; and FEMA's response efforts.

Following is a detailed summary of the key health related provisions in the ARP. Our firm has separately prepared a detailed summary of the non-health related provisions in the legislation as well. Please let us know if you would like a copy of that report as well.

Increased Funding for the Indian Health System

The final version of the ARP includes $6.094 billion for the Indian health system (Section 11001). As discussed below, Congress allocated this funding for select purposes. These funds would be available until expended, which generally means that the funds do not expire in a given fiscal year but are instead available for an indefinite period of time. However, Congress also provided that the funds "shall" be used to restore funds used for coronavirus response between January 31, 2020 and the date the bill is enacted, which is today. This second clause would suggest that the funds could only be used retroactively. However, we have been assured by legislative staff, and staff at IHS and HHS that is not the intent. We will be asking IHS to quickly clarify that these funds can be used going forward as well.

The legislation provides that the funds shall "be available on a one-time basis." Funds are not available beyond the purposes outlined in the act, and shall not be part of the amount required by section 106 of the Indian Self-Determination and Assistance Act (25 U.S.C. 5325).

Following is a brief summary of each of the pots of funding provided by the legislation.

$2 billion for lost reimbursements. The ARP provides $2 billion for lost reimbursements, "in accordance with Section 207 of the Indian Health Care Improvement Act (25 U.S.C. § 1621f)." It is unclear why the reference to Section 207 was included. Section 207 provides that third party reimbursements accrue to the entity that generated them. It would not appear to apply to or limit the use of funding from this pot of funds. There are no other conditions on the use of these funds.

$1.5 billion for testing, contact tracing and mitigation**.** The relief plan would provide $1.5 billion to "detect, diagnose, trace, and monitor COVID–19 infections," as well as "activities necessary to mitigate the spread of COVID–19 and supplies necessary for such activities." The funds can also be used for "related activities."

$600 million for vaccine-related activities. The ARP provides $600 million to "plan, prepare for, promote, distribute, administer, and track COVID–19 vaccines."

$600 million for tribal health facilities and infrastructure. The relief plan would designate a pot of funding for "the lease, purchase, construction, alteration, renovation, or equipping" of tribal health facilities to improve their response capacity in the pandemic. Eligible facilities include sanitation facilities under 42 U.S.C. § 2004a and health facilities operating pursuant to the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and certain titles of the Public Health Service Act.

$500 million for Additional Care. $500 million would be made available for "additional health care activities," "purchased/referred care" and "and other related activities." This is a broad authorization with no other limits on the use of these funds.

$420 million for mental and behavioral health services. The relief plan would provide $420 million to assist tribal governments to address the mental and behavioral health services. Covered expenses under this category include prevention and treatment services, as well as information technology and facilities needs related to mental and behavioral health.

$240 million for public health workforce development**.** The ARP provides $240 million for "necessary expenses to establish, expand, and sustain a public health workforce to prevent, prepare for, and respond to COVID–19, other public health workforce-related activities

$140 million for health information technology. The legislation provides $140 million for "information technology, telehealth infrastructure, and the Indian Health Service electronic health record system." As a result, a portion of these funds will be dedicated to the IHS's EHR system, but the remainder should be available for tribal and urban programs as well.

$84 million for urban Indian organizations (UIOs). The Indian health system allocation under the relief plan includes a specific set aside for urban Indian health. Its stated intent is to assist UIOs in maintaining operations to benefit urban Indian populations.

$10 million for potable water delivery systems. The relief plan provides $10 million in a targeted set aside for expenses relating to potable water in tribal communities under 42 U.S.C. § 2004a, which is one of the authorities IHS uses to implement the Sanitation Facilities Construction Program. This includes the necessary water supplies, fixtures, and facilities to facilitate the potable water delivery.

Tribal Consultation on IHS Funds.

IHS will be holding a rapid Tribal Consultation on the allocation of these funds on Wednesday, March 17, 2021 from 12:30 p.m. – 2:00 p.m. (ET). More information on this consultation can be found here.

CALL-IN INFORMATION: 1-800-857-5577
Participant Code: 4151302
ADOBE CONNECT: To join the meeting: https://ihs.cosocloud.com/r12qamkpnaha/
Room Passcode: ihs123

Deadline for written comments is **Friday, March 19, 2021.** Comments can be submitted to consultation@ihs.gov. Please let us know if you would like assistance in drafting these comments.

Provider Relief Fund

The Senate added an additional $8.5 billion to the Provider Relief Fund (Section 9911). As you may recall, Congress had previously appropriated $178 billion for this fund in other COVID-19 relief bills. This new funding does not have an expiration date, but is specifically targeted to providers in rural areas. Rural area is defined broadly and gives the secretary of Health and Human Services discretion to define what is considered rural. The legislative text defines a rural provider or supplier as:

> ‘‘(A) a—
> ‘‘(i) provider or supplier located in a rural area (as defined in section 1886(d)(2)(D)); or
> **‘‘(ii) provider treated as located in a rural area pursuant to section 1886(d)(8)(E);**
> ‘‘(B) a provider or supplier located in any other area that serves rural patients (as defined by the Secretary), which may include, but is not required to include, a metropolitan statistical area with a population of less than 500,000 (determined based on the most recently available data);
> ‘‘(C) a rural health clinic (as defined in section 1861(aa)(2));

''(D) a provider or supplier that furnishes home health, hospice, or long-term services and supports in an individual's home located in a rural area (as defined in section 1886(d)(2)(D)); or

''(E) any other rural provider or supplier (as defined by the Secretary).''

We anticipate that HHS will be quickly issuing guidance on which facilities will be eligible for this new set of Provider Relief Funds. Many tribal providers previously qualified for Provider Relief Funds HHS set as aside for rural providers before. As a result, we anticipate tribal providers in rural areas will be eligible for these funds as well. We will let you know as soon as HHS issues guidance on this new funding opportunity.

The legislation also clarifies that lost revenue shall be calculated by indicating the budgeted and actual revenue for budgets established before March 27, 2020. This language was likewise confirmed in Consolidated Appropriations Act, 2021 (P.L. 116-260).

As before, funds can be used for expenses and lost revenues related to COVID-19 response. Eligible expenses include "construction of a temporary structure, the leasing of a property, the purchase of medical supplies and equipment, including personal protective equipment and testing supplies, providing for increased workforce and training, including maintaining staff, obtaining additional staff, or both, the operation of an emergency operation center, retrofitting a facility, providing for surge capacity, and other expenses determined appropriate by the Secretary."

Affordable Care Act Amendments

The ARP provides increased premium subsidies for unemployed individuals who are enrolled in a federal or state marketplace health insurance plan for 2021 and 2022. Premiums would be capped based on a percentage of individual's total income and would vary based on an individual's federal poverty level (FPL). The lower the FPL, the lower the cap. Under the new law, premiums would range from $0 for individuals with incomes between 100 and 150 percent of FPL to 8.5 percent of total income for individuals with income of 400 percent FPL or higher:

Up to 150.0 percent	*0.0*	*0.0*
150.0 percent up to 200.0 percent	*0.0*	*2.0*
200.0 percent up to 250.0 percent	*2.0*	*4.0*
250.0 percent up to 300.0 percent	*4.0*	*6.0*
300.0 percent up to 400.0 percent	*6.0*	*8.5*
400.0 percent and higher	*8.5*	*8.5.*

This would provide significant additional premium assistance for the next two years, and allow individuals with incomes above 400 percent of FPL to qualify for premium assistance for the first time.

The legislation also protects individuals who received advance premium tax credits on the marketplace from having to repay excess subsidies in the event that their household income was higher than expected in 2020. The temporary waiver of excess subsidy payback requirements would apply to all income levels for the 2020 tax year. It also amends the law so that the receipt of unemployment assistance cannot raise an individual's income above 133 percent FPL for purposes of determining eligibility for premium assistance.

Medicaid, Medicare and CHIP Amendments

The ARP makes a number of changes to the Medicaid and CHIP programs. We summarize some of the most relevant here.

The legislation provides a significant incentive for non-Medicaid expansion states to expand Medicaid. It provides non-expansion states a 5 percent increase in the Federal Medical Assistance Percentage (FMAP) for their traditional, non-expansion population. The increase would last for two years, and would represent a significant funding increase for non-expansion states.

It also extends 100 percent FMAP for services received through Urban Indian organizations operating under a Title V grant with the IHS, as well as Native Hawaiian Health Centers. This means that CMS would reimburse States for 100 percent of the cost of Medicaid services received through these entities. This is the same rule that already exists for IHS and tribal facilities.

The ARP establishes mandatory Medicaid reimbursement for coronavirus vaccination and administration and treatment and exempts Medicaid and CHIP enrollees from any associated premiums or cost-sharing. It also provides that covered outpatient drugs used for coronavirus treatment are to be included in the Medicaid drug rebate program. It also increases a State's FMAP to 100 percent for services associated with vaccination for coronavirus from now until one year after the public health emergency ends. It also gives States the option to extend benefits to pregnant women for one year post-partum, and the option to provide qualifying community-based mobile crisis intervention services.

The legislation also waives certain Medicare transportation requirements for ambulance providers during the public health emergency, and provides additional funding for the Office of Inspector General to conduct audits of funds provided by HHS to address coronavirus.

Additional Mental Health and Substance Use Disorder Funding

As reported above, IHS will receive $420 million for mental and behavioral health services. However, the ARP also includes additional funding for mental health and substance use that Tribes and tribal organizations will have access to, though there are not tribal set-asides. The legislation contains $80 million for the Health Resources and Services Administration (HRSA) mental and behavioral health training for health care professionals, para-professionals, and public safety

officers. The ARP includes $40 million for grants (also funded through HRSA) for health care providers to promote mental and behavioral health among their health professional workforce.

The legislation provides $80 million to develop new grant programs at the Substance Abuse and Mental Health Services Administration (SAMHSA) to allow additional entities, such as community-based entities and behavioral health organizations, to receive grants to support mental health and substance use disorder services. Within this amount, $30 million is for grants for preventing and controlling the spread of infectious diseases and the consequences of such diseases for individuals with substance use disorder, distributing opioid overdose reversal medication to individuals at risk of overdose, connecting individuals at risk for, or with, a substance use disorder to overdose education, counseling, and health education, and encouraging such individuals to take steps to reduce the negative personal and public health impacts of substance use or misuse." And $50 million will be for grants for Community Based funding for local behavioral health needs. Funding in this section is available for promoting care coordination among local entities; training the mental and behavioral health workforce, and stakeholders; expanding evidence-based integrated models of care; addressing surge capacity for mental and behavioral health needs; providing mental and behavioral health services via telehealth; and supporting, enhancing, or expanding mental and behavioral health preventive and crisis intervention services.

Emergency Rural Development Grants for Rural Health Care

The ARP provides $500 million through the U.S. Department of Agriculture to establish a rural development program for rural health care to increase vaccine distribution capacity; provide medical supplies to increase medical surge capacity; reimburse lost revenue; increase telehealth; construction of temporary and permanent structures for health services; supporting staffing needs for vaccine administration and "any other efforts to support rural development determined to be critical to address the COVID-19 pandemic..." This funding is not specific to Indian health care providers, but will be made generally available.

Conclusion

We will continue to provide further analysis as this legislation is implemented by the Administration. If you have any questions or would like additional information on any of issues raised in this report, please do not hesitate to contact Elliott Milhollin (emilhollin@hobbsstraus.com or 202-822-8282); Geoff Strommer (gstrommer@hobbsstraus.com or 503-242-1745) or Caitrin McCarron Shuy (cshuy@hobbsstraus.com or 202-822-8282).