



215 SW Washington Street, Suite 200
Portland, OR 97204

T 503.242.1745
F 503.242.1072

HOBBSSTRAUS.COM

MEMORANDUM

March 27, 2020

TO: TRIBAL HEALTH CLIENTS

FROM: HOBBS, STRAUS, DEAN & WALKER, LLP

RE: ***President Signs Third Emergency Relief Bill in COVID-19 Response***

Today, March 27, the President signed into law a massive third emergency relief package of almost \$2.2 trillion in funding as part of the nation's ongoing response to the COVID-19 outbreak. The bipartisan law, called the "Coronavirus Aid, Relief, and Economic Security Act" (CARES Act), provides substantial and broad funding across multiple sectors to address the complex impacts of the pandemic on American health and society. In terms of healthcare support, the CARES Act provides \$150 billion for critical healthcare investments in protective personal equipment (PPE) for healthcare workers, diagnostic testing supplies, workforce training, new healthcare facilities construction, medical research, reinforcement of the Strategic National Stockpile of emergency medical supplies, and Medicare payment increases.

For Indian Country, the Act includes \$1.032 billion for the Indian Health Service (IHS). Other tribal set asides in the CARES Act include: \$125 million with the Centers for Disease Control and Prevention (CDC); \$15 million from the Department of Health and Human Services (HHS) Public Health Service and Social Services Emergency Fund; and \$15 million for Health Surveillance within the Substance Abuse and Mental Health Services Administration (SAMHSA). It also includes \$8 billion in direct funding for tribal governments to cover expenditures related to tribal COVID-19 responses.

Following passage of the CARES Act, House leadership authorized the release of a colloquy (a formal conversation that is written down for the record to clarify congressional intent about a legislative provision) on the \$8 billion set aside for tribal governments. The document clarifies that such funds are intended "to help cover the loss of revenues that would have otherwise been collected and generated by these governments to cover the wages of their employees." The Congressional Members participating in the colloquy each emphasize the broad nature of these provisions, underscoring how tribal governments uniquely rely on the generation of revenues from tribal businesses and programs to cover employee and response activity costs. A copy of the colloquy is attached.

Tribal advocates are actively working to ensure that the funds provided in the CARES Act are distributed as quickly as possible to tribal nations and organizations. We

understand that the National Indian Health Board will be hosting an All-Tribes call early next week to hear directly from tribal leaders as to how best to distribute the funding. The tribal workgroup is going to be sending three separate letters to HHS, Bureau of Indian Affairs, and the Treasury Department to urge the agencies to streamline and expedite getting the funding from this stimulus package out to Indian Country. The agencies are accepting comments from tribal nations on how to distribute the funding. Please let us know if you would like assistance in developing comments.

As discussed below, there were several important Indian healthcare policy provisions included in earlier drafts of the bill, but they did not make it into the final bill. Tribal advocates are hopeful they can be included in the next stimulus package.

This report provides a summary of the major healthcare provisions included in the stimulus package. These are brief summaries only. The CARES Act also included significant relief provisions for tribal nations, tribal businesses, and non-profit 501(c)(3) entities. These provisions are addressed in-depth in a separate memorandum prepared by our firm, a copy of which is attached. If you would like additional information on any of the topics discussed in our health or economic reports, please let us know.

I. Indian-Specific Health Provisions

\$1.032 Billion Appropriated to the Indian Health Service (Division B). Within this funding, Congress included certain set asides of mandatory funding, namely: a minimum of \$450 million for distribution through tribal shares and contracts with urban Indian health programs; \$65 million for electronic health record stabilization and support; and \$125 million that may be transferred for facility needs. The remaining funds may be used to address response needs in Indian Country for medical and equipment supplies, field triage units for patient care and testing, surveillance activities, pharmaceuticals, patient transportation, staffing needs, telehealth infrastructure, and Purchased/Referred Care.

Short Term Reauthorization of SDPI (Title III, Sec. 3832). Congress extended mandatory funding for the Special Diabetes Program for Indians at the current appropriation level of \$150 million per year through November 30, 2020. This funding is critically needed to supplement the available federal dollars for grantees in the final year of the current grant cycle – which had received only 64% of its appropriated amount for FY 2020. Permanent or long-term reauthorization of SDPI is still needed to support the upcoming FY 2021-2025 grant cycle that is expected to begin on January 1, 2021, as a competitive continuing grant application for existing grantees.

\$125 Million CDC Tribal Set Aside (Division B). The set aside is established under the CDC-Wide Activities and Program Support account, which is used to carry out the agencies public health service authorities like surveillance, diagnostics, laboratory support, and guidance. It can also be used to reimburse expenditures during a public health emergency like the current pandemic. The Act does not contain instructions on how the CDC is to distribute the funding to tribal nations. Tribal leaders were deeply concerned by the CDC's weeks-long process in distributing tribal funds appropriated in the first stimulus

bill to tribal nations, and the CDC has not yet issued a Notice of Funding Opportunity Announcement for the \$40 million in tribal funding set aside that bill. Tribal leaders and health advocates are working to try and streamline the distribution process for the \$125 million provided under the CARES Act.

\$15 Million Tribal Set Aside from the HHS Public Health Service and Social Services Emergency Fund (Division B). The Fund is administered by the Office of the Assistant Secretary for Preparedness and Response within HHS. This money can be used for an array of hospital preparedness and health center needs, as well as for reimbursements of expenses incurred in response to the pandemic prior to the CARES Act enactment date.

\$15 Million Tribal Set Aside of SAMHSA Health Surveillance and Program Support Resources (Division B). Tribal nations, tribal organizations, urban Indian health programs, and behavioral health service providers serving tribal populations are eligible for this funding. Funds can be used for a variety of mental and behavioral health services, as well as the systematic collection and analysis of public health related data for community wellness planning. A further \$410 million is appropriated generally to a Health Surveillance and Program Support line item with specific set asides for the Certified Community Behavioral Health Clinic Expansion Grant program, suicide prevention resources, and Disaster Response Grants. No details are provided on the scope of or eligibility for suicide prevention resources in the CARES Act. Tribal leaders and health organizations have raised the need for investment in mental and behavioral health services as part of the healthcare response in communications with federal officials. Tribal nations were eligible for Disaster Response Grants in the past provided that they were located within an area impacted by a natural disaster. Given that the COVID-19 outbreak is a pandemic impacting all 50 states, tribal nations should be eligible for the program again under the CARES Act.

II. General Healthcare Relief Provisions

The “Marshall Plan”, Office of the Secretary, Public Health and Social Emergency Fund (Division B). Under what has been dubbed the “Marshall Plan”, \$100 billion is allocated for eligible health care providers to remain available until expended, to prevent, prepare, and respond to coronavirus for expenses to reimburse, through grants or other mechanisms, expenses or lost revenues that are attributable to coronavirus. The Secretary of HHS is to issue instructions for applying for these funds and for required reporting instructions. Grant applications will be issued on a rolling basis. An issue to pay close attention to is how the Secretary will interpret the requirement that the funds “may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.” Among the uses of the funds are for building or construction of temporary structures, leasing of properties, medical supplies and equipment, increased workforce training, emergency operation centers, retrofitting facilities, and surge capacity.

Establishment of Public Health Service “Ready Reserve Corps” (Title III, Sec. 3214). The Public Health Service “Ready Reserve” was originally established under the

Affordable Care Act to serve as a surge force of Commissioned Corps officers in a national emergency; however, technical hurdles – like pay and recruitment – prevented it from becoming a reality. The CARES Act reestablishes the Ready Reserve with an expanded mandate to respond to national emergencies and public health emergencies. We note that this act brings to fruition a goal of the U.S. Surgeon General shared at the February 2020 meeting of the HHS Secretary’s Tribal Advisory Committee. There, Surgeon General Jerome Adams stated that instituting a Ready Reserve of at least 2,500 officers was one of his top priorities as a way to lessen the impact of Commissioned Corps deployments and ensure greater continuity in service availability in times of emergency.

Strategic National Stockpile (Division B; Title III, Sec. 3102). Congress provides a \$16 billion infusion of funds to reinforce the Strategic National Stockpile of emergency medical supplies. The Stockpile is now required to include PPE and ancillary medical supplies required for the administration of vaccines and diagnostic tests (such as swabs). We note that a provision authorizing direct IHS and tribal nation access the Stockpile sought by tribal advocates did not make it into the final version of the CARES Act passed by Congress.

Advanced Medicare Payments to Hospital Providers (Title III, Sec. 3719). The law authorizes Medicare to issue advanced payments of up to six months’ value of net reimbursements represented by unbilled discharges or unpaid bills. Eligible hospitals can elect to receive the payment through either periodic disbursements or a lump sum. The advanced payment(s) would be treated as a no-interest loan that must be repaid within 12 months. Qualifying hospitals are “subsection (d)” hospitals that are statutorily defined under the Social Security Act as all hospitals within the United States, subject to certain exceptions – none of which appear to disqualify IHS hospitals. Thus, we believe IHS hospitals qualify for advanced Medicare payments under the CARES Act, but we are working to confirm this status.

Delay of DSH Payment Reductions (Title III, Sec. 3813). The CARES Act delays scheduled reductions in Medicaid disproportionate share hospital (DSH) payments through November 30, 2020. DSH payments are made to support hospitals that treat a large number of Medicaid beneficiaries and/or uninsured patients. In the fall of 2019, CMS issued a final rule with annual reductions in DSH payments between FY 2020 and FY 2025 totaling \$44 billion. The Act delays implementation of the FY 2021 reduction from October 1 to November 30.

Substance Use Disorder Treatment Records and Care Coordination (Sec. 3221; Sec. 3224). The Act amends the law governing the confidentiality of substance use disorder (SUD) treatment records (the “Part 2” confidentiality rules) to specifically authorize the use of a patient’s written consent to cover all future uses and disclosures of SUD treatment records for the purposes of treatment, payment, and healthcare operations, as consistent with the Health Insurance Portability and Accountability Act (HIPAA) regulations, until the patient revokes such consent. There are limitations on using such information for criminal, civil, or administrative investigations, actions or proceedings, and the information cannot be used to discriminate in healthcare, housing, employment, social

services, and other purposes. The Act aligns several definitions in the Part 2 regulations with those under HIPAA, and it authorizes disclosures without written patient consent of de-identified SUD treatment information to public health authorities.

The HHS Secretary is directed to make the necessary regulatory changes to carry-out these changes within 12 months of enactment of the CARES Act, and to issue guidance on allowable patient record disclosures under HIPAA during the COVID-19 public health emergency within the next 6 months. The Secretary is also required to update the HIPAA regulations governing Notices of Privacy Practices, to account for the Act's changes to the Part 2 confidentiality provisions.

Geriatric Education and Training (Title III, Sec. 3403). The Act establishes a Geriatrics Workforce Enhancement Program to improve health outcomes for older adults through improved access to professional and clinical training services, public education, and training-related community-based programs. In awarding grants under this section, priority is to be given to applicants serving the elder populations of tribal nations and tribal organizations, as well as rural and medically underserved areas. Eligible entities include IHS health centers, Federally Qualified Health Centers (FQHCs), rural health clinics, nursing and medical schools, and institutes of higher education providing healthcare programs and healthcare continuing education programs. The HHS Secretary may also approve other health profession schools or programs not identified as eligible entities under the Public Health Service Act, such as tribal health programs.

Nursing Workforce Development (Title III, Sec. 3404). The Act authorizes nurse managed health clinics to help fill nursing shortages and provide primary care and wellness services to underserved or vulnerable populations. The clinics must be associated with a school, institute of higher education, FQHC, or non-profit health or social services agency. Contracts may be entered into with public or private entities to carry-out this section at the HHS Secretary's discretion. Professionals eligible for training to become registered nurses under this provision include IHS Community Health Aid Program practitioners.

Child Care for Health Workers and Others (Division B). The Act provides \$3.5 billion for the Child Care and Development Block grant to supplement tribal, state, and territories grants. Most tribal nations administer a child care program under this program. The bill authorizes tribal nations, states, and territories to use these funds to provide child care assistance to health care employees, emergency responders, sanitation workers, other deemed essential to responding to the crisis with regard to income eligibility requirements.

Expanded Support for Telehealth – HRSA Grants (Title III, Sec. 3212) and Medicare Services (Title III, Sec. 3703-3708). Congress previously authorized expanded support for telehealth services as a means of connecting vulnerable populations to care without the risk of exposure. It is also seen as a means of alleviating stress on healthcare systems by funneling certain screening and treatment services online. Under the CARES Act, Congress reauthorizes Health Resources and Services Administration telehealth grant programs with an emphasis on funding projects in rural areas. Tribal governments and

organizations are eligible to apply for these grants, which may be used to develop a spectrum of telehealth services and cover the costs of associated salaries, equipment purchase, installation and maintenance, data analysis, and “other such activities” to further access to and the quality of telehealth in rural and medically underserved areas.

The CARES Act also expands Medicare telehealth options at FQHCs, Rural Health Clinics, and for certain home and hospice care. FQHCs and Rural Health Clinics will be able to serve as distant sites for telehealth consultations and be reimbursed based on national average payment rates for comparable services under the Medicare Physician Fee Schedule. The Act eliminates the requirement for a pre-existing treatment relationship between a provider and patient for the purposes of rendering Medicare telehealth services that was established under a previous stimulus bill.

Reauthorization of HRSA Grants Program for Rural Health (Title III, Sec. 3213). The CARES Act reauthorizes and increases appropriations for HRSA rural health services outreach grants, rural health network development grants, and small health care provider grants. The reauthorizations are intended to strengthen rural community health through quality improvement and by increasing healthcare access, coordination of care, and integration of services. This comes at a critical time because much of the rural population includes older individuals who are at an increased risk of severe illness if they contract COVID-19. To carry out these grant programs, Congress has appropriated a total of \$79.5 million for each of the fiscal years 2021 through 2025.

Under the CARES Act, tribal nations and tribal organizations serving rural underserved populations may now be eligible to receive rural health care services outreach grants and rural health network development grants. The current law limits the receipt of funding for these two programs to rural public or rural nonprofit entities. However, as amended by the CARES Act, entities “with demonstrated experience serving, or the capacity to serve, rural underserved populations” are now eligible to receive such funding. The CARES Act does not alter the eligibility requirements for small health care provider improvement grants. These grants remain limited to rural public or rural nonprofit health care providers or providers of health care services.

The CARES Act also provides that, in awarding grants, the HHS Secretary has discretion to give preference to entities located in health professional shortage areas or medically underserved communities. IHS and tribal programs qualify for such preference because, under the law, these entities operate in health professional shortage areas and medically underserved communities.

Veterans Affairs (Division B). The bill provides \$14.432 billion for medical and telehealth services and \$605.6 million for medical facilities, including mobile treatment centers, within the Department of Veterans Affairs (VA). Targeted support for homeless veterans and vulnerable veterans residing in community living centers or VA-operated nursing homes is also provided. To reach socially isolated veterans, the law enables the VA to enter into short-term agreements with telecommunication services to connect veterans with tele-mental health services from home. Telehealth capabilities for veterans

participating in the HUD-VASH program, including Native veterans, is also covered.

Pharmaceutical and Medical Device Supplies (Title III, Sec. 3111-3121). The law includes several sweeping provisions intended to incentive and protect the production of pharmaceutical drugs. Drug manufacturers are required to maintain contingency plans to protect the supply chain of drugs and their active ingredients. Drug manufacturers must provide notice of and the reason for any change in production that could disrupt access to the drug. The Food and Drug Administration is also directed to prioritize the review of drug applications and inspections to prevent or mitigate a national drug shortage. Similarly, manufacturers of medical devices critical to public health must also provide notice of and the reasons behind any potential supply interruptions that are not pre-approved.

III. Tribal Health Priorities

Tribal advocates have been working closely with Members of Congress and their staff on the inclusion of several important Indian healthcare policy provisions in the CARES Act.¹ The provisions listed below were under negotiation, but ultimately did not make it into the final law:

- Extension of 100% FMAP to urban Indian organizations.
- Reimbursement for services provided outside of the “four walls” of an IHS or tribal clinic.
- Reimbursements of Indian Health Care Providers by Medicare at 100 percent of the applicable rate.
- Direct tribal access to the Public Health Emergency Fund.
- Direct tribal access to the Strategic National Stockpile of emergency supplies.

Additional stimulus packages are expected to be passed by Congress as the effects of the pandemic on our healthcare system, economy and society continue to materialize. Tribal advocates are hopeful that Indian healthcare policy relief provisions will be included in a future stimulus package.

Conclusion

Attached in case it may be useful, please find a FAQ document about the CARES Act and a copy of the National Indian Health Board’s analysis of its healthcare provisions. If you have any questions, please contact Elliott Milhollin (emilhollin@hobbsstrauss.com or 202-822-8282); Geoff Strommer (gstrommer@hobbsstrauss.com or 503-242-1745); or Lisa Meissner (lmeissner@hobbsstrauss.com or 202-822-8282).

¹ Attached is the Congressional Native American Caucus’s Summary of Tribal Priorities related to the CARES Act.