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MEMORANDUM

April 15, 2020

To: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker, LLP

RE: *HRSA Holds Consultation on Emergency Funding; CMS Issues FAQ on Topics Related to the Pandemic Response; CRS Publishes Report on the IHS and COVID-19*

I. HRSA Holds Consultation on Emergency Funding

On April 14, 2020, the Health Resources and Services Administration (HRSA) conducted a virtual consultation on the distribution of a \$15 million set aside for tribal entities serving rural communities established under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Tribal nations, tribal organizations, urban Indian health programs, and tribal consortia are eligible to apply for this funding, provided that the services funded by the grant are rendered in a rural setting. HRSA officials on the call reported that the set aside will be distributed through a two-year competitive grant process with individual awards capped at \$300,000. Funds can be used to fund new response activities, as well as for the reimbursement of tribal COVID-19 response expenditures made on or after January 20, 2020. HRSA clarified that recipients will be able to adjust the scope of their grant as needed to address changing local priorities. Further, recipients will have flexibility in choosing when to spend their award, including spending it all immediately upon distribution. In other words, the funds will not need to be spread out over the life of the grant. HRSA expects to release the Notice of Funding Opportunity Announcement this month. We will notify you once it becomes available.

CAPT Elijah Martin, Tribal Affairs Manager in the Office of Health Equity, reported that due to the limited number of available call-in lines, a significant number of tribal leaders were unable to join the consultation. Consequently, HRSA may schedule an additional consultation session. In the interim, tribal leaders can submit comments related to the \$15 million set aside via email to elijah.martin@hrsa.hhs.gov. Please let us know if we can be of assistance to you in this process.

II. CMS Issues FAQ on Topics Related to the COVID-19 Response

On April 13, the Centers for Medicare and Medicaid Services (CMS) issued a Frequently Asked Questions (FAQ) document providing further guidance on its policies and

actions related to the COVID-19 response. Among the major topics discussed in the guidance include: CARES Act funding, the new optional Medicaid eligibility group, enhanced federal Medicaid funding, and policy implications for the Children's Health Insurance Program (CHIP). The FAQ is available online at: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>. A summary of the central issues discussed by CMS in the FAQ follows.

New Medicaid Eligibility Group. The Families First Coronavirus Response Act (Phase II) created an optional Medicaid eligibility group for uninsured individuals to receive limited coverage for COVID-19 in vitro diagnostic testing and testing-related services beginning March 18, 2020, and lasting for the duration of the declared emergency period. "Uninsured individual" is defined in the FAQ as someone who is: (a) not eligible to receive coverage under a mandatory Medicaid eligibility group; (b) not enrolled in Medicaid coverage, except for enrollment in certain limited-benefit Medicaid eligibility groups¹; (c) not enrolled in another federally-funded healthcare program like CHIP, TRICARE, Medicare, or federal employee health plans; and (d) not enrolled in a health insurance plan through an employer, the Marketplace, retiree health plan, or COBRA continuation coverage.

The CMS Tribal Technical Advisory Group (TTAG) is working to clarify that IHS eligible individuals with no other form of coverage would qualify for Medicaid expansion as "uninsured individuals." Unlike other federally-funded health care program, IHS eligible individuals are not "enrolled in" IHS. Their eligibility and inclusion in the program is automatic. As a result, they should qualify as "uninsured individual" for purposes of the new Medicaid eligibility group authorized in the Families First Coronavirus Response Act.

CMS clarifies that there is no income or resource threshold for the new eligibility group. However, individuals must be a state resident and possess a Social Security Number, subject to certain conditions. Diagnostic testing and testing-related services can be covered at 100% Federal Medical Assistance Percentage (FMAP) following the approval of a State Plan Amendment (SPA). The FAQ states that "testing-related services do not include services for the treatment of COVID-19."

CMS notes that States may need to amend any existing managed care contracts to address the new eligibility group, including creating either a kick payment (i.e., one-time, fixed payment for certain services that are excluded from the capitation rate setting process) or non-risk payment for the managed care entity to identify eligible expenditures and properly claim 100% FMAP.

CHIP COVID-19 Coverage and Cost-Sharing Exemption. CMS states COVID-19 in vitro diagnostic testing and testing-related services are covered for all Medicaid and

¹ Specifically: individuals infected with tuberculosis; individuals eligible for family planning and related services; and individuals eligible as "medically needy" under Section 1902(a)(10)(C) and Subpart D, such as pregnant women.

CHIP enrollees from March 18, 2020, through the end of the declared emergency period. CMS clarifies that States do not need to submit a SPA to provide this CHIP coverage if the existing state plan already indicates that laboratory and radiological services are covered. States will need to submit a CHIP SPA to implement the exemption from cost-sharing requirements for these services that was provided in the Phase II legislation. We note, however, that States cannot impose cost-sharing on Native CHIP beneficiaries regardless of the status of any SPA. This is in accordance with existing federal protections for American Indian and Alaska Native under Medicaid law.

No Special Grant Awards for COVID-19 Testing Anticipated. CMS explains that States can apply for additional funds to cover allowable expenditures, including COVID-19 testing and related services, through a supplemental grant award. The agency does not intend to proactively issue special grant awards to states as part of any response funding.

CARES Act Unemployment Benefit Clarifications. CMS states that specific payments being made to eligible individuals and families under the CARES Act cannot be factored into any Medicaid or CHIP income eligibility determination. Excluded payments are limited to the \$600 weekly unemployment payment being distributed through the Federal Pandemic Unemployment Compensation program, and the "Recovery Rebates" being provided as advance tax credits/refunds by the Internal Revenue Service. Any payments received under these programs are not countable for income eligibility purposes. Other forms of unemployment compensation provided under the CARES Act, such as extended payment periods for general unemployment benefits, are not subject to this exception and can be treated as countable income.

FMAP. We note that while the FAQ includes a lengthy discussion of the 6.2% FMAP increase for States to cover certain COVID-19 related services, that percentage increase does not directly impact the Indian health system. The current 100% FMAP for services provided through an IHS or tribal facility continues to apply.

Disproportionate Share Hospital (DSH) Allotments. CMS clarifies that the CARES Act does not directly increase DSH payments. The Act instead delays the scheduled allotment reductions for fiscal years 2020 and 2021. For example, the Act eliminated the \$4 billion allotment reduction that would have taken effect on May 23 and delayed the start of the fiscal year 2021 allotment reduction until December 1, 2020.

III. CRS Publishes Report on the IHS and COVID-19

The Congressional Research Service (CRS) published a report this week entitled "COVID-19 and the Indian Health Service." It summarizes funding for the IHS by the three COVID-related bills enacted thus far this year. We have reported on these funds, the most recent report being April 13. The report also notes some specific challenges faced by the IHS/tribal healthcare system – workforce shortages, possible lack of ability to isolate COVID patients; Commissioned Corps personnel deployed away from IHS/tribal facilities;

and limited internet connectivity.

Two sources of funding not mentioned in the CRS report are:

- \$100 billion for healthcare providers to prevent, prepare for, and respond to coronavirus, including for expenses to reimburse, through grants or other mechanisms, obligations that have been incurred. The first \$30 billion of this funding has been distributed to Medicare providers based on FY 2019 FFS Medicare billings (excluding Medicare Advantage). Tribal health facilities were included in this funding distribution. The next round of funding qualifications are expected within the week and it likely will focus on rural and Medicaid providers. The TTAG has advocated to HHS that tribal healthcare providers be included in this second round of funding.
- \$8 billion allocated for tribal nations from a \$150 billion Coronavirus Relief Fund. Funds are for expenditures, including compensation for declining revenues, arising from the COVID-19 outbreak between March 1 and December 30, 2020. The Bureau of Indian Affairs and Treasury have solicited tribal input on the use and allocation of these funds, which could include health expenditures as allowable costs.

While the attached CRS report does not break new ground with regard to information, it is highly read on Capitol Hill and it is of value to see what is circulating on this important issue.

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If you have any questions or would like further information on the topics discussed in this report, 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).