



MEMORANDUM

April 29, 2020

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker, LLP

Re: *Restrictions on Use of Stimulus Funds by Tribal Health Programs*

As we have reported, Tribal health programs have received direct stimulus funding from the second and third stimulus bills—the Families First Coronavirus Response Act (Stimulus #2) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Stimulus #3). This funding came from two distinct sources:

- Indian Health Service (IHS) funding made available to Tribal health programs (\$64 million in the Families First Act, and at least \$450 million of the \$1.032 billion to the IHS in the CARES Act); and
- The \$100 billion in funding to the Department of Health and Human Services (HHS) for health care providers in the CARES Act.

The funding for each set of appropriations has different requirements.

This memorandum provides an overview of the different sets of restrictions for these distinct funding streams. Tribes should track expenditures from these funding streams separately and ensure compliance with the different sets of requirements.

I. Requirements for Funds from Direct IHS Appropriation in Families First Act and CARES Act

The IHS received \$64 million in stimulus funding from the Families First Coronavirus Response Act, and \$1.032 billion from the CARES Act, of which at least \$450 million had to be transferred to tribes operating under Title I or Title V agreements under the Indian Self-Determination and Education Assistance Act (ISDEAA). Each had its own set of requirements.

A. Families First Coronavirus Response Act: Testing Only

The Families First Coronavirus Response Act funding for the IHS states that it must be spent for coronavirus diagnostic testing. The funds are to be used for the following two purposes:

(1) An in vitro diagnostic test ... for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 ... and the administration of such a test

(2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

42 U.S.C. § 1320b-5 note, as amended.

The Families First Coronavirus Response Act specifies that the above-referenced services shall be provided:

without the imposition of any cost sharing requirements ... beginning on or after the date of this Act [March 18, 2020] to Indians (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) receiving health services the Indian Health Service, including through an Urban Indian Organization, regardless of whether such items or services have been authorized under the purchased/referred care system funded by the Indian Health Service or is covered as a health service of the Indian Health Service.

25 U.S.C. § 1621q note.

The \$64 million disbursed to the IHS under the Families First Coronavirus Response Act may only be used for HHS-approved testing for Indians. IHS guidance has made clear that any funds you received from this pot of funding that was not spent on coronavirus testing between March 18, 2020 and the end of FY 2022 must be returned to IHS.¹

HHS has also released [Terms and Conditions](#) for use of Families First Coronavirus Response Act funds, which generally provide 100 percent of Medicare rates for COVID-19 testing and related services. The Terms and Conditions require that:

¹ Indian Health Service, "Guidance on Indian Health Service COVID-19 Funding Distribution for Tribes, Tribal Organizations, and Urban Indian Organizations," (Apr. 27, 2020), https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/COVID-19_Funding_Guidance_Tribes_UrbanIndianOrganizations.pdf.

- The Recipient certifies that it is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.
- The Recipient certifies that it, or its agents, provided the COVID-19 Testing and/or Testing-Related Items and Services on the Recipient's claim form to the FFCRA Uninsured Individuals identified on the claim form; that the dates of service occurred on February 4, 2020, or later; and that all items and services for which Payment is sought were medically necessary. The Recipient also certifies that to the best of its knowledge, the patients identified on the claim form were FFCRA Uninsured Individuals at the time the services were provided.
- The Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. If the Recipient subsequently receives reimbursement for any items or services for which the Recipient requested Payment from the FFCRA Relief Fund, the Recipient will return to HHS that portion of the Payment which duplicates payment or reimbursement from another source. The Recipient will not include costs for which Payment was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.

In addition to making the above certifications, recipients must also consent to HHS publicly disclosing the payment received; may not balance bill patients; and must meet reporting requirements discussed below.

B. CARES Act: Preventing, Preparing for, and Responding to Coronavirus

The CARES Act IHS appropriation states that the funds must be used to:

prevent, prepare for, and respond to the coronavirus, domestically or internationally, including for public health support, electronic health record modernization, telehealth and other information technology upgrades, Purchased/Referred Care, Catastrophic Health Emergency Fund, Urban Indian Organizations, Tribal Epidemiology Centers, Community Health Representatives, and other activities to protect the safety of patients and staff....

Pub. L. 116-136, Title VII.

At least \$450 million is to be made available to Tribal health programs:

not less than \$450,000,000 shall be distributed through IHS directly operated programs and to tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act and through contracts or grants with urban Indian organizations under title V of the Indian Health Care Improvement Act ... *Provided further*, That amounts provided ... if transferred to tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act, will be transferred on a one-time basis and that these funds are not part of the amount required by 25 U.S.C. § 5325 [requiring payment of contract support costs], and that such amounts may be used for the purposes identified under this heading notwithstanding any other provision of law....

Id.

As a result, tribes must be able to show that they have used the funds to prevent, prepare for, and respond to the coronavirus. This would include, in our view, hiring new staff, paying salaries of furloughed employees, increasing Purchased/Referred Care (PRC) referrals, implementing new telehealth technologies and procedures, paying for increased administrative costs associated with the coronavirus response, and purchasing personal protective equipment (PPE) and other medical supplies to respond to the coronavirus.

Although the CARES Act does not explicitly state that the IHS funds can be used to make up for lost third-party revenues, we believe there is an argument they can be used for that purpose. The CARES Act allows the funds to be used to "respond to" the coronavirus. One of the direct effects of the coronavirus is that health programs have had to cancel much of the non-coronavirus-related primary and specialty care they provide, which has resulted in significant reductions in third-party revenues and significant cash flow issues for providers. We believe the "respond" language in the CARES Act IHS appropriation is broad enough to encompass any activity necessary to respond to the coronavirus, including using those funds to make up for the loss of third party revenues to maintain staffing levels so that you are "prepared" for a coronavirus outbreak, even if you have not experienced one yet, for example. However, it is important that you are able to demonstrate a link between the use of the funds and coronavirus response. We do not believe, for example, that the funds could be used to provide new or additional services to your patients that are not related to coronavirus.

CARES Act funding for facilities-type activities related to COVID-19 is available

until expended. The rest of the funding received under the CARES Act must be spent on activities between March 27, 2020 and the end of FY 2022.

The funds from the IHS under both stimulus bills were distributed directly to tribes through their Annual Funding Agreements (AFAs) (for Title I) and Funding Agreements (FAs) (for Title V). Although tribal health programs have considerable discretion to rebudget funding they receive from the IHS through their AFAs and FAs, the CARES Act specifically provides that "such amounts may only be used for the purposes identified under this heading notwithstanding any other provision of law." *Id.* We believe this language supersedes the rebudgeting authority in the ISDEAA tribal health programs have with regard to other funds they receive from the IHS.

II. Requirements for CARES Act \$100 Billion Provider Relief Fund Allocations

As we reported previously, HHS is disbursing the CARES Act's \$100 billion Provider Relief Fund in the following manner:

- \$50 billion General Allocation for Medicare facilities (\$30 billion of which has already been disbursed);
- \$400 million to IHS;
- \$10 billion for highly impacted hospitals;
- \$10 billion for rural health clinics and hospitals; and
- Remaining funds to be used for a variety of purposes, including for COVID-19 testing and treatment of the uninsured.

A. Statutory Terms and Conditions

For each of the allocations from the Provider Relief Fund, the statutory requirements of the CARES Act apply. The CARES Act provides that the purpose of the Provider Relief Fund monies is to:

prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus: *Provided*, That these 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; *Provided further*, That recipients of payments under this paragraph shall submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with conditions that are imposed by this paragraph for such payments, and such reports

and documentation shall be in such form, with such content, and in such time as the Secretary may prescribe for such purpose ... *Provided further*, That funds appropriated under this paragraph in this Act shall be available for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity....

Pub. L. 116-136, Title VIII.

The CARES Act, therefore, explicitly allows funds to be used for a health care provider's lost revenues attributable to coronavirus. The CARES Act also explicitly allows construction of temporary structures, leasing of properties, medical supplies and equipment including PPE, increased trainings, emergency operation centers, retrofitting facilities, and surge capacity.

However, the CARES Act provides that the Provider Relief Fund "may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse." *Id.*

As a result, you will not be eligible to use this funding to reimburse expenses or losses already paid for by another source. Indian health care providers have received funds through their direct appropriations from the IHS, and also received IHS specific stimulus funding from the Families First Coronavirus Response Act and the CARES Act. As a result, in order to receive funding from the \$100 billion in additional CARES Act Provider Relief Fund, you will have to be able to document that none of the expenses or losses covered by the Provider Relief Fund have already been covered by your regular IHS appropriation, the IHS specific stimulus funding, or the CARES Act funding based on Medicare payments (discussed in the next section). You will need to consult with your accountants and/or finance departments to ensure this is the case.

B. \$50 Billion Allocation for General Distribution to Medicare Providers

As discussed above, tribal health care providers that are Medicare providers received funding directly from HHS based on their 2019 Medicare billings. HHS is releasing those funds in two disbursements. The first disbursement was based on the first \$30 billion. You should have already received those funds. The second disbursement is based on the next \$20 billion, which HHS is currently disbursing.

There are different requirements for each disbursement. For the first set of funds, you need to access the HHS's attestation portal described below. For the second set of funds, you will need to access the attestation portal and a new General Distribution

Portal.

Terms & Conditions for the \$30 billion Distribution. HHS is requiring all providers who received funds based on Medicare billings to access a [CARES Act Provider Relief Fund Attestation Portal](#) where providers attest to receipt of the funds and agreement with HHS's [Terms and Conditions for the first \\$30 billion](#). Recipients that retain payments from the Provider Relief Fund for at least 30 days will be deemed to have accepted the Terms and Conditions for the first \$30 billion. The Terms and Conditions for the first \$30 billion provide that non-compliance with any term or condition is grounds for HHS to recoup some or all of the payment.

The Terms and Conditions for the first \$30 billion require that a recipient make several certifications. It must certify:

- That it billed Medicare in 2019; provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare; is not currently excluded from participation in Medicare, Medicaid, and other Federal health programs; and does not currently have Medicare billing privileges revoked;
- That payment will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the recipient only for health care related expenses or lost revenues attributable to coronavirus; and
- That it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.
- That all information it provides is true, accurate, and complete to the best of its knowledge.

The Terms and Conditions also provide that: "The Recipient acknowledges that any deliberate omission, misrepresentation, or falsification of any information contained in this Payment application or future reports may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment."

In addition to the certifications above, providers receiving funds from the Provider Relief Fund must also meet the reporting and record keeping requirements discussed below. Additionally, recipients are prohibited from seeking from patients any out-of-pocket expenses greater than what the patient would have been required to pay for in-network services for all care for a presumptive or actual case of COVID-19.

Terms and Conditions for the \$20 billion Distribution. In order to receive funds

from the second \$20 billion, tribal health programs will have to submit information to HHS through a new [General Distribution Portal](#). Instructions for applying are available [here](#); and HHS has also provided a detailed set of [FAQs](#),

In order to be eligible, you must have received funding from the first \$30 billion, and report that amount to HHS. You must also report estimated lost revenues from March and April of this year. The portal requires providers to submit your tax identification number and tax returns, and agree to meet [Terms and Conditions for the \\$20 billion](#). If you are a non-profit, the portal will ask you to provide your 990 form. If you are operating as a department of a Tribe and do not file federal tax returns, the process is not as clear. The portal does not directly address tax exempt governmental entities like tribal health programs. However, in an example, it states that state government providers can select tax exempt organization from the pull down menu and then provide the entity's audit report instead of a tax return. We believe tribal governments should be able to do the same thing, and upload their single agency audit report. The Health Resource Services Administration (HRSA) has said it is aware of the issue and looking into it.

Those Terms and Conditions are largely the same as for the \$30 billion that was previously disbursed. However, in addition to the requirements that applied to the \$30 billion, they also require recipients to submit general revenue data for calendar year 2018.

The Terms and Conditions also reiterate the language that the recipient acknowledges that deliberate omission, misrepresentation, or falsification can result in criminal, civil, or administrative penalties.

C. \$400 million Allocation for IHS

As previously reported, the HHS has designated \$400 million from the remaining \$70 billion in the Provider Relief Fund to the IHS. HHS has said that "[r]ecognizing the strain experiences by the Indian Health Service, \$400 million will be allocated for Indian Health Service facilities, distributed on the basis of operating expenses." We understand that this funding will be distributed directly to IHS and tribal facilities from HRSA, not through the IHS and existing ISDEAA agreements. However, as discussed below, such funds once received would become part of a tribe's AFA or FA and should be treated as statutory mandated grants added to the FAs under 42 C.F.R. § 137.60 et seq.

D. Allocation for Highly Impacted Hospitals and Rural Providers

HHS has not yet made available any additional terms and conditions that might apply to Provider Relief Fund monies distributed to rural providers and providers in high

impact areas. However, all such funds would have to meet the general statutory terms and conditions discussed above.

HHS has not yet announced which hospital and rural providers will receive these funds, or whether they will be subject to the same kind of attestation requirements and terms and conditions required for the other Provider Relief Fund allocations.

E. Reimbursements for the Uninsured

HRSA is taking the lead on reimbursing providers with monies from the Provider Relief Fund for testing and treatment of COVID-19 for the uninsured. For the purposes of CARES Act distributions, Congress has specified that an "uninsured individual" includes persons "not enrolled in a Federal health care program." 42 U.S.C. § 1396a(ss). Providers who have provided COVID-19 testing or treatment to uninsured patients on or after February 4, 2020 will be reimbursed at Medicare rates until funding is exhausted. It is unclear whether Tribal providers can participate in this program. We are working to clarify that point.

We think there is a good argument that IHS-eligible individuals with no other form of coverage should qualify as uninsured under the CARES Act because they are not "enrolled in" a federal health care program and therefore should meet the definition of "uninsured" that applies to CARES Act funding. 42 U.S.C. § 1396a(ss). Although IHS is a federal health program, individuals do not enroll in IHS care the way persons can enroll in Medicare, Medicaid, or other federal health care programs.

HRSA has established a [webpage](#) to provide information about this program. Sign-up for the program began on April 27, and claims may start to be submitted electronically on May 6 through the [COVID-19 Uninsured Program Portal](#). Payments are expected to be disbursed in mid-May.

HRSA's website states that to participate, providers must attest that they "have checked for health care coverage eligibility and confirmed that the patient is uninsured[, and] have verified that the patient does not have individual, employer-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse you for COVID-19 testing and/or care for that patient."

Although HRSA requires that "no other payer will reimburse" the care, there is an argument that IHS is not a "payer" that "reimburses" IHS or tribal providers for services. Rather, IHS distributes appropriations for the care of IHS-eligible individuals. Thus, we believe there is an argument that IHS-eligible individuals with no other form of coverage should qualify as uninsured with regards to the required HRSA attestation. However, we are working to clarify this point.

HHS has released [Terms and Conditions for the Uninsured Relief Fund](#). Those Terms and Conditions require that:

- The Recipient certifies that it is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.
- The Recipient certifies that it, or its agents, provided the items and services on the Recipient's claim form to the Uninsured Individuals identified on the claim form; that the dates of service occurred on February 4, 2020, or later; and that all items and services for which Payment is sought were medically necessary for care or treatment of COVID-19 and/or its complications. The Recipient also certifies that to the best of its knowledge, the patients identified on the claim form were Uninsured Individuals at the time the services were provided.
- The Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. If the Recipient subsequently receives reimbursement for any items or services for which the Recipient requested Payment from the Relief Fund, the Recipient will return to HHS that portion of the Payment which duplicates payment or reimbursement from another source. The Recipient will not include costs for which Payment was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.

Additionally, the recipient must consent to HHS publicly disclosing the payment; attest that all information submitted is true, accurate, and complete to the best of its knowledge; and agree to abide by the reporting and record-keeping requirements discussed below.

The Terms and Conditions further state that: "The Recipient acknowledges that any deliberate omission, misrepresentation, or falsification of any information contained in a request for reimbursement or future report may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment."

F. Reporting and Record-keeping Requirements for the Provider Relief Fund

All of the Terms and Conditions released by HHS to date include the following reporting and record-keeping requirements:

- The Recipient shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients.
- Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee a report. This report shall contain: the total amount of funds received from HHS under one of the foregoing enumerated Acts; the amount of funds received that were expended or obligated for each [sic.] project or activity; a detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.
- The Recipient shall maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

In addition to these requirements, tribal health programs should ensure they are meeting the requirement that the funds are not being used for losses or expenses covered by another source of funds, as discussed above.

III. General Requirements for the Use of Funds in ISDEAA

As discussed above there are two separate sets of funds tribes have received:

funds from the IHS that were distributed through an AFA or FA, and funds from the HHS, which have been distributed in several different ways.

Funds received directly from IHS through an AFA or FA must meet the terms of the Families First Coronavirus Response Act (for the first round of funding out of the \$64 million), and the terms of the CARES Act (for the next two rounds of funding out of the \$1.032 billion). In addition, they must also comply with the terms of the tribe's AFA or FA and the ISDEAA.

Tribes generally have broad discretion as to how they may use funds received through an FA, with ISDEAA providing that a tribe:

may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a funding agreement ... and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under applicable Federal law.

25 U.S.C. § 5386(e).

Funds received by a tribal health program from HHS from the \$100 billion Provider Relief Program will be transferred directly to tribal accounts bypassing IHS. Given the terms and conditions and reporting requirements that tribes and tribal organizations must agree to for receipt and use of the funds, it is likely that these funds will be treated as statutory mandated grants under regulations at 42 C.F.R. § 137.60, et seq. even if a grant instrument as such is not used to disperse the funds. The terms, conditions, and reporting requirements for receipt of the funds will govern their use rather than ISDEAA requirements. Thus, for example, the funds may not be reallocated or redesigned and reporting requirements will not be the same as ISDEAA reporting requirements. The regulations do provide for Federal Tort Claims Act coverage in carrying out these awards even though they are not awarded under the ISDEAA and ISDEAA statutory requirements do not apply.

IV. Conclusion

For additional information, please contact Elliott Milhollin (emilhollin@hobbsstrauss.com or 202-822-8282), Geoff Strommer (gstrommer@hobbsstrauss.com or 503-242-1745), or Akilah Kinnison (akinnison@hobbsstrauss.com or 202-822-8282).