Guidance on Indian Health Service COVID-19 Funding Distribution for Tribes, Tribal Organizations, and Urban Indian Organizations

This document provides guidance regarding Indian Health Service COVID-19 funding distributions to tribes and tribal organizations with Indian Self-Determination and Education Assistance Act Title I contracts or Title V compacts and urban Indian organizations with Indian Health Care Improvement Act Title V contracts. This is general guidance, and if there is a question of legal interpretation, then tribes, tribal organizations and urban Indian organizations should contact their legal counsel for further legal guidance. This document will be updated if additional IHS funding is identified and transferred through Indian Self-Determination and Education Assistance Act agreements or Indian Health Care Improvement Act contracts.

Families First Coronavirus Response Act

The Families First Coronavirus Response Act (Pub. L. No. 116-127) enacted on March 18, 2020, authorizes $64 million in new resources to respond to COVID-19 in American Indian and Alaska Native communities. On March 27, 2020, the IHS issued a letter to tribal and urban Indian organization leaders announcing the availability of and distribution decisions for this and other funding. From this amount, the IHS allocated:

- $61 million to IHS federal health programs and tribes and tribal organizations with Indian Self-Determination and Education Assistance Act agreements, using the existing distribution methodology for program increases in hospitals and health clinics funding.
- $3 million to urban Indian organizations through existing Indian Health Care Improvement Act contracts by providing a base amount for each organization and an amount based on each organization's urban Indian users.

The purpose of the Families First Coronavirus Response Act funding is limited and can only be used for COVID-19 related items and services for Indians as identified in section 6007 of division F of the Families First Coronavirus Response Act, which says it is for "COVID–19 related items and services as described in paragraph (1) of section 6001(a) (or the administration of such products) or visits described in paragraph (2) of such section furnished during any portion of the emergency period . . . ." The items and services described in section 6001(a), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act, are:

> ''(1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test, that—
>
> > ''(A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);
> > ''(B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–

3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
''(C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or
''(D) other test that the Secretary determines appropriate in guidance.''.

(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.

Therefore, funds awarded under the Families First Coronavirus Response Act must be used for Indians for either (1) or (2) above. If the funds are not used for these purposes during the period of availability, then they must be returned to the IHS. The Families First Coronavirus Response Act funding is available for fiscal years 2020-2022. Obligations for funds can begin on March 18, 2020, and are not available retroactively.

Coronavirus Aid, Relief, and Economic Security Act

The Coronavirus Aid, Relief, and Economic Security Act (Pub. L. No. 116-136), also known as the CARES Act, authorizes more than $1 billion in additional resources for COVID-19 response activities through the IHS. In letters to tribal and urban Indian organization leaders dated April 3, 2020, and April 23, 2020, the IHS announced distribution of $785 million in new resources to address COVID-19 prevention, preparedness, and response in American Indian and Alaska Native communities. The remaining $247 million in CARES Act resources will be managed centrally at the IHS Headquarters. Additional information on these resources can be found in the letter dated April 23, 2020. The IHS allocated:

- $415 million to IHS federal health programs and tribes and tribal organizations, using existing distribution methodologies for program increases in hospitals and health clinics, alcohol and substance abuse, and mental health funding.
- $155 million to IHS federal health programs and tribes and tribal organizations for Purchased/Referred Care, which is allocated using the Purchased/Referred Care distribution formula for new funds.
- $115 million to IHS federal health programs and tribes and tribal organizations for COVID-19 facilities-type activities. This includes $74 million for medical equipment and $41 million for maintenance and improvement, which are allocated using existing formulas for each program.
- $50 million to IHS federal health programs and tribes and tribal organizations, using existing distribution methodologies for program increases in community health representatives and public health nursing funding.
- $50 million to urban Indian organizations through existing Indian Health Care Improvement Act contracts by providing a one-time base amount for each organization and an additional amount based on each organization's urban Indian users.

The CARES Act specifies that the funding can be used:

> to prevent, prepare for, and respond to 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:

The portion of funds allocated for facilities-type activities are further restricted (e.g., to purchase medical equipment to prevent, prepare for, and respond to coronavirus).

If the funds are not used for these purposes during the period of availability, then they must be returned to the IHS. The majority of CARES Act funding is available for fiscal years 2020-2021. Only the portion of funds allocated for COVID-19 facilities-type activities (i.e., equipment and maintenance and improvement) are available until expended. However, it is important to note that funds may only be spent for COVID-19 and would need to be used within the reasonable period surrounding the public health emergency. If a tribe or tribal organization foresees an issue with expending these resources for COVID-19 related purposes within a reasonable period, it should contact IHS. Obligations for funds can begin on March 27, 2020, and are not available retroactively.

Guidance for both Families First Coronavirus Response Act and CARES Funding Awarded to Tribes and Tribal Organizations

Tribal health programs receive the funding resources described above as one-time, non-recurring funds through unilateral modifications to their existing Indian Self-Determination and Education Assistance Act agreements. These funds must be used for the purposes for which they were appropriated and tribes and tribal organizations should track the funds separately from their other revenue. In addition, eligible contract support costs (to the extent applicable) are available for these funding resources. During future contract support costs reconciliation, the IHS will be asking how tribes and tribal organizations spent the funds in order to negotiate eligible contract support costs.

If the authorized COVID-19 activities are not covered by a tribe or tribal organization's current Indian Self-Determination and Education Assistance Act agreement, but the tribe or tribal organization wants to carry them out, then the IHS and the tribe or tribal organization should discuss amending the Indian Self-Determination and Education Assistance Act agreement to carry out these programs, services, functions, or activities. Lastly, if the tribe or tribal organization cannot use, does not want to use, or does not agree to use the funding for its required purposes, then the tribe or tribal organization must return the funds. Please work with your Indian Self-Determination and Education Assistance Act point of contact, e.g. agency lead negotiator, Title I self-determination specialist, etc. to complete this action.

Guidance for both Families First Coronavirus Response Act and CARES Funding Awarded to UIOs

Urban Indian organizations receive the funding resources described above as one-time, non-recurring funds through bi-lateral modifications to their existing Indian Health Care Improvement Act contracts. These funds must be used for the purposes for which they were appropriated, consistent with a modified scope of work for each Indian Health Care Improvement Act contract. Urban Indian organizations should track the funds separately from their other revenue.

COVID-19 TRIBAL HEALTH CARE FUNDING CHART 6-18-20

CDC Noncompetitive Tribal Grants—$80 million			
Source: Coronavirus Preparedness Response Supplemental Appropriations Act, P.L. 116-123 **Enacted:** March 6, 2020	**Administering Agency:** CDC No cost sharing or matching funds required.	**Expenditure Deadline:** The budget period length is 12 months.	**Distribution:** Application deadline was May 31, 2020; estimated award date June 10, 2020
Purpose and Permitted Uses: Emergency funding to contracting and compacting tribes, tribal organizations, and consortia According to CDC's Notice of Funding Opportunity, permissible uses include: • Emergency operations and coordination • Health Information Technology • Laboratory capacity • Communications • Countermeasures and mitigation • Recovery activities • Other preparedness and response activities to COVID-19	**Terms and Conditions:** CDC expects the following to be included in post-award monitoring— • Tracking recipient progress in achieving the desired outcomes. • Ensuring the adequacy of recipient systems that underlie and generate data reports. • Creating an environment that fosters integrity in program performance and results Monitoring may also include— • Ensuring that work plans are feasible based on the budget and consistent with the intent of the award. • Ensuring that recipients are performing at a sufficient level to achieve outcomes within stated timeframes. • Working with recipients on adjusting the work plan based on achievement of outcomes, evaluation results and changing budgets. • Monitoring performance measures (both programmatic and financial) to assure satisfactory performance levels.	**Reporting Requirements:** CDC will conduct virtual compliance visit between 6 months and a year after award.	**Other notes:** Tribes should be sure to follow the more detailed requirements in any grant award notice. This is a broad source of funding because permissible expenditures include preparedness and response activities to the current COVID-19 pandemic. For more information, see CDC's grant opportunity and FAQ.

COVID-19 TRIBAL HEALTH CARE FUNDING CHART 6-18-20

Families First Coronavirus Response Funds: Testing Only—$64 million			
Source: Families First Coronavirus Response Act, P.L. 116-127 **Enacted:** March 18, 2020	**Administering Agency:** IHS	**Expenditure Deadline:** September 30, 2022	**Distribution:** Funds have been distributed
Purpose and Permitted Uses: Direct appropriation to IHS for COVID-19 Testing Funding may only be used for Indians, as defined in section 4 of the Indian Health Care Improvement Act, for: (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.	**Terms and Conditions:** Funds were distributed through Annual Funding Agreements (for Title I) and Funding Agreements (for Title V). Funds must be used for the COVID-19-related purposes for which they were appropriated. Funds must also meet the requirements of Annual Funding Agreements or Funding Agreements. If the COVID-19 related activities are not part of the scope of work of your annual funding agreement or funding agreement, you will need to amend your scope of work to cover the activity. IHS will also negotiate contract support costs for this funding, as applicable.	**Reporting requirements:** IHS guidance requires these funds to be tracked separately from other revenue.	**Other Notes:** This is a narrow source of funding that may only be used for testing and for items and services provided during a visit that results in a test. Any unused funds must be returned to IHS. More information is available in IHS's March 27, 2020 DTLL. IHS Guidance is available here.

COVID-19 TRIBAL HEALTH CARE FUNDING CHART 6-18-20

CARES Act IHS Direct Appropriation—$1.032 billion			
Source: Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L 116-136 **Enacted:** March 25, 2020	**Administering Agency:** IHS	**Expenditure Deadline:** Facilities-type funding available to IHS until expended. All other funding must be spent by September 30, 2021	**Distribution:** Funds have been distributed
Purpose and Permitted Use: To prevent, prepare for, and respond to COVID-19 Permissible uses include 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. The statute allowed IHS to transfer $125 million to the Facilities Account, and tribes may use those funds for medical equipment needs and maintenance and improvement according to IHS's April 23, 2020 DTLL.	**Terms and Conditions:** Funds were distributed through Annual Funding Agreements (for Title I) and Funding Agreements (for Title V). Funds must be used for the COVID-19-related purposes for which they were appropriated. Funds must also meet the requirements of Annual Funding Agreements or Funding Agreements. If the COVID-19 related activities are not part of the scope of work of your annual funding agreement or funding agreement, you will need to amend your scope of work to cover the activity. IHS will also negotiate contract support costs for this funding, as applicable.	**Reporting requirements:** IHS guidance requires these funds to be tracked separately from other revenue.	**Other notes:** For more information, see IHS's April 3, 2020 DTLL and April 23, 2020 DTLL. IHS Guidance is available here.

COVID-19 TRIBAL HEALTH CARE FUNDING CHART 6-18-20

Provider Relief Fund—$175 billion			
Source: Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L 116-136 **Enacted:** March 25, 2020 **Funds Supplemented:** Paycheck Protection Program and Health Care Enhancement Act, P.L. 116-139 (April 24, 2020)	**Administering Agency:** HHS HHS has allocated some funds to IHS. Other funds are distributed through HRSA.	**Expenditure Deadline:** None.	**Distribution:** First $50 billion has been distributed through a general distribution based on Medicare billings from 2019 and 2018 The remainder of the fund is being distributed on a rolling basis through targeted distributions as discussed below.
Purposes and Permitted Uses: to prevent, prepare for, and respond to coronavirus, for necessary expenses to reimburse, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus; for health care related expenses or lost revenues that are attributable to coronavirus; building or construction of temporary structures; leasing of properties; medical supplies and equipment; increased workforce and trainings; emergency operation centers; retrofitting facilities; and surge capacity. According to HHS's FAQs: • Every patient is considered a possible or actual case of coronavirus. Therefore, provider relief fund dollars can be used for all patients and are not limited to those who test	**Terms and Conditions:** Recipient 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 or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health programs; and does not currently have Medicare billing privileges revoked. 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. Recipient 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.	**Reporting Requirements:** Using the Attestation Portal, recipients must attest within 90 days that funds have been received. HHS FAQs confirm that providers receiving more than $150,000 in COVID-19 related funds will NOT have to submit reports to the HHS Secretary and Pandemic Response Accountability Committee within 10 days of end of each calendar quarter. HHS is going to prepare reports that meet that requirement. HHS will require additional reporting at a future date.	**Other Notes:** This is the only COVID-19 funding that specifically states it may be used for revenue replacement. Deliberate false information on an application may be punishable by criminal, civil, or administrative penalties. Failure to comply with terms and conditions can make funds subject to recoupment. For more information, see HHS's FAQs.

positive for or are suspected of having COVID-19 • Healthcare related expenses attributable to coronavirus is a broad term and can include: ○ supplies used to provide healthcare services for possible or actual COVID-19 patients; ○ equipment used to provide healthcare services for possible or actual COVID-19 patients; ○ workforce training; ○ developing and staffing emergency operation centers; ○ reporting COVID-19 test results to federal, state, or local governments; ○ building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and ○ acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery. • Lost revenues attributable to coronavirus may include revenues losses associated with	All information is true, accurate, and complete to the best of its knowledge. 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. Recipient consents to HHS publicly disclosing payment. Recipient will not seek to collect out-of-pocket expenses greater than patient would have to pay if care was provided in-networks. Retaining payment for at least 90 days without contacting HHS regarding remittance of funds is deemed to be acceptance of the Terms and Conditions.		

fewer outpatient visits, cancelled elective procedures or services, increased uncompensated care. • May be used to cover any cost the lost revenue would have covered. This can include, without limitation: employee or contractor payroll; employee health insurance**; r**ent or mortgage payments**; e**quipment lease payments**; e**lectronic health record licensing fees			
General Provider Relief Distribution—$50 billion • Initial distribution $30 billion (April 10–17) • Additional distribution $20 billion (started April 24) for eligible providers who submitted tax documents and financial loss estimates by June 3 • For providers that billed Medicare FFS in CY 2019		• Must meet Provider Relief Fund Terms and Conditions above and must also certify that the provider billed Medicare fee-for-service in 2019. • All providers who automatically received funds prior to 5:00pm, Friday, April 24, 2020 must provide an accounting of their annual revenues by submitting tax forms or financial statements and must agree to Terms and Conditions, both of which can be done through the General Distribution Portal.	
IHS Relief Fund—$500 million • Allocated May 29 • Hospitals: $2.81 million + 3% of total operating expenses		• Clinics: $187,000 + 5% (estimated service pop x avg cost per user) • UIOs: $181,000 + 6% (estimated service pop x avg cost per user) • Must meet Provider Relief Fund Terms and Conditions above • Funding automatically transferred based on formula.	
Uninsured Relief Fund—no set amount • For providers who treated uninsured COVID-19 patients on or after February 4, 2020 • HRSA's FAQs currently state that individuals who receive services through the Indian health system are not uninsured individuals for the purposes of this targeted allocation. • Reimbursement will be made for: specimen collection, diagnostic and antibody testing; testing-related visits; treatment; an FDA-approved vaccine once available. • Reimbursement must be requested through the COVID-19 Uninsured Program Portal.		• Must meet Provider Relief Fund Terms and Conditions above as well as certifying that: ○ Recipient will not engage in "balance billing" or charge any type of cost sharing for any items or services provided to Uninsured Individuals receiving care or treatment for a positive diagnosis of COVID-19 for which the Recipient receives a Payment from the Relief Fund. The Recipient shall consider Payment received from the Relief Fund to be payment in full for such care or treatment; and ○ If Recipient, prior to signing the Terms and Conditions, charged any Uninsured Individuals a fee for COVID-19-related care or treatment for which the Recipient subsequently	

COVID-19 TRIBAL HEALTH CARE FUNDING CHART 6-18-20

• For more information, see HRSA's FAQs.	received a Payment from the Relief Fund, the Recipient will communicate to the Uninsured Individuals that they do not owe Recipient any money for that care or treatment and will timely return the payment.
High Impact Relief Fund—$12 billion • Distributed May 7 to hospitals with 100 or more COVID-19 admissions Jan 1–Apr 10	• June 15 deadline for submissions for consideration for second round of distributions based on admissions Jan 1–June 10. • Must meet Provider Relief Fund Terms and Conditions above
Rural Relief Fund—$10 billion • Distributed May 6 • For acute care hospitals, CAHs, RHCs, and CHCs	• HRSA stated in call with IHS that rural tribal providers would qualify, but in fact no IHS/tribal providers received this funding. • Must meet Provider Relief Fund Terms and Conditions above
Skilled Nursing Facility Relief Fund—$4.9 billion • Allocated May 22 • For nursing facilities with 6 or more certified beds	• Payment will be $50,000 plus $2,500 per bed • Must meet Provider Relief Fund Terms and Conditions above
Safety Net Provider Relief Fund—$10 billion • Announced June 9 • For qualifying acute care facilities and children's hospitals • Acute care facilities must have: (1) a Medicare disproportionate patient percentage of 20.2% or greater; (2) annual uncompensated care of at least $25,000 per bed; and (3) a net operating margin of 3.0% or less.	• Eligibility is based on 2018 CMS cost report • Must meet Provider Relief Fund Terms and Conditions above

Medicaid & Chip Provider Relief Fund—approx. $15 billion
• Announced June 9. **Deadline to apply is July 20, 2020** and applications can be submitted through Enhanced Provider Relief Fund Payment Portal.
• Payment dependent on provider submission and will be at least 2% of revenue
• Must have directly billed Medicaid between January 1, 2018 and December 31, 2019
	• According to HHS's FAQs:
	  ○ Providers who received a General Distribution payment are not eligible
	  ○ Providers who received targeted distributions, such as from the IHS Relief Fund, are still eligible
	  ○ Providers at FQHCs are eligible so long as they meet other eligibility criteria, such as not having received a General Distribution
	• Must meet Provider Relief Fund Terms and Conditions above

COVID-19 TRIBAL HEALTH CARE FUNDING CHART 6-18-20

IHS Supplemental Testing Funds—$750 million			
Source: Paycheck Protection Program and Health Care Enhancement Act, P.L. 116-139 **Enacted:** April 24, 2020	**Administering Agency:** IHS	**Expenditure Deadline:** None.	**Distribution:** Funds began to be distributed in May 2020 and are distributed through bilateral modifications to existing ISDEAA agreements. Tribes will need to sign these modifications.
Purpose and Permitted Uses: For necessary expenses to develop, purchase, administer, process, and analyze COVID-19 tests, including support for workforce, epidemiology, use by employers or in other settings, scale up of testing by public health, academic, commercial, and hospital laboratories, and community-based testing sites, health care facilities, and other entities engaged in COVID-19 testing, conduct surveillance, trace contacts, and other related activities related to COVID-19 testing.	**Terms and Conditions:** Tribal health programs must provide a one-time spend plan, including an all-inclusive budget, as a condition of receiving the funds. Funds must be used for statutory purpose of testing-related activities. Recipients must also meet the requirements of their Annual Funding Agreements or Funding Agreements.	**Reporting Requirements:** Must submit a spend plan, including an all-inclusive budget, as a condition of receiving funds. According to the statute, the plan should include goals for the remainder of calendar year 2020, to include: (1) the number of tests needed, month-by-month, to include diagnostic, serological, and other tests, as appropriate; (2) month-by-month estimates of laboratory and testing capacity, including related to workforce, equipment and supplies, and available tests; and (3) a description of how tribe or tribal organization will use its resources for testing, including as it relates to easing any COVID-19 community mitigation policies.	**Other notes:** This is a narrow source of funding that can only be used for testing, contact tracing, and other testing-related expenses. For more information, see IHS's May 19, 2020 DTLL.