



November 30, 2021

Dear Tribal Leaders:

The Health Resources and Services Administration (HRSA) houses programs that provide equitable health care to people who are geographically isolated and economically or medically vulnerable. HRSA aims to increase opportunities to access and optimize the quality and performance of the tribal health system increasing the capacity of Indian Country to respond to the impact of disease burden among American Indian and Alaska Natives. HRSA and Indian Tribes share the goal of furthering the government-to-government relationship through true and meaningful consultation.

I would like to thank you again for your participation and recommendations during the HRSA Annual Tribal Consultation meeting, conducted via teleconference on October 8, 2021. To ensure HRSA's ongoing commitment to Indian Country, I am sharing this letter, which includes responses to the HRSA-specific questions and comments posed by tribal leaders during the consultation and through testimonies.

#### *Provider Relief Fund*

HRSA understands the concerns that tribes have raised regarding reporting requirements, administrative burden, and conditions related to using funds for Provider Relief Fund (PRF) payments. Many of these requirements are tied to statutory requirements<sup>1</sup> that HRSA must abide by, including the limitation that PRF payments may not be used to reimburse expenses or losses that other sources are obligated to reimburse. HRSA continues to explore ways to mitigate provider administrative burden while ensuring accountability of funds.

With respect to the feedback regarding updates to the PRF Frequently Asked Questions page and reporting guidance, HRSA received substantial feedback from providers requesting additional clarification on a wide variety of issues since the inception of the PRF. HRSA endeavored to respond to these requests by providing additional guidance and clarification through updates to the Frequently Asked Questions page. In addition, there have been some legislative changes that have necessitated changes to Frequently Asked Questions.

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<sup>1</sup> Funding administered by the PRF is subject to the following legislation:

- *The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Public Law 116—136, 134 STAT. 563 (2020)*
- *Paycheck Protection Program and Health Care Enhancement Act (PPHCEA), Public Law 116—136, 134 STAT. 622 (2020)*
- *The Consolidated Appropriations Act of December 27, 2020 (CRRSA), Public Law 116—123, 134 STAT. 149 (2020)*
- *Families First Coronavirus Response Act (FFCRA), Public Law 116—127, 134 STAT. 182 (2020)*
- *The American Rescue Plan Act (ARPA), Public Law 117—2, 135 STAT. 236 (2021)*

HRSA acknowledges the tribes' request, that formal announcements related to the PRF be disseminated to tribal leaders through formal Dear Tribal Leader Letters and will strive to implement this going forward.

HRSA is currently observing a 60-day grace period for Reporting Period 1 to help providers comply with their PRF reporting requirements.<sup>2</sup> Providers will not be subject to enforcement actions if they complied with PRF reporting requirements by November 30, 2021. Providers who fail to submit a completed report by the end of the 60-day grace period on November 30, 2021, may be subject to further enforcement actions, such as repayment or other debt collection activities. Providers subject to enforcement actions whose organizations do not comply may be added to a "do-not-pay list," which will impact their ability to receive and/or retain future PRF payments until the debt is cleared.

PRF funds can be used for health care-related expenses or lost revenues attributable to coronavirus. Providers have several options to report lost revenues. For more information on reporting requirements, visit the PRF Reporting webpage at: <https://www.hrsa.gov/provider-relief/reporting-auditing>. HRSA encourages all tribes to make sure they have reviewed these materials before finalizing their reporting. HRSA cannot approve any extensions on the use of funds deadlines or the reporting grace period for any providers or tribes. All unused funds must be returned to the government within 30 calendar days after the end of the applicable Reporting Time Period or associated grace period. Please see the table below for the applicable deadline to use and report on PRF funds.

<b>Period</b>	<b>Payment Received Period (Payments Exceeding \$10,000 in Aggregate Received)</b>	<b>Deadline to Use Funds</b>	<b>Reporting Time Period</b>
Period 1	April 10, 2020 to June 30, 2020	June 30, 2021	July 1, 2021 to September 30, 2021*
Period 2	July 1, 2020 to December 31, 2020	December 31, 2021	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	June 30, 2022	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	December 31, 2022	January 1, 2023 to March 31, 2023

\* Grace period until November 30, 2021

During the consultation, I also shared information regarding two additional funding opportunities available under the PRF Phase 4 General Distribution and American Rescue Plan Rural Distribution. HRSA conducted four webinars to assist providers with the application process. The application portal is now closed, and we hope many tribal organizations applied for these funding opportunities. HRSA issued the first round of ARP Rural payments on November 23, 2021. As of November 23, 2021, a total of more than \$38 million in ARP payments has been awarded to more than 50 tribal providers across 11 states.

<sup>2</sup> For more information regarding PRF Reporting Period deadlines and requirements, please see the June 11, 2021 Post-Payment Notice of Reporting Requirements at: <https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-post-payment-notice-of-reporting-requirements-june-2021.pdf>.

### *Uninsured Program*

In response to the request for American Indian/Alaska Native people to be added as eligible for HRSA's Uninsured Program, the Uninsured Program defines uninsured individuals as people who do not have health coverage at the time health services were provided. Relatedly, the Uninsured Program may not reimburse providers for care that has been reimbursed from other sources or that other sources are obligated to reimburse. Before submitting a claim, providers must have verified that the patient does not have coverage through an individual or employer-sponsored plan, a federal health care program, or the Federal Employees Health Benefits Program at the time services were rendered, and no other payer will reimburse providers for COVID-19 vaccination, testing and/or care for that patient. Since Indian Health Service (IHS) is a federal health program, IHS beneficiaries are not eligible for the uninsured program. HRSA has not declared IHS benefits to be health insurance; rather the Uninsured Program distinguishes only between people who have or do not have health coverage. IHS, Tribal, and Urban Indian may submit claims for reimbursement for testing, treatment, and vaccine administration they provide to non-IHS, Tribal, and Urban Indian beneficiaries who otherwise meet the definition of "uninsured individuals" in the Terms and Conditions of the Uninsured Program.

### *Health Workforce*

During the consultation, we received feedback on provider shortage and burnout, National Health Service Corps placements within Indian health care facilities, and additional funding to support Teaching Health Centers Graduate Medical Education (THCGME) program for community-based IHS and tribal medical residency programs, general public health scholarships and tribal set-asides to strengthen the health care workforce in Indian Country. HRSA understands the longstanding challenges regarding the workforce and how they have been exacerbated by the pandemic. I want to assure you that HRSA remains dedicated to addressing provider resiliency and burnout among all health care professionals and issued funding opportunities to address these issues. HRSA received over 430 applications across three funding opportunities, demonstrating a great need in this area. Our Bureau of Health Workforce will award recipients as quickly as possible, and HRSA is looking for opportunities to strengthen this area further. As part of this activity, HRSA intends to work with grant recipients and their partners to develop a national provider resiliency network to share resources, best practices, and lessons learned to address this widespread challenge. HRSA and tribes/tribal organizations will continue to work together on outreach to encourage sites to come in for these applications.

Additionally, HRSA released three funding opportunities to expand the Teaching Health Center program with appropriations from Section 2604 of the American Rescue Plan Act of 2021 (P.L.117-2). The Teaching Health Center program is an innovative program that funds community-based training of physicians and dentists rather than the traditional hospital-based graduate medical education programs. In Fiscal Year 2022, the Teaching Health Center Planning and Development program will provide up to \$25 million to support the development of approximately 50 new community-based residency programs across the country. In addition, an award of \$5 million will be made to a technical assistance center recipient that will provide support to the 50 new grantees. In Fiscal Year 2022, the THCGME Program will also provide up to \$46 million to support new and expanded resident full-time equivalent training in community-based primary care residency programs.

HRSA is also invested in increasing the participation of eligible and qualified community-based tribal entities in the THCGME program. We are exploring ways to increase the recruitment of providers interested in working in tribal communities, for example, reviewing and updating THCGME eligibility criteria. We also recognize the need to promote quality care and quality facilities to recruit and attract providers to work in rural areas. HRSA plans to raise this topic during our Tribal Advisory Committee meeting in December to garner feedback that can help further inform and steer additional approaches.

#### *Community Health Aide Uniform Data System Inclusion*

HRSA is aware of the concerns regarding the Community Health Aide and Practitioner (CHA/Ps) provider classification within the “Other Professional Services” measure instead of as a separate “provider” in the Uniform Data System (UDS). Tribal leaders stated that at health centers where CHA/Ps provide many primary-care associated services, the number of patients attributed to primary care providers looks lower, which makes health care delivery look high in UDS calculations for health centers with large numbers of CHA/Ps providing patient care. In addition, health centers with large numbers of CHA/Ps are at a disadvantage when applying for funding based on formulas that count medical visits but not CHA/P activity, even though CHA/Ps are certified, medically-trained providers whose certification and standards come from the Community Health Aide Program Certification Board, which is a Division of HHS and managed by IHS.

The federally-funded Community Health Aide Program (CHAP) oversees CHA/Ps. The CHAP was established to provide “effective, efficient, and patient-centered care” through Alaskan community-based providers.<sup>3</sup> CHA/Ps complete training and cultivate skills in providing health care, health promotion, and disease prevention services in rural Alaska and are now beginning to expand to additional states. The CHAP includes health professionals who work alongside licensed providers to offer patients increased access to quality care. However, a community health aide or community health practitioner may practice only under the medical supervision of a licensed physician or physician assistant.<sup>4</sup>

CHA/Ps are currently classified as “Other Professional Services” in UDS Table 5, Line 22, separate from UDS Table 5, Lines 1-10, which are for licensed independent medical providers:

- CHA/Ps are listed in Table 5 "Other Professional Services" based on credentialing and licensing requirements for providing medical care, as determined by national, standards-setting bodies that decide who should be included as a provider compared to a supporting clinical role. Because as CHA/Ps do not exercise independent clinical judgement in their provision of medical care services, they are classified alongside such professions as physical therapists, podiatrists, registered dietitians, and chiropractors as “Other Professional Services.” These criteria are not within the purview of HRSA; if these standards change, HRSA will adjust classifications in UDS.
- The licensed independent medical providers in UDS Table 5 specifically include the following: Family Physicians, General Practitioners, Internists, Obstetricians/Gynecologists, Pediatricians, Other Specialty Physicians, Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives. These independent

<sup>3</sup> [Indian Health Service – Community Health Aide Program](#)

<sup>4</sup> [2021 Community Health Aide Program Certification Board - Standards and Procedures](#)

medical providers are licensed health professionals who have obtained at least the minimum competencies and education for licensure set by a governing body (i.e., State Board).

Given that CHA/Ps may practice only under the medical supervision of a licensed clinician (physicians and physician assistants) and are not independently licensed, HRSA cannot independently make the requested change to the UDS. HRSA must align with nationally used definitions and terms, such as the taxonomy codes from the Centers for Medicare & Medicaid Services National Provider Identifier<sup>56</sup> standards maintained by the National Uniform Claim Committee. HRSA cannot create its own definitions but rather must align with what national organizations have determined to be clinical providers.

HRSA is currently reviewing how CHA/Ps are recognized across various federal programs and payors such as the Centers for Medicare and Medicaid Services (CMS) and IHS. Please note that while HRSA's UDS is a critical tool for measuring health center administrative and clinical performance, it does not play a role in reimbursement for services provided. CHA/Ps' current categorization under "Other Professional Services" does, however, ensure their FTEs, clinic visits, and virtual visits are captured in the UDS.

I also want to address a separate question regarding UDS reporting. Specifically, regarding supplemental facility data, a question was raised as to why a facility report indicates the number of patients being at 100 percent Federal Poverty Level and not 138 percent Federal Poverty Level. Health centers report their patients' poverty status using four categories of the federal poverty guidelines (100 percent and below; 101-150 percent; 151 - 200 percent; more than 200 percent) to reduce the reporting burden of completing the UDS.

Additionally, in response to the inquiry for a list on the HRSA website of dually funded I/T/U health facilities, HRSA will post the list of 35 dually-funded health centers on HRSA's Tribal Affairs [website](#) within the next few days.

### *Rural Health*

We appreciate the open dialogue and concerns raised regarding rural health grants not reaching Indian Country and the suggestion that non-competitive grants be provided to rural tribal health providers. In spring of 2020, after consultation with tribal leaders and IHS, HRSA successfully distributed \$16.3 million in CARES Act funds to 57 tribal health service providers based on need and capacity to respond to COVID-19 in rural tribal communities through the Rural Tribal COVID-19 Response Program. Information on the Rural Tribal COVID-19 Response tribal grant recipients and their projects can be found at <https://www.ruralhealthinfo.org/assets/4157-17812/tribal-covid-19-response-grantee-directory-2020.pdf>.

Additionally, HRSA awarded several tribal and tribal-serving grantees through the Rural Communities Opioid Response Program initiative. Through Rural Communities Opioid Response Program, grant recipients provided life-saving prevention, treatment, and recovery for

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<sup>5</sup> [CMS Provider Taxonomy Code](#)

<sup>6</sup> [CMS - Adopted Standards and Operating Rules](#)

opioid and other substance use disorder services, including medication-assisted treatment. We will explore how the health needs, including the identified health workforce needs, of rural tribal communities can continue to be met through HRSA's rural-specific legislative authority.

#### *340B Drug Pricing Program*

Regarding the concerns raised about manufacturers' restrictive practices against covered entities and their use of contract pharmacies, HRSA sent several [letters](#) to manufacturers alerting them that the matter was referred to the HHS Office of the Inspector General in accordance with the 340B Ceiling Price and Civil Monetary Penalty final rule. We are unable to provide additional information at this time due to pending litigation.

Additionally, on the recommendation that the Alternative Dispute Resolution (ADR) final rule be rescinded, republished as a proposed rule with opportunity to comment to better hold drug manufacturers accountable, HRSA continues to implement the 2020 ADR final rule and began accepting petitions from stakeholders on January 13, 2021, the effective date of the final rule. . To date, HRSA has received four complete ADR petitions submitted by covered entity organizations related to the contract pharmacy issue. We encourage all stakeholders to review the information on our [website](#) for more information about the ADR process. HRSA has proposed changes to the ADR rule which are with the Office of Management and Budget and the proposed changes will be shared publicly soon.

#### *Tribal Consultation and HRSA Tribal Advisory Council*

We are committed to holding meaningful consultations and as requested, will utilize the HRSA Tribal Advisory Council to aid in reviewing the [HRSA Tribal Consultation Policy](#) and setting the agenda for the HRSA Tribal Consultation. The first convening of the HRSA TAC will take place on December 1-2, 2021.

In closing, I thank you again for your participation at the HRSA Annual Tribal Consultation. As identified by tribal leaders, we will utilize the HRSA Tribal Advisory Council to help guide the agency on HRSA's consultation, programs, and funding. The agency will also look to have meaningful dialogue with Tribal Nations as we strive to develop programs that meet the unique needs in Indian Country.

Sincerely,

/S/

Diana Espinosa  
Acting Administrator