

Health Providers May Accept Provider Relief Fund Payments Without Knowing What They Signed Up For

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The outbreak of COVID-19 has taken a heavy toll on healthcare providers. Government mandates and stay-at-home orders halted many non-essential but revenue-generating procedures. Apprehension of the virus has also led patients to avoid hospitals and physician offices, postponing or foregoing care they would otherwise receive. At the same time, healthcare providers have seen increases in expenses due to the virus, more COVID-19 patients, and more expensive medical supplies and equipment. Caught between these two forces, revenue for many providers has dried up and some have been forced to close their doors.

The CARES Act

In an attempt to alleviate these revenue woes, on March 27, 2020 Congress passed the Coronavirus Aid, Relief and Economic Security (CARES) Act.ⁱ Among many other initiatives, the CARES Act created the Provider Relief Fund (PRF) and funded it with \$100 billion. This initial appropriation was meant to provide relief funds to “hospitals and other healthcare providers on the front lines of the coronavirus response”.ⁱⁱ In addition to this initial appropriation, on April 24, 2020 Congress passed the Paycheck Protection Program and Health Care Enhancements Act (CARES Act 2.0) and added another \$75 billion to the PRF, bringing the fund’s total size to \$175 billion.ⁱⁱⁱ The United States Department of Health and Human Services (HHS) administers distribution of the PRF and created two categories of payments: general allocations and targeted allocations. HHS rolled out these payments, especially the general allocations, with a swiftness fitting the dire need. However, this haste left many of the finer details of the program unclear, including the compliance requirements of providers who received the payments.

General Allocations under the Provider Relief Fund

The general allocations came in two waves. The first wave of \$30 billion in payments was deposited directly in the accounts of providers on April 10 and April 17, 2020. HHS did not solicit requests or process applications for these funds. Rather, to distribute the funds as quickly as possible, HHS used data already in hand, 2019 Medicare fee-for-service (FFS) revenue, and automatically distributed funds based on that data. These payments corresponded to approximately 6.6% of a provider’s 2019 Medicare FFS revenue.^{iv}

However, for many providers, Medicare FFS revenue represents a small percentage of overall revenue. For these providers, receiving 6.6% of their Medicare FFS revenue amounted to very little relative to their overall revenue and losses. To attempt to fill this gap, HHS released a second wave of \$20 billion in payments. These payments began on April 24, 2020 and went to the same providers who had received payments in the first wave. This second wave was based not on Medicare FFS revenue, but on

general revenue data. For providers who had previously submitted revenue data for providers in CMS cost reports, HHS automatically deposited a second payment in April 24, 2020. Providers who received payment in the first wave but had not previously submitted revenue data to CMS and HHS (and therefore did not receive an automatic payment in the second wave) were eligible to receive this second wave of funding via an application process through the PRF General Distribution Portal. To apply, a provider was required to supply, before June 3, 2020, to HHS: 1) its “gross receipts or sales” or “program service revenue” as listed in its most recent federal tax return; 2) its estimated lost revenue in March and April 2020 due to COVID-19; 3) a copy of its most recent federal tax return; and 4) the Tax Identification Numbers (TINs) of any subsidiaries that have received a PRF payment but that do not file separate tax returns.^v Additional payments under the second wave began after April 24, 2020 on a weekly, rolling basis.

The payments under the PRF are grants, not loans, and do not need to be repaid so long as the provider complies with a series of terms and conditions governing use of the payment. If a provider does not comply with the terms and conditions, HHS may seek recoupment of the payment.^{vi} HHS has indicated that there will be “significant anti-fraud and auditing work,” including by the HHS Office of Inspector General (OIG).^{vii} Statements made in connection with the payment may also trigger liability under the federal False Claims Act.^{viii} In addition to audits and liability after-the-fact, providers who accept payments from the PRF are required to submit periodic reports to HHS regarding use of the payments.

After receiving a payment, including an automatic payment, the provider must enter the PRF Payment Attestation Portal to accept or reject the payment and its term and conditions. A provider who received a payment under the first wave was required to accept the terms and conditions or contact HHS to remit the payment within 45 days of receiving the payment. A provider who does not enter the portal and affirmatively accept the term within 45 days shall be deemed by HHS to have accepted and shall be subject to the terms of the payment.^{ix} The time frame to accept or remit a payment in the second wave is 90 days from receipt of payment.^x Within the portal, the provider must certify that they are eligible to receive the payment, that they received the correct amount, and that they will comply with the reporting and recordkeeping requirements, as well as the limitations on the use of the payment.

Eligibility

A provider is eligible to receive a general allocation payment if it (1) billed Medicare in 2019, (2) provides or provided, after January 31, 2020, diagnosis, testing or care for individuals with possible or actual cases of COVID-19, (3) is not currently terminated, precluded, or excluded from Medicare, Medicaid, and other federal healthcare programs, and (4) does not currently have their Medicare billing privileges revoked.^{xi} For purposes of eligibility, HHS considers all patients to be possible cases of COVID-19.^{xii} The implication of these eligibility criteria is that a provider who billed Medicare in 2019 would have received a payment automatically. However, if such a provider ceased operation prior to January 31, 2020, they would not be eligible to retain the payment. Similarly, a provider who provided care after January 31, 2020, but who did not bill Medicare in 2019, did not receive a payment and is not eligible, even though they likely have the same need.

Correct Payment Amount

In the portal a provider must also certify that the total of all payments received through the PRF matches their estimated allocation. HHS intended that the total amount received by a provider under the PRF constitute approximately 2% of their 2018 patient revenue.^{xiii} However, in the first wave of payments,

providers received approximately 6.6% of their 2019 Medicare FSS revenue. Some providers who received the initial 6.6% were therefore later told that this amount far exceeded the total allocation they were supposed to receive. In this situation, HHS indicated that providers “should reject the entire General Distribution payment and submit the appropriate revenue documents” so that HHS could determine the correct payment.^{xiv}

Further adding to the confusion, HHS used the terms “net” and “gross” revenue interchangeably. Many policy sources referred to the general allocation payments as proportional to “net” revenue.^{xv} However, in practice, HHS collected documentation from providers on “Gross Receipts or Sales” and issued a formula to calculate a provider’s estimated total payment that relies on “Gross Receipt or Sales.”^{xvi} Likely responding to this inconsistency, HHS attempted to clarify that the payments are based on *the lessor of 2% of 2018 net patient revenue or the sum of incurred losses in March and April, 2020* and indicated that “If the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual patient revenue, you will not receive additional General Distribution payments.”^{xvii} This explanation did little to address the concerns of providers for whom 6.6% of 2019 Medicare FSS revenue far exceeds HHS’s 2% goal. Providers should carefully read the terms and formula they encounter in the portal for updates and consult with their counsel or accountant to address any concerns and ensure that they are entitled to any funds they receive.

Reporting and Recordkeeping Requirements

All recipients of PRF general allocation payments must comply with up to three reporting and recordkeeping requirements, which are contained in the payment’s term and conditions.

First, a recipient must agree to retain records in accordance with 45 CFR 75.302 and 45 CFR Sections 75.361 through 75.365 and make these available upon request to HHS and/or the OIG.^{xviii}

Second, a recipient must agree to submit periodic reports to HHS to ensure compliance with the terms and conditions. Although recipients agree to the terms and conditions of the PRF payments, HHS has not yet specified the format, content, or timing of these reports, but indicates that they would do so in the future.^{xix}

Third, the terms and conditions require any recipient of more than \$150,000 from any federal coronavirus relief effort to submit quarterly reports to HHS and the Pandemic Response Accountability Committee. This report must contain: 1) the total amount of funds received from HHS under all coronavirus relief efforts; 2) the amount of funds received that the provider expended or obligated for each project or activity; 3) 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 4) detailed information on any sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees.^{xx} However, HHS later released guidance indicating that separate quarterly reports were unnecessary because the public posting of payment amounts by provider satisfies the reporting requirements of the CARES Act.^{xxi} This guidance also indicated that HHS would at a later date “develop a report containing all information necessary for recipients of PRF payments to comply with this provision.”^{xxii}

Limitations on Use of Payment

The aspects of the PRF that have caused the most confusion are the limitations on the use of the PRF payment. The two primary use limitations are:

1. The recipient must certify 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.
2. The recipient must certify that the payment will only be used to prevent, prepare for, and respond to coronavirus and that the payment shall reimburse the recipient only for healthcare related expenses or lost revenues that are attributable to coronavirus.^{xxiii}

The first limitation is common in many federal relief programs and governs the priority of PRF funding. Where another source has reimbursed the provider for an expense, the provider must agree not to “double-dip” and use the PRF payment for that same expense. The most common application of this requirement be to providers receiving funds via the Paycheck Protection Program (PPP). If a provider received funding through the PPP and used it to cover some or all of payroll for a period, the provider may not use the PRF payments for the same payroll expenses. Similarly, if a source other than the PRF is obligated to reimburse the provider for an expense, the provider may not use the PRF payment for that expense. This term may imply that a provider who has business interruption or a similar insurance policy must file a claim and receive a denial notice before it can use the PRF payment toward an expense that the policy may cover.

The second term allows providers two options for using the PRF payment in their efforts “to prevent, prepare for and respond to coronavirus.” First, as part of these efforts, they may use it for “healthcare related expenses” attributable to coronavirus. This may include purchase of ventilators, personal protective equipment (PPE), and other similar costs directly attributable to providing healthcare services to patients with COVID-19. This also may allow providers to pay facility and personnel costs when treating patients with a COVID-19 suspected or confirmed diagnosis. Alternatively, providers may use payments to substitute for “lost revenue” that is attributable to coronavirus. This second option appears to be the primary policy purpose of the PRF as HHS has indicated that it “would like the [general allocation] to replace a percentage of a provider’s annual gross receipts, sales, or program service revenue.”^{xxiv}

In addition to these two primary limitations, HHS has included several others that are not specific to the PRF or the coronavirus. These include prohibitions on using the PRF payment for lobbying, executive pay in excess of \$197,300, providing abortions, conducting embryo research, promoting the legalization of controlled substances, maintaining or establishing a computer network that does not block access to pornography, ACORN funding, and needle exchanges.^{xxv}

Lastly, providers who accept the payment must agree not to engage in “balance billing” of COVID-19 patients. Providers must certify that “for all care for a presumptive or actual case of COVID-19,” they will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.^{xxvi} HHS has clarified that this term is *not* a ban on balance billing all patients, only those that are presumptive or actual cases of COVID-19.^{xxvii}

Compliance Strategy

HHS has also indicated that it does not intend to recoup the payment if the provider's lost revenue and increased expenses exceed the amount of the provider's PRF funding.^{xxviii} It is therefore important for the provider to thoroughly document both their lost revenue and their increased expenses. Lost revenue can be calculated year-over-year comparing actual revenue in 2020 to the same period in 2019, although comparing actual to budgeted or expected revenue since the beginning of the public health emergency may be more appropriate where a provider's business has changed significantly since early 2019.^{xxix} To document increased expenses, a provider may need to develop internal systems to track purchases of ventilators, PPE, necessary facility changes required for COVID-19 prevention, *etc.*

Additionally, because the PRF payment must only be used "to prevent, prepare for, and respond to coronavirus," it is equally important to document that any lost revenue or expenses are attributable to COVID-19. Providers may find it helpful to create a separate bank account to segregate the PRF payment from its operating revenues and document the fund's use in separate ledger.

Providers should be aware that HHS is publicly listing all providers who received a general allocation payment. The list includes the provider's name, state, city, and the amount received.^{xxx} The terms and conditions of the \$20 billion second wave (but not in the \$30 billion first wave) of payments included a provision that the provider consented to public disclosure of the payment and acknowledged that a third party might use that information to calculate the provider's revenue.^{xxxi}

Lastly, HHS has indicated that there is no appeals or dispute process for decisions made regarding the PRF payments.^{xxxii} Indeed, HHS is not taking direct inquiries from providers regarding payment amount, other than to remit the entire payment.^{xxxiii} This position arguably conflicts with due process, but it may be a symptom of the rapid rollout of the PRF payments and HHS may implement an appeals process at a later date.

Targeted and Additional Allocations

In addition to the general allocations described above, HHS has also announced a series of targeted allocations to be paid from the PRF: \$12 billion for COVID-19 high impact areas; \$10 billion for rural providers; \$500 million for the Indian Health Service; \$4.9 billion for skilled nursing facilities; \$10 billion for safety net hospitals; and \$15 billion for Medicaid and CHIP providers; and the creation of a new claims system to reimburse providers for COVID-19 treatment of the uninsured.^{xxxiv} Lastly, because only \$102.4 billion dollars^{xxxv} of the initial \$175 billion has been allocated, it is possible that further funds will be distributed as general allocation payments.

Conclusion

Providers must carefully weigh accepting payments from the PRF.^{xxxvi} While some cash-strapped providers would certainly welcome the influx of capital, there are strings attached. Moreover, the program was implemented with such speed that it is not always clear precisely what those strings are. The best way to remain in compliance with the PRF until more guidance is released is to document every expenditure made from the fund, avoid commingling the PRF payment with other funds, and follow the strict remittance rules. By accepting the payment, a provider opens itself to multiple compliance challenges, some of which it may not be able to fully analyze at the time. The risk is likely worth it for some, but every provider should consider their circumstance and needs when deciding whether to accept this payment.

ⁱ Pub. L. 116-136.

ⁱⁱ CARES Act Provider Relief Fund, Dept. of Health and Human Services (last updated June 17, 2020), <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html> (last accessed June 18, 2020).

ⁱⁱⁱ Pub. L. 116-139.

^{iv} CARES Act Provider Relief Fund: General Information, Dept. of Health and Human Services (last updated June 17, 2020), <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html> (last accessed June 18, 2020). The formula given by HHS for a provider to estimate their payment under this wave is to divide the provider's 2019 Medicare FFS revenue by 453 billion, then multiply by 30 billion. *Id.*

^v CARES Act Provider Relief Fund Frequently Asked Questions, Dept. of Health and Human Services (last updated June 17, 2020) <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html> (last accessed June 18, 2020).

^{vi} Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions, Dept. of Health and Human Services; Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions, Dept. of Health and Human Services.

^{vii} CARES Act Provider Relief Fund Frequently Asked Questions, *supra* (this answer added May 6, 2020).

^{viii} 31 USC §§ 3729 – 3733.

^{ix} *Id.*; Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions, *supra*. The period was initially within 30 days of receipt but was lengthened to 45 days. HHS Extends Deadline for Attestation, Acceptance of Terms and Conditions for Provider Relief Fund Payments to 45 Days, Dept. of Health and Human Services (May 7, 2020).

^x Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions, *supra*.

^{xi} Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions, *supra*; Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions, *supra*.

^{xii} "HHS broadly views every patient as a possible case of COVID-19." CARES Act Provider Relief Fund Frequently Asked Questions, *supra* (this answer added May 6, 2020).

^{xiii} "In general, providers can estimate payments from the General Distribution of approximately 2% of 2018 (or most recent complete tax year) patient revenue. To estimate your payment, use this equation: (Individual Provider Revenues/\$2.5 Trillion) X \$50 Billion = Expected Combined General Distribution. To estimate your payment, you may need to use 'Gross Receipts or Sales' or 'Program Service Revenue.'" *Id.* (this answer modified June 12, 2020)

^{xiv} *Id.* (this answer modified June 12, 2020)

^{xv} "\$50 billion of the Provider Relief Fund is allocated for general distribution to Medicare facilities and providers impacted by COVID-19, based on eligible providers' net patient revenue," CARES Act Provider Relief Fund, *supra*; "the whole \$50 billion general distribution is allocated proportional to providers' share of net patient revenue," *Id.*; "Payments are determined based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April." CARES Act Provider Relief Fund Frequently Asked Questions, *supra* (this answer modified June 12, 2020).

^{xvi} *Id.*

^{xvii} *Id.* (this response added May 14, 2020, modified June 12, 2020).

^{xviii} Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions, *supra*; Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions, *supra*.

^{xix} *Id.*; see also CARES Act Provider Relief Fund Frequently Asked Questions, *supra* (this response added June 2, 2020) ("All providers receiving Provider Relief Fund payments will be required to comply with the reporting requirements described in the Terms and Conditions and specified in future directions issued by the Secretary.").

^{xx} Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions, *supra*; Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions, *supra*.

^{xxi} CARES Act Provider Relief Fund Frequently Asked Questions, *supra* (this answer added June 13, 2020).

^{xxii} *Id.* (this answer added June 13, 2020).

^{xxiii} Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions, *supra*; Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions, *supra*.

^{xxiv} General Distribution Portal FAQs, Dept. of Health and Human Services.

^{xxv} *Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions*, supra; *Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions*, supra.

^{xxvi} *Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions*, supra; *Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions*, supra.

^{xxvii} *CARES Act Provider Relief Fund Frequently Asked Questions*, supra (this answer added May 6, 2020). “A presumptive case of COVID-19 is a case where a patient’s medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record.” *Id.* (this answer modified June 12, 2020).

^{xxviii} *CARES Act Provider Relief Fund Frequently Asked Questions*, supra (this answer added May 6, 2020).

^{xxix} HHS has approved both of these methodologies for calculating lost revenue for purposes of the Application Portal. *CARES Act Provider Relief Fund Frequently Asked Questions*, supra.

^{xxx} Dataset available at <https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6>.

^{xxxi} *Relief Fund Payment from Initial \$30 Billion General Distribution Terms and Conditions*, supra; *Relief Fund Payment from \$20 Billion General Distribution Terms and Conditions*, supra.

^{xxxii} *CARES Act Provider Relief Fund Frequently Asked Questions*, supra.

^{xxxiii} *Id.*

^{xxxiv} *CARES Act Provider Relief Fund: General Information*, supra.

^{xxxv} *CARES Act Provider Relief Fund Distribution Summary*, Dept. of Health and Human Services (June 12, 2020).

^{xxxvi} For the general allocations, HHS is no longer accepting modifications to applications. *CARES Act Provider Relief Fund Frequently Asked Questions*, supra (this answer modified June 12, 2020). For the targeted allocations, where circumstances change, HHS has advised providers to return the entire payment and call the Provider Support Line at (866) 569-3522 for guidance to receive the correct payment. *Id.* (this answer added June 13, 2020).