WINSTON & STRAWN LLP

CLIENT ALERT

HHS Distributes $30 Billion from CARES Act Provider Relief Fund

APRIL 13, 2020

On April 10, 2020, the U.S. Department of Health and Human Services ("HHS") announced an immediate infusion of $30 billion into the health care system through the CARES Act Provider Relief Fund. The funding is intended to be used to support health care-related expenses or lost revenue attributable to the COVID-19 outbreak, and to ensure uninsured Americans can get testing and treatment for COVID-19.

HHS' announcement comes on the heels of comments made by CMS Administrator Seema Verma earlier this week during a White House press briefing, wherein she recognized that health care providers are dealing with increased expenses related to the COVID-19 response (*e.g.*, establishing "hospitals without walls" for testing/screening) and are not performing essential services (*e.g.*, canceled elective surgery, moving to telemedicine with reduced payments). She further stated that while CMS' implementation of the Accelerated and Advanced Payment Program has resulted in a distribution of over $34 billion (with roughly 70 percent of the 25,000 requests processed in the past week), these are essentially "loans" to providers.

In contrast to Accelerated Payments, the $30 billion in grants is being distributed immediately—with payments (the "CARES Relief Payments") arriving via direct deposit beginning April 10, 2020—to eligible providers. The CARES Relief Payments are not loans and will not need to be repaid. However, providers absolutely need to understand the Terms and Conditions relating to the CARES Relief Payments (discussed in greater detail below). The CARES Relief Payments are NOT part of the CMS Accelerated and Advance Payment Program, through which providers can apply for loans against anticipated reimbursement based on past performance that must be paid back to CMS.

All facilities and providers that participated in the Medicare program and received Medicare fee-for-service ("FFS") reimbursements in 2019 are eligible for this initial rapid distribution of funds. The initial disbursement of $30 billion will go to the following entities and individuals:

- All facilities and providers that received Medicare FFS reimbursements in 2019 are eligible for this initial rapid distribution.
- Payments to professional practices that are part of larger medical groups will be sent to the group's central billing office.

- All CARES Relief Payments are made to the billing organization according to its Taxpayer Identification Number ("TIN").

As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.

CMS expects that this quick dispersal of funds will provide relief to both providers in areas heavily impacted by the COVID-19 pandemic and those providers who are struggling to keep their doors open due to healthy patients delaying care and canceling elective services.

This initial tranche of CARES Relief Payment distributions will be determined as follows:

- Providers will be distributed a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements in 2019. Note, the share does not include Medicare Advantage (managed care) payments.
- A provider can estimate their payment by dividing their 2019 Medicare FFS (not including Medicare Advantage) payments they received by $484 billion, and multiply that ratio by $30 billion. Providers can obtain their 2019 Medicare FFS billings from their organization's revenue management system.
- As an example: A community hospital billed Medicare FFS $121 million in 2019. To determine the amount it would receive, use this equation:

$$\$121,000,000/\$484,000,000,000 \times \$30,000,000,000 = \$7,500,000$$

If you are an eligible provider, the CARES Relief Payments will be distributed automatically as follows:

- HHS is using UnitedHealth Group ("UHG") to provide the CARES Relief Payments to providers.
- Providers will be paid via Automated Clearing House account information on file with UHG or the Centers for Medicare & Medicaid Services ("CMS").
- The automatic payments will come to providers via Optum Bank with "**HHSPAYMENT**" as the payment description.
- Providers who normally receive a paper check for reimbursement from CMS will receive a paper check in the mail for this payment as well, within the next few weeks.
- Within 30 days of receiving CARES Relief Payments, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment. The portal for signing the attestation will be open the week of April 13, 2020, and will be available on the HHS.gov website. HHS has also established a CARES Provider Relief line at (866) 569-3522.
- HHS' payment of this initial tranche of funds is conditioned on a health care provider's acceptance of the Terms and Conditions, which acceptance must occur within 30 days of receipt of payment. If a provider receives payment and does not wish to comply with these Terms and Conditions, the provider must contact HHS within 30 days of receipt of payment and then remit the full payment to HHS. HHS will provide instructions on how that repayment should be made in the future.
- The Terms and Conditions for CARES Relief Payments should be reviewed by providers in detail, but the certifications required from providers include the following:
  - Provider must certify that it: (i) billed Medicare in 2019; (ii) currently provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; (iii) is not currently terminated from participation in Medicare; (iv) is not currently excluded from participation in Medicare, Medicaid, and other federal health care programs; and (v) does not currently have Medicare billing privileges revoked;
  - Provider must certify that the payment will only be used to prevent, prepare for, and respond to coronavirus, and that the payment shall reimburse the provider only for health care-related expenses or lost revenues that are attributable to coronavirus;

- Provider 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;
- Provider shall submit reports as the HHS 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 HHS Secretary in future program instructions directed to all providers receiving CARES Relief Payments;
- 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 CARES Act, Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act, or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit a report to the HHS Secretary and the Pandemic Response Accountability Committee. 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 reach project or activity; and
  - A detailed list of all projects or activities for which large covered funds were expended or obligated, including: (i) 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 (ii) detailed information on any level of subcontracts 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
- Provider must also maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR § 75.302 (Financial Management) and 45 CFR § 75.361-75.365 (Record Retention and Access), and other information required by future program instructions to substantiate the reimbursement of costs under this award;
- Upon request, providers shall promptly submit copies of such records and cost documentation upon the request of the HHS Secretary, and provider agrees to fully cooperate in all audits the HHS Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions; and
- The Terms and Conditions also identify the relevant statutory provisions that apply, including limitations on use of funds for gun control advocacy, lobbying, abortion, embryo research, and legalization of controlled substances.

While these CARES Relief Payments are a significant infusion of cash for many facilities and providers, as discussed above, they are not without terms and conditions. Facilities and providers need to pay careful attention to the aggregation of coronavirus funds they receive and the tracking and reporting requirements. As additional information about those requirements becomes available, we will update this alert.

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For any questions regarding the impact of the CARES Act Provider Relief Fund payments, please contact Amandeep Sidhu (asidhu@winston.com), or your Winston relationship attorney. View all of our COVID-19 perspectives here. Contact a member of our COVID-19 Legal Task Force here.

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