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CARES Act Provider Relief Fund Infuses $30 Billion into Healthcare System

Update: On April 16, 2020, the HHS has officially launched the attestation portal, which can be found here. Clients that intend to keep funds from this stimulus are expected to complete the attestation within 30 days of receiving funds. In order to complete this attestation, you will need: Tax ID#, Bank Account Information (account number and routing number) and the amount of the grant received.

If you do not wish to comply with the Terms and Conditions of the grant, you may also return the funds to HHS within 30 days of receipt. Failure to return the funds will be viewed as acceptance of the Terms and Conditions. The instructions for returning funds have not been posted to the website at the time this White Paper has been written, but providers can call the CARES Provider Relief hotline at (866) 569-3522 for further instruction. Please complete this process promptly and reach out to your Practice Manager, if you have any questions about this process.

On March 27, 2020, President Trump signed the CARES Act, which provides $100 billion in relief funds to hospitals and other healthcare providers on the front lines of coronavirus response and is administered by the Department of Health and Human Services (HHS). The purpose of this funding is to support healthcare related expenses or lost revenue attributed to COVID-19, which is expected to ensure Americans access to treatment for COVID-19.

Beginning April 10, 2020, $30 billion is being distributed via direct deposit. These payments are not loans, but rather grants and will not need repaid. The amount of the grant is determined by a provider's share of total Medicare Fee for Service (FFS) reimbursements in 2019. Total FFS payments in 2019 were approximately $484 billion in 2019. To estimate payment, divide your practice's total 2019 Medicare FFS payments by $484 billion. Next, multiply that number by $30 billion. This will provide an estimate of your stimulus grant. It is also important to note that the Medicare FFS amount in the numerator is for only traditional Medicare payments and does not include monies from Medicare Advantage plans. HHS provides the following example of the calculation:

- A community hospital received Medicare FFS payments in 2019 of $121 million. The following shows their payment of this first wave of funding:

($121,000,000/$484,000,000,000) x $30,000,000,000 = $7,500,000

HHS is partnering with UnitedHealth Group to provide rapid payment to eligible providers via the Automated Clearing House (ACH) direct deposit. These payments are coming from Optum Bank with "HHSPAYMENT" as the description. Providers that normally receive their monies from CMS via paper check will have a payment sent over the next few weeks, according to the HHS website.

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Within 30 days of receiving payment, providers must sign an attestation to confirm receipt of the funds and indicating they agree with the Terms and Conditions. Attestations are expected to be accepted beginning April 13, 2020 and the attestation site is not available at the time this is being written. If a provider does not wish to comply with the terms and conditions, the provider must: contact HHS within 30 days of receipt of payment and then remit the full payment to HHS as instructed. The terms and conditions link includes 10 pages and you are encouraged to read through it thoroughly in order to ensure you comply. Some of the key terms and conditions are:

- The Recipient certifies that it billed Medicare in 2019; currently provides 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 care programs; and does not currently have Medicare billing privileges revoked.
- The Recipient certifies that the 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 that are attributable to coronavirus.
- 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.
- 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 reach 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,

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or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

- The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a possible or actual case of COVID-19, Recipient certifies that it 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 Recipient.
- SEC. 202. Executive Pay. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.
    - This is set at $192,300 per this reference.

There are many other conditions listed, which are mostly related to the spending of the monies, to ensure they are not used for special interests. In reading the conditions above, it is clear that practices will need to set-up strict tracking measures on these funds to ensure compliance and for future reporting.

There is still another $70 billion in grants that was appropriated to HHS for financial relief of hospitals and providers by the CARES Act. According to the HHS, the Administration is working on targeting distributions that will focus on providers in areas heavily impacted by the COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population, and providers requesting reimbursement for the treatment of uninsured Americans.

APS will continue to monitor the allocation of these funds and requirements placed upon providers who receive and keep the funds. We will provide updates to attestation processes as soon as the information is available. If you have any additional questions after review of this article and provided resources, please contact your Practice Manager.