Did you receive a deposit from HHS? Before you spend it, read this.

In addition to proceeds from the U.S. Small Business Administration's ("SBA") Payment Protection Program and the Centers for Medicare & Medicaid Services' ("CMS") Accelerated and Advance Payment Program, the U.S. Department of Health & Human Services ("HHS") recently deposited $80 billion into health care providers' bank accounts as part of its Provider Relief Fund. But unlike the SBA and CMS loans, HHS's distributions do not need to be repaid.

The Provider Relief Fund, part of the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, is a $100 billion program providing relief to health care providers based on their prior Medicare billings. Initially, as part of HHS's general allocation of funds, $26 billion was deposited into providers' accounts on April 10th, based on Medicare's 2019 billings. On April 17th, providers received an additional $4 billion. These payments are made to providers via Optum Bank with "HHSPAYMENT" as the description.

On April 24th, some providers were sent an advance payment based on the revenue data they submitted in CMS cost reports. Providers without adequate cost report data on file will need to submit their revenue information at https://www.hhs.gov/providerrelief to receive additional funds. Additional allocations of funds will be made separately for the following: (1) COVID-19 high impact areas; (2) treatment of the uninsured; (3) rural providers; (4) Indian Health Service facilities; and (5) skilled nursing facilities, dentists, and other providers who solely treat Medicaid patients.

But, beware…use of these funds requires meeting certain eligibility requirements and complying with other terms and conditions. Providers should follow the steps below upon receiving Provider Relief Fund proceeds.

Step One: Determine Eligibility

First, recipients must determine whether they are eligible to receive the funds.

HHS has provided the following eligibility requirements[1]:

- "All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution.
- Payments to practices that are part of larger medical groups will be sent to the group's central billing office.
    - All 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.
- 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 cancelled elective services.
- If you ceased operation as a result of the COVID-19 pandemic, you are still eligible to receive funds so long as you provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. Care does not have to be specific to treating COVID-19. *HHS broadly views every patient as a possible case of COVID-19* [emphasis added]."

Unfortunately, with regard to the balance billing prohibition, which appears to apply broadly to all patients (regardless of payor), CMS has not provided much clarity yet. According to Kaiser Health News, an HHS spokesperson stated the following with regard to this condition, "The intent of the terms and conditions was to bar balance billing for actual or presumptive COVID-19. We are clarifying this in the terms and conditions."[2] Thus, we can expect that CMS will limit this prohibition to the specified patients.

[1] Last visited on May 8, 2020.
[2] Health News, *In Fine Print, HHS Appears To Ban All Surprise Billing During The Pandemic*, Apr. 17, 2020, available here: https://khn.org/news/in-fine-print-hhs-appears-to-ban-all-surprise-billing-during-the-pandemic.

If a recipient provider is not eligible, then the funds must be returned to HHS. The provider must contact HHS within 30 days of receipt of payment and remit the payment to HHS as instructed.

Step Two: Determine Whether Terms and Conditions Can be Met

Second, if a provider meets the eligibility requirements, it must determine whether it meets the terms and conditions for payment. Not complying with these terms and conditions is grounds for HHS to recoup the payment. The recipient must certify the following, among other things:

- The recipient billed Medicare in 2019;
- The recipient provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 (again, note that HHS considers every patient a possible case of COVID-19);
- The recipient is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D;
- The recipient is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and
- The recipient does not currently have Medicare billing privileges revoked.

Additional information can be found here: https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions.pdf.

Step Three: Attest to the Terms and Conditions

Attestations must be made by recipients within 45 days of receipt of the payment.[3] Providers must attest that they will use the payment only "to prevent, prepare for, and respond to coronavirus, and that the [p]ayment shall reimburse the [r]ecipient only for health care related expenses or lost revenues that are attributable to coronavirus."[4] Attestations can be made here: https://covid19.linkhealth.com/#/step/1.

[3] HHS updated the attestation deadline from 30 days to 45 days on May 7, 2020.
[4] HHS, *Acceptance of Terms and Conditions*, available here: https://www.hhs.gov/sites/default/files/terms-and-conditions-provider-relief-30-b.pdf.

If the provider does not return the payment within 45 days from the date of receipt, HHS will presume that the recipient has accepted the terms and conditions.

Step Four: Submit Required Quarterly Reports

Complete the necessary administrative steps required by HHS, including submitting a quarterly report detailing (1) the amount of funds receipt from HHS; (2) the amount expended; and (3) an explanation of how the funds were expended, including expended funds to subcontractors.

At Buchalter, we understand that these are challenging and rapidly changing times. We have attorneys experienced in adapting and navigating clients through these trying environments and are here to help however you need. If we can be of assistance and to discuss various options and specific situations, please feel free to contact Andrew Selesnick (aselesnick@buchalter.com) or Anne Brendel (abrendel@buchalter.com).

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