Key Physician Provisions

Coronavirus Aid, Relief, and Economic Security (CARES) Act
The Coronavirus Aid, Relief, and Economic Security (CARES) Act had a series of provisions, which may be of interest to physicians. The final bill text is here, with the appropriations summary (Division B) from Republicans here and Democrats here, unemployment/retirement summary here, Finance Committee health provisions summary here, HELP Committee summary here, HELP Committee one pager here, Small Business Committee summary here, and one pager here.

Paycheck Protection Program and Health Care Enhancement Act
The Paycheck Protection Program and Health Care Enhancement Act added $75 billion to the CARES Act Provider Relief Fund.

Key Provisions
Small business relief
There are four main provisions to provide relief to physicians, physician practices, and (in some instances) physician professional organizations:

1. Paycheck Protection Program;
2. CARES Act Provider Relief Fund;
3. Accelerated and Advance Payments through Medicare; and
4. Loans, loan guarantees, and other investments under the Coronavirus Economic Stabilization Act.

Paycheck Protection Program
Paycheck Protection Program (PPP) provides a loan of up to $10 million or 250% of the average monthly payroll to help assist small businesses (with less than 500 employees) with salaries (and related expenses) and certain other items. If you maintain your workforce and retain appropriate salary levels, the Small Business Administration (SBA) may forgive a portion of the loan proceeds that are used to cover payroll and certain other expenses following loan origination. For more information, visit here (SBA resource), here (Hart Health resource), and here (Hart Health FAQ).

CARES Act Provider Relief Fund
Division B of the CARES Act includes key language related to an initial $100 billion for health care services related to the COVID-19. Specifically, the funds are “to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus.” The funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

1 Key language begins on p. 750.

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The Paycheck Protection Program and Health Care Enhancement Act added $75 billion to the CARES Act Provider Relief Fund.

**HHS and Other Announcements**

On April 3, during the Task Force press conference, Secretary Azar noted that a portion of the $100 billion provided to the Public Health and Social Services Fund for health care providers in the CARES Act would be allocated to cover the cost of the treatment for the uninsured. Such funding would be through the same mechanism as COVID-19 testing. As a condition of receiving the funds, providers would have to agree not to balance bill, and the reimbursement rates would be set at Medicare rates. The Secretary further noted that additional specifics regarding the rest of the funds would be forthcoming.

On April 7, CMS Administrator Seema Verma noted that $30 billion of the $100 billion fund through the PHSSEF for health care providers, $30 billion will be available via grants, based on Medicare revenue, and such funds will NOT be on a first come, first serve basis. To receive the funds, providers will need to register with CMS. Money can be direct deposited. She acknowledged that certain providers (e.g., pediatricians, OB/Gyns, etc.) do not serve a large portion of the Medicare population. As such, CMS will address those issues in the second wave of funding from the fund. During that announcement, there was no discussion regarding the uninsured.

On April 10, HHS issued information regarding the $30 billion, including a press release, a fact sheet, and Terms and Conditions. Providers will be distributed a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements in 2019. Many health care providers received the funds on April 10. Within 30 days of receipt of the funds, a provider must attest to receiving the funds and agree to the Terms and Conditions. Otherwise, the provider needs to contact HHS and then remit the full payment as instructed. HHS has subsequently clarified that not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions. HHS subsequently released data on the $30 B distribution of the funds by State and Congressional district. In addition, the House Ways and Means Committee Republicans issued information, including a fact sheet, FAQ, and information on the amount of funds to each State.

On April 16, the CARES Act Provider Relief Fund Payment Attestation Portal went live. The portal has a variety of steps, including confirmation of eligibility, billing TINs, verifying payment information, attestations (likely related to the Terms and Conditions), and confirmation.

On April 22, HHS announced additional allocations through the CARES Act Provider Relief Fund.

On May 1, HHS announced the distribution of $10 billion to 395 hospitals who provided inpatient care for 100 or more COVID-19 patients through April 10, 2020, and will distribute an additional $2 billion to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments. Also on May 1, HHS announced the distribution of $10 billion rural distribution will include, rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural areas.

On May 7, HHS announced that it would extend the deadline for attestation, acceptance of the terms and conditions for the fund to 45 days (from the previous 30 days). On that same day, Energy and Commerce Chairman

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2 The Terms and Conditions have been updated at least three times – on April 13, April 20, and April 24. Therefore, the ensuing discussion focuses on the latest Terms and Conditions. However, these Terms and Conditions have changed and may change again.
Frank Pallone, Jr. (D-NJ) and Ways and Means Chairman Richard E. Neal (D-MA) sent a letter to Health and Human Services (HHS) Secretary Alex Azar and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma today raising a series of concerns over the methodology used to distribute and the lack of transparency into how COVID-19 relief funds and loans for health care providers are being spent.

On May 13, Energy and Commerce Committee Subcommittee on Health Republican Leader Dr. Michael Burgess (R-TX) sent a letter to Subcommittee Chairwoman Anna Eshoo (D-CA) to ask for a hearing on how funds are being distributed to providers from Provider Relief Fund.

On May 20, HHS issued a press release reminding eligible providers that they have until June 3, 2020, to accept the Terms and Conditions and submit their revenue information to support receiving an additional payment from the Provider Relief Fund $50 billion General Distribution. Also on May 20, HHS announced the distribution of funding to rural health clinics for testing.

On May 22, HHS announced it has begun distributing $4.9 billion in additional relief funds to skilled nursing facilities (SNFs) to help them combat the devastating effects of this pandemic. That same day, HHS announced a 45-day extension for providers who are receiving payments from the Provider Relief Fund to accept the Terms and Conditions for Provider Relief Fund payments. This announcement means providers have now been granted 90 days from the date they received a payment to accept HHS Terms and Conditions or return the funds. On May 22, HHS announced a $500 M distribution to tribal hospitals, clinics, and urban health centers.

On May 29, Representative Lloyd Doggett (D-TX), Chair of the House Ways and Means Health Subcommittee, and Representative Katie Porter (D-CA), member of the Committee on Oversight and Reform, sent a letter to HHS, noting concerns that funds had been distributed to “hospitals previously closed, mega-corporations, and possible fraudsters.”

On June 3, House Energy and Commerce Chairman Frank Pallone, Jr. (D-NJ), House Energy and Commerce Ranking Member Greg Walden (R-OR), Senate Finance Chairman Charles E. Grassley (R-IA) and Senate Finance Ranking Member Ron Wyden (D-OR) sent a letter to HHS voicing concerns that funds has not yet been allocated to Medicaid providers.

On June 9, HHS announced additional distributions from the Provider Relief Fund to eligible Medicaid and Children's Health Insurance Program (CHIP) providers that participate in state Medicaid and CHIP programs. HHS expects to distribute approximately $15 billion to eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Allocation. HHS is also announcing the distribution of $10 billion in Provider Relief Funds to safety net hospitals that serve our most vulnerable citizens. The safety net distribution will occur this week. On June 10, several members of Congress commended HHS for “taking the first steps to address the needs of Medicaid-dependent providers by awarding about $25 billion to providers with vulnerable patient populations. The Committee leaders reiterated, however, that more needs to be done to address the ongoing needs of large numbers of Medicaid-dependent providers that will not benefit from yesterday’s announcement.”

To assist with distributing the funds, HHS has contracted with UnitedHealth Group. For questions regarding the distribution of funds, please call the toll-free CARES Provider Relief line at 866-569-3522.

The chart below summarizes the information to date on the various distributions.
<table>
<thead>
<tr>
<th>Target Group</th>
<th>Funding allocation</th>
<th>Formula</th>
<th>Distribution Timeline</th>
<th>Additional processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Allocation</td>
<td>$50 B</td>
<td>$30 B proportionately based on Medicare FFS in 2019</td>
<td>April 10 ($26 B) – 17 ($4B)</td>
<td>On April 24, HHS provided additional information regarding the funds, including a General Distribution Portal, General Distribution Portal user guide, and General Distribution FAQs (with updates on May 6). Physicians had to sign into the General Distribution Portal and submit relevant information to receive additional funds (from the $20 B distribution) by June 3, 2020. By May 4, HHS updated its Attestation portal to provide additional information regarding how to calculate funds to be received from the General Distribution.³ By April 8, that language was removed. For a listing of providers (aligned with billing TIN) who has received at least one payment from the General Distribution to which they have attested, visit here.</td>
</tr>
<tr>
<td>“Hot Spots”</td>
<td>Initial $12 B</td>
<td>Proportionately based on total number of Intensive Care Unit beds as of April 10, 2020, and total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020, along with a DSH adjustment.</td>
<td>Announcement on May 1 Notice to hospitals on June 8; announcement on June 9; data due Jun 15.</td>
<td>For facilities only at this time. Therefore, not as relevant to physicians. For a State breakdown of the first round, visit here. Link to the Terms and Conditions, methodology, State and county distribution, and list of providers who received the funds.</td>
</tr>
<tr>
<td></td>
<td>Future $10 B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural providers</td>
<td>$10 B</td>
<td>Proportionately based on operating expenses</td>
<td>Announcement on May 1</td>
<td>For facilities only at this time. Therefore, not as relevant to physicians. On May 1, HHS announced the distribution of $10 billion rural distribution will include, rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural areas. For a state-by-state breakdown, visit here. Link to the Terms and Conditions.</td>
</tr>
<tr>
<td>Indian Health</td>
<td>$500 M</td>
<td>Proportionately based on operating expenses</td>
<td>Announcement on May 22</td>
<td>For facilities only at this time. Therefore, not as relevant to physicians.</td>
</tr>
</tbody>
</table>

³ HHS plans to make publicly available the names of payment recipients and the amounts received, for all providers who attest to receipt of a payment and acceptance of the Terms and Conditions. You should only attest if you believe the payment you received is consistent with your estimated allocation. To calculate your estimated total allocation, divide your "Gross Receipts or Sales" or "Program Service Revenue" by 2.5 trillion and then multiply by 50 billion. ((Gross Receipts or Sales) / 2,500,000,000,000) * 50,000,000,000

To estimate the amount likely to be received via this portal application, subtract the amount of payments already received from your total estimated total allocation above.

Please do not attest if the payments you have received already exceed your estimated total allocation. Please contact the CARES Provider Relief hotline at (866) 569-3522 if you believe that you have received an overpayment.
<table>
<thead>
<tr>
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<th>Additional processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Testing</td>
<td>$225 M</td>
<td>n/a</td>
<td>Announcement on May 20</td>
<td>For facilities only. Therefore, not as relevant to physicians. Link to Terms and Conditions and State-by-State breakdown.</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>$4.9 B</td>
<td>$50,000, plus a distribution of $2,500 per bed for all certified SNFs with six or more certified beds</td>
<td>Announcement on May 22</td>
<td>For facilities only. Therefore, not as relevant to physicians. Link to Terms and Conditions and State-by-State breakdown.</td>
</tr>
<tr>
<td>Safety Net Hospitals</td>
<td>$10 B</td>
<td>For hospitals that serve a disproportionate number of Medicaid patients or provide large amounts of uncompensated care</td>
<td>Announcement on June 9</td>
<td>For facilities only at this time. Therefore, not as relevant to physicians. Link to Terms and Conditions.</td>
</tr>
<tr>
<td>Medicaid &amp; CHIP</td>
<td>$15 B</td>
<td>At least 2 percent of reported gross revenue from patient care; the final amount each provider receives will be determined after the data is submitted, including information about the number of Medicaid patients providers serve.</td>
<td>Announcement on June 9</td>
<td>Link to Terms and Conditions. Read the Medicaid Provider Distribution Instructions - PDF. Download the Medicaid Provider Distribution Application Form - PDF.</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Dependent on the claims received; $10B*</td>
<td>Based on claims; paid at Medicare rates</td>
<td>Registration starting April 27</td>
<td>As announced in early April, a portion of the $100 billion Provider Relief Fund will be used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured. Every health care provider who has provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the program and will be reimbursed at Medicare rates, subject to available funding. Steps will involve: enrolling as a provider participant, checking patient eligibility and benefits, submitting patient information, submitting claims, and receiving payment via direct deposit. Providers can register for the program on April 27, 2020 and begin submitting claims in early May 2020. For more information, visit <a href="https://www.hrsa.gov/coviduninsuredclaim">https://www.hrsa.gov/coviduninsuredclaim</a>. As a condition, providers are obligated to abstain from &quot;balance billing&quot; any patient for COVID-19-related treatment. To receive the funds, an entity must agree to the Terms and Conditions for uninsured testing or uninsured care and treatment. On April 27, HHS provided the portal for the uninsured, along with a FAQ. For more information on the uninsured portions, see our summary here.</td>
</tr>
</tbody>
</table>

Additional allocations: TBD

There are some providers who will receive further, separate funding, including dentists.
### Which Portal Should I use?

Given the number of portals included within the CARES Act Provider Relief Fund, see below for all of the relevant links and some general information.

**General Distribution Portal.** If a provider received funds from the initial $30 B distribution and a provider would like to be eligible to receive additional funds from the $20 B distribution, visit the General Distribution portal, which was launched on April 24. HHS closed the application process for this portal on June 3, but the portal remains open. Currently, the website notes: “All providers who had automatically received funds prior to 5:00 pm, Friday, April 24th, must provide HHS with an accounting of their annual revenues by submitting tax forms or financial statements. These providers must also agree to the program Terms and Conditions if they wish to keep the funds.”

**Enhanced Provider Relief Payment Portal.** By June 11, HHS launched the Enhanced Provider Relief Payment Portal. This portal is currently open to Medicaid/CHIP Providers, and per the FAQs the application for this funding must be submitted by July 20, 2020.

**Attestation Portal.** To attest to the Terms and Conditions and to confirm receipt of these funds, visit the attestation portal, which was launched April 16 and updated in early May.

**Uninsured Claims Reimbursement Portal.** To register and submit claims related to the uninsured, visit the uninsured claims reimbursement portal, which was launched on April 27.

### Terms and Conditions for the General Allocation

For the $30 B allocation, the initial Terms and Conditions were provided on April 10 and updated on April 13, April 20, April 24, and early June. In comparing the latest version of the $30 B Terms and Conditions to the initial Terms and Conditions for the $20 B, the language is identical, except that the $20 B Terms and Conditions includes additional language specific to the allocation.4

In reviewing the Terms and Conditions, there are a few key items for providers to consider, as detailed below.

**Possible or Actual cases.** The provider must attest that s/he “provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.” The initial terms and conditions did not include the specific date. While not included in the Terms and Conditions, HHS on its FAQs further notes that “HHS broadly views every patient as a possible case of COVID-19.” With the addition of the

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4 The additional language is as follows: The Recipient shall also submit general revenue data for calendar year 2018 to the Secretary when applying to receive a Payment, or within 30 days of having received a Payment.

The Recipient consents to the Department of Health and Human Services publicly disclosing the Payment that Recipient may receive from the Relief Fund. The Recipient acknowledges that such disclosure may allow some third parties to estimate the Recipient’s gross receipts or sales, program service revenue, or other equivalent information.
date and the HHS clarification, a provider may be able to attest to this requirement if s/he treated any patient after January 31, whether via telehealth or in-person.

**Reallocation funds.** At this time, there is not a process to allow an entity to reallocate the funds to different TIN in light of changes in ownership or new providers. This is a particular issue given that the legacy TINs may not be able to attest to the ability to treat patients and, as such, may have difficulty in attesting to retain the funds. To address this topic, HHS has updated its FAQs to attempt to provide additional clarity regarding evolving TINs.

**Bans balanced billing.** In essence, to retain the funds, a provider must not balance bill for “all care for a presumptive or actual case of COVID-19.” For those patients, the provider must not seek from the patient more than the patient would have been obligated to pay if the provider was an in-network provider. On May 6, HHS updated its FAQs to clarify that a “presumptive case” 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.” Further, the FAQs clarified that, if the insurer was not going to directly pay the provider for the patient’s cost-sharing requirements, then “the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.” On June 19, HHS further indicated that the “[s]ome Terms and Conditions relate to the provider’s use of the funds, and thus they apply until the provider has exhausted these funds.”

**Use of funds.** Another key requirement is that 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.” This requirement is confusing at best, and it seems virtually impossible to use the funds at the same time for both care and lost revenue. Thankfully, on June 1 with additional revisions on June 22, HHS provided clarity on the use of funds through its FAQs. Specifically, HHS noted the following (with the June 22 modifications in bold):

> The term “healthcare related expenses attributable to coronavirus” is a broad term that may cover a range of items and services purchased to prevent, prepare for, and respond to coronavirus, including:
> - supplies used to provide healthcare services for possible or actual COVID-19 patients;
> - equipment used to provide healthcare services for possible or actual COVID-19 patients;
> - workforce training;
> - developing and staffing emergency operation centers;
> - reporting COVID-19 test results to federal, state, or local governments;

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5 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 presumptive 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. (Language updated on April 20.)

6 Full FAQ is as follows:

For how long are the Terms and Conditions of the Provider Relief Fund applicable? *(Added 6/19/2020)*
All recipients receiving payments under the Provider Relief Fund will be required to comply with the Terms and Conditions. Some Terms and Conditions relate to the provider’s use of the funds, and thus they apply until the provider has exhausted these funds. Other Terms and Conditions apply to a longer time period, for example, regarding maintaining all records pertaining to expenditures under the Provider Relief Fund payment for three years from the date of the final expenditure.
• building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
• acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery.

Providers may have incurred eligible health care related expenses attributable to coronavirus prior to the date on which they received their payment. Providers can use their Provider Relief Fund payment for such expenses incurred on any date, so long as those expenses were attributable to coronavirus and were used to prevent, prepare for, and respond to coronavirus. HHS expects that it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

The term “lost revenues that are attributable to coronavirus” means any revenue that you as a healthcare provider lost due to coronavirus. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care. Providers can use Provider Relief Fund payments to cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus. HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover:
• Employee or contractor payroll
• Employee health insurance
• Rent or mortgage payments
• Equipment lease payments
• Electronic health record licensing fees

You may use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if you have a budget prepared without taking into account the impact of COVID-19, the estimated lost revenue could be the difference between your budgeted revenue and actual revenue. It would also be reasonable to compare the revenues to the same period last year.

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. HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at https://www.hhs.gov/provider-relief/index.html.
**Reporting Requirements.** The Terms and Conditions suggest extensive reporting requirements\(^7\) for the program.\(^8\) HHS has stated that additional guidance on those reporting requirements is forthcoming.

**Recoupment.** Per the FAQs, HHS has not defined a recoupment process but contemplates doing so.\(^9\) The May 6 FAQ updates provide conflicting information regarding whether HHS will opt to recoup any “overpaid amounts.” First, the it states that “Generally, HHS does not intend to recoup funds as long as a provider’s lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received.”\(^10\) Separately, the

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\(^7\) 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 each 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, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

\(^8\) The May 6 updates to the FAQs indicated that “HHS will provide guidance in the future about the type of documentation we expect recipients to submit. Additional guidance will be posted at [https://www.hhs.gov/provider-relief/index.html](https://www.hhs.gov/provider-relief/index.html).”

\(^9\) Full FAQ reads as follows:

**How will HHS recoup funds from providers that are required to repay all or part of a Provider Relief Fund payment?**

(Added 5/29/2020)

HHS has not yet detailed how recoupment or repayment will work. However, the Terms and Conditions associated with payment require that the Recipient be able to certify, among other requirements, that it was eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus). Additionally, recipients must submit all required reports as determined by the Secretary. Non-compliance with any Term or Condition is grounds for the Secretary to direct recoupment of some or all of the payments made. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

\(^10\) Full FAQ reads as follows:

**Does HHS intend to recoup any payments made to providers not tied to specific claims for reimbursement, such as the General Distribution payments?**

(Added 5/6/2020)

The Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, do not exceed total payments from the Relief Fund. Generally, HHS does not intend to recoup funds as long as a provider’s lost revenue and increased expenses exceed the amount of Provider Relief funding a provider has received. HHS reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or
document notes that “[i]f a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment.”11

Not an exhaustive list. The Terms and Conditions include a statement that “[t]his is not an exhaustive list and you must comply with any other relevant statutes and regulations, as applicable.” Further, the notice states that “[n]on-compliance with any Term or Condition is grounds for the Secretary to recoup some or all of the payment made from the Relief Fund.”

Changing calculations for distribution. HHS initially distributed the funds based proportionately based on 2019 Medicare FFS but then later, according to the May 14 FAQ (which were further updated May 29 and June 12), opted to base it upon “at least 2% of that provider’s net patient revenue regardless of the provider’s payer mix. 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. 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.” (emphasis added to changed language) Note: The FAQ suggests that it is net patient revenue, but subsequent FAQs (and the user guide) indicate that it is based on gross patient revenue.12

Subcontractors. Another key statement is that “[t]hese Terms and Conditions apply directly to the recipient of payment from the Relief Fund. In general, the requirements that apply to the recipient, also apply to subrecipients and contractors, unless an exception is specified.” The May 6 updates to the FAQ also further address this topic.13
**Document internal conversations.** Especially in light of the application of whistleblower protections, all internal conversations regarding the funds (especially as it relates to any ambiguities) should be well documented.

**No other reimbursement.** One additional requirement is that 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.” A recent FAQ sheds some light on the interaction of this program with other programs. ¹⁴

**Salary cap.** The funds provided cannot 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.” According to OPM, Executive Level II is $197,300 for 2020. A recent HHS FAQ suggests that the funds are subject to this restriction. The FAQ¹⁵ further clarifies that “[f]or the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Funds may pay an individual’s salary amount in excess of the salary cap with non-federal funds.”

**90 Days.** HHS has made at least two changes to extend the time for attestation – press release on May 7 (which extended it to 45 days) and press release on May 22 (which extended it to 90 days). Recently, HHS updated the Terms and Conditions to conform with the 90-day requirement.

**Tax status.** The information provided does not make the tax status clear, although one may assume that it is likely taxable income. Therefore, it would be helpful if HHS provided clarity regarding what taxes, if any, should apply to the funds.

**Statutory Summary**
Both the CARES Act and the Paycheck Protection Program and Health Care Enhancement Act used the same statutory language to describe the fund and the requirements of the fund.

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Yes, if the independently contracted provider also attested to receiving a payment from the Provider Relief Fund then the provider is banned from balance billing for care provided to a “presumptive or actual COVID-19 patient.”

¹⁴ Full FAQ reads as follows:

**If a provider secures COVID-19-related funding separate from the Provider Relief Fund, such as the Small Business Administration’s Paycheck Protection Program, does that affect how they can use the payments from the Provider Relief Fund? Does accepting Provider Relief Fund payments preclude a provider organization from seeking other funds authorized under the CARES Act? (Added 5/29/2020)**

There is no direct ban under the CARES Act on accepting a payment from the Provider Relief Fund and other sources, so long as the payment from the Provider Relief Fund is used only for permissible purposes and the recipient complies with the Terms and Conditions. By attesting to the Terms and Conditions, 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.

¹⁵ Full FAQ reads as follows:

**What is the definition of Executive Level II pay level, as referenced in the Terms and Conditions? (Added 5/29/2020)**

The Terms and Conditions state that none of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other mechanism, at a rate in excess of Executive Level II. The salary limitation is based upon the Executive Level II of the Federal Executive Pay Scale. Effective January 5, 2020, the Executive Level II salary is $197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Funds may pay an individual’s salary amount in excess of the salary cap with non-federal funds.
Definition: “eligible health care providers” means public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities not otherwise described as the Secretary may specify, within the United States (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID–19.

**Payments.** Directs the Secretary of Health and Human Services to, on a rolling basis, review applications and make payments. The term “payment” means a pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary. That payments are directed to be made in consideration of the most efficient payment systems practicable to provide emergency payment.

**Use of Funds.** Funds are available for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity.

**Application process.** An eligible health care provider shall submit to the Secretary of Health and Human Services an application that includes a statement justifying the need of the provider for the payment and the eligible health care provider shall have a valid tax identification number.

**Reports.** Recipients are required to submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with the required conditions.

**Accelerated and Advanced Payments Through Medicare**

Section 3719 of the CARES Act made changes to the Accelerated and Advanced Payments mechanism through Medicare, primarily to provide additional changes to address hospital concerns. CMS launched the amended program on March 28. The program will provide accelerated payments to requesting providers and advance payments to requesting suppliers, including physicians and non-physician practitioners, who submit a request to the appropriate Medicare Administrative Contractor (MAC) and meet the following criteria:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider’s/supplier’s request form,
- Is not in bankruptcy,
- Not be under active medical review or program integrity investigation, and
- Does not have any outstanding delinquent Medicare overpayments.

CMS intends to provide assistance first to those providers and suppliers that experience increased demand and surge in patients. MACs responsible for processing accelerated/advance payment requests for different states, will prioritize those states that were hit the hardest (currently, these states are reported to be California, New York, and Washington). Most providers and suppliers will be able to request up to 100% of the Medicare payment amount for a three-month period. Based on this formula, qualified providers/suppliers will be asked to request a specific amount using an Accelerated/Advanced Payment Request Document provided on each MAC’s website.

For complete details on the process, please review the following fact sheet.

On April 7, CMS announced that $34 billion had been made available through this program. On April 10, CMS provided a state-by-state analysis of the use of this program, broken down by provider type (i.e., Part A providers and only Part B providers).
On April 26, CMS announced that, in light of the CARES Act Provider Relief Fund, it was reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately. Since expanding these programs on March 28, 2020, CMS approved over 21,000 applications totaling $59.6 billion in payments to Part A providers, which includes hospitals. For Part B suppliers, including doctors, non-physician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing $40.4 billion in payments.

**Key Considerations**

*Loan, not grant.* The monies provided through this program must be repaid.

**Quick repayment terms.** For physicians, repayment begins 120 days after the issuance of the payment and ends 210 days from the date of the accelerated or advance payment was made.

**Recoupment.** At the end of the 120-day period, the recoupment process will begin and every claim submitted by the provider/supplier will be offset from the new claims to repay the accelerated/advanced payment. Thus, instead of receiving payment for newly submitted claims, the provider’s/supplier’s outstanding accelerated/advance payment balance is reduced by the claim payment amount. This process is automatic.

**Interest Rate.** As is statutorily required in the *Federal Claims Collection Act*, Medicare regulation 42 CFR Section 405.378 provides for the charging and payment of interest on overpayments and underpayments to Medicare providers. The Secretary of Treasury certifies an interest rate quarterly. Treasury utilizes the most comprehensive data available on consumer interest rates to determine the certified rate. Interest is assessed on delinquent debts in order to protect the Medicare Trust Funds. The current interest rate is 10.25%.

**Title IV, Subtitle A: Coronavirus Economic Stabilization Act**

Section 4003 establishes a key fund for loans, loan guarantees, and other investments for companies with losses tied to the coronavirus pandemic that threaten their continued operation. Of the $500 billion fund, $25 billion is available to airlines, $4 billion to cargo air carriers, and $17 billion for companies “critical to national security”, with the remainder ($454 billion) for everyone else. Until March 1, 2022, companies that receive aid could not increase compensation for executives and other employees who made more than $425,000 in 2019. Any severance pay or other termination benefits paid to those employees during that period could not exceed twice their 2019 compensation.

**Additional Key Health Provisions**

A list of additional key health provisions is included below.

**Appropriations**

- **$16 billion to replenish the Strategic National Stockpile** supplies of pharmaceuticals, personal protective equipment, and other medical supplies, which are distributed to State and local health agencies, hospitals and other healthcare entities facing shortages during emergencies.
- **$3.5 billion for BARDA to expand the production of vaccines**, therapeutics, and diagnostics to help combat this pandemic.
- **$1 billion for the Defense Production Act** to bolster domestic supply chains, enabling industry to quickly ramp up production of personal protective equipment, ventilators, and other urgently needed medical supplies.
HELP Committee Provisions

- **Limitation on liability** for volunteer health care professionals during COVID-19 emergency response. Makes clear that doctors who provide volunteer medical services during the public health emergency related to COVID-19 have liability protections. (Section 3215)

- Requiring the **strategic national stockpile to include certain types of medical supplies**. Clarifies that the Strategic National Stockpile can stockpile medical supplies, such as the swabs necessary for diagnostic testing for COVID-19. (Section 3102)

- Treatment of respiratory protective devices as covered counter-measures. Provides **permanent liability protection for manufacturers of personal respiratory protective equipment**, such as masks and respirators, in the event of a public health emergency, to incentivize production and distribution. (Section 3203)

- Rapid **coverage of preventive services and vaccines for coronavirus**. Coverage of diagnostic testing for COVID-19. Clarifies that all testing for COVID-19 is to be covered by private insurance plans without cost sharing, including those tests without an EUA by the FDA. (Section 3201 and 3717)

- Pricing of diagnostic testing. For COVID-19 testing covered with no cost to patients, requires an insurer to pay either the rate specified in a contract between the provider and the insurer, or, if there is no contract, a cash price posted by the provider. (Section 3202)

- **Telehealth network and telehealth resource centers grant programs**. Reauthorizes Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technologies for health care delivery, education, and health information services. (Section 3212)

Finance Committee Provisions

- **Increasing Medicare telehealth flexibilities** during emergency period. Allows the Secretary to waive the requirements under section 1834(m). (Section 3703)

- Increasing Provider Funding through Immediate **Medicare Sequester Relief**. Temporarily lifts the Medicare sequester, which reduces payments to providers by 2 percent, from May 1 through December 31, 2020. The Medicare sequester would be extended by one-year beyond current law to provide immediate relief without worsening Medicare’s long-term financial outlook. (Section 3709)

- **Extension of the work geographic index floor under the Medicare program**. Extends the floor until December 1, 2020. (Section 3801)

- **Amendments relating to reporting requirements with respect to clinical diagnostic laboratory tests**. Delays certain reporting requirements and payment adjustments. (Section 3719)