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. Loan payments will be deferred for at least six months. 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 the first eight weeks of payroll and certain other expenses following loan origination.¹ 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-19.² Specifically, the funds are “to prevent, prepare for, and respond to coronavirus, domestically

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¹ Under section 1106, the bill details a process by which first an entity receives a loan, and then an entity can apply for loan forgiveness for certain business expenses, with certain restrictions related to any reduction in the number of employees. Once the SBA has confirmed those amounts and other necessary information, then within 90 days, the SBA pays the lender confirmed business expense amount or the amount of the loan, whichever is less.

² Key language begins on p. 750.

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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.

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

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3 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.
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 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.

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 ($26B) – 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 will likely need to sign into the General Distribution Portal and submit relevant information to receive additional funds (from the $20 B distribution). By May 4, HHS updated its Attestation portal to provide additional information regarding how to calculate funds to be received from the General Distribution. By April 8, that language was removed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$20 B to reconcile the initial payment (if any) so that the provider ultimately receives a proportion of a provider’s 2018 patient revenue</td>
<td>April 24 for initial distribution (around $10B)</td>
<td></td>
</tr>
</tbody>
</table>

4 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.

Prepared by Hart Health Strategies Inc., 5/22/2020
<table>
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<tr>
<td>&quot;Hot Spots&quot;</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</td>
<td>For facilities only at this time. Therefore, not as relevant to physicians. 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. For a State breakdown, visit <a href="#">here</a>. Link to the <a href="#">Terms and Conditions</a>, methodology, State and county distribution, and list of <a href="#">providers</a> who received the funds.</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 <a href="#">here</a>. Link to the <a href="#">Terms and Conditions</a>.</td>
</tr>
<tr>
<td>Indian Health</td>
<td>$400 M</td>
<td>Proportionately based on operating expenses</td>
<td>April 24</td>
<td>For facilities only at this time. Therefore, not as relevant to physicians.</td>
</tr>
<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 <a href="#">Terms and Conditions</a> and State-by-State <a href="#">breakdown</a>.</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 <a href="#">Terms and Conditions</a> and State-by-State <a href="#">breakdown</a>.</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 <a href="#">testing</a> or uninsured <a href="#">care and treatment</a>. On April 27, HHS provided the portal for the uninsured, along with a <a href="#">FAQ</a>. For more information on the uninsured portions, see our summary <a href="#">here</a>.</td>
</tr>
</tbody>
</table>

*Not included in HHS’ information but relayed by Hill staff regarding the intent.*

**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.

**Attestation Portal.** To attest to the Terms and Conditions for the General Distribution 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, and April 24. 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.5

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 website further noted that “HHS broadly views every patient as a possible case of COVID-19.” With the addition of the 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.

**Reallocating funds.** At this time, there is a 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 on May 19, 20, and 21 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.”6 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

5 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.

6 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.)
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.”

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.” Unfortunately, HHS did not provide enough information for providers to easily untangle how to provide appropriate accounting for these items, especially given that many health care services may be under additional obligations (e.g., Medicare payment for certain telehealth services), interactions with other government programs (e.g., the Paycheck Protection Program), etc.

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. On its website, HHS has stated that “these are payments, not loans” but has not clarified whether this is an “extramural mechanism” subject to this restriction.

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 fund at the same time for both care and lost revenue. Therefore, additional clarity is needed, especially in light of the extensive reporting requirements for the program. It would be best if the Department of Health and Human Services provided a list of potential items for use with these funds (e.g., PPE, certain payroll costs, non-cash expenses such as depreciation, etc.).

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 Economic 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 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 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.”
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 on an unspecified date), 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. The May 6 FAQ updates provide conflicting information regarding whether HHS will opt to recoup any “overpaid amounts.” First, 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.” Separately, the 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.”

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9 Full FAQ reads as follows:

How can I estimate 2% of patient revenue to determine my approximate General Distribution payment? (Added 5/14/2020)

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.” Providers should work with a tax professional for accurate submission.

This includes any payments under the first $30 billion general distribution as well as under the $20 billion general distribution allocations. Providers may not receive a second distribution payment if the provider received a first distribution payment of equal to or more than 2% of patient revenue. (emphasis added)

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 increased expenses due to COVID-19. Failure to comply with other Terms and Conditions may also be grounds for recoupment.

11 Full FAQ reads as follows:

What should a provider do if a General Distribution payment is greater than expected or received in error? (Modified 5/20/2020)

Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 45 days of payment via ACH or within 60 days of check payment issuance. If 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
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.12

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.

30 Days Versus 45 - 60 Days. Despite the announcement on May 7 providing for a longer period of time for attestation and the update to the FAQs on May 20 clarifying that individuals would have 60 days to return the funds via check,13 the Terms and Conditions have not been updated with this new information and continue to denote 30 days.

Tax status. The information provided does not make the tax status clear, although one may assume that is it 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.

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.

correct payment. If a provider believes they are underpaid, they should accept the payment and submit their revenues in the provider portal to determine their correct payment.

12 Full FAQ reads as follows:

If a hospital receives a Provider Relief Fund payment under the General, Rural or High Impact Distribution and the hospital contracts with an independently contracted provider (e.g., anesthesiologist or laboratory), is that independently contracted provider banned from balance billing for care provided to a “presumptive or actual COVID-19 patient”? (Added 5/6/2020)

Yes, if the independently contracted provider also attested to receiving a payment from the Provider Relief Fund.

13 Full FAQ reads as follows:

What action does a provider need to take after receiving a Provider Relief Fund payment? (Modified 5/20/2020)
The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meet these terms and conditions of the payment. The CARES Act Provider Relief Fund Payment Attestation Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 45 days of receipt of payment via ACH or within 60 days of check payment issuance will be viewed as acceptance of the Terms and Conditions. A provider must attest for each of the Provider Relief Fund distributions received.
**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)