HHS Issues Stimulus Payments Under CARES Act to Eligible Providers

Paul L. Croce and Glenn P. Prives

Greenbaum, Rowe, Smith & Davis LLP Client Alert

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The U.S. Department of Health and Human Services (HHS) has begun the release of $30 billion of the $100 billion Public Health and Social Services Emergency Fund that is part of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Many providers have already received these funds. Payments from the Fund are not loans, but they do come with certain terms and conditions for acceptance and retention.

Eligibility: All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial distribution. This applies even to facilities and providers who ceased operation as a result of the COVID-19 pandemic, as discussed below.

Process of Payments: Most payments will be made by direct deposit using Automated Clearing House account information on file with United Health Group or the Centers for Medicare & Medicaid Services (CMS). The automatic payments will come to providers via Optum Bank with "HHSPAYMENT" as the payment description. However, providers who normally receive a paper check for reimbursement from CMS will receive a paper check by postal mail for this payment as well within the next few weeks. 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 according to the billing entity's federal taxpayer identification number.

How Payment Distributions Are Determined: Providers will receive a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements in 2019. A provider can estimate their payment by dividing the 2019 Medicare FFS (not including Medicare Advantage) payments they received by $484,000,000,000 (the total amount of all Medicare FFS reimbursements in 2019) and multiply that ratio by $30,000,000,000.

Attorneys

Paul L. Croce

Conditions to Keeping the 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.

Additionally, within 30 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment. The attestation portal is available **here**. If a provider does not return the payment within the 30-day period and does not sign the attestation, the provider will automatically be deemed to have attested to the terms and conditions. To return the payment, the provider should go to the attestation portal and follow the instructions to reject the funds.

It is vital that providers carefully review these terms and conditions to ensure that they are actually eligible for these payments. Simply receiving the payment does not mean that the recipient will automatically qualify to retain the payment.

The conditions for eligibility include, without limitation, the following:

- The recipient certifies that it billed Medicare in 2019; provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare; is not currently excluded from participation in Medicare, Medicaid, and other federal health care programs; and does not currently have Medicare billing privileges revoked.
- The recipient certifies that the payment will only be used to prevent, prepare for, and respond to coronavirus, and shall reimburse the recipient only for health care related expenses or lost revenues that are attributable to coronavirus.

Additional HHS Guidance: HHS has issued some additional guidance, which among other things states as follows: 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.

This additional guidance suggests that "eligible providers" is intended to be broadly interpreted, as it suggests that all patients are potential COVID-19 patients and that providers are eligible to receive the payments if the provider has been financially impacted by the pandemic even if they have not actually treated COVID-19 patients. This is contrary to what the providers must certify to retain payments, which is that they provide or have provided diagnoses, treatment and care to actual or potential COVID-19 patients, and that the funds will only be used to prevent, prepare for, and respond to coronavirus.

Because of this seemingly contradictory guidance, concerns have been raised regarding whether a provider that would never be in the business of treating a patient for COVID-19, but nevertheless received payment, will be permitted to retain the payment.

These concerns are not easily resolved. On the one hand, HHS may have included the statement that "every patient [is] a possible case of COVID-19" simply because it feels the need to tie payments to COVID-19, since the funds were allocated through the CARES Act, but nevertheless intends all providers receiving payments to be able to retain them.

On the other hand, HHS may be intentionally vague in its guidance. As noted above, in order to ensure providers receive needed payments as quickly as possible, HHS is distributing these funds in the first instance to all providers who received Medicare FFS payments in 2019, without regard to their areas of practice or whether they in fact have treated COVID-19 patients. By leaving its guidance vague, HHS has left open its options to try and recover funds it feels in hindsight should not have been distributed.

Accordingly, a determination of whether a provider is entitled to keep these funds should be made on a provider-by-provider basis. In the case of acute care hospitals and family medicine practices which have been treating actual COVID-19 patients, there is little dispute that these providers will be permitted to keep any payments received, at least to the extent the payments do not exceed the provider's expenses and lost revenue attributable to the coronavirus. However, the question of whether payments could be retained by other providers remains less clear. For example, a mental health practice that provides counseling services may not have any patients who have contracted or are suspected of contracting COVID-19. Nevertheless, they may be treating patients experiencing mental distress due to the stay-at-home orders or fear of contracting the virus. A colorable argument could be made that payment should be retained by these practices as, while the treatment provided is not for the direct treatment of COVID-19, the need for treatment was created by it, and thus, was in response to the coronavirus pandemic.

Other providers are even further removed and must be cautious in accepting these payments. While a provider may have been impacted by an inability to perform procedures due to the restrictions in place, it would be difficult to argue the payments received by these providers will only be used to prevent, prepare for, and respond to coronavirus. There is a possibility that HHS could seek to recover payments made to these providers. Accordingly, such providers must be careful in determining whether they can or should execute the required certifications.

A few other conditions of note are as follows:

- The recipient must certify that it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse. HHS has not yet issued additional guidance on this condition.
- The recipient must submit reports to ensure compliance with these conditions, with additional quarterly reporting requirements for recipients receiving more than $150,000 total in funds under the CARES Act, the Families First Coronavirus Response Act (FFCRA), and any other COVID-19

appropriated funds. HHS will issue further guidance regarding the reports and documentation needed to support providers' requests for funding as well as confirming what funds count towards this threshold and what funds do not.

- The recipient must maintain records and cost documentation information to substantiate the reimbursement of costs under this award. The recipient must submit copies of these records, cost documentation, and fully cooperate in all audits to ensure compliance with the terms and conditions.

Given the possibility that HHS may issue further guidance that may impact a provider's decision as to whether to retain these funds, a provider may consider waiting until closer to the end of the 30-day deadline to complete the attestation.

Please contact the authors of this Alert with questions, or to discuss your specific circumstances.

Paul L. Croce
Healthcare Department
pcroce@greenbaumlaw.com | 973.577.1806

Glenn P. Prives
Healthcare Department
gprives@greenbaumlaw.com | 973.577.1776