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APRIL 13, 2020

HHS begins distributing $30B to health care providers affected by the pandemic under the CARES Act

By Harsh Parikh

Starting Friday, April 10, the United States Department of Health and Human Services (HHS) began making payments totaling $30 billion to hospitals and other health care providers. The new funds will automatically be dispersed to all eligible providers proportionally based on their 2019 Medicare payments. Providers **do not** need to separately apply for these funds.

The government is hoping that 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." [1]

Here are five key takeaways:

- **Payments are under "Phase 3" CARES Act legislation.** These payments from the Public Health and Social Services Emergency Fund (Relief Fund) are pursuant to the recently enacted Coronavirus Aid, Relief, and Economic Security Act (the CARES Act). The bipartisan CARES Act appropriated $100 billion for the Relief Fund for "health care providers for health care related expenses or lost revenues that are attributable to coronavirus." The new law did not establish a particular process for distributing the Relief Fund, but directed HHS to establish "the most efficient payment systems practicable to provide emergency payment."

- **Distributions are based on 2019 Medicare fee for service payments.** HHS is distributing $30 billion from the Relief Fund to all eligible Medicare providers. The amount will be based on the organization's 2019 Medicare fee-for-service payments. The calculation does not take into account Medicare Advantage reimbursement. The formula below can estimate a provider's expected payment:

[1] https://www.hhs.gov/provider-relief/index.html

$$\frac{2019\ Medicare\ FFS\ Payments}{\$484\ Billion} \times \$30\ Billion$$

- **Terms and conditions.** Providers must attest to several terms and conditions within 30 days after receipt of the payments, including that the provider:
  - will only use the payment to: (a) prevent, prepare for, and respond to coronavirus, and (b) cover health care related expenses or lost revenues that are attributable to coronavirus;
  - currently provides diagnoses, testing, or care for individuals with possible or actual cases of COVID-19;
  - certify that the provider will only collect the same in-network cost sharing amounts from out-of-network patients for all care rendered for possible or actual cases of COVID-19;
  - currently has Medicare billing privileges and is not terminated or otherwise excluded from participating in Medicare, Medicaid, and other federal health care programs;
  - will not "double dip" with other funding sources (i.e., the payment cannot reimburse expenses or losses that have been reimbursed from other sources);
  - submit reports to HHS, as requested;
  - maintain records and cost documents; and
  - if receiving more than $150,000 in aggregate from federal relief programs, provider must submit to HHS and the Pandemic Response Accountability Committee a report that includes, among other things: (a) total amount of funds received, (b) total amount of funds expended or obliged for each project/activity, and (c) subcontractor information.

  The attestation can be completed through an online portal. Eligible providers should carefully review these terms and conditions with their counsel, as a false attestation can subject an organization to significant liabilities.

- **This is not the Centers for Medicare and Medicaid (CMS) Accelerated and Advance Payment Program.** The Relief Fund distributions are distinct from advanced payments that many providers recently received (or may apply to receive) from their Medicare Administrative Contractors (MACs) under the CMS Accelerated and Advance Payment Program. The payments through the Relief Fund are not loans and do not need to be repaid.

  On the other hand, funds from the CMS Accelerated and Advance Payment Program are required to be repaid. Repayment begins 120 days after issuance of the payment. Once the repayment period begins, MACs will automatically withhold all Medicare payments of the provider. Hospitals have one year and other providers have 210 days from the date that the accelerated payment was made to repay the balance, or they will be charged an overpayment interest fee by their MACs.

- **There is still $70 billion remaining in the Relief Fund.** The agency promises that it is rapidly working on targeted distributions for the remaining $70 billion from the Relief Fund. Future HHS distributions will focus particularly on rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population, and providers requesting reimbursement for the treatment of the uninsured.

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