What To Know About COVID-19 Provider Relief Funds

Oregon Association of Hospitals and Health Systems

May 6, 2020
How to Ask a Question
Agenda

- Overview of Provider Relief Funds
- Terms and Conditions (including Balance Billing)
- Documentation Best Practices
- Liability for Non-Compliance
- Questions
HHS Provider Relief Fund Website

- Most important information is available here: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html
- Updated very frequently
- Describes allocations, Terms and Conditions, and some information on how the funding was distributed (e.g., by state or congressional district)
- Links to HRSA Uninsured Program website
- Links to various portals to submit information and attest to Terms and Conditions
CARES Act - $100 Billion Appropriated

- General Relief Allocation - $50 billion
- Targeted Allocation - $12 billion
- Rural Allocation - $10 billion
- Tribal Allocation - $400 million
- Uninsured Allocation - ??
- Remaining to be Allocated - ~$27.6 billion
- HRSA is administering Provider Relief Fund with UnitedHealth Group as its contractor
General Allocation - $50 Billion

- First $30 billion distributed 4/10 & 4/17
  - Based on 2019 Medicare FFS Revenue
  - Paid out based on TIN
  - “No Strings Attached”…Except for all these Terms & Conditions
  - 30 days to attest at: https://covid19.linkhealth.com/

- Remaining $20 billion began distribution on 4/24
  - Goal is to distribute the entire $50 billion general allocation proportionally based on providers’ net patient revenues
  - Formula: \[\frac{(\text{Gross Receipts or Sales or Net Patient Revenue})}{2,500,000,000,000} \times 50,000,000,000\]
  - Providers must attest in a 2nd portal and provide information for HHS to verify net patient revenue and losses
Second Round of General Allocation

- Cost report providers should have received funding without application

- All providers will need to provide the following information:
  - “Gross Receipts or Sales” or “Program Service Revenue” as submitted on federal income tax return; providers who do not file a tax return must use Net Patient Revenues from its most recent audited annual financial statements
  - Estimated revenue losses in March 2020 & April 2020 due to COVID-19; may use a reasonable method of estimating revenue, such as a comparison between budgeted revenue and actual or a comparison to revenues in the same period last year
  - Copy of most recently filed federal income tax return or copy of audited financial statements for providers who do not file tax returns
  - A listing of the TINs of the provider’s subsidiary organizations that have received relief funds but that DO NOT file separate tax returns
  - The amount of payments received from Provider Relief Funds well as the transaction numbers or check numbers

- HHS reviewing application weekly on Wednesdays at 12 pm ET

- Link: https://covid19.linkhealth.com/docusign/#/step/1
General Allocation Considerations

- Providers are only eligible for the second round of funding if they received a distribution in the first round of funding.
- Changes of ownership and unique tax filings may impact distributions.
- Second round is not “first come, first served” . . . but HHS is reviewing applications every Wednesday and funding is limited.
- Calculate your expected share and be on the lookout for overpayments.

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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.
High Impact Allocation - $12 Billion

- Hospital-only allocation for areas most impacted by COVID-19
- HHS used COVID-19 positive admissions data input into TeleTracking portal for dates of admission 1/1/20 – 4/10/20
- Hospitals with at least 100 COVID-19 admissions that were entered into the portal will receive this funding
- Hospitals will receive a fixed payment per admission, with an additional amount taking into account their Medicare/Medicaid DSH & UCC
- No allocations for Oregon in this round
Rural Allocation - $10 Billion

- Rural acute care hospitals, CAHs, RHCs, and Community Health Centers located in rural areas are eligible
- Hospitals will receive minimum of $1 million
- RHCs & CHCs will receive minimum of $100,000
- Additional payments over the minimum based on operating expenses
- Oregon will receive $172 million amongst 165 providers
Uninsured Program

- $2 billion appropriated through other stimulus bills as well as a portion of $100 billion in CARES Act Provider Relief Funds
- Portal opened on HRSA website 4/27, claims can be submitted starting 5/6
- Reimbursement available for providers who have tested uninsured individuals for COVID-19 or have treated uninsured individuals with a COVID-19 diagnosis on or after Feb 4th, 2020
- UnitedHealth is administering program and Optum tools are being used
- Reimbursement will be at Medicare rates, subject to exhaustion of allocated funds
- Separate Terms and Conditions for treatment and testing
Uninsured Allocation - Portal

- Multi-step process:
  - Sign in with or sign up for an Optum ID
  - Validate your TIN – this can take 1-2 days to process
  - Register for direct deposit/ACH through Optum Pay (this can take 7-10 business days)
    - Be sure to select “CARES-Act Healthcare Relief Program” as your Market Type during this step
  - Add your provider roster (can take 1-3 business days to process)
    - Only needed for the specific providers who are seeking to submit claims for uninsured patients
    - There will be a batch form available
  - Complete patient attestation and upload patient roster; can be updated in the future
    - Can be done individually or in batches
  - Submit claims electronically using payer ID 95964

- Link: [https://coviduninsuredclaim.linkhealth.com/](https://coviduninsuredclaim.linkhealth.com/)

- REMEMBER: funding is limited!
Other Allocations & Funds

- Some providers will receive additional Provider Relief Funds, including skilled nursing facilities, dentists, and providers that solely take Medicaid.

- Paycheck Protection Program & Health Care Enhancement Act appropriated another $100B to HHS:
  - $75B for hospitals and healthcare providers – language same as the CARES Act
  - $25B related to COVID-19 testing, including $1B to cover costs of testing uninsured

- Stay tuned for more developments
Terms & Conditions

- Important to read and consider the T&Cs that apply to each allocation you receive because they are each unique
- Some allocations require affirmative attestation before funding
- Others will be deemed to be accepted without attestation if you retain direct deposits and do not contact HHS to return the money
- Amount of funding distributed may be made public
- Quarterly reporting on use of funds and documentation requirements
- Penalties can be serious – recoupment or worse
Terms & Conditions – Key Issues

- **Use of funds:**
  - HHS seems to be taking a broad view of acceptable uses for funding
  - Apply the straight face test to your uses, and watch for new guidance

- **No double-dipping:**
  - Be careful not to apply Provider Relief Funds to same costs covered by other sources (e.g. FEMA, state funding, or any other grants)
  - Interaction with Paycheck Protection Program, business interruption insurance, and the like
Terms & Conditions - Balance Billing

- T&Cs say that all care for a “presumptive or actual case of COVID-19” are subject to balance billing restrictions
  - Reasonable to assume that “presumptive” is different from “possible”
  - No clear guidance about how to handle cases where the patient happens to test positive
  - Separate requirements apply to cost-sharing waivers in other situations
- Providers may not collect out-of-pocket expenses exceeding the patient’s in-network obligations
  - Impossible to know in-network benefits without coordinating with the plan
  - Payment from Uninsured Program is “payment in full”; avoid collecting any amount from uninsured patients up front
Documentation Best Practices

- Identify all funding sources in play to avoid double-dipping
- Set up GL department dedicated to COVID or have some other GL marker
- Allocate HHS funds towards lost revenues first, if possible
- Make sure you are going to portals and inputting requested information
- Track funds received in separate operating income accounts
- Track your donated resources
- Document and provide justification for any contracts obtained outside your normal procurement processes
Documentation Best Practices

- Track purchase orders & invoices associated for equipment purchases, rentals, supplies as a result of COVID-19, such as:
  - Personal hygiene items
  - Cots
  - Triage and medically necessary tests and diagnosis
  - Treatment, stabilization, and monitoring
  - First-aid assessment and provision of first aid
  - Durable medical equipment (oxygen equipment, wheelchairs, walkers, hospital beds, crutches, other medical equipment)
  - Consumable medical supplies
  - Temporary facilities, such as tents or portable buildings for treatment
  - Leased or purchased equipment for use in temporary medical care facilities
  - Security for temporary medical care facilities
  - Use of ambulances for distributing immunizations and setting up mobile medical units

- Track payroll for employees with COVID-related duties and move to those specific GL depts. when possible
- Track overtime for permanent employees in accordance with your payroll policy
- Track management costs associated with COVID-19 response
Liability for Non-Compliance

- **Attestation:**
  - Provider acknowledges receipt of funds
  - Provider acknowledges acceptance of Terms and Conditions
  - Provider attests to eligibility for payment
  - Provider agrees to be audited and to future adjustments in payments if required

- **Deemed** acceptance of terms and conditions if funds are kept for 30 days or longer without contacting HHS

- Terms and Conditions not exhaustive list of requirements; must also “comply with any other relevant statutes and regulations, as applicable”
Liability for Non-Compliance – Enforcement

- Significant funding creates inherent risk of mismanagement, abuse, or outright fraud.

- Section 4018 of the CARES Act creates an Office of the Special Inspector General for Pandemic Recovery within the US Department of the Treasury to coordinate auditing and investigation of the management and spending of funds under any program established under the CARES Act.

- CARES Act includes appropriations to the OIGs for all government agencies and departments receiving funds under the act to fund oversight and auditing of programs funded thereunder.

- Egregious abuse of funding will be subject to criminal enforcement under laws criminalizing false statements and fraudulent schemes.
Liability for Non-Compliance – Civil False Claims Act

- Federal **False Claims Act**, 31 USC § 3729 *et seq.* ("FCA")
  - Enacted in 1863 to combat fraudulent sales of supplies to Union Army during Civil War
  - Powerful whistleblower provision provides financial incentives for individuals to bring cases on behalf of the government
    - Whistleblowers entitled by law to receive between 15-30% of any settlement or judgment, plus attorneys fees
  - Potentially applies whenever a claim for payment is submitted to the federal government
  - FCA cases in healthcare and government contracts / procurement contexts are common
Liability for Non-Compliance – Civil False Claims Act

- During the last ten years, nearly $38 billion was recovered under the FCA from companies that do business with the federal government
- Why? Whistleblower incentives to identify and bring cases, plus astronomical potential liability
  - Treble (3x) damages
  - Per-claim penalties of $11,665 – $23,331 as of January 2020
- Uptick in FCA enforcement following 2008 financial crisis; similar prediction in wake of various federal COVID-19 funding programs
Liability for Non-Compliance – Civil False Claims Act

- FCA triggered by a knowing submission of a false claim or knowing false statement made in support of a claim for payment.
- Knowledge under the FCA does not require actual knowledge – “reckless disregard” of the truth or falsity is enough.
- FCA cases can be based on false certifications of compliance if the certification was false when made.
- The underlying violation that is covered by the certification, however, must be material to payment.
  - Would government have made the payment if it had known the true facts?
  - Attestation language: “Your commitment to full compliance with all Terms and Conditions is material to the Secretary’s decision to disburse these funds to you.”
Liability for Non-Compliance – Civil False Claims Act

- Unique challenges for CARES Act funding
  - Timeframes may result in attestations being signed without careful review
  - Deemed acceptance of terms and conditions
  - Automatic nature of payments
  - Lack of regulatory guidance on meaning of Terms and Conditions
  - Materiality issues - are all mistakes treated equally?
  - “Reverse false claims” risk for failure to refund overpayment
  - “Pay and chase” enforcement strategy is likely
  - Public posting of recipients and payment amounts
Thank You

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