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HHS Imposes Terms and Conditions on Disbursed PHSSEF Funds and Prepares to Disburse Additional Amounts

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Healthcare

The Department of Health and Human Services (HHS) has released details relating to the disbursement of the first $30 billion of $100 billion in funding allocated by the CARES Act to the Public Health and Social Services Emergency Fund (PHSSEF). Pub. L. 116- 136, Div. B (Mar. 27, 2020). HHS began making payments to eligible providers on April 10, 2020.

On April 14, HHS officials reportedly spoke privately with health-care industry leaders about the disbursement of another $30 billion from the $100 billion fund. The Administration has not yet publicly released details of the methodology or timeframe for allocating this second tranche of funds.

The funds disbursed under the $100 billion fund are separate from funds that providers and suppliers can access under the Medicare Accelerated and Advance Payment Program. As of April 15, CMS had already disbursed $81 billion in accelerated and advance payments. These payments provide a loan to providers and suppliers that have seen a disruption in cash flow due to COVID-19, and allow them to access up to six months of their Medicare reimbursements in advance. These accelerated and advance payments must be repaid, however, starting 120 days after disbursement, and must be completely repaid within one year of the disbursement. By contrast, funds received through the PHSSEF are not a loan, and providers will have no repayment obligation, unless they do not satisfy all the terms and conditions imposed on acceptance of the funds.

Who is Eligible to Receive Payments?

Generally, providers (including facilities) that received Medicare fee-for-service (FFS) reimbursement in 2019 are eligible to receive a portion of the first $30 billion tranche of funding. This appears to include both Medicare Part A and Part B providers, including any laboratories that had Medicare FFS reimbursements in 2019. Providers are ineligible if their Medicare billing privileges are currently revoked, if they have been terminated from participation in Medicare, or if they are excluded from participation in any Federal health care program, even if they received Medicare payments in 2019.

In addition, providers are eligible only if, after January 31, 2020, they have provided diagnosis, testing, or care to individuals with actual or possible cases of COVID-19, and must attest to this as a condition of receiving a portion of the $30 billion. This requirement is imposed by the

CARES Act itself, and HHS has stated that it "broadly views every patient as a possible case of COVID-19."

Terms and Conditions of Payment

Although HHS had previously stated that this $30 billion of funding would be provided with "no strings attached," HHS has imposed several terms and conditions for accepting payment. Providers accepting payment must sign an attestation form confirming receipt of the funds and agreeing to the Terms and Conditions of payment within 30 days of receiving payment, or must return the full payment. HHS recently clarified that it would treat all providers that do not return the full payment within 30 days as having accepted the Terms and Conditions of payment. A copy of the complete terms and conditions can be found here.

HHS has not provided any guidance on whether or how it intends to enforce compliance with the Terms and Conditions. Many of the Terms and Conditions are not articulated at the level of specificity necessary to accurately determine eligibility for funding and permissible uses of funding. As a result, providers should carefully consider whether they are able to attest to compliance with the Terms and Conditions, as failure to comply potentially has ramifications under anti-fraud-and-abuse statutes, including the False Claims Act.

A. Balance Billing

Providers accepting any portion of the $30 billion are prohibited from balance billing actual or possible COVID-19 patients. Specifically, providers must certify that, "for all care for a possible or actual case of COVID-19," the provider "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 paid by an in-network Recipient [sic]." HHS has not announced any sunset to this requirement, and providers may be required to refrain from balance billing for all actual and potential COVID-19 patients until explicitly released from the obligation. Because HHS has stated that it "broadly views every patient as a possible case of COVID-19," HHS could take the position that the balance-billing prohibition applies to all incoming patients, regardless of their symptoms or the purpose of their visit.

This requirement relates principally to situations in which a provider is treating patients with commercial insurance, since Medicare-enrolled participating providers generally are prohibited from balance billing Medicare beneficiaries. HHS has given no guidance on how providers should determine what a patient would have paid in-network.

B. Limitation on How Funds May be Used

Providers must certify that payments received 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." HHS does not provide any additional guidance on what sorts of activities this would include, but the CARES Act states that funding can be used for testing, treatment and care for patients, as well as the cost of acquiring necessary equipment or for building infrastructure to assist in the care of COVID-19 patients. Public statements by members of Congress, the Administration and HHS suggest that payments can be used to offset lost revenue from canceled procedures, though it is unclear how providers must demonstrate that lost revenue is "attributable to" coronavirus.

HHS further prohibits the use of these funds for specifically identified purposes, including but not limited to: executive pay at rates in excess of specified amounts; gun control advocacy; lobbying; abortions, except in the case of rape, incest, or to protect the life of the mother; and embryo research. In addition, to the extent that entities aim to use this funding to conduct clinical trials that would involve human subjects, those entities would be required to comply with all participant protection requirements of the Office of Human Research Protection.

Finally, HHS distributed funding from the $30 billion based on each provider's historical percentage of Medicare reimbursement, rather than projected need. HHS has not specified what providers should do if they later determine that some portion of the funds received exceed the amounts required for coronavirus-related activities.

C. Other Sources of Reimbursement

The CARES Act specifies that providers accepting payment from the $100 billion fund must certify that the funding will not be used to reimburse expenses or losses that have been reimbursed from other sources, or that other sources are obligated to reimburse. HHS has not offered any additional guidance on this provision, including how to determine whether another source is "obligated" to reimburse an expense or loss. Moreover, although HHS requires providers to be prepared to submit reports demonstrating compliance with this and other requirements, it does not specify precisely how providers should track these expenditures.

D. Reporting and Record-Keeping Obligations

Any Recipient (whether an individual or an entity receiving payment) that has received more than $150,000 total in funds from any coronavirus-related appropriations act, including the CARES Act, must report to the Secretary and the Pandemic Response Accountability Committee on a variety of measures. The report must contain at least the total funds received from HHS, a detailed list of all projects or activities for which covered funds were expended or obligated, including the amounts expended for each project or activity, and the estimated number of jobs created or retained, where applicable. Reports must be made within 10 days after the end of each calendar quarter.

Funding Recipients must also maintain records and cost documentation, which must be available to the Secretary upon request. Recipients must also fully cooperate in any subsequent audits by the Secretary, Inspector General, or Pandemic Response Accountability Committee.

How Are Payment Amounts Calculated?

Payment amounts will be allocated according to each provider's share of the total Medicare FFS reimbursements in 2019, which totaled approximately $484 billion. Payments received under Medicare Advantage are not counted towards a provider's total Medicare FFS reimbursements in 2019. As a result, providers and facilities located in areas with a large number of Medicare Advantage beneficiaries may see a disproportionately lower portion of the $30 billion.

Providers can calculate their payments by 1) obtaining their total Medicare FFS reimbursements from their revenue management system; 2) dividing that number by $484 billion, to determine the percentage of total Medicare FFS reimbursements that was collected by that provider; and 3) multiplying that fraction by $30 billion, to determine the total anticipated payout. As an example, a community hospital that received $121 million in Medicare FFS revenue in 2019,

constituting 0.025 percent of $484 billion in total Medicare FFS payments in 2019, would receive 0.025 percent of $30 billion, or $7.5 million.

All reimbursement will be calculated and distributed based on 2019 payments made to providers' Tax Identification Numbers (TINs), rather than the more specific National Provider Identifier (NPI). Large organizations and health systems that have several TINs will receive a separately calculated payment to each of their TINs. Individual physicians who bill to Medicare under their employer organization or group practice TIN will not receive direct individual payments. Instead, payments will be calculated based on the organization's total Medicare FFS revenue under the relevant TIN, and will be paid out to the billing organization. Physicians seeking individual payments will need to take the additional step of working with their relevant organization or group practice to receive further disbursement and allocation of the payments.

What is the Process for Disbursing Payments?

HHS is working with UnitedHealth Group (UHG) to provide payment to eligible providers. Most providers will receive a direct deposit to the Automated Clearing House information on file with UHG or HHS. Some providers have reportedly already received deposits in their accounts. Providers who are not already signed up to receive payment from HHS electronically will receive a paper check in the mail. HHS states that those providers can expect payment "within the next few weeks."

Priorities for the Remaining $70 Billion Under the PHSSEF

HHS has publicly stated that it intends to target the remaining $70 billion to several groups of providers, including rural providers, providers that have lower shares of Medicare reimbursement, such as those who predominantly serve the Medicaid population, and providers "requesting reimbursement for the treatment of uninsured Americans." HHS has also stated that it will focus some funding on areas particularly impacted by the COVID-19 pandemic.

In a private meeting with healthcare providers on Tuesday, April 14, HHS reportedly discussed plans to disburse a second tranche of funding, also totaling $30 billion. According to reports, two-thirds of this funding, or approximately $20 billion, would be allocated based on the provider's portion of overall provider revenue. Revenue would be calculated according to Internal Revenue Service data, and would take into consideration all provider income sources, including revenue from private insurers, Medicaid, Medicare Advantage, and other sources. The remaining $10 billion would be allocated to hospitals with large numbers of COVID-19 patients.

It is not clear whether providers who have already received funding under the first tranche of funding would be eligible to receive additional funds under this second tranche. HHS has not yet spoken publicly about this second round of funding, or released any additional information about the timeframe for its disbursal.

If you have any questions concerning the material discussed in this client alert, please contact the following members of our Health Privacy practice:

Anna Kraus	+1 202 662 5320	akraus@cov.com
Joan Kutcher	+1 202 662 5206	jkutcher@cov.com
Shruti Barker	+1 202 662 5031	sbarker@cov.com
Paige Jennings	+1 202 662 5855	pjennings@cov.com

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