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# Provider Relief Fund Can Assist Health Care Providers Affected by COVID-19 Outbreak but Attention to Terms & Conditions is Key

Many health care providers have received assistance in response to the COVID-19 outbreak and may be eligible for additional funding.

The Coronavirus Aid Relief and Economic Security Act ("CARES Act") set aside $100 billion in funding for health care providers to as a Provider Relief Fund ("Fund"). The intent of the fund is to cover health-care-related expenses and lost revenue attributable to the COVID-19 outbreak. Providers may obtain money from the Fund and still participate in the Paycheck Protection Program or obtain Small Business Administration Disaster Loans.

Potential recipients, however, should pay heed to the reporting, disclosure and recordkeeping requirements that result from acceptance of the terms and conditions of the funding.

**General Summary**

- The first round of distributions from the Provider Relief Fund are in the form of grants ("Grants") to facilities and providers. The Grants are administered via the U.S. Department of Health & Human Services ("HHS").

- The initial round of Grants was distributed to providers by April 27, 2020.

- The Grants are not loans and do not need to be repaid.

- The Grants are automatic for eligible providers and do not need to be applied for. Recipients who do not attest to the terms and conditions will be deemed to have accepted same.

- The Grants are provided via direct deposit, where possible.

- HHS has determined that every patient is a possible case of COVID-19 and no specific impact from COVID-19 care need be proven.

- Providers who have gone out of business or suspended operations as a result of the outbreak are still eligible.

- Payments are based on the provider's share of Medicare fee-for-service reimbursements in 2018 and 2019.

- 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.

- Within 45 days of receipt, the provider must confirm the payment and agree to the terms and conditions. All eligible providers will receive the payment, so *any provider that chooses not to agree to the terms and conditions must contact HHS for instructions on how to return the funds*.

**What to Do If You Received a General Allocation Grant**

Of the $100 billion allocated to health care providers to address health care expenses and lost revenue related to COVID-19, the first distribution was the sum of $30 billion that was disbursed in April 2020. Then, a $20 billion allocation was made to providers in the following weeks.

This combined $50 billion is known as the "general allocation." The second phase of the general allocation was based on a combination of cost reports (if filed) or reported gross receipts and other data entered in the HHS portal.

1. *Providers who received "general allocation" funds from the initial $30 billion and/or second $20 billion need to file an attestation accepting the terms and conditions. This is undertaken via the Attestation Portal.*
2. *Recipients **also** must submit revenue information to be verified. This is undertaken via the General Distribution Portal.*
3. *These two steps are only for providers who have already received funds from the initial $50 billion of Grants.*

Providers who did not receive funding by 5:00pm EST Friday April 24 are not eligible to obtain any "general allocation" funds but can still seek "targeted allocation" funds.

Providers who did receive Grants via the automatic distribution but do not wish to agree to the terms and conditions must contact HHS to return the funds.

**Additional Funds From the Targeted Allocation**

In addition to the general allocation of $50 billion, there will be a second distribution of another $50 billion. The second $50 billion is known as the "targeted allocation."

Providers who received money from the "general allocation" must sign an attestation for those initial funds before they can apply for this second "targeted allocation" payment.

Like the initial "general allocation" funds, the second round of "targeted allocation" funds are awards, not loans, and will not need to be repaid.

Thus, providers who did not receive a "general allocation" but wish to seek payments from the Fund will need to apply through other mechanisms, including the "targeted allocation."

The first option for a "targeted allocation" is reimbursement for COVID-19 treatment of uninsured persons. Application for such an allocation can be made via the HHS Uninsured Claims Portal.

**Eligibility**

Providers must attest to eligibility, including:

- The provider billed Medicare in 2019;
- It provided, after January 31, 2020, diagnosis, testing, or care for individuals with possible or actual cases of COVID-19

  - Note: HHS states that it broadly views *every patient* as a possible case of COVID-19. Therefore, any practice that has interacted with patients is deemed affected.
- The recipient is not currently terminated from participation in Medicare, Medicaid or other Federal health care programs;
- The recipient does not currently have Medicare billing privileges revoked; and
- The recipient certifies that it will not use the payment contrary to the terms and conditions.

**Terms & Conditions**

Within 45 days of receiving the payment, recipients must access the portal and sign an attestation confirming receipt of the funds and agreeing to the Terms and Conditions of payment. Not returning the payment within 45 days of receipt will constitute consent to the Terms and Conditions.

Uses of Funds. The recipient must agree to use the funds to reimburse expenses or losses that have not been reimbursed from other sources. Expenses that are being paid for by other programs like the Paycheck Protection Program or the Economic Impact Disaster Loans cannot be reimbursed from the Grants.

Although providers are generally free to use the funds to support their operations, there are a number of specific restrictions on the use of funds, including, for example, a limitation on use for salaries of highly compensated employees and on uses such as lobbying.

Reporting. The Terms and Conditions also stipulate reporting requirements for a recipient. If a recipient receives more than $150,000 total in funds under *any act* making appropriations for the coronavirus response and related activities, then they must submit to the Secretary and the Pandemic Response Accountability Committee a report no later than 10 days after the end of each calendar quarter.

When reporting to HHS, a report must include the total amount of funds received from HHS under one of the enumerated acts. The recipient shall include the amount of funds received that were expended or obligated for each “project” or “activity.” While project and activity are not defined in the terms and conditions, it is likely that these words a recipient should report the health care expenses related to a recipient’s facility or practice. It is critical that recipients keep documents and track their expenses related to their practice.

Recipients should total all the money they’ve received from any federal stimulus act on a reporting form. If the total funds received exceeds $150,000, then a recipient has a reporting requirement and will need to detail where all funds were spent. Thus, recipients must be meticulous in tracking where they are spending any HHS money they receive. Documentation is key.

Recordkeeping. The Terms and Conditions enumerate specific conditions recipients must follow in terms of maintaining records and the cost of such documentation. Recipients should also be prepared to answer to any audits from the Secretary, the Inspector General, or the Pandemic Response Accountability Committee.

Disclosure. The Recipient also consents to HHS publicly disclosing the payment that the Recipient may receive from the Fund. Thus, the recipient acknowledges that such disclosure could enable third parties to estimate the recipient's gross receipts or sales, program services revenue or other equivalent information.

In-Network Rates. If a recipient has a COVID-19 patient(s), the recipient must certify 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. A recipient cannot request reimbursement if a COVID-19 patient is uninsured. That is to say, the recipient cannot select a payment from that patient that's any higher than standard in-network payment from a commercial provider.