CARES ACT PROVIDER RELIEF FUND
BACKGROUND, CONSIDERATIONS & FREQUENTLY ASKED QUESTIONS

Last Updated: April 24, 2020 at 7 p.m. ET

Background

Providers have access to a number of new funding sources as a result of COVID-19. Each of these funding sources requires providers/organizations to agree to certain terms and each has their own documentation requirements.

Providers/organizations should establish tracking systems now in order to be able to accurately report eligible expenses and losses attributable to the COVID-19 crisis.

CARES Act Provider Relief Fund

On March 27, the Coronavirus Aid, Relief, and Economic Security Act (CARES) was passed and signed into law, appropriating $100 billion to a Provider Relief Fund for the COVID-19 pandemic. The fund is managed by the Office of the Secretary of the Department of Health and Human Services (HHS) and dollars are held within its Health Resources Services Administration (HRSA). The funds are being distributed as automatic payments through United Health Group(UHG) via Optum Bank with "HHSPAYMENT" as the payment description. HHS began distributing these dollars on April 10 and announced its plan for a second tranche which HHS will begin distributing on April 24.

Fund Allocations

- **Tranche 1, April 10 -17:** $30 billion distributed through direct deposit from UHG's Optum Bank into the accounts of providers who billed Medicare fee-for-service (FFS) based upon a percentage of their total 2019 Medicare FFS reimbursements.

- **Tranche 2, April 24:**
  - $20 billion being distributed in payments to Medicare facilities and providers for whom Medicare FFS reflects a small share of their revenue and based off of 2018 cost report data.
  - $10 billion to targeted hospitals in areas particularly impacted by the COVID-19 outbreak (application required)
  - $10 billion for rural health clinics and hospitals (distributions to begin week of April 27)
  - $400 million for the Indian Health Service facilities based upon operating expenses. (distributions to begin week of April 27)
  - Unspecified amount going to skilled nursing facilities, dentists, and providers that exclusively serve Medicaid recipients.
  - An unspecified portion (as announced I early April) will be used to reimburse health care providers at Medicare rates for COVID-19 treatment of uninsured individuals, until funds run out.

Resources

To help our members be prepared for potential future audits, reporting and compliance with these programs, LeadingAge has put together the following items to provide a roadmap:

- **CARES Act Provider Relief Fund Backgrounder, Considerations and FAQ document (**this document) including "Questions Providers Should Consider Before Completing the Attestation and Using the Money" (below)
- **COVID 19 Stimulus Bill Facility Eligibility Calculators and Explainer,** developed by LeadingAge Wisconsin, helps providers assess eligibility for the full array of COVID-19 -related funding options.

Coming soon we will be sharing supporting tools that will:

- **Assist with funds documentation**: that will help providers identify what items to track related to the Provider Relief Funds to be able to submit future reports to HHS.
- **Clarify HHS expectations** regarding the use of the funds (awaiting reply to LeadingAge CEO Katie Sloan's letter to HHS Secretary Alex Azar)

Timeline

- **April 10:** UnitedHealth Group begins depositing the first $26 billion of Provider Relief Funds into Medicare provider accounts on behalf of CMS and the CARES Act

- **April 16:** HHS Portal for signing the attestation opened

- **April 17 :** $4 billion distributed to remaining Medicare providers as part of first tranche of funds.

- **April 23:** Congress passes bill with additional $75 billion for the Provider Relief Fund. **–NEW**

- **April 24:**

    - HHS begins distribution of $20 billion in payments to providers for whom Medicare FFS reflects a small share of their revenue and based off of 2018 net patient revenue as reported in CMS cost report data.
    - President signs the bill adding $75 billion to the Provider Relief Fund **–NEW**

- **Week of April 27:**

    - Second tranche distributions begin going out to hospitals hard hit by COVID-19, rural health clinics and hospitals, and Indian Health Service facilities.
    - Providers can enroll in program to reimburse providers care and services provided to uninsured COVID-19 patients

- **TBD:** Distribution of unspecified dollars to Medicaid-exclusive providers.

- **May 10**: Deadline for providers to sign attestation or return Provider Relief Fund dollars for those who first received funds on April 10. All other providers have 30 days from receipt of funds.

Attestation

All providers receiving CARES Act Provider Relief Funds must complete the online attestation within 30 days of receipt of the funds regardless of whether the provider intends to keep the funds or not.

NEW – Providers need to attest separately for each payment they have received from the Provider Relief Fund, as the terms and conditions are "slightly different" according to information received from HHS on April 24, 2020. Terms and Conditions for each tranche of funds can be found here. The Terms & Conditions for the second round of funds include the following additional items:

1) providers cannot be currently precluded from receiving Medicare advantage or Part D payments;
2) providers must submit general revenue data for calendar year 2018 to the Secretary when applying to receive the funds or within 30 days of having received a payment;

3) Providers must consent to HHS publicly disclosing the payment amount the provider may receive from the Relief Fund knowing that other parties may be able to derive the provider's gross receipts or sales, revenue or other information from this disclosure; and

4) Providers must certify that all information the provided by the recipient of the funds is true, accurate and complete to the best of their knowledge.

NEW – If you're a Medicare provider who has received funds: Providers who have received the second round of general distributions to Medicare providers ($20B distribution) will use the newly-created General Distribution Portal to upload the required financial information. Through this portal, they will need to attest to each payment associated with their billing Taxpayer Identification Number(s) and upload their most recent IRS tax filings as well as estimates of lost revenues for March and April 2020.

NEW – HHS has also put together a CARES Act Provider Relief Fund Application Guide to assist providers in preparing to complete the information required through the General Distribution portal.

Providers who choose to reject the funds must complete the attestation indicating their rejection of the funds. It is not clear at this time how funds will be returned if a provider opts not to accept the funds.

Before You Attest: Questions Providers Should Consider Before Agreeing to Terms & Conditions and Using the Money

These questions and considerations were compiled with guidance from **LeadingAge Silver Sponsor, CLA.**

LeadingAge thinks that it will be appropriate for most members to sign the attestation agreement but as we noted in our April 20 letter to HHS Secretary Alex Azar there are many questions we still need HHS to answer and clarify so we are able to comply. The questions and information below are designed to make sure you've thought through the systems or processes you need to put in place to comply.

To sign the attestation and accept the Terms and Conditions providers must use this link.

- **Since January 31, has your organization provided or does it currently provide "diagnoses, testing, or care for individuals with possible or actual cases of COVID-19"?**

  The terms and conditions don't define the following terms "care" nor "possible cases of COVID-19". The HHS website on the CARES Act Provider Relief Fund, however, states that "HHS broadly views every patient as a possible case of COVID-19." However, this same statement is not included in the Relief Fund Payment Terms and Conditions document. We have asked for further clarification from HHS on this point and will share updates with members as they become available.

- **Does your organization have "health care related expenses or lost revenues that are attributable to coronavirus?** The Relief Funds Payment Terms and Conditions require that the funds, "… 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." There are no further specifics about what expenses or lost revenues will count at this time. We think it is likely that many of the additional expenses and lost revenues providers have incurred will be counted as COVID-19 related, as they were required for prevention and preparation for the virus but LeadingAge has also asked for additional guidance from HHS. At this point, we would recommend that members track all expenses and lost revenues they believe are related to COVID-19 and once we have further guidance from HHS, providers can sort out those that may not qualify.

- **How will you document the expenses incurred were "used to prevent, prepare for and respond to coronavirus"?**

  So far, HHS has not provided additional information about their expectations related to reporting on their COVID-19 expenses and lost revenue but reports are required under the Terms & Condition and the CARES Act (See below for more information on reporting). Until further information is available, CLA recommends:

  - **For COVID-19 Expenses**: Track bonuses, hazard or incentive pay for staff, use of agency staff, personal protection equipment, additional housekeeping and/or laundry costs, anything above the usual and customary expenses.
  - Set up **separate general ledger(GL) accounts** and report excess expenses in the GL accounts.
  - **For lost revenue**: Consider comparing revenue and census over the past 12 months to today's revenue and census to gauge potential lost revenue. Use a typical per patient day rate for each payor type to support the lost revenue.
  - **Track by payer and provider type:** It is not yet clear if the funds must be used exclusively for Medicare services or be specific to the service line receiving the funds (e.g., SNF) within an organization that may have multiple service lines under a single Tax Identification Number. For now, it is recommended to track expenses by payer and provider type pending further HHS guidance.
  - **Timeframe:** Reports will be required quarterly to HHS and the Pandemic Response Accountability Committee according to the Relief Fund Terms and Conditions. The first report is expected to be due July 10 for funds distributed in April – June 2020.

- **What if your organization receives more money through various relief funds than is expended? How is that money to be returned?**

  At present, the HHS CARES Act Provider Relief Fund website states, "These are payments, not loans, to healthcare providers, and will not need to be repaid." However, the CARES Act and Relief Payment Terms & Conditions clearly establish an expectation that the funds will only be used for "health care related expenses or lost revenues, that are attributable to coronavirus." So until we are able to obtain more clarity on this issue from HHS, we would like to emphasize the importance of providers tracking their expenses and lost revenues now to ensure they can document and report this information to HHS and the Pandemic Response Accountability Committee at the prescribed times (see below in FAQs for additional details on reporting requirements).

- **Which program funds should your organization use first (e.g. Paycheck Protection Program or CARES Act Provider Relief funds)? What about other relief funds and/or loans?**

  As you are tracking expenses and lost revenues, providers should be aware that their expenses can only be counted once across COVID-19 relief funds and the Provider Relief Fund dollars are essentially the payer of last resort according to the Terms & Conditions, which state, " The recipient certifies 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." A good example is wages and salaries paid under the Paycheck Protection Program cannot also be counted under the Provider Relief Fund. In addition, if states increase their Medicaid provider rates or distribute lump sum funding to providers due to COVID-19, providers will want to carefully document which expenses are tied to these services versus Medicare to ensure that expenses aren't attributed to both pots of money. It is also unclear how HHS will verify this information.

- **What will be the audit process following the declared end of the national emergency health? Will funds be taken back if not properly supported? Will there be an appeal process?** There are currently no answers to these questions but providers should keep this in mind when they complete the attestation and use the available funds. The CARES Act gives the HHS Office of the Inspector General audit authority for these funds.

- **Is your organization in a cost-reimbursed Medicaid state? If so, how will the use of relief funds impact your future Medicaid reimbursement rates? Will the state require the funds to be offset against expenses?** (For example, Minnesota already said yes, the funds must be offset.)

- **What are other potential risks of accepting the funds and attesting to the Provider Relief Fund Terms and Conditions?**
  Practically speaking, we think the risks of accepting and using the funds are low or no different than other grants or payments that providers accept every day but providers will need to closely follow the evolving guidance related to the funds to be sure to comply.
    - **Future Clawback:** HHS or Congress could clawback some portion of the relief funds from non-COVID areas but in an election year, there is low probability of this occurring.

- **Payback of unused funds:** Your organization may be required to pay back some portion of the funds if your organization's lost revenues and expenses don't equal or exceed the amount your organization received. Having said that, the reality is providers will have some eligible expenses and lost revenues that will use a good portion if not all of the funds. So again, this is a relatively low risk.
- **Ineligible expenses/losses:** Future guidance may not include expenses or lost revenues your organization incurred in the HHS definition of eligible expenses and lost revenues, or your incurred expenses or lost revenues may have been incurred outside the yet-to-be-determined timeframe. Nonetheless, you will have a number of expenses and lost revenues that will be counted.

- **Potential HHS OIG audits:** There is the potential to be audited by the HHS Office of the Inspector General based upon receipt of the funds. If the audit finds funds were improperly used, providers may be subject to civil monetary penalties and/or future exclusion from participation in Medicare, Medicaid, and other government programs. This is nothing new to providers as the HHS OIG could audit existing health care programs that we participate in.

- **False Claims Act:** Submitting required reports to HHS that include false information regardless of intent could subject a provider to potential False Claims Act complaints and other civil liability including financial penalties for each claim.

Applying for Reimbursement for Medicare Services Provided to Uninsured – New

In addition to the direct payments being made to health care providers, an unspecified amount of the Provider Relief Funds will be used to reimburse health care providers who have provided testing, testing-related visits or treatment for uninsured patients with a COVID-19 diagnosis on or after February 4, 2020.

The Process – New

- **Provider Enrollment:** Beginning April 27, 2020, providers must register for the program as a provider participant. Skilled nursing facilities, home health and other post acute care providers are eligible for this reimbursement. Hospice services are excluded.
- **Confirm Uninsured Status:** All providers seeking reimbursement must check for health care coverage eligibility and confirm that the patient is uninsured. You have verified that the patient does not have individual, employer-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse you for COVID-19 testing and/or care for that patient.
- **Submit Claims:** Enrolled providers can begin submitting claims electronically for care and services provided to confirmed uninsured individuals in the U.S. on May 6, 2020. All claims are subject to Medicare timely filing requirements.
- **Reimbursement rates:** Enrolled providers will be eligible to be reimbursed at current year Medicare fee schedule rates, which will start to be deposited in mid-May for services provided to uninsured individuals. These reimbursements will continue the funds run out. No specific amount has been designated for this reimbursement. This payment must be accepted as payment in full.
- **No balance billing:** Providers must agree not to balance bill these patients.

- **Payment**: Enrolled providers will receive payment via direct deposit into their bank account.

Website for more information on how to get reimbursement for care provided to uninsured COVID-19 patients. This site will be updated with "much more information" beginning April 27.

Frequently Asked Questions (FAQs)

Q. Who qualifies as an "eligible health care provider" to receive Provider Relief Funds?

Answer: According to the CARES Act, an "eligible health care provider" means "public entities, Medicare or Medicaid enrolled suppliers and providers, and such for-profit entities and not-for-profit entities not otherwise described in this proviso as the Secretary may specify, within the US (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." The first tranche of funds was distributed to Medicare fee-for-service(FFS) providers. The second tranche of funds are being distributed to providers for whom a small share of their revenue is derived from Medicare FFS, targeted hospitals in areas that have been particularly impacted by COVID – 19, rural health clinics and hospitals, Indian Health Service facilities, and providers who solely serve Medicaid recipients.

Q. Who should I call if my organization did not receive any funds and we provide Medicare services so believe we are eligible for the funds?

Answer: Providers for whom Medicare FFS is a small share of the organization's revenue and did not receive a payment on April 24 may be lacking sufficient cost report data for HHS to complete this transaction. For these providers, you will need to submit revenue information through a provider portal that is scheduled to open the week of April 22 and will be found on the HHS CARES Act Provider Relief Fund website. After HHS receives and validates the data, they will be sending out payments weekly to eligible providers on a rolling basis.

Providers can submit their questions about the funds to: HOSPITALCOVID19@hhs.gov

In addition, HHS has established a **toll-free CARES Provider Relief line** where providers who believe they qualify for a payment but have not yet received one can call (866) 569-3522 to determine the status of their payments and the amount they will receive.

Additionally more details about the Fund can be found at the HHS CARES Act Relief Fund website: https://www.hhs.gov/provider-relief/index.html

Q. If a facility received funds but no longer owns the facility, how is the money to be paid back?

Answer: More than one facility has run into this scenario because distributions were based off of ownership and Medicare FFS revenues in 2019. It is not clear yet how those funds can be returned but providers receiving funds under these circumstances should not use these funds nor try to pass them along to the new owner if the organization was sold, as there is no current guidance for this situation. Providers may contact the HHS at the above listed email to inquire about next steps.

Q. **Are the Provider Relief Funds a loan, a grant, something else?**

Answer: HHS clearly states on the CARES Act Provider Relief Fund website, "These are payments, not loans, to healthcare providers, and will not need to be repaid." However, the Terms & Conditions also clearly state the funds are only to be used for certain eligible expenses and lost revenues related to COVID-19. According to the HHS April 22 announcement regarding the second tranche of funds, HHS reiterated, "All recipients will be required to submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to coronavirus. There will be significant anti-fraud and auditing work done by HHS, including the work of the Office of the Inspector General. "

Q. What are the terms and conditions?

Answer: This is the link to the Relief Fund Payment Terms and Conditions document
At a high level, the key requirements include:

- Must use funds for COVID-19 related health care expenses and lost revenues;
- Must provide care to those with possible or actual cases of COVID-19;
- Cannot "balance billing" any patient for COVID-related treatment;
- Must report quarterly to HHS and the Pandemic Response Accountability Committee;
- Not submit reimbursement for expenses covered by another funding source;
- Retain appropriate records and cost documentation.
- Prohibits using the funds to pay an individual through a grant or extramural mechanism in excess of the Executive Level II salary level which as of January 2020 is $197,300.
- Prohibits using the funds for: gun control advocacy efforts, lobbying, abortions, embryo research, promotion of legalization of controlled substances, pornography, funding Association of Community Organizations for Reform Now or its affiliates; or needle exchange,
- Cannot require employees or contractors to sign internal confidentiality agreements prohibiting them to lawfully act as a whistleblower
- Requires certain terms to be included in nondisclosure agreements
- Funds are not available to entities that have unpaid federal tax liability
- Prohibits knowingly using the funds to contract with a corporation with a felony criminal conviction in the prior 24 months.

It appears that providers can retain the funds while determining which expenses can be paid using these dollars and return any unused portion.

Q. What should I consider before signing the Payment Relief Fund Terms and Conditions?

Answer: See the section above titled, "Before You Attest: Questions Providers Should Consider Before Agreeing to Terms & Conditions and Using the Money"

Q. If my organization is not willing to agree to the terms and conditions or needs to return any portion of the Provider Relief Funds for any reason, how do I indicate that to HHS and what is the process for returning funds?

Answer: LeadingAge has sent a letter to HHS Secretary Alex Azar asking for further information on the process for returning all or some portion of the funds. We will update this document when we receive additional information

Q. If I take no action within 30 days of receipt of the funds related to the attestation of the Payment Relief Fund Terms & Conditions, what happens?

Answer: It is LeadingAge's understanding that your organization will be assumed to have accepted the terms and conditions but HHS has instructed in the Attestation portal that they want both providers who are accepting the terms and conditions as well as those not willing to attest to complete the questions in the portal.

Q. What must I document now in order to comply with the terms and conditions of the Provider Relief Fund?

Answer: The HHS Secretary will establish reporting and documentation requirements that must be followed. The Relief Fund Terms and Conditions specify that providers must report on the following items quarterly:

- Total amount of funds received from HHS under one of the Acts;
- Amount of received funds that were expended or obligated for each project or activity;
- Detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.

Q. What accountability is there for this program?

Answer: Health and Human Services must report to the House and Senate Committees on Appropriations no later than 3 years following the final payments. This report shall outline the OIG's audit findings with respect to the program. The HHS Secretary must also report to these committees within 60 days of the enactment of the CARES act and update the committees every 60 days thereafter until all the funds are spent.

Q. How will HHS distribute the remaining dollars and what providers or expenses will it be for?

Answer: As of April 22, the second tranche of funds are being distributed to providers for whom a small share of their revenue is derived from Medicare FFS, targeted hospitals in areas that have been particularly impacted by COVID – 19, rural health clinics and hospitals, Indian Health Service facilities, and providers who solely serve Medicaid recipients.

Q. What must be reported? To whom shall it be reported? And when are these reports due? What funds do these reports cover?

Answer: Providers are required under the Relief Fund Terms and Conditions to submit a quarterly report to the HHS Secretary and the Pandemic Response Accountability Committee if the recipient received more than $150,000 across all the Acts making appropriations for the coronavirus response and related activities. These reports will be due no later than 10 days following the calendar quarter

end or minimally: July 10, 2020; October 10, 2020; and January 10, 2021.
The reports must include the following content:

- Total amount of funds received from HHS under one of the Acts;
- Amount of received funds that were expended or obligated for each project or activity;
- Detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.

- Funds specifically covered by the reporting requirement include: Coronavirus Aid, Relief, and Economics Security(CARES) Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities.

Q. Will HHS or CMS prescribe a reporting format or is each entity free to document as they see fit?
Answer: We are awaiting further guidance from HHS on whether it will issue a reporting format, template or portal that providers must use to report their use of these and other COVID-19 funding sources.

Q. If my organization receives more than one round of Provider Relief Funds, do we need to sign an attestation for each pot of funds? NEW

Answer: YES. HHS clarified on April 24 that Medicare providers receiving more than one payment from the Fund must sign a separate attestation for each payment, as the Terms and Conditions are slightly different for each payment. Providers receiving the second round of funds as providers with low Medicare FFS revenue must also submit financial data to HHS through its newly-created (April 24) General Distribution Portal.

Q. How are the two sets of Terms & Conditions different? -- NEW

Answer: – Providers need to attest separately for each payment they have received from the Provider Relief Fund, as the terms and conditions are "slightly different" according to information received from HHS on April 24, 2020. Terms and Conditions for each tranche of funds can be found here. The Terms & Conditions for the second round of funds include the following additional items:

1) providers cannot be currently precluded from receiving Medicare advantage or Part D payments;
2) providers must submit general revenue data for calendar year 2018 to the Secretary when applying to receive the funds or within 30 days of having received a payment;

3) Providers must consent to HHS publicly disclosing the payment amount the provider may receive from the Relief Fund knowing that other parties may be able to derive the provider's gross receipts or sales, revenue or other information from this disclosure; and

4) Providers must certify that all information the provided by the recipient of the funds is true, accurate and complete to the best of their knowledge.