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The Provider Relief Fund: Welcome relief or compliance minefield?

By Andrew B. Wachler and Stephen J. Shaver

Andrew B. Wachler (awachler@wachler.com) is Principal and **Stephen J. Shaver** (sshaver@wachler.com) is an Associate Attorney at Wachler & Associates PC in Royal Oak, MI.

The outbreak of COVID-19 has sent shock waves through the US economy. In the healthcare industry, hospitals and healthcare providers have seen nonessential but revenue-generating procedures postponed and distancing guidelines lead to steep declines in other services.[1] At the same time, they have seen a surge in actual and potential COVID-19 patients, as well as rapid increases in the prices of many basic medical supplies and equipment.[2] Caught between sudden expenses and a sudden drop in revenue, many hospitals and healthcare providers are struggling for operating capital[3] and some have shut down entirely.[4]

In response, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act on March 27, 2020.[5] Among the measures contained in the CARES Act was the creation of the CARES Act Provider Relief Fund (PRF).[6] The PRF's goal is to provide financial relief to hospitals and healthcare providers by distributing funds directly into the accounts of hospitals and healthcare providers. The distribution of these funds is administrated by the Department of Health & Human Services (HHS). Congress initially appropriated $100 billion for the PRF but, on April 24, 2020, passed the Paycheck Protection Program and Health Care Enhancement Act and appropriated an additional $75 billion for the fund.[7] HHS has divided the first $100 billion into a series of general and targeted allocations. Each allocation from the PRF comes with conditions and limitations on the use of the funds, creating a plethora of compliance challenges for providers.

Two waves of general allocations

The general allocations have been distributed in two waves. The first wave prioritized speed over all else. Because of the dire needs of many providers, this haste was not unwelcome. On April 10, 2020, HHS deposited $26 billion directly into the accounts of hospitals and providers, and on April 17, 2020, it distributed $4 billion more.[8] No applications were required, and HHS made these one-time deposits automatically into the bank account associated with the qualifying recipient's Tax Identification Number (TIN).[9] To distribute the funds quickly, HHS used information already in its possession to determine the eligibility of providers and the amount each provider would receive, namely Medicare fee-for-services (FFS) reimbursements for 2019. The amount of the payments corresponded to approximately 6.6% of the provider's 2019 Medicare FFS revenue.

In the haste with which the first wave was distributed, HHS was only able to account for FFS revenue. This approach left an imbalance for providers who bill Medicare but who have significant revenue from other sources. The second wave of general allocations, consisting of an additional $20 billion in payments, began to remedy this imbalance.[10] This wave of payments went to the same providers as the first wave and was based on net patient revenue from all sources. The first payments under the second wave went out on April 24, 2020, and were made to Medicare Part A providers for whom HHS already had net patient revenue data contained in CMS cost reports. These payments were made automatically and without need for application.

All providers eligible for the general distribution, including those who received automatic payments in the first or second waves, are required to submit revenue information to HHS for verification via the PRF General Distribution Portal.[11] Providers who received a payment as part of the first wave, but who did not automatically receive a payment in the second wave, may apply to HHS to be included in the second wave, also through the General Distribution Portal (although HHS has also referred to it as the PRF Application Portal).[12] To apply through this portal, a provider must supply to HHS: its "gross receipts or sales" or "program service revenue" as listed in its most recent federal tax return; its estimated lost revenue in March and April 2020 due to COVID-19; its most recent federal income tax return; and the TINs of any subsidiaries that have received a PRF payment but that do not file separate tax returns. Payments for approved applications were scheduled to begin after April 24, 2020, on a weekly, rolling basis.

Terms and conditions of general allocation payments

These payments are considered grants, not loans, and do not need to be repaid. However, a failure to comply with the terms and conditions of the grant[13] may lead to HHS recoupment of the funds.[14]

In addition, the payment is subject to the civil and criminal provisions of the False Claims Act.[15] HHS has indicated that there will be "significant anti-fraud and auditing work," including by the HHS Office of Inspector General.[16] Regardless of future audits, all providers who receive payments from the PRF are required to submit reports to HHS regarding use of the payment.[17]

These terms and conditions are accessed through the PRF Payment Attestation Portal and must be accepted, or the payment returned, within 45 days of receipt of the payment.[18] If a provider does not affirmatively accept the terms and conditions and does not contact HHS to return the payment within 45 days of receipt, HHS shall deem the provider to have accepted the terms and conditions. This time frame was initially 30 days but was later extended to 45 days, likely due to the myriad compliance challenges presented by the terms and conditions and the near-daily pace at which HHS was updating the program in late April and early May. The terms and conditions include[19] certifications regarding eligibility to receive the payment, requirements for reporting and recordkeeping, and several limitations on the provider's use of the payment.[20]