PUBLICATION

Overview of HHS Provider Relief Fund Payments and Updated Guidance

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On May 1, 2020, the Department of Health and Human Services (HHS) announced additional payments under the COVID-19 Provider Relief Fund to reimburse providers for health care related expenses and revenue losses attributable to COVID-19. The new distributions provide $12 billion to 395 hospitals with high numbers of COVID-19 admissions and $10 billion to rural providers. The payments follow $50 billion already distributed to providers based on revenues.

Congress initially appropriated $100 billion for the Relief Fund through the CARES Act, the third stimulus bill to address the COVID-19 pandemic, and has since provided an additional $75 billion to HHS.

Meanwhile, HHS has extended to May 24, 2020, the deadline by when providers should complete an attestation to accept the first payment distribution to providers, which HHS issued on April 10, 2020. HHS continues to update guidance related to how providers can receive funding, complete attestations to accept payments, and comply with terms and conditions.

COVID-19 High Impact Payments

HHS is distributing $10 billion through a High Impact Relief Fund to 395 hospitals that provided inpatient care for 100 or more COVID-19 patients through April 10, 2020. HHS identified the 395 hospitals based on self-reported admissions data from hospitals. The HHS announcement indicates that the 395 hospitals accounted for 71 percent of COVID-19 inpatient admissions reported to HHS across nearly 6,000 hospitals. According to a methodology document issued by HHS, the 395 hospitals received $76,975 per inpatient admission.

HHS paid an additional $2 billion to these hospitals based on their level of care to low-income patients. The methodology document indicates that the hospitals received an add-on payment "in proportion to each facility's share of Medicare Disproportionate Share funding." HHS has not provided additional detail on this methodology, but the agency has indicated that the additional payments are in recognition of the fact that entities that treat large volumes of "Medicare or uninsured populations" often have fewer financial resources and may not be as prepared to "withstand the impacts of the coronavirus."

HHS has published a database listing the 395 hospitals and their payment amounts and has also published a breakdown of the payments by state and, in some cases, county.

Rural Provider Payments

HHS is distributing $10 billion to rural acute general hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers (CHCs) located in rural areas. HHS has published a breakdown of the payments by state and has included providers that received targeted payments for rural providers in a database that includes providers that received a payment from the General Allocation and/or Rural Provider Allocation and have accepted payments.

As outlined in its methodology document, HHS is paying rural acute care general hospitals and CAHs a minimum payment of $1 million, with an add-on payment based on operating expenses as reported on Medicare cost reports. Rural hospitals with annual operating expenses greater than $10,000 are receiving a

base payment of $3 million, plus the add-on payment. Non-hospital sites are receiving a minimum payment of $100,000, plus an add-on payment based on operating expenses.

Eligible providers have begun to receive funds by direct deposit. HHS indicates in its announcement that the payments will be issued based on the physical address of the facility, as reported to the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), regardless of the facility's affiliation with organizations based in urban areas.

Review of Relief Fund Distributions

To date, HHS has issued payments through four separate distributions, outlined below. HHS has published a database of providers who have accepted funding under the General Allocation and/or Rural Provider Allocation and the amounts received. HHS has also shared a breakdown of the first round of General Allocation payments by state and Congressional district.

Relief Fund Allocation	Date Issued	Total Payment Amount	Recipients	Distribution Methodology
General Allocation (Payment 1)	April 10, 2020	$30 billion	Entities that billed Medicare in 2019	Share of 2019 Medicare FFS revenues
General Allocation (Payment 2)	April 24, 2020	$20 billion	Entities that billed Medicare in 2019	Share of 2018 revenues across all payors*
High Impact Allocation	May 1, 2020 (announced)	$12 billion	Hospitals with at least 100 inpatient COVID-19 admissions as of April 10, 2020	Payment per admission + add-on based on Medicare DSH
Rural Allocation	May 1, 2020 (announced)	$10 billion	Rural acute general hospitals, CAHs, RHCs, and rural CHCs	Base payment + add-on based on operating expenses

HHS is viewing the first two distributions as part of the same General Allocation. HHS determined the payment amount under the first round of General Allocation payments based on a provider's Medicare 2019 fee-for-service (FFS) revenues as a share of overall Medicare FFS revenues. Many providers expressed concern that they were at a disadvantage under the methodology, as compared to other providers, because they treat fewer Medicare FFS beneficiaries.

HHS used a different methodology to determine the payment amount under the second round of General Allocation payments and based the payments on a provider's 2018 net patient revenue across all payer sources as a share of all revenues across the country. However, HHS is applying the new methodology to the entire $50 billion distributed through the first two allocations. As a result, the total payment received by a provider between the first and second payments combined is based on the new methodology.

In addition to the four distributions described, HHS is also using a portion of the $100 billion initially provided by Congress for the Relief Fund to reimburse providers for the treatment and testing of uninsured COVID-19 patients. HHS has not indicated what portion of the Relief Fund will be used to fund the COVID-19 Uninsured Program. Providers that have rendered treatment or testing for uninsured COVID-19 patients on or after February 4, 2020, can enroll in the program and submit claims for reimbursement at Medicare rates, subject to available funding. Enrollment in the program opened April 27, 2020, and providers began submitting claims on May 6, 2020.

**HHS is applying this methodology across the total $50 billion distributed through the General Allocation.*

Updated HHS Instructions and Guidance

HHS continues to issue new instructions and guidance related to the Relief Fund payments. For each payment under the Relief Fund, a recipient must accept or reject the funding. To accept the funding, a provider must agree to the terms and conditions associated with the payment. Different terms and conditions documents apply to each payment distribution.

The same allowed and prohibited uses of the funding apply across each terms and conditions document. Recipients must use the funds to "prevent, prepare for, and respond to coronavirus" and "reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus." Recipients may not use the funds to "reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse." Recipients may also not use the funding for salaries above $197,300, and for lobbying expenses.

Attestation Portal

HHS instructs providers to accept or reject each payment by completing an attestation through the Attestation Portal. HHS initially set a deadline for recipients to complete an attestation within 30 days of receiving a payment, but HHS has extended the deadline to 45 days. For providers that received the first payment on April 10, 2020, HHS initially set the deadline to complete the attestation for May 9, 2020. The extended deadline is now May 24, 2020.

HHS previously updated the Attestation Portal instructions to include a formula that providers could use to estimate the total allocation a provider should receive between the first and second payments combined, which HHS refers to as the General Allocation. As of the date of this alert, these instructions no longer appear on the Attestation Portal website.

The formula instructed providers to divide "Gross Receipts or Sales" or "Program Service Revenue" by 2.5 trillion and then multiply by 50 billion. HHS instructed providers to "only attest if you believe the payment you received is consistent with your estimated allocation." Although not stated in the formula, HHS has suggested elsewhere that the payments are based on 2018 net patient revenues.

HHS also requested that providers not attest "if the payments you have received already exceed your estimated total allocation." HHS instructed providers to contact the CARES Provider Relief hotline at 866.569.3522 "if you believe that you have received an overpayment."

Although, as of the date of this alert, this language no longer appears on the Attestation Portal website, and the attestation instructions do not address potential overpayments. HHS has issued an FAQ addressing overpayments, which we discuss below.

General Distribution Portal

HHS has also updated instructions related to the submission of data for providers to receive the second round of payments under the General Allocation. Providers who file Medicare cost reports received an automatic second payment on April 24, 2020, based on cost report revenue data. Providers that do not file cost reports must apply for a second payment by submitting tax returns showing revenue information through a General Distribution Portal.

Information that providers must submit through the General Distribution Portal includes:

1. "Gross Receipts or Sales" or "Program Service Revenue" as submitted on a provider's federal income tax return;
2. Estimated revenue losses in March 2020 and April 2020 due to COVID-19;
3. Most recently filed federal income tax return;
4. Listing of the tax identification numbers (TINs) any of the provider's subsidiary organizations that have received relief funds, but that do not file separate tax returns.

It is not clear whether all of this information is related to how HHS will distribute payments under the second distribution of the General Allocation, as HHS has indicated that the second distribution is based on 2018 revenues. HHS specifies in an FAQ document that the information collected through the General Distribution portal "may also be used in allocating other Provider Relief Fund distributions."

Although cost-reporting entities received automatic payments under the second distribution, they must also submit this data through the General Distribution Portal for HHS to use in verifying the provider's revenue information.

General Distribution FAQs

HHS continues to make updates to an FAQ document addressing the use of the General Distribution Portal and the process to complete attestations. Recent updates address key areas of concern for providers, including potential overpayments, reporting requirements, and the ban on balance billing for Relief Fund recipients:

Overpayments: A new FAQ indicates that, if a provider believes it was overpaid, it should reject the entire payment and submit revenue information through the General Distribution Portal for HHS to use to determine the correct payment. The FAQ does not define what would constitute an overpayment or how a provider would know if it has been overpaid. The FAQ also does not address what a provider should do if it has already completed an attestation to accept a payment and the provider now believes it has been overpaid.

Reporting Requirements: Providers receiving more than $150,000 in funding under the CARES Act and related legislation to address COVID-19 must submit quarterly reports to the government outlining use of funding. A new FAQ confirms that the first quarterly reporting will be for the current calendar quarter, which ends on June 30, 2020. The terms and conditions associated with the Relief Fund payments indicate that reports will be due within 10 days of the end of each calendar quarter. This would appear to make the first reports due by July 10, 2020. The FAQ also indicates that HHS may request additional reports prior to then and that HHS will issue more guidance about the type of documentation the agency will expect providers to submit.

Balance Billing: The terms and conditions associated with the Relief Fund payments prohibit balance billing, but the scope of the ban has not been clear. The terms and conditions describe the ban as applying to all care for a *presumptive* or actual case of COVID-19. A new FAQ defines a "presumptive case" of COVID-19 as "a

case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record."

The FAQs do not address a common question raised by providers related to the attestation process when there has been a change in ownership. In some cases, HHS distributed a Relief Fund payment to a previous owner of a provider organization instead of the current owner. Providers have raised questions as to how the new owner could complete the attestation process to accept the payment, given that the Attestation Portal requires a provider to enter the TIN and bank account number of the entity that received the payment.

Compliance Considerations and Future Payment Distributions

In light of the updates HHS is making to the Relief Fund attestation instructions and associated guidance, providers should continue to monitor the Relief Fund webpage and HHS announcements. In particular, it is possible that HHS could issue additional FAQs before the new deadline to complete attestations for the first round of payments, now set for May 24, 2020.

Meanwhile, HHS has indicated plans for additional Relief Fund allocations, including to providers who may not have received payments due to the methodologies used by HHS. Specific providers noted by HHS as possible recipients of future distributions include skilled nursing facilities, dentists, and providers who are solely recipients of Medicaid.

Of the original $100 billion provided to HHS by Congress, $28 billion remains. As noted above, HHS is using an unknown portion of this amount to fund the COVID-19 Uninsured Program. HHS has not yet indicated how the agency will distribute the additional $75 billion appropriated by Congress.

In recent days, a number of stakeholders have pushed HHS for additional payments to particular provider types and have raised questions about the payment methodologies used by HHS. Safety net hospitals have called for targeted payments to hospitals that treat high volumes of Medicaid and uninsured patients. Long term care providers have asked HHS to provide payments to nursing homes and assisted living facilities. The Medicaid and CHIP Payment and Access Commission (MACPAC) has urged HHS to focus payments on high-Medicaid providers. Democrats in the U.S. House and Senate have also requested information from HHS on the payment methodologies used by HHS and whether providers who treat high volumes of low-income patients have been appropriately targeted.

Baker Donelson continues to monitor coronavirus developments and we will provide information on any further efforts to provide funding to health care providers. For any questions, please contact Sheila P. Burke. You may also visit the Coronavirus (COVID-19): What You Need to Know information page on our website.