HHS Issues Additional Guidance on Qualifications for CARES Act Funding

May 8, 2020

On May 6, 2020, the Department of Health and Human Services ("HHS") issued updated information ("FAQ") related to the $50 billion "General Distribution" to Medicare providers from funds appropriated through the Coronavirus Aid, Relief, and Economic Security ("CARES") Act.[1] The FAQ contains important information about HHS' interpretation of the terms and conditions associated with CARES Act funding. Providers now have 45 days to decide whether to retain the funds and provide the required attestation to the associated terms and conditions or to return the money.

As we highlighted last month, providers could be subject to a government investigation or suit under the False Claims Act ("FCA"), and potentially be subject to large damage awards if they receive money for which they are ineligible (including a larger grant than they are entitled to receive) or spend the CARES Act funding in ways that are contrary to the HHS terms and conditions. Before accepting the funds and providing the required attestation, providers should confirm—and be prepared to document where appropriate—that they are eligible for CARES Act funding; have received the appropriate amount of CARES Act funding; and are spending the funding for appropriate purposes.

Factors to Consider Prior to Signing Attestation

In the updated FAQ, HHS emphasizes that the CARE Act provides that the distributed funds must be used to cover expenses related to COVID-19 and lost revenues. Prior to signing the attestation, providers should consider at least three possible reasons a future audit could conclude they were overpaid from this General Distribution:

[1] We have previously discussed this funding here.

- HHS based the payment on faulty, incomplete or outdated information
    - HHS' initial allocations of funds to providers were made on the basis of 2019 Medicare fee for service data. Subsequent allocations were made by HHS in some instances on the basis of other cost reports regarding total 2018 revenues that providers have submitted to HHS.
    - HHS has opened a portal for providers to provide additional or corrected information on their revenues and expenses.
    - Providers should confirm that all data submitted to HHS for 2018, 2019 and through the provider portal does not contain material errors.
    - HHS posted and then removed formulas for the calculation of the initial $30 billion allocation and the total $50 billion General Distribution fund. Since those formulas appear to have been withdrawn by HHS, providers should not rely on them. Nonetheless, if a provider's initial allocation exceeded 6% of its 2019 Medicare fee for service billings by a material margin or its total allocation exceeded 2% of its total 2018 revenues by a material margin, such a provider should carefully review the data provided to HHS for errors and consider whether it is required to return the funds it has received from HHS.
- The provider received more in funding than it suffered in losses or expenses related to COVID-19
    - Providers should be prepared to prove to an auditor that CARES Act funding was spent for proper purposes. This might entail (i) documenting COVID-19-related expenses and (ii) calculating and recording losses from reduced patient visits and forgone procedures from February through May, 2020—and potentially losses in the upcoming months. To the extent the funds a provider received exceed COVID-19-related expenses or losses incurred, a provider may consider segregating those funds and making use of them only when it incurs subsequent costs or lost revenues.
    - HHS has not yet specified the period during which the losses or expenses must be incurred to qualify. Providers with smaller losses may need to consider whether they reasonably anticipate near-future losses or expenses that may justify their payments.
- The provider received funding from another source (including other COVID-19 related funding) to cover the same losses.

- Providers should document in their internal accounting records which losses or expenses they are covering with these General Distribution funds.

- Some providers will receive funds from multiple sources on top of the General Distribution, including those providers that receive special allocations in COVID-19 high-impact areas or rural hospitals; reimbursements for the treatment of uninsured COVID-19 patients; or small business grants and state grants. Such providers should be particularly careful to document how they are spending each category of funds and be prepared to establish that each source of funding is being spent for an appropriate purpose.

- At this time, it does not appear that an auditor would be likely to consider loans such as Medicare Accelerated or Advance Payments as funding to cover the same loss because such funds must be repaid starting in four months. If any such loans are forgiven in the future, however, providers would likely need to be able to document that those funds were used to cover different losses or expenses than those covered by the General Distribution funds.

Depending on their situation, providers may need to return funds or seek additional funding to achieve the intended portion of the provider's net revenues and cover the providers' losses and expenses. HHS is directing providers who believe they were overpaid to return the ***entire*** payment and then reapply through the provider portal for the correct amount of funding. Providers that believe they were underpaid are still able to seek additional funding from the remaining $20 billion of General Distribution funding. They can read more here and should provide the additional requested information here.

Providers have 45 days from the date on which they receive the payment to decide whether to return the funds or sign the attestation.

Note that HHS is now publishing the amount of funding received by each provider that has completed an attestation.

Balance Billing Bar for Actual or Presumptive COVID-19 Patients

The updated FAQ also provides some additional information on how HHS will interpret the prohibition on "balance billing" patients who are treated for COVID-19 that providers must agree to in order to accept the General Distribution funds. Providers who receive these funds are prohibited from charging out-of-network patients who are treated for "a presumptive or actual case of COVID-19" more for their care than they

would charge an in-network patient—otherwise known as balance billing. HHS has now explained that "[a] presumptive case of COVID-19 is 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."

This definition of "presumptive case" is likely to present challenges to providers who otherwise engage in the practice of balance billing. COVID-19 can present with widely varied symptoms. Given the shortage of tests, particularly in the earlier days of the pandemic, providers may have seen patients without realizing, for example, that a patient's heart attack or pneumonia was triggered by an underlying COVID-19 infection. Even if a provider did suspect COVID-19, if no test was available they may not have ordered one, so there may be no code in the patient's medical record allowing a billing clerk to know the case was a presumptive COVID-19 case. There may also be cases where the COVID-19 diagnosis was missed initially and then made by another provider. Providers should evaluate their billing procedures to determine how billing staff can ensure that they are not balance billing presumptive or actual COVID-19 patients. All new procedures, and their implementation, should be documented and carefully monitored for compliance.

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For more information regarding the legal impacts of the coronavirus, please visit our Coronavirus Resource Center.

Please do not hesitate to contact us with any questions.

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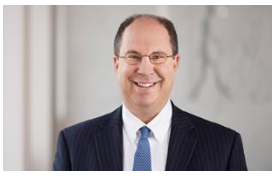
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