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The Provider Relief Fund: Welcome relief or compliance minefield?

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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]

Provider eligibility to receive general allocation payments

Under the terms and conditions, the provider must certify that they are eligible to receive the payment and that they received the appropriate amount. To be eligible for the payment, the provider must certify[21] that it "billed Medicare in 2019; provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked."[22] It is important to note that, for the purposes of the eligibility criteria, HHS considers all patients to be possible cases of COVID-19.[23] However, any provider who did not bill Medicare in 2019 is not eligible, even if they are currently providing COVID-19 care. Any provider who billed Medicare in 2019, but did not provide care after January 31, 2020, is similarly ineligible.

A provider also must certify that the total amount of all payments they received through the PRF is consistent with its estimated allocation. A provider's total estimated allocation is intended to be approximately 2% of their "2018 (or most recent complete tax year) gross receipts or sales/program service revenue." However, the first wave of general allocations included payments to providers of approximately 6.6% of their 2019 Medicare FFS

revenue. This methodology led to certain providers receiving a payment, then being told that it was more than that for which they were eligible. Complicating matters further, HHS initially did not allow providers to remit anything less than the entire payment.

Limitations on provider use of general allocation payments

Perhaps the portions of the PRF requiring the most demystification are the limitations on the use of the PRF payment. There are two[24] primary use limitations:[25]

1. The recipient must certify 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."
2. The recipient must certify that "the Payment will only be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus."

The first is a term relating to the priority of the PRF funding that is common to federal relief programs. If another source has already reimbursed a provider for an expense, the provider may not double-dip by claiming to use the PRF payment for the same expense. For example, if a provider secured funding under the Paycheck Protection Program and used it to pay for April payroll, it may not later claim to use the PRF payment for April payroll as well. Further, if another source is legally obligated to reimburse the provider for an expense, the provider may not use the PRF payment for that expense, regardless of whether the other source has reimbursed the provider yet. For example, if a provider has an insurance policy under which the insurance company is obligated to reimburse the provider for some loss, the provider likely may not use the PRF for that loss, even if the insurance company has not paid out yet.

The second term gives providers two potential and non-mutually exclusive options for how to use the PRF payment. They may use it for healthcare expenses related to coronavirus: PPE, ventilators, etc. By definition, these expenses are "to prevent, prepare for, and respond to coronavirus." While this category of expenses will be substantial for a select group of providers, other providers will have suffered significant decreases in revenue but expended little in the way of providing COVID-19 care, simply by the nature of their business. Fortunately, providers are also able to use the PRF payment as reimbursement for lost revenue attributable to coronavirus. This appears to be the primary goal of the PRF, as other relief sources provide funding for COVID-19 care, and HHS has indicated that it would like the general allocation "to replace a percentage of a provider's annual gross receipts, sales or program service revenue."[26] However, HHS has not provided a specific formula to calculate lost revenue attributable to coronavirus.

Two possible solutions may be found in the methods that HHS has indicated it will accept to calculate lost revenue when a provider applies for additional funding through the General Distribution Portal, as discussed above.[27] HHS describes these methods as examples, indicating they may accept other methods. The first method is the difference between budgeted revenue and actual revenue for March and April of 2020. The second method is the difference between actual revenue in March and April of 2020 and actual revenue in March and April of 2019. Logically, either methodology can be extended to include losses attributable to coronavirus prior to March 2020 and after April 2020. However, a significant change in a provider's business between early 2019 and the present may lead these two methods to yield significantly different calculations of lost revenue. In this situation, a provider should exercise caution before rushing to a calculation that justifies a windfall payment and should carefully document their internal discussions regarding the ambiguity of this term and the provider's good faith attempt at compliance.

When deploying the PRF payment to reimburse lost revenue attributable to coronavirus, a provider must not forget that such a deployment must also be "to prevent, prepare for, and respond to coronavirus." Most likely, using the PRF to reimburse lost revenue *attributable to coronavirus* is also *aresponse to coronavirus*. However, a compliance issue arises where the provider's revenue is used to contract for services, some of which are not COVID-19 related. For example, a provider contracts to split its revenue with a management company, and in return, the management company supplies facilities, equipment, and administrative services. Many, but not all, of the items supplied by the management company will be items that help a provider "prevent, prepare for, and respond to coronavirus." Therefore, simply splitting the PRF payment with the management company is likely a violation of the terms and conditions of the payment. To properly document compliance with the PRF, it is likely that the management company must give the provider line items of the services rendered so that the provider can document that the PRF payment was only deployed to meet those items that satisfy the restrictions on the use of the payment.

Lastly, any provider who receives a PRF payment must agree not to engage in "balance billing" of COVID-19 patients. That is, the provider must certify[28] that "for all care for a presumptive or actual case of COVID-19 … 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" provider.[29] It is worth noting that while HHS considers every patient to be a "possible case of COVID-19," this certification applies only to balance billing of "presumptive or actual" cases of COVID-19.[30] Therefore, while other factors or government programs may affect a provider's ability to balance bill non-COVID-19 patients, this restriction does not.

There are several other use restrictions which are not specific to the PRF or to the coronavirus. Recipients are prohibited from using the funds for:[31] lobbying, providing abortions, embryo research, promoting the legalization of controlled substances, maintaining or establishing a computer network that does not block access to pornography, ACORN funding, needle exchanges, as well as other government-wide general provisions.[32]

Strategies for compliance with use restrictions

As is often the case when receiving federal funds, the key to demonstrating compliance with the restrictions of the PRF is thorough documentation. Separate accounts and separate ledgers for funds received from each relief source are some of the most useful tools. Real-time tracking of usage of supplies and equipment, purchases for COVID-19–related purposes, and all other COVID-19–related activity and projects are also valuable for demonstrating that PRF funds were deployed in an approved way. Some providers may need to establish new internal systems to specifically track COVID-19–related expenses. All providers should document their lost revenue attributable to coronavirus, as well as how they calculated that figure. All providers should also document their compliance with the eligibility criteria. Where the terms and conditions are vague or HHS guidance unclear, the next best course is to document internal discussions to demonstrate a good-faith attempt at compliance.

In brief, HHS views the payment from the PRF as filling the gap in a provider's revenue. Consequently, the provider should document both its gap in revenue due to the coronavirus and that it properly used the payment to fill the gap. It is essential to document how each dollar of the payment was deployed and that each deployment was for an approved purpose, both to file the necessary reports with HHS and to prepare for a potential future audit.

Reporting and record-keeping requirements

All recipients of PRF general allocation payments are required to submit reports to HHS to ensure compliance with the terms and conditions. All recipients must also retain records in accordance with 45 C.F.R. § 75.302 and 45 C.F.R. §§ 75.361–75.365 and make these available upon request to HHS and/or the Office of Inspector General. Additionally, the terms and conditions of the payments require any recipient of more than $150,000 from any federal coronavirus relief effort to submit quarterly reports to HHS and the Pandemic Response Accountability Committee. However, HHS has released guidance that providers need not submit these reports, because the public disclosure of the names of payment recipients and their payment amounts satisfies the requirements of the CARES Act, and HHS at a later date will "develop a report containing all information necessary for recipients of Provider Relief Fund payments to comply with this provision."[33]

Public disclosure and taxability of payments

There are two additional issues relating to the general allocations. The first is public disclosure. HHS has published a list of all providers who received a payment in either general allocation.[34] The data set lists the provider's name, state, city, and the amount they received. The terms and conditions of the second wave of general allocations, but not the first wave, included express consent by the provider to public disclosure of the payment.[35] The second issue is taxation. As of the writing of this article, HHS has not issued guidance on whether PRF payments constitute taxable income or if they are exempt, as are loans under the Paycheck Protection Program.

Targeted allocations for high-impact areas, rural areas, and the Indian Health Service

In addition to the general allocations, HHS will use parts of the Provider Relief Fund for several targeted allocations. First, HHS allocated $12 billion to hospitals in geographic areas that have been particularly affected by COVID-19.[36] Hospitals had to apply for these high-impact funds by April 25, 2020, by submitting to HHS their TIN, National Provider Identifier, total number of intensive care unit beds as of April 10, 2020, and total number of admissions with a positive diagnosis for COVID-19 from January 1 to April 10, 2020.[37] HHS selected 395 hospitals to receive payments under this allocation.[38] These hospitals accounted for 71% of COVID-19 inpatient admissions reported to HHS and all had provided inpatient care for at least 100 COVID-19 patients as of April 10, 2020. These hospitals received a fixed amount per COVID-19 inpatient admission, plus an additional amount based on Medicare and Medicaid disproportionate share and uncompensated care payments. Second, HHS allocated $10 billion for rural health clinics and hospitals. These providers received a minimum base payment ($100,000 for non-hospital providers and $1,000,000 for hospitals) plus an additional amount based on operating expenses. Third, HHS allocated $500 million for Indian Health Service facilities, distributed based on operating expenses.[39] Fourth, HHS allocated $4.9 billion for skilled nursing facilities.[40] Each facility with six or more certified beds was allocated $50,000, plus $2,500 per certified bed. Fifth, HHS allocated $10 billion to safety net hospitals, defined as hospitals with a Medicare Disproportionate Payment Percentage of 20.2% or greater, average uncompensated care per bed of $25,000 or more, and profitability of 3% or less. Sixth, HHS allocated $15 billion to Medicaid and the Children's Health Insurance Program providers who did not receive payment in the general allocations.

Targeted allocation for COVID-19 treatment of the uninsured

For the last of the targeted allocations, payments for COVID-19 treatment for the uninsured, HHS has not allocated a specific amount of funds. Rather, HHS has set up a new claims process.[41] Providers must enroll in the program, check patient eligibility, submit patient information, and submit claims. Providers are eligible to enroll in this allocation if, on or after February 4, 2020, they provided care or treatment related to a positive COVID-19

diagnosis for individuals who were insured at the time services were provided and they are not terminated, excluded, or precluded from Medicare, Medicaid, or other federal healthcare programs.[42] Enrollment opened to providers on April 27, 2020, and HHS began processing claims in early May.

Claims for treatment provided on or after February 4, 2020, are eligible to be paid under this program will be paid at 100% of the Medicare rate or, if there is no Medicare rate, at calculated average rates. It is important to note that this program is for treatment related for *positive diagnosis* of COVID-19 only, where the general allocations discussed above could be used to reimburse for costs associated with actual or potential cases of COVID-19.

Terms and conditions of targeted allocations

The targeted allocations are subject to many of the same terms and conditions as the general allocations. This includes the two primary use limitations discussed above: the payment may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse; the payment will only be used to prevent, prepare for, and respond to coronavirus; and the payment shall reimburse the recipient only for healthcare-related expenses or lost revenues that are attributable to coronavirus. The targeted allocations are also subject to restrictions on balance billing; consent to public disclosure, reporting, and record-keeping requirements; and other government-wide general provisions. Lastly, providers who receive payments from multiple allocations within the PRF must accept the terms and conditions of each payment separately through the specific portal set up for each allocation.

Conclusion

As with many federal programs, the payments from the Provider Relief Fund create compliance challenges for healthcare providers. However, with thorough documentation and consultation with counsel and accounting, providers can overcome these challenges and use the payments to provide the relief intended.

Takeaways

- The Provider Relief Fund includes $175 billion in direct payments to healthcare providers.
- Payments are divided into several distinct allocations.
- Payments are grants with restrictions on how providers may use them.
- Providers must accept or reject the payment and its restrictions within 45 days of receipt.
- Many of the restrictions create compliance challenges for providers.

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