

MICHIGAN SOCIETY OF EYE PHYSICIANS AND SURGEONS

Federal Funding for Health Care Providers Authorized by CARES Act

Updated April 23, 2020

There are two health care provider payment programs established by the CARES Act: (1) the Provider Relief Fund ("PRF") - a grant to eligible health care providers that does not have to be repaid; and (2) the Accelerated and Advanced Payment Program ("AAPP") - a loan available to Medicare providers that is subject to repayment. Physicians participating in Medicare are eligible for each program. A brief summary of each program is provided below. Links to referenced publications are provided in the summary. It is anticipated that additional governmental guidance will be issued for both programs in the coming weeks.

Provider Relief Fund

Due to conflicting statements published by the U.S. Department of Health and Human Services ("HHS"), there continues to be uncertainty for some health care providers as to whether they will be able to certify compliance with one of the Terms and Conditions necessary to retain PRF funds. The uncertainty is due to a conflict between a standard in the HHS Terms and Conditions and statements by HHS in its published guidance.

The standard HHS established in its Terms and Conditions is that a health care provider certifies that it "provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." In contrast, guidance published by HHS suggests that the standard is not as rigid as stated in the Terms and Conditions—"This quick dispersal of funds will provide relief to both providers in areas heavily impacted by the COVID-19 pandemic and *those providers who are struggling to keep their doors open due to healthy patients delaying care and cancelled elective services*" and that "If you ceased operation as a result of the COVID-19 pandemic, you are still eligible to receive funds so long as you provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. *Care does not have to be specific to treating COVID-19. HHS broadly views every patient as a possible case of COVID-19.*"

Health care providers must evaluate on a case-by-case basis their ability to certify compliance with the standard stated by HHS in the Terms and Conditions. It is possible that HHS may be trying to keep its options open to recover PRF funds that it decides, after the fact, that it should not have distributed in the first place. Providers who are uncertain as to whether they can make the certification should consider waiting, until close to their 30-day attestation deadlines, before deciding whether to retain or return the PRF funds, in order to see if HHS issues clarifying guidance.

1. **Definitions.** "Payment" means the funds received from the Public Health and Social Services Emergency Fund ("Relief Fund"). "Recipient" means the health care provider, whether an individual or an entity, receiving the Payment. The CARES Act defines "eligible health care providers" to mean "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 United States (including territories), that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID- 19.”

➤ *See paragraph 5(a), below, for additional standards which eligible providers must satisfy.*

2. **Nature of the Payment.** The Payment is funded by the Relief Fund through an appropriation authorized by the CARES Act. The Relief Fund is administered by HHS to improve the nation’s preparedness against naturally occurring and man-made health threats and threats to the ability of HHS to carry out such missions. The Relief Fund is not part of the Medicare or Medicaid budgets. Although a principal standard for eligibility to receive the Payment is a health care provider’s participation in Medicare or Medicaid, use of the Payment is not limited to services or items related to Medicare or Medicaid patients.
3. **Direct Deposit of Payment.** No application is required. The Payment will be automatically deposited into an eligible provider’s financial institution account via ACH account information on file with UnitedHealth Group or CMS. Automatic payments will be direct deposited to providers via Optum Bank with "HHSPAYMENT" as the description. Payments are made to providers according to their tax identification numbers (TIN). Payments for employed physicians and physicians in group practices will be made to their organizations, not to them individually. Providers who normally receive paper checks for reimbursement from CMS will receive paper checks in the mail for this payment within the next few weeks.
4. **Estimate of Payment Amount.** A provider can estimate its payment by dividing its 2019 Medicare fee for service (FFS) payments (excluding Medicare Advantage) received by \$484,000,000,000 and multiplying that ratio by \$30,000,000,000.
5. **Decision to Keep or Return Payment.** Within 30 days of receipt of the Payment, the Recipient must either (i) sign an attestation confirming receipt of the funds and agree to the terms and conditions or (ii) complete the attestation to indicate that the Payment is rejected and return the funds. The HHS Payment Portal will guide Recipients through the attestation process and may be accessed by clicking [here](#).
 - *Guidance published by HHS to date does not address whether Recipients can return some or all of the Payment after the 30-day period expires. Unless HHS publishes guidance on point, a Recipient which retains the Payment should assume that it will be required to spend the Payment in accordance with requirements of the attestation.*
6. **Terms and Conditions.** As a condition of keeping the Payment, a Recipient must certify by the attestation that it does or will comply with the following requirements and conditions:

- a. 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; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.
 - *There continues to be uncertainty as to the extent that diagnoses, testing, or care must be specific to treating actual or presumptive COVID-19, as stated above at page 1.*
 - *Also see paragraph (g) below on balance billing.*
- b. The Payment will only be used to prevent, prepare for, and respond to coronavirus, and the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.
 - *The CARE Act states that funds are available “to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus” and that “for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity. . . .”*
- c. 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.
- d. It will submit reports as the HHS Secretary determines are needed to ensure compliance with conditions that are imposed on the Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients.
- e. Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) (*i.e., this includes Payments to Recipients which are from the Relief Fund*), 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, shall submit to the Secretary and the Pandemic Response Accountability Committee a report. This report shall contain: the total amount of funds received from HHS under one of the foregoing enumerated Acts; the amount of funds received that were expended or obligated for each project or activity; a 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.

- *To date, HHS has not identified the exact form and content of quarterly reports. It is possible that a standard report for federal grants may be used. Standard form SF-425 can be viewed by clicking [HERE](#).*

f. It shall maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.

- *The referenced federal regulations establish requirements applicable to federal agencies making federal awards to non-federal entities. The regulations generally require award recipients to maintain financial records and supporting documents for three years from the date of submission of the final expenditure report. The record retention requirement is subject to specified exceptions, including the following: (a) If any litigation, claim, or audit is started before the expiration of the 3–year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken; (b) when the recipient is notified in writing by HHS to extend the retention period; (c) records for real property and equipment acquired with federal funds must be retained for 3 years after final disposition; or (d) when recipients must report program income after the period of performance, the retention period for the records pertaining to the earning of the program income starts from the end of the recipient’s fiscal year in which the program income is earned.*
- *Federal authorities have the right to access to any documents, papers, or other records of the recipient pertinent to the federal award, for audits and examinations. The rights of access are not limited to the required retention period, but last as long as the records are retained by the recipient.*

g. The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a possible or actual case of COVID-19, Recipient certifies that 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 Recipient.

➤ *The ban on balance billing—when read together with HHS’ published guidance stating that care does not have to be specific to treating COVID-19, and that HHS broadly views every patient as a possible case of COVID-19—raises the question whether a Recipient is prohibited from balance billing any patient, even if not treated for COVID-19. An HHS spokesperson has been quoted in the media as stating that “The intent of the terms and conditions was to bar balance billing for actual or presumptive COVID-19.”*

- h. Various additional statutory provisions listed in the Terms and Conditions apply, including the following:
 - i. Funds cannot be used to pay the salary of an individual at a rate in excess of \$197,300.
 - ii. Funds cannot be made available to any corporation which has any unpaid, assessed federal tax liability, for which all legal remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the taxing authority.
 - iii. Funds are subject to prohibitions on gun control advocacy, lobbying, abortions, embryo research, legalization of controlled substances, pornography, funding ACORN, funding for needle exchange and other listed matters.
 - iv. Compliance is required with applicable restrictions on confidentiality and non-disclosure agreements, trafficking in persons, whistleblowers and human subjects protections.

7. **Grant and Taxation Treatment.** The Payment does not need to be repaid if retained, but if retained, the Recipient must comply with the requirements of the attestation, including how the Payment is spent.

➤ The CARES Act does not exempt the Payment from federal income taxation. A Recipient should confirm with its tax advisor that spending the Payment as required by the attestation and CARES Act would offset any potential taxable income resulting from receipt of the Payment.

8. **Resources.**

- a. HHS Guidance ([HERE](#)).
- b. Provider Relief Fund Payment Terms and Conditions ([HERE](#)).
- c. CARES Act, see PDF pages 280-284 and in particular page 283-284 ([HERE](#)).

Accelerated and Advanced Payment Program

1. **Nature of Program.** This program is a loan, not a grant. AAPP funds must be repaid. There is no loan forgiveness option under the program.

2. **Eligible Health Care Providers.** Medicare Part A providers and Part B suppliers which meet the following qualifications are eligible:
 - a. Have billed Medicare for claims within 180 days immediately prior to the date of signature on the physician's request form;
 - b. Not be in bankruptcy;
 - c. Not be under active medical review or program integrity investigation; and
 - d. Not have any outstanding delinquent Medicare overpayments.

3. **Amount of Payment.**
 - a. Qualified providers/suppliers will be asked to request a specific amount.
 - b. Most providers/suppliers will be able to request up to 100% of the Medicare payment amount for a previous three-month period.
 - c. Inpatient acute care hospitals, children's hospitals, and certain cancer hospitals are able to request up to 100% of the Medicare payment amount for a six-month period.
 - d. Critical access hospitals can request up to 125% of their payment amount for a six-month period.

4. **Request Form.** Providers/suppliers must complete and submit a one page request form (available [HERE](#)).

5. **Recoupment.** After receiving accelerated or advance payment, providers/suppliers continue to submit their Medicare claims as usual and will receive full claims payments during the first 120 days. At the end of the 120 day period, CMS will begin to apply claims payments to offset the balance of accelerated/advance payments.

6. **Repayment Deadline.** The deadline for repayment varies based on provider or supplier type:
 - a. Inpatient care hospitals, children's hospitals, certain cancer hospitals and critical access hospitals have up to one year from the date the payment was made to repay the balance.
 - b. All other providers and Part B suppliers (including physicians) have to repay the balance 210 days from the date of the payment.

7. **Interest.** No interest is charged on accelerated/advance payments that are repaid by Part B suppliers within 210 days of disbursement. If repayment within this timeframe is a hardship for the practice, physicians can request that the MAC provide an extended repayment plan; however, interest is charged on extended repayment plan payments at 10.25%.

8. **Resources.**
 - a. American Medical Association - Program Summary ([HERE](#)).
 - b. American Medical Association - FAQs ([HERE](#)).
 - c. CMS Fact Sheet ([HERE](#)).