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CLIENT ALERT

HHS Begins Delivery of Cares Act Provider Relief Funding – What Providers Should Consider

April 13, 2020

The Department of Health and Human Services (HHS) released on Friday the initial terms and conditions related to the distribution of the first tranche of the $100 billion Public Health and Social Services Emergency Fund. Rather than await the submission of applications by eligible healthcare providers, HHS has instead begun a rapid delivery of an initial $30 billion in relief funding to providers and suppliers that are enrolled in Medicare and received Medicare fee-for-service reimbursement in 2019. These eligible entities are being allotted a portion of the initial $30 billion distribution based on their proportionate share of the approximately $484 billion of Medicare fee-for-service reimbursements made in 2019. Subsequent distributions will be targeted at providers particularly impacted by the COVID-19 outbreak, rural providers, and providers of services with lower shares of Medicare fee-for-service reimbursement or who predominantly serve the Medicaid population, *e.g.*, nursing homes, pediatric hospitals and pediatricians, and OB-GYNs. Funds will also be used to reimburse providers for COVID-19 care for uninsured Americans.

Providers have begun receiving payments via the Automated Clearing House account information on file used for reimbursements from Centers for Medicare & Medicaid Services (CMS). Providers who normally receive a paper check for reimbursement from CMS will receive a paper check in the mail for this payment over the coming weeks. These payments are not loans and, if used consistent with the applicable terms and conditions, will not need to be repaid. Providers must sign an attestation, which is expected to be released this week, confirming receipt of the funds and agreeing to the terms and conditions of payment within 30 days via online portal. It is these strings attached that providers must be wary of as they make use of these special funds.

Those identified as eligible to receive funds from this first distribution should have received an email on April 10th to that effect. If you believe you are eligible, are reimbursed electronically, but did not receive an email or do not receive a payment via Optum Bank with "HHSPAYMENT" in the payment description, reach out to the CARES Provider Relief line at (866) 569-3522. Importantly, HHS has indicated that an entity is still eligible even if it has ceased operations as a result of the pandemic so long as you provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. Further, HHS has stated that to meet this requirement, care does not have to be specific to treating COVID-19 as "HHS broadly views every patient as a possible case of COVID-19."

Applicable Terms and Conditions

While the required attestation has not yet been released, the applicable terms and conditions at present include the following:

- **Usage Restrictions:** Entities must certify that they will use the funds only for expenses or losses attributable to coronavirus ***and*** that such expenses or losses have not been reimbursed—and are not otherwise obligated to be reimbursed—by other sources. The term "other sources" is not otherwise defined. The statutory language specifically notes that these funds are available for "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" – presumably if not otherwise reimbursable by "other sources." Additionally, there are a number of other FY 2020 consolidated appropriation and government-wide general provisions that apply to the use of the CARES Act funds. For example, the funds may **not** be used (a) to pay the salary of an individual at a rate in excess of Executive Level II ($197,300); (b) for lobbying; (c) for a contract, grant, or cooperative agreement that restricts employees through confidentiality agreements from reporting fraud, waste, or abuse; and (d) to enter into an arrangement with an entity with unpaid Federal tax liability under certain circumstances. Also, the "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections," of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013), the Trafficking Victims Protection Act of 2000, and Human Subjects Protections apply.

- **Out-of-Pocket Payment Restrictions:** Entities must agree not to seek out-of-pocket payments from COVID-19 patients greater than in-network rates.
- **Reporting Requirements:** In addition to further potential reporting obligations that will be set forth at a later date, entities receiving more than $150,000 of funds under any of the three coronavirus-related acts or future acts—not just in this distribution— must provide quarterly reports containing a detailed list of all project or activities for which the funds were expended or obligated, among other requirements.
- **Records Requirements:** Entities must maintain appropriate records and cost documentation to substantiate the reimbursement of costs under this award sufficient to demonstrate compliance with the terms and conditions. Entities must agree to submit copies of such records upon request and comply with all audits by the Secretary, Inspector General, or Pandemic Response Accountability Committee.

If an entity receives a payment distribution and does not wish to agree to these terms and conditions or does not want to sign the attestation, the provider must contact HHS within 30 days of receipt of payment and then remit the full payment to HHS as instructed.

Audits, Investigations, and Potential False Claims Act Liability

In order to mitigate at the outset, entities that choose to use the relief funds should be aware of the risks associated with using the payments. In addition to the reporting requirements mentioned above and those that are forthcoming—which demand continuing compliance with the use restrictions for the funds and impose recordkeeping requirements—use of relief funds also subjects entities to HHS OIG audits related to the funds, as well as potential liability under the False Claims Act (FCA), among other potential liabilities.

The CARES Act provides that HHS OIG shall perform an audit of the relief funds used and must provide a final audit report within three years of final payment to the Senate and House Committees on Appropriations (the Committees). Further, HHS will provide a report to the Committees on the obligation of funds to providers every 60 days. As such, the Act specifically authorizes OIG to audit both interim and final payments made under the program, and entities which elect to use the relief funds must be prepared to submit to these OIG audits. Because of OIG's Congressional reporting obligations, there is both a high likelihood of OIG audit of recipients related to the use of these funds along with added Congressional oversight. For example, the House Ways & Means Committee has itself released guidance on Friday indicating that recipients cannot, for example, balance bill patients. Further, given that use of the funds are limited to necessary expenses or lost revenues due to the pandemic not

otherwise reimbursable from other sources, there may be differences in OIG's interpretation of whether the funds were used for an appropriate purpose. At a minimum, this may necessitate returning certain disallowed funds following an audit.

Providers who accept relief funds should also be conscious of potential liability under the False Claims Act, 31 U.S.C. § 3729, et seq. (FCA). The FCA provides up to treble damages for those who knowingly present, or cause to be presented, a false claim for payment to the government. The FCA also imposes liability on those who knowingly avoid or conceal an obligation to return money back to the government. This latter theory of liability is known as a "reverse false claim." Failure to abide by the terms and conditions could result in FCA liability for providers who make use of the relief funds.

HHS has announced that the relief payments are being made in "lump sum" form and that recipients will not have to request funds before they are deposited in provider accounts. While this automatic disbursement may not constitute a "claim" for purposes of the FCA, that does not foreclose an FCA action. Rather, because use of the funds being distributed is conditioned on a provider's express acceptance of and compliance with the terms and conditions, providers could be liable under the FCA's reverse false claims provision. 31 U.S.C. § 3729(a)(1)(G). A reverse false claim does not require a fraudulent claim or request for payment from the government; it is premised on the theory that a provider, by virtue of a false statement or certification of compliance, has retained money that it is obligated to return to the government. In short, there is little doubt that the FCA will be used as a tool in later actions—whether initiated by government audit or investigation or a whistleblower complaint—asserting that certain recipients have misused the emergency funds.

Recipients of these relief funds should carefully consider their ability to comply with the HHS terms and conditions and should ensure that proper controls are in place for compliant use of the funds. It is imperative that recipients initiate a proactive monitoring program designed to ensure that the funds are both being used for authorized means and that such use is readily verifiable upon audit. Recipients should consult counsel and weigh the potential for liabilities to determine an appropriate risk mitigation strategy based on your unique situation.

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