

Promoting COVID-19 Provider Relief Fund Compliance

The Coronavirus Aid, Relief, and Economic Security Act appropriated \$100 billion for the Provider Relief Fund available to hospitals and other healthcare providers to partially offset reduced revenue and increased costs associated with the COVID-19 pandemic. This money is considered a grant, not a loan, and is separate from the Medicare accelerated payments provisions also included in the CARES Act, which are loans that must be repaid.

To be eligible as a recipient, a healthcare provider must have billed Medicare in 2019; must be an active Medicare provider (e.g., has current billing privileges and has not been terminated); have provided testing or treatment for known or suspected COVID-19 patients after January 31, 2020; and must not be barred from participating in federal healthcare programs. Recipients are identified at the tax identification number level; therefore, employed physicians' payments will be routed to their health system, and group practice members' payments will be routed to their group.

Healthcare providers who receive a grant from the Provider Relief Fund must confirm receipt within 30 days, agree to the terms and conditions described below, and confirm the accuracy of their previously submitted Medicare Cost Report data. If a healthcare provider keeps the grant but does not meet those requirements within 30 days, it is considered to have agreed to the terms and conditions by default. UnitedHealth Group is managing this process, as well as disbursement, for the U.S. Department of Health and Human Services; the portal for confirming receipt and agreeing to the terms and conditions is available [here](#).

Compliance and finance leaders should familiarize themselves with the terms and conditions, as well as educate revenue cycle staff involved in billing and collections, to avoid future risk of false claims concerns. The terms and conditions also apply to healthcare providers' contractors or other pass-through subrecipients. Failure to comply with the terms and conditions also could result in Provider Relief Fund remittances being recouped by HHS.

Where is the money going?

☐ All Medicare providers - \$50 billion

- Half of the Provider Relief Fund (\$50 billion) is being disbursed automatically, in two waves, based on historical Medicare fee-for-service reimbursement and cost report data. The first wave, \$30 billion, was remitted automatically based on 2019 Medicare fee-for-service reimbursement. For example, a healthcare provider that received roughly 1% of Medicare's total fee-for-service payments in 2019 received roughly 1% of the funds in this first wave.
- Another \$20 billion has been or will be remitted automatically based on 2018 Medicare Cost Report data. The second wave of automatic payments is intended to calibrate payments made in the first wave, ensuring the total amount sent to a provider is proportional to expected need. HHS will use cost report data to calculate a second wave payment that, in aggregate with the first wave payment to that provider, results in the provider's portion of the \$50 billion pool matching their percentage of total net patient revenue in 2018. Direct deposits are being used as much as possible; they will appear in

accounts as direct deposits from OptumBank as “HSPAYMENT.” Providers not set up with direct deposit will receive paper checks.

Providers in COVID-19 hot zones - \$10 billion

- Another \$10 billion was set aside for healthcare providers in COVID-19 hot zones through mid-April 2020, such as New York. Recipients were informed that they were eligible to apply, but an application was not guaranteed approval. The deadline for application submissions is 3:00 pm Eastern on Saturday, April 25, 2020.

Rural providers - \$10 billion

- Similarly, \$10 billion was set aside for rural healthcare providers, which are facing exacerbated financial difficulties due to the cancellation of nonemergent services, even if they are not in COVID-19 hot zones. This \$10 billion will be disbursed automatically, and HHS will use operating costs in an attempt to ensure awards are proportional.

Indian Health Services providers - \$400 million

- Another \$400 million was set aside for Indian Health Services healthcare providers and will be disbursed automatically based on operating costs, much like the rural providers' awards.

Other - \$29.6 billion

- Subtracting those amounts from the CARES Act appropriation leaves a pool of \$29.6 billion in the Provider Relief Fund. While exact details have not yet been released, HHS will be setting aside portions of that pool for other specific groups, such as healthcare providers that exclusively bill Medicaid, skilled nursing facilities, and dentists. The remaining funds after those awards are made appear to be what HHS will use to cover the costs of COVID-19 testing and treatment for uninsured individuals.

What are the terms and conditions?

The money must be used to cover COVID-19 costs

- This includes healthcare provided or healthcare-related expenses incurred “to prevent, prepare for, and respond to coronavirus,” as well as expected revenue that was lost due to COVID-19, such as nonemergency services that could not be provided.
- Costs for executive pay are explicitly excluded. Other costs, such as for lobbying, also are excluded. The full terms and conditions, which list all excluded costs, are available [here](#).

The money cannot cover COVID-19 costs if another entity has paid or is required to pay them

- An example is an insured patient's COVID-19 treatment covered by their plan.

Balance billing is restricted

- Insured patients who are out of network cannot be charged cost-sharing amounts higher than what they would have owed had they been treated by an in-network provider if they were known or suspected to have COVID-19.
- Many of the large commercial payers are waiving all cost-sharing amounts for in-network care; therefore, an out-of-network patient with that coverage would not owe any cost-sharing either. Examples of commercial payers waiving COVID-19 treatment and testing cost-sharing (though many have attached expiration dates of May 31, 2020, to their policy) include Aetna ([click here](#) for more information), BlueCross Blue Shield ([click here](#) for more information), Cigna ([click here](#) for more information), Humana ([click here](#) for more information), and UnitedHealthcare ([click here](#) for more information).
- Healthcare providers receiving Provider Relief Fund grants for the cost of COVID-19 testing and treatment for uninsured patients cannot balance bill those patients for that care.

How can we avoid noncompliance?

Meet reporting deadlines

- Quarterly reports are required from any healthcare provider receiving at least \$150,000 from the Provider Relief Fund or from another federal relief fund, including those established by HHS in the future due to the COVID-19 pandemic. The reports must be made to HHS and the Pandemic Response Accountability Committee. While further details on format could be forthcoming, the report must be submitted within 10 days of the quarter's end and must include:

- Total amount received from the Provider Relief Fund or other federal relief fund
 - How those amounts were spent or have been committed to future expenses
 - This includes a project name and description, details about contractors and/or subrecipients being paid to help complete the project, and how many jobs this project created or sustained
 - What amounts remain unspent
- Also be prepared for future audits. The terms and conditions specify that records must meet the accounting criteria in 45 CFR §75.302 and 45 CFR §75.361 - §75.365.

□ Create a unique cost identifier

- A Provider Relief Fund cost center, payment code, or dedicated account will simplify future expense tracking and reporting.

□ Educate billers and follow-up staff

- The business office will need to alter workflows that automatically drop self-pay charges to prevent that from occurring on COVID-19 claims. Self-pay follow-up staff will need to be provided scripting to explain balance billing restrictions to patients—especially if their care results in self-pay charges that do not fall under the restrictions, such as non-COVID-19-related treatment for non-COVID-19 patients.

COVID-19 is an ongoing situation and organizations' processes are changing daily to adapt to various needs during this crisis. As such, this information is up-to-date as of April 24, 2020. HBI is continually monitoring the situation and updating material as we gather additional information. While HBI has attempted to ensure the accuracy of research provided in this document, the information has been obtained from numerous resources. Therefore, HBI cannot guarantee its accuracy and is not liable for any claims or losses that arise from errors or omissions within this document.