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May 4, 2020

Re: The CARES Act, the Department of Health and Human Services (HHS) and the Provider Relief Fund.

Information relevant to the foregoing subject and topics.

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Gentlepersons,

Division B of the CARES Act stipulates:

DIVISION B—Emergency appropriations for coronavirus health response and agency operations

TITLE VIII
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of The Secretary
Public Health and Social Services Emergency Fund
(including transfer of funds)

For an additional amount for "**Public Health and Social Services Emergency Fund**", $100,000,000,000, to remain available until expended, 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**:

- Provided,
  That these funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse:

- Provided further,
  That recipients of payments under this paragraph shall submit reports and maintain documentation as the Secretary determines are needed to ensure compliance with conditions that are imposed by this paragraph for such payments, and such reports and documentation shall be in such form, with such content, and in such time as the Secretary may prescribe for such purpose:

- Provided further,
  That "**eligible health care providers**" means 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,
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testing, or care for individuals with possible or actual cases of COVID–19:

- Provided further,
  That the Secretary of Health and Human Services shall, on a rolling basis, review applications and make payments under this paragraph in this Act:

- Provided further,
  That funds appropriated under this paragraph in this Act shall be available 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:

- Provided further,
  That, in this paragraph, the term "**payment**" means a pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary:

- Provided further,
  That payments under this paragraph shall be made in consideration of the most efficient payment systems practicable to provide emergency payment:

- Provided further,
  That to be eligible for a payment under this paragraph, an **eligible health care provider** shall submit to the Secretary of Health and Human Services an application that includes a statement justifying the need of the provider for the payment and the eligible health care provider shall have a valid tax identification number:

- Provided further,
  That, not later than 3 years after final payments are made under this paragraph, the Office of Inspector General of the Department of Health and Human Services shall transmit a final report on audit findings with respect to this program to the Committees on Appropriations of the House of Representatives and the Senate:

- Provided further,
  That nothing in this section limits the authority of the Inspector General or the Comptroller General to conduct audits of interim payments at an earlier date:

- Provided further,
  That not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall provide a report to the Committees on Appropriations of the House of Representatives and the Senate on obligation of funds, including obligations to such eligible health care providers summarized by State of the payment receipt:

- Provided further,
  That such reports shall be updated and submitted to such Committees every 60 days until funds are expended:

- Provided further,

> That such amount is designated by the Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

(See: CARES Act at: https://www.congress.gov/bill/116th-congress/house-bill/748/text#toc-H165BCD10ED84484EA6114C0F6FF4E663 or see: https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf)

The following information related to the Relief Fund is taken from the **Department of Health and Human Services (HHS)**, **Centers for Medicare and Medicaid Services (CMS)** website, in part. (https://www.hhs.gov/provider-relief/index.html)

CARES Act Provider Relief Fund
UPDATE: The CARES Act Provider Relief Fund Payment Attestation Portal is now open. Providers who have been allocated a payment from the initial $30 billion general distribution must sign an attestation confirming receipt of the funds and agree to the terms and conditions within 30 days of payment.

Immediate infusion of $30 billion into healthcare system
Recognizing the importance of delivering funds in a fast and transparent manner, The Secretary of HHS have distributed $30 billion of the $100 billion relief immediately – with payments arriving via direct deposit beginning April 10, 2020 – to eligible providers throughout the American healthcare system. **These are payments, not loans, to healthcare providers, and will not need to be repaid.** However, since they monies are tied to a providers Tax Identification Number (TIN), the monies may be taxable.

Who is eligible for initial $30 billion:
- All facilities and **providers** that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution.
  - All relief payments are made to the billing organization according to its Taxpayer Identification Number (TIN).
  - As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.
- 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.

How are payment distributions determined?
- Providers will be distributed a portion of the initial $30 billion based on their share of total Medicare FFS reimbursements in 2019. Total FFS payments were approximately $484 billion in 2019.

What to do if you are an eligible provider
- HHS has partnered with UnitedHealth Group (UHG) to provide rapid payment to providers eligible for the distribution of the initial $30 billion in funds.
- Providers will be paid via Automated Clearing House account information on file with UHG or the Centers for Medicare & Medicaid Services (CMS).
  - The automatic payments will come to providers via Optum Bank with "HHSPAYMENT" as the payment description.

  - Providers who normally receive a paper check for reimbursement from CMS, will receive a paper check in the mail for this payment as well, within the next few weeks.
  - Within 30 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment. Click here to sign the attestation and accept the Terms and Conditions .
- HHS' payment of this initial tranche of funds is conditioned on the healthcare provider's acceptance of the Terms and Conditions - PDF, which acceptance must occur within 30 days of receipt of payment. Not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions, the provider must do the following: contact HHS within 30 days of receipt of payment and then remit the full payment to HHS as instructed. The CARES Act Provider Relief Fund Payment Attestation Portal will guide providers through the attestation process to accept or reject the funds.

Is this different than the CMS Accelerated and Advance Payment Program?
Yes. The CMS Accelerated and Advance Payment Program has delivered billions of dollars to healthcare providers to help ensure providers and suppliers have the resources needed to combat the pandemic. The CMS accelerated and advance payments are a loan that providers must pay back. For more information from CMS, click here. *(Information regarding this program will be sent in a separate message)*

How this applies to different types of providers
All relief payments are being made to providers and according to their tax identification number (TIN).

- *Employed Physicians:* Employed physicians should not expect to receive an individual payment directly. The employer organization will receive the relief payment as the billing organization.
- *Physicians in a Group Practice:* Individual physicians and providers in a group practice are unlikely to receive individual payments directly, as the group practice will receive the relief fund payment as the billing organization. Providers should look to the part of their organization that bills Medicare to identify details on Medicare payments for 2019 or to identify the accounts where they should expect relief payments.
- *Solo Practitioners:* Solo practitioners who bill Medicare will receive a payment under the TIN used to bill Medicare.

Be aware of the Terms and Conditions, including the provision that HHS stipulates that the Terms and Conditions must be accepted in order to take possession of the funds allocated. Part of the Terms and Conditions state:

> "The Recipient certifies 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; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked." (Emphasis added.) (https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions-04132020.pdf)

What the specific highlighted terms immediately above mean exactly is not clear or readily known. To muddy the waters further, HHS updated its web page recently adding:

> "Care does not have to be specific to treating COVID-19. HHS broadly views every patient as a possible case of COVID-19." (https://www.hhs.gov/provider-relief/index.html)

Again, the meaning and intent of these two provisions are not explicit or clear.

Nevertheless, the member needs to be aware that HHS **Terms and Conditions** must be accepted within 30 days of receipt of payment. Not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions. If a provider receives payment and does not wish to comply with the Terms and Conditions, she must contact HHS within 30 days of receipt of payment and then remit the full payment to HHS as instructed.

Lastly, the same day HR 266 was enacted on April 24, 2020, increasing the monies available to HHS for the Healthcare Provider Relief program, HHS announced that it will be disbursing an additional $20B of the initial $50B allotment earmarked to providers. Specifically, HHS indicated that "Medicare providers for whom HHS did not have adequate cost report data on file will need to submit their revenue information to the General Distribution Portal to be able to receive additional general distribution funds and agree to the Terms and Conditions for this additional distribution. Providers who received their additional money automatically will still need to submit their revenue information so that it can be verified via the portal. Click here for FAQs on the General Distribution Portal - PDF.

The bottom line is that the NYSCA cannot decide for the member whether a member should accept the Relief Fund payment from HHS or not. The Association strongly recommends that every NYSCA member who billed Medicare in 2019 and is likely due a payment from the CARES Act Provider Relief Fund to carefully review both the Terms and Conditions to the Fund and the CARES Act Provider Relief Fund web page. Members should use her or his professional judgment. If a member feels that s/he cannot abide by the Provider Relief Fund Terms and Conditions, the member must return the funds received to the HHS as instructed.