CARES ACT INCREASED FUNDING FOR THE PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

by Jeremy L. Belanger and Mark E. Wilson

The Coronavirus Aid, Relief, and Economics Security Act (the "CARES Act") provided additional funding for the U.S. Department of Health and Human Services' ("Department") Public Health and Social Services Emergency Fund (the "Fund") to assist health care providers.

The Department's guidance indicates that the following "providers" that would qualify for funds are large organizations and health systems that bill Medicare, organizations that employ physicians and bill Medicare, group practices that bill Medicare, and solo practitioner that bill Medicare. Physicians in organizations and group practices should not expect to receive any funds directly, as the payments will go to the organization that bills Medicare.[1]

This Fund is different than many other Medicare programs. Under the Accelerated Payment program, which was also expanded by the CARES Act, accelerated payments provided to certain hospitals are loans that must be repaid. The Fund has been created to provide payments, not loans, to health care providers that bill Medicare, and will not need to be repaid so long as the provider qualifies and complies with the requirements of the Fund.

The funds are being provided to support health care-related expenses or cover lost revenue attributable to COVID-19. The Department has determined that every patient is a possible case of COVID-19 and that care not specifically related to COVID-19 can cause health care related expenses attributed to COVID-19. Thus, funds are available, even if qualified provider performs services that are not to treat COVID-19. However, the CARES Act does not define "lost revenues that are attributed to coronavirus." Providers should be prepared to estimate lost revenues and lost operating margins including lost revenue from replacing procedures with higher reimbursements to those with a lower reimbursement, lost volume due to lower capacity, cancelled procedures, and a lower number of providers.

In order to qualify, a health care provider must certify the following:

1. The provider billed Medicare fee for service (not Medicare Advantage) in Calendar Year ("CY") 2019;
2. The provider currently provides diagnoses, testing, or care for possible or actual COVID-19 patients;
3. The provider has not been terminated by Medicare, is not currently excluded from participation in Federal health care programs, and has not had its Medicare billing privileges revoked;
4. The payment will only be used to prevent, prepare for, and respond to COVID-19;
5. The provider will only be reimbursed for healthcare-related expenses or lost revenue attributed to COVID-19 and the funds will not be used to reimburse expenses or losses reimbursed by other sources.

Providers with unpaid federal tax liability or federal criminal felony convictions within the past 24 months do not qualify for the payments. Additionally, entities that capture or procure chimpanzees from the wild, including for research purposes, do not qualify for funds.

The Fund requirements include restrictions on confidentiality and nondisclosure provisions in agreements with employees and contractors. Providers will need to review agreements with their employees and independent contractors prior to certifying compliance with the Fund's requirements. Providers with strict confidentiality provisions and nondisclosure provisions may not qualify for payments and, if received, would need to remit the payment to the Department. Providers may need to amend their agreements to ensure compliance, as the Department requires certain terms to be included in these provisions.

Recipients of the funds will be required to submit reports required by the Department to ensure compliance. Entities that receive more than $150,000 in funds under a CARES Act or any other COVID-19 response act must submit a report within 10 days after the end of each Calendar Year quarter. The report must contain the total amounts received from the Department, a detailed list and description of projects or activities the funds were used for, and detailed information for any subcontracts or subgrants awarded by the recipient.

The Department is making the initial infusion of $30 billion automatically via direct deposit to qualified providers beginning on April 10, 2020. Providers can estimate their payments by calculating their CY 2019 Medicare fee for service payments, excluding Medicare advantage payments, and dividing that amount by $484 billion and then multiplying that ratio by $30 billion.

Providers will be required to sign the Terms and Conditions (the "Terms") within 30 days of receipt of the initial payments, but failure to do so does not require remittance of the funds. Failure to return signed Terms is treated as an acceptance of the Terms and providers will be required to comply with the

[1] https://www.hhs.gov/provider-relief/index.html

Terms. Providers who do not want to comply with those terms must inform the Department and remit the full payment.

There are numerous restrictions on use of the payments received, which may impact whether providers want to accept the Terms. These limitations include:

a. Payments cannot be used to pay the salary in excess of Executive Level II, which is $197,300 for CY 2020.
b. Providers must not collect out-of-pocket expenses from a COVID-19 patient greater than the in-network cost required.
c. The payments cannot be used to advocate or promote gun control.
d. The provider cannot use any part of the payments to influence, support, or defeat any federal or state legislation, regulation, administrative action, or order.
e. The provider cannot use the funds for any abortion unless the pregnancy is the result of rape or incest or the pregnancy places the woman in danger of death.
f. The provider cannot use the funds for embryo creation or research or other embryo research in which embryos are destroyed, discarded, or knowingly subjected to risk of injury or death.
g. The provider cannot promote the legalization of any drug or other substance located on Schedule I of the list of controlled substances (e.g., marijuana) unless there is significant medical evidence of a therapeutic advantage.
h. Funds cannot be used to set up a computer network unless it is designed to prevent the viewing, downloading, or exchange of pornography.
i. The funds cannot be used to purchase sterile needles or syringes for illegal drug use unless there is a state or local health department determination that there is or is a risk for a significant increase in hepatitis or HIV.
j. The funds cannot be used for publicity or propaganda purposes.

An additional $70 billion in funding is available, and there will be targeted distributions to areas particularly impacted by COVID-19, such as rural providers, providers with lower Medicare reimbursements, providers who predominantly serve Medicaid patients, and providers treating uninsured Americans.

There are many elements of the Terms and the Fund which can carry risks for health care providers receiving funds. Dickinson Wright's health care attorneys can assist providers in navigating this process to ensure compliance with the Fund's requirements.

ABOUT THE AUTHORS

Jeremy L. Belanger is an Associate in Dickinson Wright's Troy office. He can be reached at 248.433.7542 or jbelanger@dickinsonwright.com.

Mark E. Wilson is a Member in Dickinson Wright's Troy office. He can be reached at 248.433.7581 or mwilson@dickinsonwright.com.