



## Health and Human Services Distributes \$30B in Relief Grants

On April 10, 2020, the Department of Health and Human Services began distributing \$30 billion from the \$100 billion health care provider portion of the Coronavirus Aid, Relief, and Economic Security (CARES) Act to support COVID-19 impacted health care providers. Another \$20 billion was distributed beginning April 24. These are grants and do not have to be repaid.

### Key Takeaways

- Funds were allocated using a formula that generally conveyed 6.2% of an eligible recipient's 2019 Medicare FFS revenue.
- Funds were directly deposited by United Healthcare Group into accounts of providers with electronic fund transfer arrangements; providers paid with paper checks will receive their share of the funds by paper checks, and that may take a few weeks to be processed and received.
- By accepting payment, a recipient must agree to a set of terms and conditions (10-pages) within 30 days of receipt of payment. The electronic portal for a fund recipient is at <https://covid19.linkhealth.com/>, and the terms and conditions have changed from when the portal first became available. Fund recipients should carefully review the Terms and Conditions that they are asked to accept. The terms are in effect until the funds have been fully exhausted.
- HHS used 2019 Medicare revenues as a proxy for allocating funds and a means for distributing funds quickly. Due to this, the funds included Part B drug payments in the totals. Providers with little or no Medicare FFS revenue were left out by this approach. HHS indicated that the distribution of the remaining \$70 billion will focus on providers in hotspot COVID-19 areas, and rural providers and providers that may not have been eligible for this first round of funding, including providers with lower shares of Medicare reimbursement or that predominantly serve the Medicaid population.

### Eligible Recipients

Hospitals, physicians and others who had FFS Medicare reimbursement in 2019.

### Summary of Current Terms and Conditions (TC)

Eligible providers must meet the following criteria:

- The provider currently provides diagnoses, testing or care for individuals with possible or actual cases of COVID-19. HHS considers any patient as being a potential case.
- The provider is not currently terminated from participation in Medicare and has billing privileges.
- The provider is not currently excluded from participation in Medicare, Medicaid and other federal healthcare programs.
- Unlike some of the other funding sources available to providers in response to the COVID-19 pandemic (e.g., Medicare Advance Payment Program), the payments from the fund are not loans, and providers will not be required to repay them. HHS is distributing the funds in a rapid fashion, with payment generally arriving through direct deposit starting on April 10.
- Providers must certify to the TC within 30 days of accepting the funds.
- For the distribution of the \$30 billion, HHS has calculated grants based on 6.2 percent of the recipient's full 2019 Medicare FFS payments including copayments.
- All relief payments are made to providers according to their tax identification number (TIN). Large organizations and physician group practices will receive relief payments from their billing TINs. Physician group practices will receive payments under the TIN

at which they receive payments from Medicare. Employed physicians will not receive an individual payment; the payment will go to their billing organization.

- If a provider receives payment and does not wish to comply with the TC, the provider must contact HHS within 30 days of receipt of payment and return the full payment to HHS.
- Recipients who receive funds totaling more than \$150,000 from various COVID-19 funding streams must report quarterly on the use of these funds. Does not include Advanced Payments made through your MAC.
- Recipient 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 (i.e., Part B drugs).
- A balance billing provision that is now clarified to only be applicable for actual COVID-19 care. Recipient will charge patients for care associated with presumptive or actual case of COVID-19 only the amount that the patient would have otherwise been required to pay if the care had been provided by an in-network provider, and the Recipient will not seek to collect from the patient out-of-pocket expenses in a greater amount.

### **Next Steps**

Many of the TC are ambiguous and confusing; some may be perceived as onerous. Members should continue to seek clarification with their attorneys and/or accountants. Recipients should carefully consider the gravity of the TC.