Health Care Alert: HHS CARES Act Relief Funding Guidance Addresses Provider Compliance Obligations, Highlights Potential FCA Risk

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As discussed in our previous client alert, the Coronavirus Aid, Relief and Economic Security (CARES) Act authorized the distribution of billions of dollars in provider relief funding to mitigate the devastating effects of the COVID-19 pandemic on the health care industry. Although this funding offers much-needed relief for many providers, accepting it means certifying compliance with the related Terms and Conditions – including the requirement that provider relief payments will be used to reimburse the recipient only for "health care related expenses or lost revenues that are attributable to coronavirus." Providers of all types have been grappling with the meaning of these phrases. If the interpretation of these concepts is later found to be inappropriate, health care providers could face substantial financial liability, including under the False Claims Act (FCA).

Background: HHS Distribution of CARES Act Relief Funding

Of the initial $100 billion of provider relief funding authorized under the CARES Act, $50 billion was allocated for general distribution to Medicare facilities and providers impacted by COVID-19. To be eligible for this general distribution, a provider must (1) have billed Medicare in 2019, and (2) have provided, after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. According to guidance from the department of Health and Human Services (HHS), the agency "broadly views every patient as a possible case of COVID-19."

To expedite providers getting money as quickly as possible, HHS made an initial, automatic disbursal of $30 billion from the general distribution, allocated proportionately to each provider's share of Medicare fee-for-service reimbursements in 2019. The remaining $20 billion of the general distribution is being allocated so that the overall $50 billion general distribution will be based on net patient revenue in 2018 from all sources, not just Medicare, and the balance of the CARES Act provider relief funding will be divided into targeted allocations for areas and provider types that have been particularly impacted by the

COVID-19 outbreak. Most recently, HHS announced a targeted allocation of $4.9 billion to skilled nursing facilities (SNFs), stating that each certified SNF with six or more certified beds will be eligible to receive a fixed distribution of $50,000, plus a distribution of $2,500 per bed.

Compliance Obligations of CARES Act Relief Funding Recipients

Generally, HHS states that providers will **not** be required to repay any CARES Act relief funds they receive, so long as the applicable terms and conditions are satisfied. However, these Terms and Conditions expressly state that "full compliance" is material to HHS' decision to disburse the funds, suggesting that even technical errors could serve as the basis for a repayment demand (and potential FCA liability).

In addition to imposing detailed reporting and recordkeeping requirements, as noted above, the Terms and Conditions require recipients to certify that provider relief payments will be used to reimburse only "health care related expenses or lost revenues that are attributable to coronavirus." In FAQ guidance published this week, HHS clarifies that eligible "health care related expenses" may include (without limitation):

- Supplies used to provide health care services for possible or actual COVID-19 patients;
- Equipment used to provide health care services for possible or actual COVID-19 patients;
- Workforce training;
- Developing and staffing emergency operation centers;
- Reporting COVID-19 test results to federal, state, or local governments;
- Building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide health care services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- Acquiring additional resources, including facilities, equipment, supplies, health care practices, staffing, and technology to expand or preserve care delivery.

"Lost revenues" eligible for reimbursement may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care, and provider relief funds may be used to cover any cost that (1) prevents, prepares for, or responds to COVID-19; and (2) otherwise would have been covered by such lost revenue. Notably, HHS appears to interpret the former requirement broadly, stating expressly that provider relief funds may be used to cover:

- Employee or contractor payroll;
- Employee health insurance;
- Rent or mortgage payments;
- Equipment lease payments; and
- Electronic health record licensing fees.

The new FAQ guidance also contemplates that instructions regarding "the types of documentation [HHS will] expect recipients to submit" are still forthcoming, so it will be imperative for providers to continue monitoring for updates. In the meantime, providers should carefully account for each CARES Act provider

relief dollar spent, thoroughly documenting "health care related expenses or lost revenues that are attributable to coronavirus."

Potential FCA Risk

The FCA authorizes fines of up to three times the governments' loss plus per-claim penalties of up to $23,330[1] for (among other things) every government payment obligation improperly avoided, including an "overpayment"[2] that is not timely investigated and returned. In addition, the HHS Office of Inspector General (OIG) may impose significant civil monetary penalties (CMPs) for FCA violations, and OIG recently published a proposed rule that would both (1) establish new CMP authorities applicable to federal "grants, contracts, and other agreements," and (2) implement increases in maximum penalty amounts that were authorized in the Bipartisan Budget Act of 2018 (for more information, see our previous client alert).

Particularly in light of the fact that the FCA's "qui tam" provisions allow private whistleblowers to bring suit on behalf of the government (and share in its financial recovery), providers certifying compliance with the provider relief funding Terms and Conditions must take proactive measures to ensure they are prepared should they face scrutiny after the dust has settled. Notably, HHS recently added FAQ guidance for providers seeking to retract an attestation, stating that they may do so by calling the provider support line (866-569-3522, extension 711). After each of the large expenditures of federal disaster relief funds, such as Hurricane Katrina and the 2008 banking crisis, the Department of Justice made significant efforts to recoup funds distributed under the respective programs. Every indication exists that this will occur again.

If you have questions about the terms and conditions of your relief funding, steps you should be taking to document how the funds are being used, or about HHS CARES Act provider relief funding generally, please contact Liam Gruzs, Nita Garg, Mairi Mull, or your regular Vorys attorney.

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VORYS COVID-19 TASK FORCE

Vorys attorneys and professionals are counseling our clients in the myriad issues related to the coronavirus (COVID-19) outbreak. We have also established a comprehensive Coronavirus Task Force, which includes attorneys with deep experience in the niche disciplines that we have been and expect to continue receiving questions regarding coronavirus. Learn more and see the latest updates from the task force at vorys.com/coronavirus.

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[1] This limit is adjusted annually for inflation.

[2] In this context, an "overpayment" includes any payment to which a provider was not entitled.