Illinois Health and Hospital Association

FACT SHEET

(Updated May 1, 2020)

Provider Relief Fund: Distribution of Tranche One

- **Description of Provider Relief Fund**: $175 billion in total funds available to hospitals, health systems, and other providers. Hospitals may *apply* for funding to "prevent, prepare for, and respond to coronavirus." Providers will be reimbursed through grants and other payment mechanisms. The Department of Health and Human Services (HHS) announced on April 10 that there will be three rounds of funding from the provider relief fund, with tranche one (described below) beginning April 10. (Established in the CARES Act.)
- **Tranche One:** Beginning April 10, HHS infused $30 billion into the healthcare system. These are payments, not loans, and do not need to be repaid so long as the conditions described below are met. An HHS announcement, including detailed information about the distribution and use of the tranche one, is available here.
- **Eligible providers**: All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for tranche one payments.
- **Payment Determinations:** Facilities and providers will be paid based on their share of total Medicare FFS reimbursement in 2019. Total FFS payments were approximately $484 billion in 2019.
    - Providers can estimate their payment from tranche one by dividing their received 2019 Medicare FFS payments by $484 billion. Medicare Advantage payments should not be included in the provider's 2019 payment total.
    - For questions about Tranche One payments, please call the CARES Provider Relief Hotline at **1-866-569-3522.**
- **Eligible expenses**:
    - Healthcare-related expenses or lost revenues *not otherwise reimbursed* and directly attributable to COVID-19.
    - Examples include forgone revenue from cancelled procedures; building or construction of structures (including retrofitting); medical supplies and equipment, personal protective equipment (PPE); testing; and increased staffing or training. These examples are based on plain reading of legislative text, however final determination is subject to forthcoming HHS guidance.
    - Provider Relief Funds may not be used for expenses or losses that have been reimbursed from other sources, or that other sources are *obligated* to reimburse. Even if qualified expenses are *eligible* for reimbursement from another mechanism, an entity may still apply for funding from the Provider Relief Fund while simultaneously applying for funding from other sources. However, should the entity subsequently receive reimbursement for expenses from any

other source after receiving funding for the same expenses from the Provider Relief Fund, the entity will be required to repay the funding it received from the Provider Relief Fund.

- **How to receive payments:** HHS is working with UnitedHealth Group (UHG) to distribute payments to eligible providers. Providers will be paid via Automated Clearing House account information on file with UHG or CMS. Automatic payments will be distributed to providers via Optum Bank with "HHSPAYMENT" as the payment description. Providers that normally receive paper checks from CMS will receive a paper check in the mail within the next few weeks.
    - *Large Organizations and Health* Systems: Payments will be made for each billing TIN that bills Medicare.
    - *Employed Physicians*: Employed physicians will not receive individual payments directly; rather, employer organizations will receive all payments as the billing organization.
    - *Physicians in a Group Practice*: Individual physicians and providers in a group practice are unlikely to receive individual payments; rather, the group practice will receive the payment as the billing organization.
- **Conditions of Receiving Funds:** Within 30 days of receiving this payment, providers must sign an attestation confirming receipt of the funds and agreeing to the Terms and Conditions of payment via the HHS attestation **portal**.
- **Terms and Conditions of Payment**: Providers must accept the Terms and Conditions as determined by HHS **within 30 days of receipt of payment. Providers must visit the HHS attestation portal to accept the terms and conditions.** If a provider does not wish to comply with these Terms and Conditions, they must contact HHS within 30 days of receipt of payment for instructions on how to remit the full payment. Terms and Conditions include certification that the recipient:
    - Billed Medicare in 2019;
    - Provides or provided after Jan. 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19;
    - Is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D;
    - Is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs;
    - Does not currently have Medicare billing privileges revoked;
    - Will only use payment to prevent, prepare for, and respond to coronavirus, ad that the payment shall reimburse the recipient only for health care related expenses or lost revenues that are attributable to coronavirus;
    - **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**;
    - Shall submit reports as the Secretary of HHS determines are needed to ensure compliance with conditions that are imposed on the payment;
    - Certifies that all current and future provided information is true, accurate and complete to the best of the recipient's knowledge and that any deliberate

omission, misrepresentation, or falsification of any information may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment;

- **Within 10 days of the end of each calendar quarter**, recipients that receive **more than $150,000 total in funds** under the CARES Act, the Coronavirus Preparedness and Response Supplemental Appropriates Act, the Families First Coronavirus Response Act, or any other Act primarily making appropriations for the coronavirus response and related activities, **shall submit to the Secretary of HHS and the Pandemic Response Accountability Committee a report.** The report must contain the following:
  - Total amount of funds received from HHS under any Act making appropriations for the coronavirus response;
  - Amount of funds received that were expended or obligated for each project or activity;
  - Detailed list of all projects or activities for which large covered funds were expended or obligated, including project names, descriptions, and the estimated number of jobs created or retained by the project (where applicable);
  - Detailed information on any level of subcontracts/subgrants awarded by the covered recipient or its subcontractors/subgrantees. This must include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.
- Maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR 75.302 – Financial Management, and 45 CFR 75.361 through 75.365 – Record Retention and Access. Other information required by future program instructions to substantiate the reimbursement of costs under this award must also be maintained. This includes prompt submission of copies of any required records and cost documents upon the request of the Secretary of HHS.
- Full cooperation in all audits the Secretary of HHS, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.
- Should a patient with possible or actual COVID-19 require treatment from an out-of-network provider, the provider must refrain from collecting any out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient.
- There are several other statutory provisions within the Terms and Conditions. Please refer to the link above prior to accepting the Terms and Conditions.

- **IHA recommends***:* Hospitals are urged to closely **track their COVID-19 expenses, and the finance stream used to pay for those expenses, using a tool similar to this.** For example, hospitals should consider:
    - Creating a specific pay code for employees, identifying hours spent to support the command center, COVID screening, and additional COVID-19-related shifts;
    - Using Google sheets to track high-risk or back-ordered supplies;
    - Tracking overtime for permanent employees associated with COVID-19;
    - Tracking both regular and overtime hours spent associated with COVID-19 for unbudgeted employees;
    - Tracking management costs and keeping detailed timesheets of employees performing grant management and other duties related to COVID-19; and
    - Tracking any donated resources from volunteer organizations, which may be used to offset the non-federal share for your hospital or health system.

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