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COVID-19 Financial Relief for Providers: CARES Act Provider Relief Fund, Uninsured Program, and Coverage Issues

Moderator:
Nina Marsden

Presented by:
- Paul Garcia
- Katrina Pagonis

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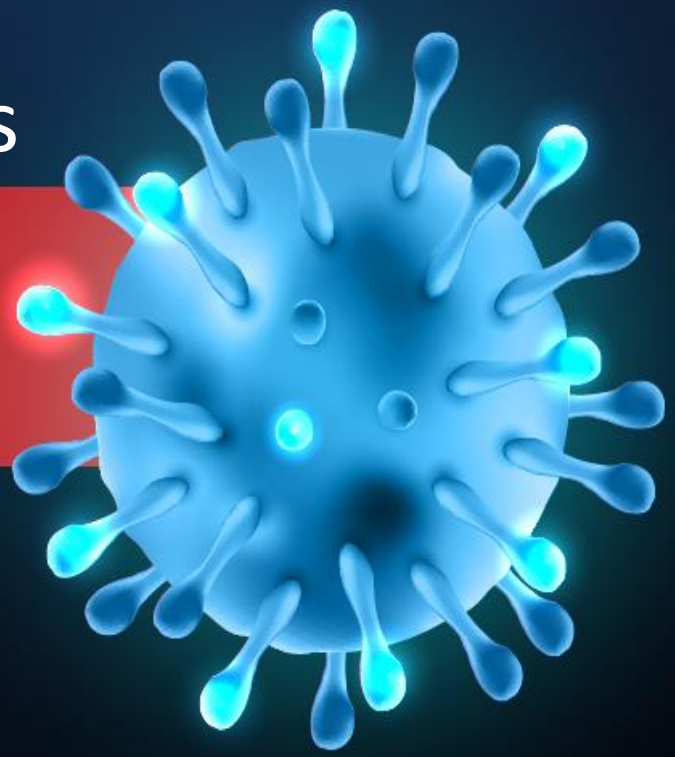
Hooper, Lundy & Bookman's

Coronavirus COVID-19

Updates and Resources



For links to guidance from various state and federal agencies regarding COVID-19 go to www.hlbcovid19.com

Relevant Guidance

HLB Webinar: COVID-19 Financial Relief for Providers—Supplemental Payments, Loans, and Beyond (April 16, 2020)

- Webinar Audio Recording
- Webinar Slides

HLB Insights: Financial Relief Guide (UPDATED April 27, 2020)

HLB has assembled a Financial Relief Guide to help health care providers identify and access financial resources available to them during the COVID-19 public health emergency.

- Financial Relief for Providers During the COVID-19 Pandemic: Guide

Agenda

COVID-19 Financial Relief for Providers

1) CARES Act Provider Relief Fund
2) COVID-19 Uninsured Program
3) Other Sources of Coverage

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Provider Relief Fund

Provider Relief Fund Appropriations

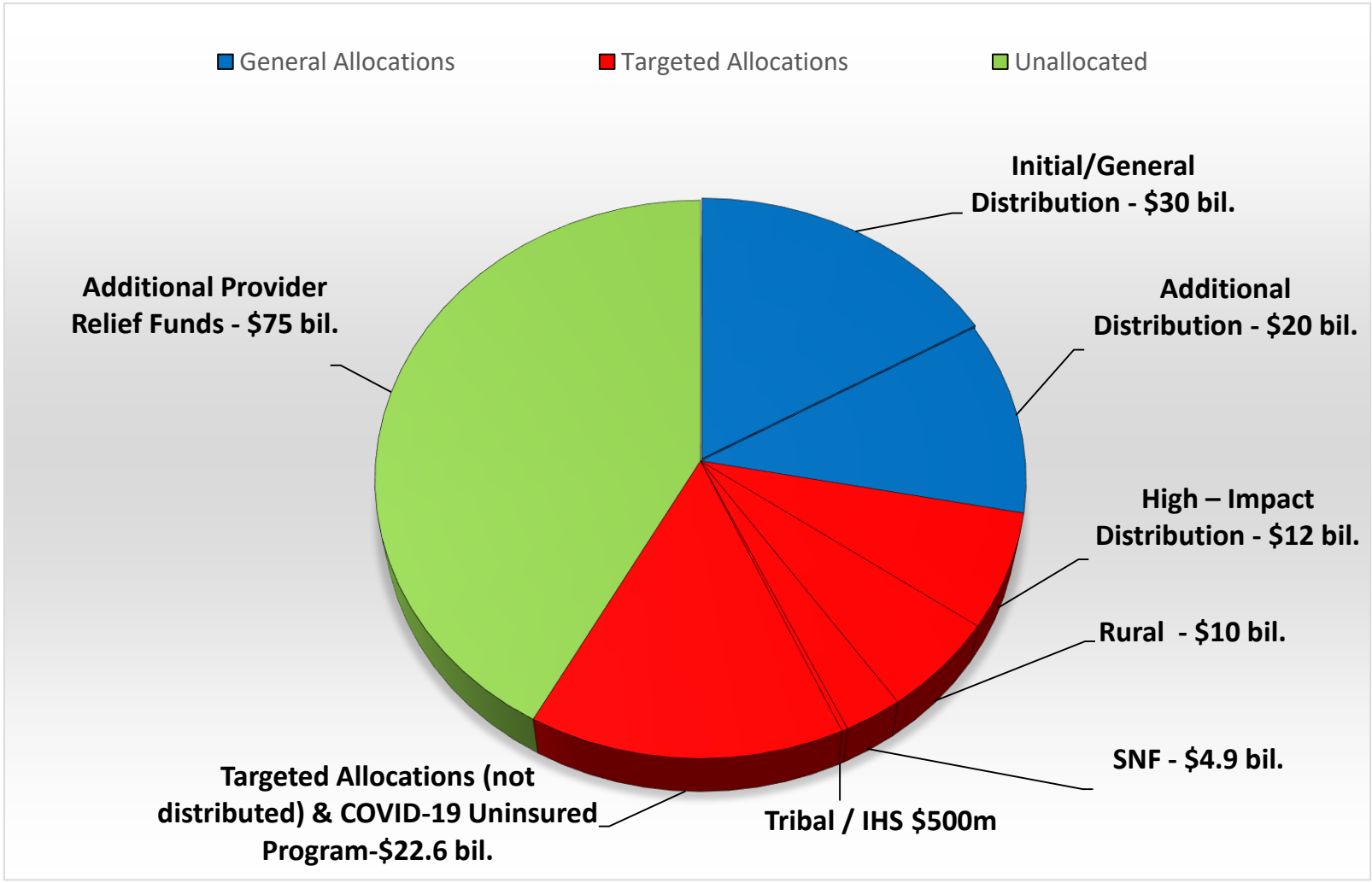
CARES Act: *$100 billion*

PPP and Health Care Enhancement Act: *$75 billion*

Purpose:

- prevent, prepare for, and respond to COVID-19, 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 COVID-19.

Overview of Provider Relief Fund Allocations



General Distribution: $50 Billion

$30B Initial Distribution
4/10-4/17
(2019 Medicare FFS payments)

+

$20B Additional Distribution
4/23-present
(2018 gross receipts minus initial distribution)

→

$50B Total
(2018 gross receipts)

Highlights

- Must sign an attestation:
  - confirming receipt
  - agreeing to terms & conditions for each distribution
  - confirming payment amount
- Retaining funds for 90 days is deemed acceptance
- HHS funds go to organization's TIN
- Payments/grants, not loans
- No appeal process

Targeted Distributions

$12B High-Impact Distribution

- Paid May 7 to 395 Hospitals with ≥ 100 COVID-19 inpatients through April 10
- $2B distributed based on DSH

$10B Rural Distribution

- Paid May 6 to 4,000 Rural Health Care providers (hospitals, CAHs, RHCs, CHCs)

$4.9B Skilled Nursing Facilities

- Paid May 22 to over 13,000 SNFs

$500M Indian Health Service

- Paid May 29 to ~300 Tribal Hospitals, Clinics, and Urban Health Centers

Highlights

- Each Targeted distribution has specific terms and conditions (https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html)
- Specific formulas determine targeted allocations
- Additional targeted distributions? DSH and Medicaid?

Audits

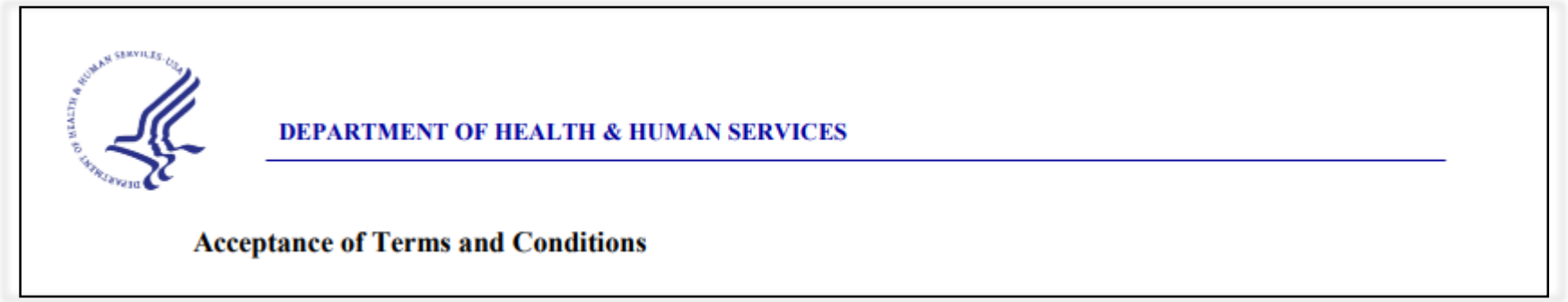
Audits will likely focus on:

- if funds were utilized for an approved purpose (T&Cs, attestations)
- if provider sought improper balance billing from patients

Failure to comply may result in:

- recoupment
- sanctions & financial penalties

Permitted Uses



DEPARTMENT OF HEALTH & HUMAN SERVICES

Acceptance of Terms and Conditions

- Providers must certify that Provider Relief Fund monies:

  "will only be used to prevent, prepare for, and respond to coronavirus" *and* *only to reimburse for "health care related expenses or lost revenues that are attributable to coronavirus."*

- Funds cannot be used to reimburse expenses or losses that have "been reimbursed from other sources or that other sources are obligated to reimburse.

- Funds cannot be used to "pay the salary of an individual . . . at a rate in excess of Executive Level II" ($197,300)

Permitted Uses (cont.)

Health Care Related Expenses Attributable to coronavirus

- Must be used to “prevent, prepare for, and respond to coronavirus”
- When incurred?
- Examples in FAQ:
  - Supplies/equipment to provide healthcare services for possible/actual COVID-19 patients
  - Workforce training
  - Emergency operations centers
  - Reporting COVID-19 test results to federal, state, or local governments;
  - Expanding capacity (temporary structures for COVID-19 care or non-COVID-19 care)
  - Expanding or preserving care delivery (facilities, equipment, supplies, healthcare practices, staffing, and technology)

Permitted Uses (cont.)

Lost Revenue Attributable to Coronavirus

The term “lost revenues that are attributable to coronavirus” means **any revenue that you as a healthcare provider lost due to coronavirus**. This may include revenue losses associated with fewer outpatient visits, canceled elective procedures or services, or increased uncompensated care.

Providers can **use** Provider Relief Fund payments to **cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus**. Thus, these costs do not need to be specific to providing care for possible or actual coronavirus patients, but the lost revenue that the Provider Relief Fund payment covers must have been lost due to coronavirus.

HHS encourages the use of funds to cover lost revenue so that providers can respond to the coronavirus public health emergency by maintaining healthcare delivery capacity, such as using Provider Relief Fund payments to cover [payroll, health insurance, rent/mortgage, equipment lease, EHR licensing fees].

Documentation Requirements

Providers must maintain "appropriate records and cost documentation," including:

- source documentation,
- must be maintained for at least three years*, and
- must be promptly submitted to HHS upon HHS request.

*Consider longer retention periods associated with financial records and cost-reporting.

Reporting Requirements

- All providers must submit reports to HHS at a time and in a form specified by HHS.
- Providers receiving more than $150,000 must submit quarterly reports w/in 10 days after the end of each calendar quarter, beginning July 10.
- Additional guidance forthcoming

Terms and Conditions: Balance Billing

"The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all ***care for a presumptive or actual case of COVID-19***, Recipient certifies that it ***will not seek to collect from the patient 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."

Changes of Ownership

Distribution is based on TIN, not Provider Number

Funds cannot be transferred to new owner:

- If seller is ineligible to receive (no COVID-19 care on or after 1/31/20) or cannot use the funds in accordance with the T&C, funds are returned
- If the buyer TIN did not receive 2019 FFS Medicare payments, it is ineligible to receive a general distribution payment

Adjusting gross receipts if purchased practice revenue not reflected on most recent tax return:

- Adjusted gross receipts = (gross receipts shown on most recent tax return) + (gross receipts of the practice acquired not reflected on the tax return) – (gross receipts of providers sold not reflected in the tax return)
- If adjusted gross receipts exceed gross receipts on tax return by more than 20%, can enter adjusted gross receipts
- Does not apply if acquired entity files own tax return

Health Systems

Attestation by Parent (5/21/20 FAQ):

- Parent entity can report revenue and attest for subsidiaries that are disregarded or consolidated entities in a single submission

Flexibility to Allocate Funds (6/2/20 FAQ):

- Parent organization with subsidiary billing TINs that received payments may attest and keep payments as long as associated providers were eligible and can otherwise attest
- Parent can control and allocate Provider Relief Fund payment to subsidiaries by attesting to accepting subsidiaries' payments and agreeing to Terms & Conditions

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COVID-19 Uninsured Program

Uninsured Program – Overview

Multiple authorities and funding sources make up the Uninsured Program, which:

- Provides claims-level reimbursement for COVID-19 testing or treating uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020.
- Pays at Medicare rates (without 20% add-on)

The Program is being administered by United Health Group through a contract with the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA).

Uninsured Program - Participation

To participate, providers must:

- Use their Optum ID, or create an Optum ID, to gain entry to the HRSA COVID-19 Uninsured Program Portal.
- Take the following steps in the program portal:
  - Validate TIN (takes 1-2 days)
  - Set up direct deposit (“Optum Pay”) (takes 7-10 days)
  - Add Provider Roster (takes 5-7 days)
  - Add and Attest to Patient Roster
  - Submit Claims for Reimbursement

Attestation Items

- Agree to HRSA COVID-19 Uninsured Program Terms & Conditions
- Verified patient is uninsured
- Will accept program reimbursement as payment in full and will not balance bill
- Understand that reimbursement is subject to available funding
- May be subject to review or audit process and will provide any and all information related to the disposition or use of the funds received under the program for auditing and/or reporting purposes

Verifying Uninsured Status

Uninsured Attestation:

- “I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 testing or care for the patient”

Verifying ID:

- Must seek to obtain Social Security Number or State ID
- “By choosing No ID I attest that in the provision of care to this patient, he or she was asked for an official form of identification such as a Social Security Number or State-issued identification and no identification was provided”

Temporary Member ID—Valid for 30 days

Claims Submission

- Electronic only, within 365 calendar days of service
- “All claims submitted must be complete and final. Interim bills, corrected claims, late charges, voided claim transactions and appeals will not be accepted.”
- Smart Edits
  - Electronic Data Interchange capacity that detects claims with potential errors
  - Smart Edits message sent within 24 hours of claim receipt, will provide instructions to resolve and resubmit
  - FAQ and Reference guide available: https://coviduninsuredclaim.linkhealth.com/claims-and-reimbursement.html

Coverage Details

Covered Services

- Specimen collection, diagnosis, antibody testing
- Testing-related visits (office, urgent care, ER, or telehealth)
- COVID-19 Treatment
  - Office visit/telehealth
  - Hospital (ER, Inpatient, Outpatient, Observation)
  - SNF / LTAC / IRF / HHA
  - DME
  - Ambulance
- FDA-approved vaccine

Excluded Services

- Treatment without COVID-19 primary diagnosis (except for pregnancy, where COVID-19 diagnosis may be secondary)
- Hospice services
- Outpatient prescription drugs

Reimbursement

Payment is “subject to available funding”

Professional Claims—Medicare fee schedule rates with applicable geographic adjustments

Facility Claims—Medicare FFS rates, except:

- IPPS claims will not include 20% DRG weight increase
- CAH, RHC, Children’s Hospital, and PPS Exempt Cancer Hospitals rates will not be updated
- Ground/water ambulance: $350/claim
- Air ambulance: $2,300/claim
- Home health paid on a per-visit methodology by service

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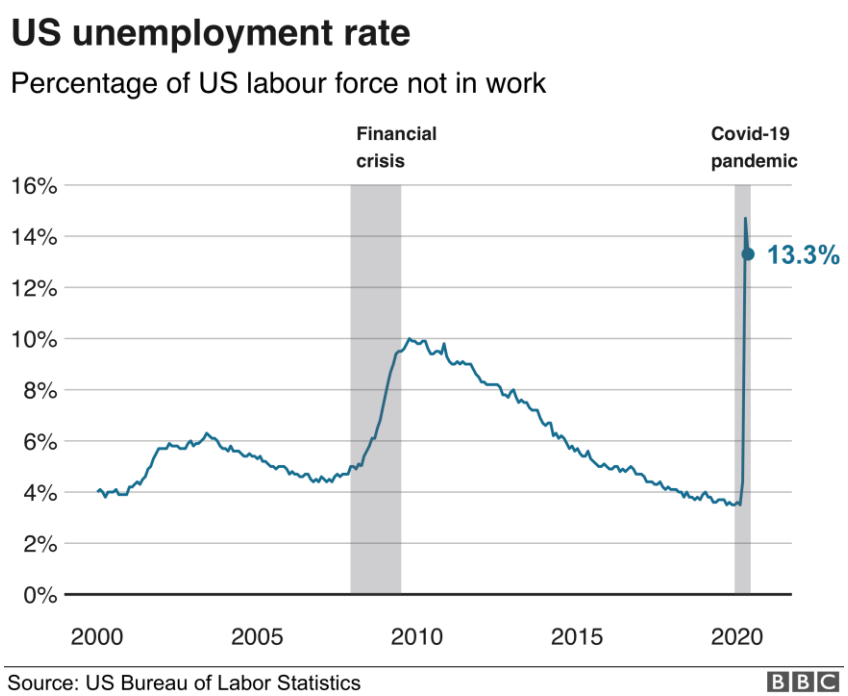
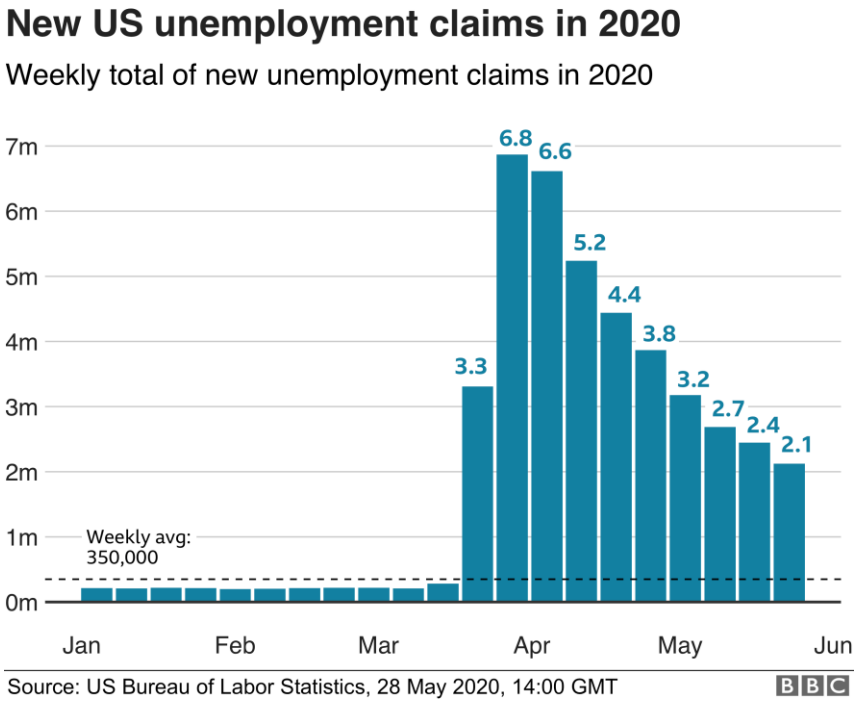
Other Coverage Options

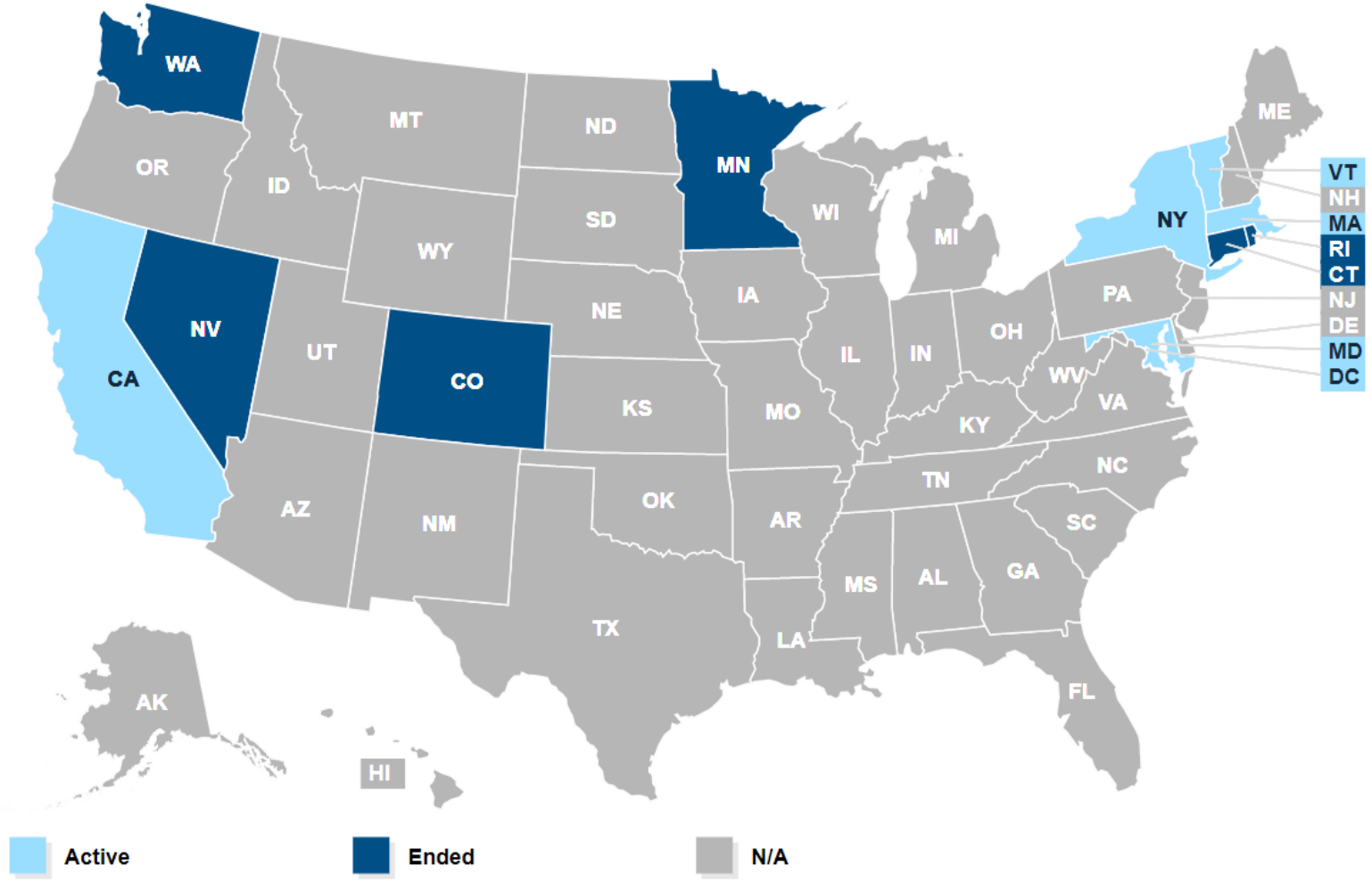
Unemployment Rates and COVID-19





Source: BBC https://www.bbc.com/news/business-52828511 and https://www.bbc.com/news/business-52938993

Marketplace COVID-19 Special Enrollment Periods (SEPs)



Source: Kaiser Family Foundation
https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/

Marketplace Special Enrollment Periods

Qualifying Life Events

- Loss of coverage
- Moved to new state or service area of a new plan
- Marriage
- Birth or adoption

Timing

- For most qualifying events, 60-day deadline
- Effective date is prospective for most qualifying events (following month or second month), but retroactive to birth or adoption

Documentation verifying qualifying life event

COBRA Continuation Coverage

Available to those that lose health care coverage (e.g., due to job loss) if:

- The employer continues to offer a group health plan
- The employer has 20 or more employees (some state mini-COBRA laws may apply to smaller employers)

Timing:

- Election within 60 days of COBRA notice
- Premium due 45 days after electing coverage
- Coverage is retroactive to the date coverage would have been otherwise lost
- IRS and DOL Joint Notice extends certain timeframes during COVID-19: https://www.federalregister.gov/documents/2020/05/04/2020-09399/extension-of-certain-timeframes-for-employee-benefit-plans-participants-and-beneficiaries-affected

DOL COVID-19 FAQs for Participants and Beneficiaries: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/covid-19.pdf

Hospital Presumptive Eligibility

ACA requires all states to implement hospital presumptive eligibility (HPE) policies for Medicaid.

- HPE begins on the date the qualified hospital approves HPE and continues until an eligibility determination or the end of the following month
- Relies on attestation of income information (no income verification)
- Available to all MAGI-based Medicaid eligibility groups in the state, and states may make HPE available for other eligibility groups

Questions

Nina A. Marsden

Partner

Email: nmarsden@health-law.com

Phone: 310.551.8153

Paul L. Garcia

Associate

Email: pgarcia@health-law.com

Phone: 310.551.8124

Katrina A. Pagonis

Partner

Email: kpagonis@health-law.com

Phone: 415.875.8515