IMMEDIATE ACTION REQUIRED – UPCOMING CARES ACT RELIEF FUND DEADLINES AND LATEST UPDATES

The Department of Health and Human Services ("HHS") issued multiple updates related to the CARES Act Provider Relief Fund on May 20. These updates include announcing a June 3 deadline for eligible health care providers ("Providers") to submit revenue information through the Provider Relief Fund General Distribution Payment Portal ("General Distribution Payment Portal"), updating the Frequently Asked Questions document (again) and announcing additional payments to Rural Health Clinics ("RHCs") that come with their own new and separate Terms and Conditions.

The June 3 deadline is in addition to the upcoming deadline for many Providers to accept the Terms and Conditions for payments from the first tranche of the CARES Act Relief Fund.

More information on these deadlines, the latest Relief Fund Updates and other related issues is included below.

HIGHLIGHTS AND KEY TAKEAWAYS

- The 45-day deadline for agreeing to the Terms and Conditions for Relief Fund payments issued on April 10 is approaching fast – it falls this weekend on May 24 (per HHS). Hall Render has confirmed that Providers are able to attest to individual Relief Fund payments.
- HHS announced Providers have until June 3 to submit required revenue information to validate prior payments and support additional payments from the $50 Billion General Distribution through the General Distribution Payment Portal. Providers that do not submit revenue information by June 3 will no longer be eligible to receive potential additional funding from the $50 Billion General Distribution.
- HHS updated its CARES Act Provider Relief Fund FAQ document to add a series of FAQs addressing common health care industry transactions (hospital mergers, physician practice acquisitions, etc.) and the impact on Relief Fund Payments.
- The updates also revised the FAQ for determining whether a Provider has received an "overpayment" from the Relief Fund. This latest revision adds to the evolving guidance on this issue, without providing much clarification.
- HHS started distributing additional payments of just under $50,000 to each of the 4,500 RHCs across the United States. The funds are to support COVID-19 testing. HHS posted a new Terms and Conditions document specific to these payments.

TERMS AND CONDITIONS ATTESTATION DEADLINES

Despite ambiguous language in a May 20 Press Release stating that recipients have until June 3 to do so, the deadline for attesting and accepting the Terms and Conditions for any payments received on April 10 is still this weekend – May 24. Providers have 45 days to attest and accept the Terms and Conditions from any of the General Relief Fund Payment allocations. The original timeframe was 30 days, but HHS extended the timeframe to 45 days in an announcement on May 7. That means that Providers who received an initial payment from the first tranche on April 10 have until May 25 to submit the required attestation. Note, however, that HHS appears to have calculated the deadline incorrectly in the Press Release announcing the extension, describing 45 days from April 10 as May 24. Also note, May 24 is the Sunday of Memorial Day weekend, and May 25 is Memorial Day, a federal holiday.

Providers can attest to a specific Relief Fund payment by only entering the specific dollar amount for a particular payment in Step 3 of the process for submitting the attestation in the HHS Relief Fund attestation portal (available here). HHS has also reiterated in multiple places that any Provider who retains a payment for at least 45 days without rejecting the funds are deemed to have accepted the applicable Terms and Conditions. As noted below, there is also a new Terms and Conditions document for the RHC payments associated with testing.

GENERAL DISTRIBUTION PAYMENT PORTAL DEADLINE – JUNE 3

HHS announced on May 20 that Providers have until June 3 to submit required revenue information via the General Distribution Payment Portal in order to remain eligible to potentially receive an additional payment from the Provider Relief Fund $50 Billion General Distribution. According to the HHS Press Release announcing the deadline (available here), Providers that do not submit their revenue information by June 3 will no longer be eligible to receive potential additional funding from the $50 Billion General Distribution.

All Providers who received a payment from the General Distribution are required to report certain revenue information and submit tax forms or other financial statements via the General Distribution Payment Portal. Not every Provider, however, is entitled to an additional payment. While the HHS Press Release focuses on eligibility to potentially receive a second payment, we recommend all Providers that have received a General Distribution payment report the required information through the portal by the June 3 deadline.

As a reminder, Providers who already submitted the required revenue and tax information through the General Distribution Payment Portal may go back into the portal to provide updated information.

ONGOING UPDATES TO RELIEF FUND FAQS

On May 20, HHS twice updated the CARES Act Provider Relief Fund FAQ document (previously titled the General Distribution FAQs and available here). This is the third substantial set of revisions to the Relief Fund FAQs, which were previously updated on May 6 and May 15.

The May 20 revisions include a new series of FAQs that address common health care transaction scenarios, including the merger, acquisition, and sale of providers or suppliers and the impact on Relief Fund payments. The FAQs address past and current transactions. For example, one of the FAQs clarified that an organization that sold its only practice or facility under a change in ownership in 2019 and is no longer providing services, cannot accept payment and transfer it to the new owner. Instead, the prior owner must reject the payment.

In addition to the substantive changes, these latest revisions underscore the fact that HHS will continue to revise and add to these FAQs on an ongoing basis. Providers should be careful to review the most updated version of the FAQs prior to making any decisions based on guidance included in the FAQs. Some of the FAQs have been changed multiple times since the document was originally published and there will be future revisions.

REPAYMENT AND OVERPAYMENT CONSIDERATIONS

One of the FAQs originally added on May 6 addresses potential Relief Fund overpayments and the obligation to reject payments in some situations.

In late April, HHS added language to the Attestation Portal stating that if a Provider received more in the General Allocation than 2% of their net patient revenue, it should not attest to the Terms and Conditions and should contact the CARES Provider Relief hotline concerning a potential overpayment. That language was removed from the Attestation Portal in May around the same time HHS issued its first FAQ on the subject.

The FAQ appeared to pivot from the use of the general 2% net patient revenue calculation to a Provider-specific determination focused on if the total Relief Fund payments exceeded actual and expected COVID-19 expenses and lost revenues. HHS revised this FAQ in these most recent revisions to remove a single sentence from the response. Here is that FAQ with the now removed sentence struck through:

> **What should a provider do if a General Distribution payment is greater than expected or received in error?** *(Added 5/6/2020-Revised 5/20/2020)*
>
> Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 45 days of payment. ~~Generally, if a provider does not have or anticipate having COVID-related lost revenues or increased expenses equal to or in excess of the relief payments received, they should return the funds.~~ If a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment. If a provider believes they are underpaid, they should accept the payment and submit their revenues in the provider portal to determine their correct payment.

Interestingly, that sentence was added to a different FAQ during the second set of revisions on May 20 with a helpful clarification. One of the new FAQs addresses whether an organization could return a portion of a payment as a result of selling a part of a practice in 2019 or January 2020. In the answer, HHS states that a Provider may not return a portion of a Relief Fund payment, but that the Provider may accept the funds as long as it can attest to meeting the applicable Terms and Conditions. HHS then goes on to state that:

> "Generally, if a provider anticipates that its COVID-related lost revenues or increased expenses will be *materially* less than the value of the Provider Relief Fund payment received, the provider should reject the entire General Distribution payment . . ." (emphasis added).

This suggests that as long as a Provider anticipates that its COVID-19-related lost revenue or increased expenses will be materially greater than the Relief Fund payment received, the payment should not be viewed as an overpayment that requires the Provider to reject the payment now. All Relief Fund payments may ultimately be subject to a reconciliation that looks at the total amounts received compared to COVID-19-related lost revenues and expenses. Still, this language supports a more flexible standard for determining whether the Provider has received an overpayment that is based directly on language in the CARES Act rather than the general 2% net patient revenue calculation.

Another issue presented for health care systems or networks deploying their provider operations in a multi-corporate/legal entity structure, is how the over or under funding analysis applies to various EINs within the system. Is the analysis by eligible health care provider, EIN or on a controlled group basis? HHS guidance and reporting methodology (per the various portals) seems to follow EINs and tax filing methodology (by single EIN or single consolidated tax returns for multiple EINs in a controlled group).

For-profit systems/networks are typically required to file a consolidated income tax return, while tax-exempt systems filing the Form 990 are rarely able to do so. Instead each EIN/legal entity must file its own Form 990. How to perform this analysis, especially at this early juncture, remains to be seen. Because of the inconsistent and evolving guidance from HHS on this issue, Providers should work with legal counsel and financial advisors prior to making any decisions to reject a Relief Fund payment.

NEW $50,000 PAYMENTS TO RURAL HEALTH CLINICS

HHS also announced on May 20 that it was distributing $225 million to RHCs for COVID-19 testing. It appears the payments are being distributed to each of the approximately 4,500 RHCs across the United States, including both freestanding and provider-based RHCs. Payment is based on the number of certified clinic sites an organization operates, with each clinic site receiving a payment of just under $50,000.

The same day HHS posted a new Terms and Conditions document for these payments. The document includes many of the same restrictions included in the other Relief Fund Terms and Conditions documents. The most notable exception is that the Terms and Conditions document specifies that these funds must only be used to reimburse the RHC for COVID-19 testing and COVID-19 testing expenses.

If you have questions or would like additional information about this topic, please contact:

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