SQUIRE PATTON BOGGS

HHS Updates Reporting Requirements for Provider Relief Fund Payments and Sets the Table for Coming Oversight

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On October 22, the Department of Health and Human Services (HHS) updated its guidance on how hospitals and other providers should report their use of the nearly US$165 billion in Provider Relief Fund payments that have been distributed for expenses and lost revenues attributable to the COVID-19 pandemic.

Reversing course from September, HHS says providers may use the funds to replace their lost gross revenue, not just their lost profits, from patient care. The guidance details how to report using the funds to cover revenue losses, as well as expenses attributable to COVID-19, and HHS also updated its FAQs on the use of the funds.

While HHS's latest instruction comes as a welcome relief for providers, the agency has also made clear that "HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight … to ensure that Federal dollars are used appropriately." HHS will soon be examining the first reports on use of funds, due by February 15, 2021, from providers that received over US$10,000 of CARES Act funding. In addition, HHS is not the only one watching, as the media and Congress have already questioned the methodology behind the HHS disbursements, and whistleblowers may see rich opportunities through the False Claims Act (FCA).

Given this environment of heightened scrutiny, hospitals and providers should strive to rigorously monitor and account for their proper receipt and use of the Provider Relief Fund payments. While pandemic-related losses and expenses likely dwarf total payments (e.g., total losses through July were estimated to top US$200 billion), some areas of caution include identifying where potentially overlapping funding sources might be available and HHS's ban on balance billing for COVID-19-related care. As with any other important task, an ounce of prevention in using and documenting Provider Relief Fund payments will be worth a pound when trying to cure any investigation.

HHS's Guidance on Reporting COVID-19-Related Expenses and Revenue Losses

The Provider Relief Fund reporting portal is scheduled to open on January 15, 2021. The first reports – which are applicable only to providers that accepted payments totaling US$10,000 or more – are due on February 15, 2021, and must include all fund expenditures in 2020. Providers with funds left over in 2021 will have another six months to use them and will have to file a second report mid-year 2021.

HHS's guidance details how to report COVID-19-related expenses and revenue losses.

Reporting Expenses Attributable to COVID-19

- Providers may report any healthcare-related expenses incurred in "treating confirmed or suspected cases of coronavirus, preparing for possible or actual coronavirus cases, maintaining healthcare delivery, etc." This is a broad category of expenses and includes both direct expenses and related overhead activities. The payments may cover healthcare-related expenses incurred before the payments were received, though most likely not before January 1, 2020. Only expenses that no other source has reimbursed or will reimburse qualify. HHS's FAQs list examples of the types of eligible healthcare related expenses, including:
  - 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.

Recipients of US$10,000 –$499,000 simply report such expense in two aggregated categories: "general and administrative expenses" and "other healthcare related expenses."

Recipients of US$500,000 or more must detail their specific expenses under those two general categories in a number of subcategories. For example, the G&A expenses category includes payment subcategories for mortgage/rent, insurance, personnel, fringe benefits, equipment leases, utilities, and other. Under the healthcare-related expenses category, there are subcategories for supplies, equipment, information technology, facilities, and others.

- On October 28, the FAQs were updated with examples covering several nuances in calculating expenses eligible for reimbursement, including how to calculate salary payments up to the cap on executive pay; how to account for the partial payment of an expense by an alternative source; how to calculate increased costs for supplies (e.g., PPE) and equipment; how to report the cost of capital equipment purchases; how to allocate overhead for a parent organization; and how to account for any interest earned on Provider Relief Fund disbursements.
- The updated FAQs also now allow greater flexibility to providers that are part of a system in using funds received as part of the General Distribution: subsidiary providers that received and accepted General Distribution payments may transfer payments to their parent entities, for use by the parent or for transfer to other subsidiary providers. Regardless of which entity originally attested to receipt of the funds, the parent entity may submit the report on the use of the General Distribution payment. This ability to transfer funds is a change from HHS's original instruction limiting the use of any Provider Relief Fund distributions to the entity that had accepted a General Distribution payment. That limit would still apply to recipients of targeted distributions.

Reporting Revenue Lost Due to COVID-19

- Reporting 2019 and 2020 patient care revenue, to show lost revenue:
  - Any Provider Relief Fund amounts not consumed by COVID-19-related expenses may be reported as covering lost patient care revenue. A provider's available lost revenue is simply the amount of the difference between its 2019 and 2020 actual revenue from patient care-related sources, including Medicare, Medicaid, commercial insurance, self-pay and other sources.
    - Importantly, HHS's latest instruction overrides guidance from September that had limited eligible "lost revenues" to lost profits from patient revenue. HHS explained that it has reversed course because the September guidance "generated significant … opposition from many stakeholders and Members of Congress" and the consensus is that providers should be allowed to apply Provider Relief Fund "payments against all lost revenues without limitation."
  - The 2019 and 2020 revenue amounts are to be reported by calendar quarter.
  - HHS has also explained:

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

    Limit on executive salary pay – Provider Relief Funds may not be used to pay salary in excess of "Executive Level II" of the Federal Executive Pay Scale, i.e., salary amounts above US$197,300, excluding fringe benefits and indirect costs. The FAQs were recently updated with a helpful example on calculating the use of the funds up to the salary cap.
  - Any funds not used in 2020 may be used during the first half of 2021 for COVID-19-related expenses and lost revenue.
- **Reporting other assistance received in 2020** – Providers must report COVID-19-related relief received from a list of other federal, state and local sources (e.g., the Paycheck Protection Program, FEMA, CARES Act testing), business insurance, or other sources.
- **Reporting total calendar year 2019 and 2020 expenses** – Providers must report, on a quarterly basis, G&A expenses and healthcare-related expenses.
- **Reporting other nonfinancial data** – Providers must also report, on a quarterly basis, certain personnel, patient, and facility metrics, along with information on any change in ownership.

The Provider Relief Fund Reports Will be Closely Scrutinized

HHS has cautioned that, along with the HHS OIG, it "will have significant anti-fraud monitoring" and oversight of the Provider Relief Funds. "HHS has not yet detailed how recoupment or repayment [of misused funds] will work," but stressed the terms and conditions for the funds will be subject to heightened scrutiny and oversight:

- Providers must certify that they are "eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus)."
  - The FAQs note "HHS broadly views every patient as a possible case of COVID-19."
- "Recipients must submit all required reports," which include the reporting obligations described above, starting in February 2021.
- "Non-compliance with any Term or Condition is grounds for the Secretary to direct recoupment of some or all of the payments made."

Additionally, though not stated in HHS's FAQs, any wrongful retention or misuse of the Provider Relief Fund disbursements could lead to allegations of fraud, criminal charges or FCA liability.

Potential Government Actions Arising From the Provider Relief Fund

FCA cases concerning the Provider Relief Fund, with or without merit, are inevitable; and those cases and providers' defenses against them will be impacted by HHS's evolving guidance. First, the expanded use of the funds discussed above can be a catch-22: healthcare providers obviously benefit from less restriction on how they may deploy the funds, but that can lead to greater risks for mistakes, or perceived overreaching. Second, the promised scrutiny by HHS will serve as a call to action for not only the Department of Justice (DOJ), but more specifically whistleblowers (or relators) pursuing actions under the FCA's qui tam provision.

Those cases will likely be filed throughout next year in sealed complaints (often by providers' employees or associates), alleging that providers "knowingly present[ed], or cause[d] to be presented, a false or fraudulent claim for payment or approval" of Provider Relief Funds. 31 U.S.C. § 3729(a)(1)(A). While the allegations may run the gambit, examples from prior government relief programs include that funds were spent inappropriately for a variety of reasons, such as:

- funds were spent on allegedly inflated expenses (including in exchange for kickbacks);
- funds were allegedly used to benefit provider representatives personally rather than to further COVID-19-related healthcare delivery; and
- funds were allegedly wasted on bogus supplies, equipment, or services (as to which the provider allegedly failed to take reasonable and prudent measures to mitigate related losses).

We will know soon enough: the cases will start becoming unsealed throughout next year as well, as DOJ makes decisions to intervene or decline, or even seek dismissal.

Of course, the Government (and the whistleblower) will have the burden of proof. That is harder to establish generally if funds are permitted to be used to cover a greater variety of losses and additional expenses, because providers can argue the restrictions (and the continued lessening of them) were not definitive or detailed enough to "knowingly" do anything wrong, including submitting a false claim. However, that does not mean these cases will not arise. The goal should be to head them off early and less expensively when they do. HHS's reporting landscape provides that opportunity: by carefully and thoroughly documenting the support and reasoning as discussed above (an ounce for a pound), providers can signal to the government early that there is nothing to see here. The same, of course, goes for DOJ criminal action, where the burden is even higher. Evidenced intent to comply with HHS's reporting guidance will distinguish providers from the overt fraud the DOJ has been pursuing to date, such as falsifying company records and number of employees.

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