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CARES Act Provider Relief Fund: Connecting HHS's Dots on Whether Your Tranche #1 Payment Is an Overpayment

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After the U.S. Department of Health and Human Services (HHS) automatically distributed $30 billion to providers as Tranche #1 Relief Fund payments based on 2019 Medicare fee-for-service payment data, HHS subsequently released a new formula that was based on 2018 "program service revenue" and intended to calculate providers' payments under Relief Fund Tranches #1 and #2 cumulatively. For providers whose Tranche #1 payments alone exceeded their expected payment under the new "program service revenue" formula, there have been ongoing questions about whether such providers were "overpaid" and needed to reject and return their Tranche #1 payments.

*While guidance in this area has evolved frequently,**[1]** there is support that HHS does not consider a Tranche #1 payment that merely exceeds a provider's expected payment under HHS's "program service revenue" formula to be an overpayment*. The below chart contains examples of HHS guidance and actions that lend support to this position. It is important to note that payments that were received in error or that exceed a provider's qualifying expenses and losses will need to be returned.[2] While HHS says that unused payment amounts should be returned "at the conclusion of the pandemic,"[3] HHS has not otherwise defined the end date for qualifying expenses and losses or the process for returning unused payment amounts.

HHS Removed "Do Not Attest" Language	HHS removed language from the Provider Relief Fund payment attestation portal that had instructed providers not to attest if their Tranche #1 payment exceeded their expected payment under the "program service revenue" formula.
HHS Characterizes the "Program Service Revenue" Formula As Calculating a Provider's *Minimum* Payment Amount	HHS updated its communications to providers and its Relief Fund FAQs[4] to characterize the "program service revenue" formula as calculating the *minimum* amount of payment a provider can expect to receive under Tranches #1 and #2 cumulatively, as opposed to a maximum amount or "cap." In its Relief Fund FAQs, HHS says that "[p]roviders do not need to be able to prove, at the time they accept a Provider Relief Fund payment, that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment."[5]
HHS Appears to Be Focusing Future Enforcement on Proper Use of Relief Payments	In its Relief Fund FAQs, HHS says: "Generally, HHS does not intend to recoup funds as long as a provider's lost revenue and increased expenses exceed the amount of provider relief funding a provider has received."[6] "HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if, at the conclusion of the pandemic, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they

	will return this money to HHS. HHS will provide directions in the future about how to return unused funds."[7] "Retention and use of these funds are subject to certain terms and conditions. If these terms and conditions are met, payments do not need to be repaid at a later date."[8] The referenced terms and conditions do not require rejection of Tranche #1 payments based on application of the "program service revenue" formula.

Because the evaluation of relief funds is fact-specific and relies on constantly evolving HHS guidance, providers should consult their Husch Blackwell attorney who can advise on particular risks and considerations.

Contact us

If you have any further questions or require more information regarding this update, please contact Meg Pekarske, Andrew Brenton or your Husch Blackwell attorney.

Comprehensive CARES Act and COVID-19 guidance

Husch Blackwell's CARES Act resource team helps clients identify available assistance using industry-specific updates on changing agency rulemakings. Our COVID-19 response team provides clients with an online legal Toolkit to address challenges presented by the coronavirus outbreak, including rapidly changing orders on a state-by-state basis. Contact these legal teams or your Husch Blackwell attorney to plan a way through and beyond the pandemic.

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[1] Note that HHS has updated its Relief Fund FAQs repeatedly, sometimes on a near-daily basis. This article is based on the version of the FAQs that appeared on HHS's website as of June 9, 2020. It is likely that HHS will continue to update its FAQs subsequent to the publication of this article.

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[2] "HHS reserves the right to audit Relief Fund recipients in the future to . . . collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19." *See*

HHS, Relief Fund FAQs at 10 (last accessed June 9, 2020). Note that HHS has not further defined what receiving a relief payment "in error" means.

[3] *See* HHS, Relief Fund FAQs at 6 (last accessed June 9, 2020).

[4] "HHS is distributing an additional $20 billion of the General Distribution to providers to augment their initial allocation so that $50 billion is allocated proportional to providers' share of 2018 gross receipts or sales/program service revenue. The allocation methodology is designed to provide relief to providers, who bill Medicare fee-for-service, with *at least* 2% of that provider's gross receipts regardless of the provider's payer mix" (emphasis added). *See* HHS, Relief Fund FAQs at 10 (last accessed June 9, 2020).

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[5] *See* HHS, Relief Fund FAQs at 6 (last accessed June 9, 2020).

[6] *See* HHS, Relief Fund FAQs at 10 (last accessed June 9, 2020).

[7] *See* HHS, Relief Fund FAQs at 6 (last accessed June 9, 2020). *See also* HHS, Relief Fund FAQs at 5 (last accessed June 9, 2020) ("HHS has not yet detailed how recoupment or repayment will work.").

[8] *See* HHS, Relief Fund FAQs at 2 (last accessed June 9, 2020).