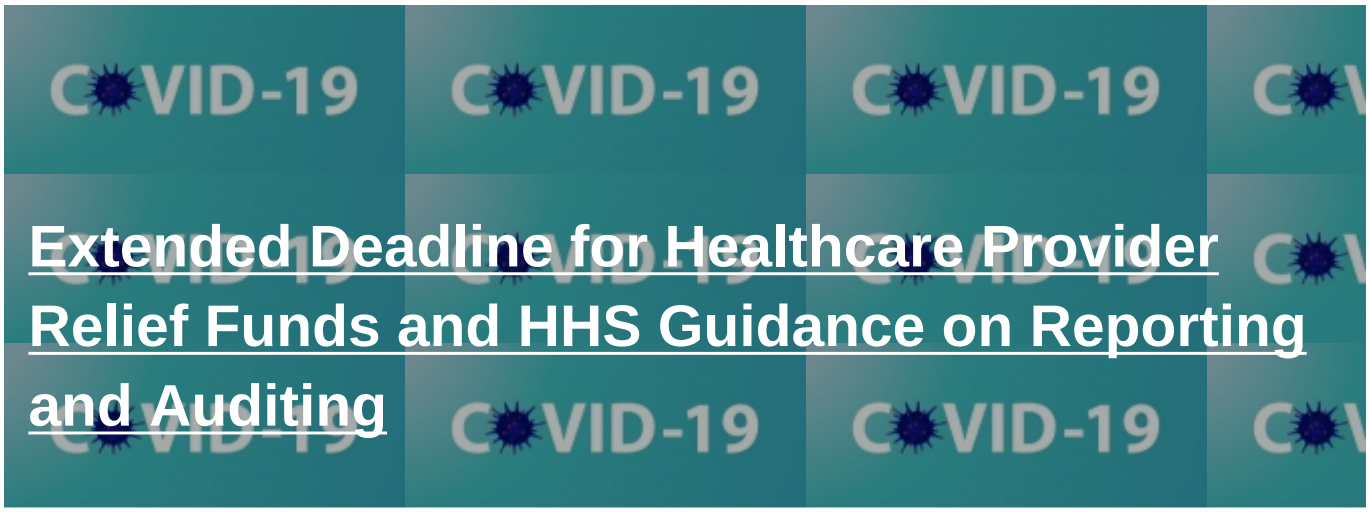


Extended Deadline for Healthcare Provider Relief Funds and HHS Guidance on Reporting and Auditing

August 20, 2020

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On March 27, 2020, President Trump signed the **Coronavirus Aid, Relief, and Economic Security Act** ("CARES Act") into law, allocating $100 billion in funding for the CARES Act Provider Relief Fund (the "Fund"). As outlined in previous alerts, the U.S. Department of Health and Human Services ("HHS") automatically distributed $50 billion of the Fund to eligible healthcare providers in two waves throughout the month of April 2020 ("Phase One").

In the first two weeks of August 2020, HHS announced its extension of the application deadline for a **second phase of relief** ("Phase Two") and published **revised guidance** on the reporting requirements for providers who have received aid from the Fund. These announcements have implications for those providers who received relief in Phase One as well as for those who were ineligible for the first round of Fund relief.

Please note that the Fund and the related HHS guidance are nuanced and may raise specific questions not addressed herein. The summary below is not an exhaustive list of all information on this issue, and there may be additional provisions that are relevant to your facility or practice. The entirety of HHS guidance on the Fund may be found **here.**

Phase Two General Distribution of Provider Relief

In June of 2020, HHS announced that certain providers could apply to receive a portion of the $15 billion in Phase Two funding. The initial deadline to submit applications was July 20, which was then extended to August 3, 2020. On August 10, 2020, HHS announced that it is once again extending the deadline for providers to apply for Phase Two funds. Eligible providers now have until August 28, 2020 to **submit their applications** for relief.

The deadline extension announcement also outlines which providers are eligible to apply for Phase Two funding. Although Phase Two was initially meant to aid healthcare entities that missed the opportunity to receive Phase One funds, eligibility for Phase Two was ultimately expanded to providers that fall into one of the following categories:

- Providers that billed Medicare fee-for-service during January 1, 2019 through December 31, 2019; or
- Providers that were not eligible for Phase One funding due to:
    - A change in ownership in 2019 or 2020 under Medicare Part A; and
    - No Medicare fee-for-service revenue in 2019; or
- Providers that received a Phase One payment, but:
    - Missed the June 3 deadline to submit revenue information; or
    - Did not receive Phase One payments totaling two percent of their annual patient revenue; or
- Providers that billed Medicaid / CHIP programs or Medicaid managed care plans for health-related services between January 1, 2018 and December 31, 2019; or
- Providers that billed a health insurance company for oral healthcare-related services as a dental service provider; or
- Licensed dental services providers who do not accept insurance and have billed patients for oral healthcare-related services; or
- Providers who previously received a Phase One payment, but rejected and returned the funds and are now interested in reapplying.

The full HHS guidance on provider eligibility with regard to Phase Two payments may be found **here.**

Eligible providers who apply to Phase Two may receive up to a total of two percent of revenue reported from patient care. These payments will be distributed on a rolling basis, so applying early may boost a provider's chance of receiving funding.

As with all other healthcare provider relief distributed from the Fund, the providers who do receive payment must attest to the terms and conditions of payment within 90 days. The terms and conditions for Phase Two payments track with the terms and conditions required with Phase One payments (outlined in detail **here**), with two minor differences:

- There is no condition requiring providers to have billed Medicare in 2019; and
- There is no term requiring providers to submit general revenue data from calendar year 2018.

If you believe you may be eligible for Phase Two funding, you may submit an application on the HHS portal **here.**

HHS Guidance Regarding Relief Fund Reporting Requirements

In early August 2020, HHS issued **guidance** on the reporting and auditing requirements for providers who retain Fund relief payments exceeding $10,000 in the aggregate. The guidance clarifies the reporting requirement mentioned in the terms and conditions that providers must attest to when accepting Fund payments.

Specifically, the terms and conditions require payment recipients to submit reports to HHS in the form, and with such content, as specified by the HHS Secretary. The reports allow providers to demonstrate their compliance with the terms and conditions (e.g., spending the funds for permissible purposes), and will be submitted through a portal that goes live on October 1, 2020.

Fund recipients must submit a report of how they spent the relief payments through December 31, 2020 through the portal on or before February 15, 2021. If recipients spent all of their funds prior to December

31, 2020, they may submit a single final report at any time between October 1, 2020 and February 15, 2021. If there are funds left to be spent after December 31, 2020, the provider must submit a second and final expenditure report through the portal no later than July 31, 2021. HHS has advised that it "expects that providers will fully expend their payments" by the final report deadline of July 31, 2021.

This reporting requirement applies to providers who have received payments from all Fund distributions, including the General Distribution (Phase One and Phase Two), as well as Targeted Distributions (e.g., rural providers, skilled nursing facilities, etc.). HHS also announced that providers will not be required to submit quarterly reports to the HHS and the Pandemic Response Accountability Committee as was previously required by the terms and conditions. Although guidance on the topic is constantly evolving, HHS indicated that it will release more detailed reporting requirements on its **Provider Relief website** in the coming weeks.

HHS Guidance Regarding Relief Fund Auditing Requirements

In addition to the reporting obligation outlined above, the HHS announced that Fund payment recipients may also be subject to the HHS general auditing requirements. For commercial for-profit organizations, the HHS audit requirement is triggered when the organization receives $750,000 or more in annual federal awards and at least one award is an HHS grant. Per the HHS announcement in August 2020, Fund distributions (general and targeted) must be counted towards calculation of the $750,000 threshold.

If the audit requirement is triggered, commercial organizations have two choices regarding how to conduct the audit:

- A financial-related audit in accordance with generally accepted government auditing standards; or
- A single audit that meets the requirements contained in HHS' regulations at Title 45 CFR Subpart F.

FAQS regarding the audit requirement may be found **here.**

Regardless of whether the audit requirement is triggered, HHS has warned it will have "significant anti-fraud monitoring of the funds distributed" and that the HHS Office of Inspector General will provide oversight "to ensure that Federal dollars are used appropriately." Therefore, Fund distribution recipients should maintain the proper documentation to support all expenditures of Fund money.

This article is general in nature and does not constitute legal advice. Readers with legal questions should consult the authors, Mark Opara (mopara@sb-kc.com) and Emily Crane (ecrane@sb-kc.com) or any shareholders in Seigfreid Bingham's Health Law Group, including Mark Thompson, Lori Beam, Joseph Hiersteiner, Mark Gilgus, John Neyens, Heath Hoobing, and John Fuchs, or your regular contact at Seigfreid Bingham at 816-421-4460. For more information and updates, visit ***our COVID-19 Resources page.***