

Good information for providers as they evaluate the risks/benefits of accepting the initial CMS funds distribution.

Also, in case you missed it, Kaiser Health News and NPR reported over the weekend about an ambiguous phrase in the [HHS post regarding the distribution](#).

Providers accepting the funds agree to **not balance bill COVID-19 patients, and:**

- *"If you ceased operation as a result of the COVID-19 pandemic, you are still eligible to receive funds so long as you provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. Care does not have to be specific to treating COVID-19. HHS broadly views every patient as a possible case of COVID-19."*

And this provision...

"HHS' payment of this initial tranche of funds is conditioned on the healthcare provider's acceptance of the Terms and Conditions, which acceptance must occur within 30 days of receipt of payment. Not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions"

CARES Act grants could spark False Claims Act issues

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<https://www.modernhealthcare.com/legal/cares-act-grants-could-spark-false-claims-act-issues>

While CMS Administrator Seema Verma touted that Congress' COVID-19 provider grant funds would have "no strings attached," agreeing to the assistance could open providers up to False Claims Act liability risks.

Many providers on April 10 received part of a \$30 billion fund created in the Coronavirus Aid, Relief, and Economic Security Act, as well as a list of terms and conditions from HHS for keeping the money.

Several of the terms and conditions have prompted providers to seek counsel from their attorneys. Even if providers aren't technically filing a claim and didn't apply for the grants, they are not allowed to keep any money they aren't legally eligible for and could be penalized for "reverse false claims."

"There was a very long string attached to it," said William Jordan, a former Department of Justice official and partner at Alston & Bird.

Under the HHS provisions, providers can only use the funds "to prevent, prepare for, and respond to coronavirus," and for "healthcare related expenses or lost revenues that are attributable to coronavirus."

Documenting lost revenues may be easier for providers if they can compare patient volumes from 2019 or 2020 budget projections, according to James Segroves, a partner at Reed Smith.

"That may be the cleanest way to try to demonstrate compliance and not have to deal with years of investigation," Segroves said.

If providers don't document how they are complying with any one of the terms and conditions, it could provide an opening for FCA litigation.

The grant conditions require providers to track how the money is spent for quarterly reporting requirements and future audits, which may be easiest if the funds are kept in a separate account. Jordan said it's still possible to use the funds without a separate account, but it's important to maintain stringent accounting practices.

The added requirement may force some health systems and practices to reprioritize their expenses and bulk up their compliance practices, especially if they don't have a sophisticated system in place.

"What your compliance plan is on January 1, 2020 is not the same plan that should be in place on May 1," King & Spalding partner Michael Paulhus said.

Providers could run afoul of false claims law if they use the grants to double-dip for expenses that another assistance program covers. Some of the money can be used for payroll expenses, but with limits— employees can only be paid using grant funds up to an annual rate of up to \$197,300, so salaries for more highly paid workers would need to be paid at least partly using separate funds.

Grant recipients are also banned from billing out-of-network patients more for COVID-19 treatments than they would have otherwise paid in-network. But if contracts didn't exist previously, it could throw a wrench in calculating in-network rates, according to Hooper, Lundy & Bookman founding partner Lloyd Bookman. Insurers use a wide variety of benefit designs to determine those rates.

"I don't understand how providers do that in the real world," Bookman said.

Providers have 30 days to either agree to HHS' terms and conditions or return the grant money. Since some of the regulatory terms are ambiguous, some lawyers suggested their clients should keep a paper trail of how they interpreted HHS' requirements or reach out to the agency for clarification.

If any FCA issues arise in the future, having record of interpretations can help establish whether a provider intentionally tried to defraud the government.

"The regulations may change and the interpretations may change, and you have to be willing to repay the funds if that happens. But with the benefit of hindsight, this will be an important step," said Crowell & Moring partner David Robbins.

The regulatory system is moving at warp speed, and it's possible that more clarity on providers' obligations could come later. Bookman said he is currently advising clients to hold off on agreeing to the grant terms until later in the 30-day window to make sure they have as much information as possible. If

providers don't agree to or reject the terms by the HHS deadline, they are automatically considered as agreeing to them.

The coronavirus pandemic has caused providers to scramble as they brace for a surge of sick patients or try to pay bills as their revenue shrinks without elective procedures. The federal government may consider those extenuating circumstances as they're considering bringing a false claims case.

"Everybody is human. They have compassion. But they will bring cases," Robbins said.