

Payments for COVID-19 Related Services Furnished to Uninsured Patients Under the Provider Relief Fund

The following provides an overview of the Department of Health and Human Services (HHS) Claims Reimbursement for Testing and Treatment to Health Care Providers and Facilities Serving the Uninsured Program (the Program) and summarizes our analysis and interpretation of some key terms and conditions associated with the Program. The terms and conditions for the COVID-19 testing portion of the Program can be found [here](#), and the terms and conditions related to the COVID-19 treatment portion, [here](#). (We will collectively refer to these as the “Program terms”).¹

In general, while some of the terms appear ambiguous, we do not believe any of the Program terms are sufficiently concerning that health centers should be counseled not to enroll and ultimately participate in the Program especially given the current financial circumstances most health centers find themselves in.

I. Overview of Program

Program funds to cover COVID-19 treatment for the uninsured are one of various “targeted allocations” that HHS intends to make under the Provider Relief Fund, an appropriation of \$100 billion authorized in the Coronavirus Aid, Relief, and Economic Security (“CARES”) Act.² Program funds to reimburse COVID-19 testing for the uninsured are drawn in part from a \$1 billion appropriated to HHS for this purpose in the Families First Coronavirus Response Act.³

The Program is being administered by the HHS Health Resources and Services Administration (HRSA), which contractually delegated some responsibilities to UnitedHealth Group. On April 27, HRSA released informational guidance on the program addressing the following. HRSA issued a fact sheet, [COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured](#); as well as an accompanying document, [Frequently Asked Questions for Coronavirus Aid, Relief, and Economic Security \(CARES\) Act Provider Relief Fund](#).

¹ The terms relating to treatment and those relating to testing are substantially similar. The reason there are two separate sets of terms and conditions appears to be that the appropriation for the testing portion is from the Families First legislation, and the appropriation for the treatment portion is from the CARES Act. The chief difference between the two sets of terms relates to the definition of “uninsured.” The Families First Coronavirus Response Act, Pub. L. 116-127 (Mar. 18, 2020), Title V (governing the testing portion of the funds) included a specific definition of the term “uninsured,” whereas the CARES Act provision creating the \$100 billion Provider Relief Fund (Pub. L. 116-136 (Mar. 27, 2020), Div. B, Title VIII) did not.

² CARES Act, Div. B, Title VIII. In the law, the fund is termed the Public Health and Social Services Emergency Fund.

³ Families First Coronavirus Response Act, Pub. L. 116-127 (Mar. 18, 2020), Title V.

Following are some basic features of the Program.

- a. Eligibility:** Providers are eligible to sign up for payment for COVID-related services to the uninsured under the Program if they “hav[e] conducted COVID-19 testing or provided treatment for uninsured individuals with COVID-19 on or after February 4, 2020.” Providers who are on the HHS list of excluded individuals/entities or have had their Medicare enrollment revoked by CMS are ineligible to receive funding. We do not see any indication that providers need to be already enrolled in Medicare in order to be eligible to receive the funding.
- b. Services:** The Program will pay for “qualifying testing for COVID-19.” This includes testing-related visits taking place in an office, urgent care or emergency room setting, or via telehealth, as well as specimen collection, diagnostic and antibody testing. As for COVID-19 related treatment, the Program will pay for the following, where COVID-19 is the primary diagnosis: office visits (including via telehealth); care and encounters in other settings (emergency room, inpatient, outpatient/observation, skilled nursing facility, longterm acute care (LTAC) facilities, home health, durable medical equipment (including ventilators and oxygen); emergency and non-emergency ground ambulance transportation; and, once they become available, FDA-approved drugs for COVID-19. The Program will not cover any services not typically covered by Medicare or any service (except certain services for pregnant women) where COVID-19 is not the primary diagnosis.
- c. Amount of Payment:** HHS states that providers will be “reimbursed generally at Medicare rates, subject to available funding.” HHS additionally states: “Reimbursement will be based on current year Medicare fee schedule rates except where otherwise noted.” As noted below, neither the informational materials nor the terms and conditions specify the type or amount of payment for federally qualified health centers (FQHCs) under the Program.
- d. Registering as a Program Provider:** As described by HRSA (COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured), steps required in order to receive payment will involve “enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit.” As to “checking patient eligibility,” providers must attest that they have confirmed that the patient is uninsured (i.e., the patient does not have individual or employer-sponsored insurance and “no other payer will reimburse [the provider] for COVID-19 testing and/or care for that patient”); and that they agree to accept Program reimbursement as payment in full and not to balance bill the patient.

- e. **Post-Claim Review and Audit:** Providers must agree to Program terms and conditions (see below for discussion of some key terms) and acknowledge that they may be subject to post-reimbursement audit review. Notably, HHS states that all claims submitted are final and “no interim bills or corrected claims will be accepted”; this is different from standard Medicare policies, where claims may be corrected after filing. All claims must be submitted electronically.
- f. **Effective date:** While the HHS documents do not clearly specify the effective date of the Program with respect to coverage for outpatient services, it appears to us that HHS intends to cover services rendered on or after February 4, 2020.
- g. **Timeline:** HHS allowed providers to begin enrolling in the program on Monday, April 27. HRSA and UnitedHealth Group began providing technical assistance on Wednesday, April 29. HHS states: “Providers can begin submitting claims on May 6 and can expect to begin receiving reimbursements by mid-May.”

II. Analysis of Key Terms and Conditions

Providers must accept numerous terms and conditions in order to participate in the Program. Some terms are required by the law, and others have been added independently by HHS.⁴ Prior to the submission of claims (which begins on May 6, 2020), health centers should carefully review the Program requirements, as well as all terms and conditions document, in evaluating potential participation in the Program. In particular, it is important for health centers to review the following terms as they may have implications operationally:

a. Relationship to Other Funding Sources

The fourth bullet point in each of the Program terms requires recipients of Program payments to certify (1) that they will not use the payments to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse; (2) that they will reimburse the Provider Relief fund if they subsequently receive payment that duplicates payments under the Fund; and (3) that they “will not include costs for which Payment [under the Program] was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.”

Under the fourth term, recipients must certify that they will forgo “uncompensated care reimbursement through federal or state programs for items or services for which Payment was received.” A subsequent term requires recipients to consider payment from the Program “to be payment in full for such care or treatment.”

⁴ CARES Act, Div. B, Title VIII.

Unlike some other providers, many health centers have received multiple sources of funding under the various COVID-19 legislative enactments, including the CARES Act, to support the provision of COVID-related services. As such, it is important for health centers to account separately for all funding spent to cover the direct and indirect costs of furnishing COVID-related services to ensure that the same costs are not claimed on more than one source of funding. Rather, the different funding and revenue streams should be spent so that they supplement one another. This is particularly important when considering that the costs associated with the provision of COVID-19 testing and treatment for uninsured individuals often go beyond the scope of clinical services and may include facility and technology costs (e.g., telehealth equipment; costs associated with temporary testing sites).

As noted above, the fourth bullet-point term also requires recipients of Program payments to attest that they “will not include costs for which Payment was received in cost reports.” Health centers typically report on Medicare/Medicaid cost reports all allowable costs (regardless of the patient’s coverage type) relating to types of services/activities that the relevant program covers. All activities relating to COVID-19 testing and treatment would be included on Medicare and (as applicable) Medicaid FQHC cost reports; however, only costs attributable to the relevant program are charged to that program, through an allocation mechanism such as visits. Notably, since the implementation of the Medicare FQHC prospective payment system (PPS), the Medicare cost report is the basis for payment for only for a limited number of clinical activities. We believe the reference to omission of costs on cost reports was probably simply inartful drafting, and not meant to impact health centers’ Medicare and Medicaid (if applicable) FQHC cost reporting obligations.

b. Method and Amount of FQHC Provider Payment Under Program

The eleventh Program term states: “The Secretary will reimburse the Recipient generally at 100 percent of Medicare rates (including any amounts that would have been due to the provider as patient cost sharing) for the items and services that Respondent provided to Uninsured Individuals for which the Recipient submits claims to the Relief Fund.”

Information disseminated by HRSA and United Health Care (to which HRSA has contractually delegated some Program functions) provides details on payment for certain specific provider types, but does not list FQHCs. Thus, at this time it is not clear whether FQHCs may enroll in the program as Facilities and may bill for covered services at the FQHC PPS rate (so long as the services/encounters have qualifying codes); or whether instead, FQHCs would be paid on a fee schedule for professional and laboratory services (similarly to physician groups enrolled under Medicare Part B).

Note that it is possible that in some cases, the FQHC PPS may not be the most beneficial method of Program payment. If the majority of the clinical activity that the Program would likely cover for a given health center (for example, testing not typically administered in the context of a core provider visit) is not encounter-eligible, then a fee schedule methodology may in fact yield greater payment. Thus it is possible that in the case of some health centers, the Part B Physician

Fee Schedule payment might in fact be more advantageous than PPS payment under this Program.

c. Financial Management and Record Retention Requirements

The ninth Program term requires recipients of Program payments to comply with various provisions of 45 C.F.R. Part 75, including financial management and record retention and access. These accountability provisions are similar to those included under the health centers' grant award. As noted above, given the multiple sources of funding provided to health centers under the various COVID-19 related legislative enactments, it is important for health centers to account for each funding source in accordance with its particular terms and conditions. Further, health center records regarding the Program should be clear about the distinction for purposes of health centers' annual audits under the Uniform Guidance, etc.

d. Undocumented Noncitizens

Some health centers have asked whether undocumented noncitizens can qualify as "uninsured individuals" whose COVID-19 testing and treatment can be paid for by the Program (see first bullet-point term). While we do not see any express prohibition on inclusion of undocumented noncitizens, we believe that as a practical matter, it would be perilous for health centers to bill the Program for testing and treatment provided to this population. HRSA's operational guidance requires Program participants to check patients' eligibility (i.e., their uninsured status) and provide information on the patients to HHS. Screening and reporting information on undocumented patients could place those patients in vulnerable position.

e. Prohibition on Billing Uninsured Individuals

The twelfth bullet-point term states: "The Recipient certifies that it will not engage in 'balance billing' or charge any type of cost sharing for any items or services provided to Uninsured Individuals receiving care or treatment for a positive diagnosis of COVID-19 for which the Recipient receives a Payment from the Relief Fund."

This provision implies that health centers should not apply their schedule of charges and sliding fee discount schedule (SFDS) (if applicable) to determine out-of-pocket payment due from uninsured individuals whose treatment and care are paid for under the Program, and that the Program should effectively be considered a third-party payor for purposes of the application of SFDS. However, the Program terms do not resolve the question of whether, for purposes of HRSA program requirements, a health center may effectively consider the individuals whose treatment is paid for under the Program to be, on the one hand, insured (with an "insurer" – the Program – that imposes no cost-sharing); or, on the other hand, uninsured, self-pay individuals for whom the health center would be either sliding applicable fees to \$0 (for patients earning annual incomes at or below 100% of the Federal Poverty Guidelines ("FPG")) or waiving applicable fees on an individualized basis (for patients earning annual incomes above 100% of the FPG), in light of the availability of Program funding.

In its latest update to the field provided on May 4, 2020, HRSA indicated that it will publish Frequently Asked Questions regarding the intersection of the Program and the health center SFDS. In the meantime, health centers that plan to register with the Program should revise their policies and procedures to reflect that they do not intend to seek any out-of-pocket payment from uninsured, self-pay individuals whose testing/treatment services have been charged to the Program, consistent with the Health Center Program statutory, regulatory and programmatic requirements that address waiver of fees.

Relatedly, providers are also required to certify that they will timely return to uninsured individuals any fees collected from the individual for COVID-19 testing or treatment, if that care is billed to the Program. It is especially important for health centers to take this into account if they intend to submit claims to the Program for retroactive dates of service. If health centers did charge uninsured patients fees for services ultimately billed to the Program, then the fees must be refunded (or, if the fees were charged but not collected, the charge should be reversed in the system).