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Health Care Resources

Programs highlighted below:

- *Provider Relief Fund*
- *Distance Learning and Telemedicine Grant Program*
- *Federal Communications Commission COVID-19 Telehealth Program*
- *Connected Care Pilot Program*
- *Administration for Community Living (ACL)*
- *U.S. Department of Health and Human Services Reimbursement for Uninsured Individuals*
- *Medicare Add-on for Inpatient Hospital COVID-19 Patients*

Provider Relief Fund

The CARES Act that provides $100 billion in relief funds to hospitals and other healthcare providers on the front lines of the coronavirus response. This funding will be used to support healthcare-related expenses or lost revenue attributable to COVID-19 and to ensure uninsured Americans can get testing and treatment for COVID-19. Fifty billion of the Provider Relief Fund is allocated for general distribution to Medicare facilities and providers impacted by COVID-19, based on eligible providers' 2018 net patient revenue. The initial $30 billion was distributed between April 10 and April 17, and the remaining $20 billion is being distributed beginning Friday, April 24.

Eligible Providers

- All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution. Provider Relief Fund payments can be used to reimburse healthcare providers, at Medicare rates, for COVID-related treatment of the uninsured.
- Payments to practices that are part of larger medical groups will be sent to the group's central billing office.
    - All relief payments are made to the billing organization according to its Taxpayer Identification Number (TIN).
- As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.
- This quick dispersal of funds will provide relief to both providers in areas heavily impacted by the COVID-19 pandemic and those providers who are struggling to keep their doors open due to healthy patients delaying care and cancelled elective services.
- 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.

- All relief payments are being made to providers and according to their tax identification number (TIN).For example:
    - Large Organizations and Health Systems: Large Organizations will receive relief payments for each of their billing TINs that bill Medicare. Each organization should look to the part of their organization that bills Medicare to identify details on Medicare payments for 2019 or to identify the accounts where they should expect relief payments.
    - Employed Physicians: Employed physicians should not expect to receive an individual payment directly. The employer organization will receive the relief payment as the billing organization.
    - Physicians in a Group Practice: Individual physicians and providers in a group practice are unlikely to receive individual payments directly, as the group practice will receive the relief fund payment as the billing organization. Providers should look to the part of their organization that bills Medicare to identify details on Medicare payments for 2019 or to identify the accounts where they should expect relief payments.
    - Solo Practitioners: Solo practitioners who bill Medicare will receive a payment under the TIN used to bill Medicare.

Payment Distributions

- Funds are being disbursed immediately.
- Providers will be distributed based on their share of total Medicare FFS reimbursements in 2019. Total FFS payments were approximately $484 billion in 2019.
- A provider can estimate their payment by dividing their 2019 Medicare FFS (not including Medicare Advantage) payments they received by $484,000,000,000, and multiply that ratio by $30,000,000,000. Providers can obtain their 2019 Medicare FFS billings from their organization's revenue management system.
- As an example: A community hospital billed Medicare FFS $121 million in 2019. To determine how much they would receive, use this equation:
    - $121,000,000/$484,000,000,000 x $30,000,000,000 = $7,500,000

Repayment

These are payments, not loans. They do not need to be repaid.

Distribution and Payment of Funds

- HHS has partnered with UnitedHealth Group to provide rapid payment to eligible providers.
- Providers will be paid via Automated Clearing House account information on file with UHG or the Centers for Medicare & Medicaid Services (CMS).

  - The automatic payments will come to providers via Optum Bank with "HHSPAYMENT" as the payment description.
  - Providers who normally receive a paper check for reimbursement from CMS, will receive a paper check in the mail for this payment as well, within the next few weeks.
- Within 45 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment. The portal for signing the attestation will be open the week of April 13, 2020, and will be linked on this page.
- HHS' payment is conditioned on the healthcare provider's acceptance of the Terms and Conditions. Acceptance of the Terms and Conditions must occur within 45 days of receipt of payment. Not returning the payment within 30 days of receipt will be viewed as acceptance of the Terms and Conditions. If a provider receives payment and does not wish to comply with these Terms and Conditions, the provider must do the following: contact HHS within 30 days of receipt of payment and then remit the full payment to HHS as instructed.

Provider Relief Fund Terms and Conditions

The following is a list of the CARES Act Provider Relief Fund Terms and Conditions as required by the Department of Health and Human Services for facilities and providers requesting funds. This is the list of terms and conditions that specifically pertain to the CARES Act Provider Relief Fund. There are additional terms and conditions that apply to all recipients of CARES Act funding programs and include limitations on using funds for gun control advocacy, lobbying, embryo research, and others. You can read more about these additional terms and conditions here.

- The “Payment” means the funds received from the Public Health and Social Services Emergency Fund (“Relief Fund”). The Recipient means the healthcare provider, whether an individual or an entity, receiving the Payment.
- The Recipient certifies that it billed Medicare in 2019; provides or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and does not currently have Medicare billing privileges revoked.
- The Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.
- The Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.
- The Recipient shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all recipients. The Recipient shall also submit general revenue data for calendar year 2018 to the Secretary when applying to receive a Payment, or within 30 days of having received a Payment.

- The Recipient consents to the Department of Health and Human Services publicly disclosing the Payment that Recipient may receive from the Relief Fund. The Recipient acknowledges that such disclosure may allow some third parties to estimate the Recipient's gross receipts or sales, program service revenue, or other equivalent information.
- The Recipient certifies that all information it provides as part of its application for the Payment, as well as all information and reports relating to the Payment that it provides in the future at the request of the Secretary or Inspector General, are true, accurate and complete, to the best of its knowledge. The Recipient acknowledges that any deliberate omission, misrepresentation, or falsification of any information contained in this Payment application or future reports may be punishable by criminal, civil, or administrative penalties, including but not limited to revocation of Medicare billing privileges, exclusion from federal health care programs, and/or the imposition of fines, civil damages, and/or imprisonment.
- Not later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than $150,000 total in funds under the Coronavirus Aid, Relief, and Economics Security Act, the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act, or any other Act primarily making appropriations for the coronavirus response and related activities, shall submit to the Secretary and the Pandemic Response Accountability Committee a report. This report shall contain:
    - The total amount of funds received from HHS under one of the foregoing enumerated Acts;
    - The amount of funds received that were expended or obligated for reach project or activity; and
    - A detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 allowing aggregate reporting on awards below $50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget.
- The Recipient shall maintain appropriate records and cost documentation including, as applicable, documentation required by 45 CFR § 75.302 – Financial management and 45 CFR § 75.361 through 75.365 – Record Retention and Access, and other information required by future program instructions to substantiate the reimbursement of costs under this award. The Recipient shall promptly submit copies of such records and cost documentation upon the request of the Secretary, and Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions.
- The Secretary has concluded that the COVID-19 public health emergency has caused many healthcare providers to have capacity constraints. As a result, patients that would ordinarily be able to choose to receive all care from in-network healthcare providers may no longer be able to receive such care in-network. Accordingly, for all care for a

possible or actual case of COVID-19, Recipient certifies that it will not seek to collect from the patient out-of-pocket expenses in an amount greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network recipient.

For more information

For more information on the Provider Relief Fund providers can call the CARES Provider Relief line at (866) 569-3522. Answers to frequently asked questions can be found here.

Distance Learning and Telemedicine Grant Program

The U.S. Department of Agriculture's Distance Learning and Telemedicine grant program is designed to bolster telemedicine capabilities for hospitals and health systems in rural areas. The CARES Act provides $25 million to support the program. Funding will help improve telehealth infrastructure for rural communities while also helping to meet current telemedicine needs through the COVID-19 National Emergency.

Open for applications from April 14 to July 13, 2020.

Eligibility

1. Be legally organized as an incorporated organization, an Indian tribe or tribal organization, as defined in 25 U.S.C. 5304; a state or local unit of government, a consortium; or other legal entity, including a private corporation organized on a for-profit or not-for-profit basis. Each applicant must provide evidence of its legal capacity to contract with the Rural Utilities Service to obtain the grant and comply with all applicable requirements.

   Consortium: A consortium is a combination or group of entities formed to undertake the purposes for which the distance learning and telemedicine financial assistance is being requested.

   - If the applicant is an existing established consortium with the legal ability to contract with the Federal Government, that organization can apply in the name of the formal consortium.
   - If the applicant is an informal consortium which by itself lacks the legal capacity to contract with the Federal Government, each individual entity must contract with RUS in its own behalf.
   - An informal consortium may have a legally organized host organization which will apply on behalf of the consortium and be designated as the project owner with all awardee responsibilities.

2. Either operate a rural community facility or deliver distance learning or telemedicine services to entities that operate a rural community facility or to residents of rural areas at rates calculated to ensure that the benefit of the financial assistance is passed through to such entities or to residents of rural areas.

Eligible purposes

1. Acquiring, by lease or purchase, eligible equipment. If leased, the cost of the lease during the three-year life of the grant is eligible. The following are examples of eligible

equipment. This list is not exhaustive. Neither does it convey blanket eligibility. A computer is not automatically eligible. It must be used for an eligible purpose. Remember also that the purpose of the DLT Grant program is to deliver education or medical care between remote sites via telecommunications, not simply to furnish educational or medical technology.

- Computer hardware and software
- Site licenses and maintenance contracts
- Extended warranties (up to 3 years)
- Audio and video equipment
- Computer network components
- Telecommunications terminal equipment
- Data terminal equipment
- Interactive audio/video equipment
- Inside wiring
- Broadband facilities, if owned by the applicant

2. Acquiring instructional programming that is a capital asset (including the purchase or lease of instructional programming already on the market). Renewals of instructional programming are not eligible nor is classroom equipment (such as laboratory equipment). Also, expenses (such as those for tuition, fees for coursework on a per course basis, or fees for cultural events or virtual field trips) are not capital assets and therefore, are not eligible.
3. Providing technical assistance and instruction for using eligible equipment, including any related software; developing instructional programming that is a capital asset and providing engineering or environmental studies relating to the establishment or 11 expansion of the phase of the project to be financed with the grant. The costs for this category cannot exceed 10% of the grant amount requested.

Grant Amounts

The minimum Grant amount which can be requested is $50,000. The maximum Grant amount which can be requested is $1,000,000.

Matching Requirements

The grant applicant's matching contribution must at least total 15 percent of the grant amount requested and be used for eligible grant purposes.

The DLT grant program is designed to bolster telemedicine capabilities for hospitals and health systems in rural areas. Funding will help improve telehealth infrastructure for rural communities while also helping to meet current telemedicine needs through the COVID-19 National Emergency.

Application Guide

Distance Learning and Telemecicine Grant Program Application Guide can be found here.

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Federal Communications Commission COVID-19 Telehealth Program

The CARES Act provides $200,000,000 to the (Federal Communications Commission (FCC), "including to support efforts of health care providers to address coronavirus by providing telecommunications services, information services, and devices necessary to enable the provision of telehealth services. The Program will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended.

Eligibility

The COVID-19 Telehealth Program is limited to nonprofit and public eligible health care providers that fall within the following categories of health care providers-

- post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- community health centers or health centers providing health care to migrants;
- (local health departments or agencies;
- community mental health centers;
- not-for-profit hospitals;
- rural health clinics;
- skilled nursing facilities (as defined in section 395i–3(a) of title 42); and
- consortia of health care providers consisting of one or more entities described above.

Health care providers seeking to participate in the COVID-19 Telehealth Program must obtain an eligibility determination from the Universal Service Administrative Company (USAC) for each health care provider site that they include in their application. Interested health care providers that do not already have an eligibility determination can obtain one by filing an FCC Form 460 through My Portal on USAC's webpage.

Eligible Services and Devices

Examples of eligible services and connected devices that COVID-19 Telehealth Program applicants may seek funding for include:

- Telecommunications Services and Broadband Connectivity Services: Voice services, for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equiment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.

Applications

Applications may be filed beginning at 12:00 PM (ET) on April 13, 2020, and funding decisions will be made on a rolling basis. The Commission will continue to accept and review applications until the funding is exhausted or the current COVID-19 pandemic has ended.

The COVID-19 Telehealth Program application form is available here.

For More Information

More information about the FCC's COVID-19 Telehealth Program can be found on the FCC's Frequently Asked Questions Page here.

Connected Care Pilot Program

The Connected Care Pilot Program will make $100 million available over three years to pay 85% of costs of broadband connectivity, network equipment, and other information services necessary for an eligible health care provider to provide connected care services—particularly to low-income households and/or veterans.

All eligible nonprofit and public health care providers regardless of whether they are non-rural or rural, can apply for the Pilot Program.

Eligible health care providers include:

- post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- community health centers or health centers providing health care to migrants;
- local health departments or agencies;
- community mental health centers;
- not-for-profit hospitals;
- rural health clinics;
- skilled nursing facilities (as defined in section 395i–3(a) of title 42); and
- consortia of health care providers consisting of one or more entities described above.

Eligible health care providers must first submit applications to the Federal Communications Commission, and after review, the Commission will announce the selected projects and provide further information on additional requirements for the Pilot Program.

Connected care services can be provided by doctors, nurses, or other health care professionals. Health care providers will have the flexibility to identify the medical conditions to be treated through their proposed pilot projects, and whether to treat a single medical condition or multiple medical conditions. For purposes of the Pilot Program, the Commission uses the U.S. Department of Health and Human Services' definition of "medical condition" to identify the types of health conditions that can be treated through the Pilot—"any condition, whether physical or mental, including but not limited to any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation.

Healthcare providers that have not already been found to be eligible for an existing FCC program can obtain an eligibility determination by filing FCC Form 460 with the Universal Service Administrative Company.

Applications for the Connected Care Pilot Program will be accepted starting on the effective date of the program rules, which will be announced by the FCC. The Pilot Program requirements will not become effective until approved by the Office of Management and Budget (OMB). No applications will be accepted before that date. The deadline for applying will be 45 days after the effective date (which will be 30 days after the order is published in the Federal Register) or 120 days after the decision was released, whichever is later.

Providers can file applications for both the COVID-19 Telehealth Program and the Connected Care Pilot Program, however they cannot obtain funding from both programs for the same activities.

More information on the Connected Care Pilot Program can be accessed here.

Administration for Community Living (ACL)

The CARES ACT includes $955 million for ACL to support nutrition programs, home and community based services, support for family caregivers, and expand oversight and protections for seniors and individuals with disabilities. The CARES Act funding includes:

- $200 million for Home and Community Based Services (HCBS), which will help greater numbers of older adults shelter in place to minimize their exposure to COVID-19. These include personal care assistance; help with household chores and grocery shopping; transportation to essential services (such as grocery stores, banks, or doctors) when necessary; and case management.
- $480 million for home-delivered meals for older adults. With this funding, states can also expand “drive-through” or “grab-and-go" meals for older adults who typically would participate in meal programs at community centers and other locations that have been closed due to social distancing measures.
- $85 million for Centers for Independent Living to provide direct and immediate support and services to individuals with disabilities who are experiencing disruptions to their independent, community-based living due to the COVID-19 pandemic. Services will ensure individuals with disabilities have the supports they need to safely stay in their homes or return home after a hospitalization or institutionalization during (and directly after) COVID-19.
- $20 million for nutrition and related services for Native American Programs to help tribes and tribal organizations provide meals and supportive services directly to Native American elders.
- $100 million for the National Family Caregiver Support Program to expand a range of services that help family and informal caregivers provide support for their loved ones at home. These include counseling, respite care, training, and connecting people to information.
- $20 million to support State Long-term Care Ombudsman programs in providing consumer advocacy services for residents of long-term care facilities across the country. Restrictions on visitation have significantly increased demand for ombudsman services, as families seek assistance in ensuring the well-being of their loved ones. Ombudsman programs will seek to expand their virtual presence to residents and their families, and

continue to promote the health, safety welfare, and rights of residents in the context of COVID-19. This funding will give Ombudsman programs the flexibility to hire additional staff and purchase additional technology, associated hardware, and personal protective equipment once in-person visits resume.

- $50 million for Aging and Disability Resource Centers (ADRCs), which will fund programs that both connect people at greatest risk to COVID-19 to services needed to practice social distancing and seek to mitigate issues created by it, such as social isolation. ADRCs across the country are reporting unprecedented demand for assistance with applications for services, care coordination, services that support people in returning home following hospitalization, and the like.

The majority of these additional funds ($905 million) are being awarded to states, territories, and tribes for subsequent allocation to local service providers. Grant amounts are determined based on the formulas defined under the program authorizing statutes. The remaining $50 million will be awarded by the close of April.

U.S. Department of Health and Human Services Reimbursement for Uninsured Individuals

As part of the CARES Act, the U.S. Department of Health and Human Services (HHS), will provide claims reimbursement to health care providers generally at Medicare rates for testing uninsured individuals in the United States for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis. Health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 can request claims reimbursement through the program electronically and will be reimbursed generally at Medicare rates, subject to available funding.

Eligibility

Health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 can request claims reimbursement through the program electronically and will be reimbursed generally at Medicare rates, subject to available funding. Steps will involve: enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit.

To participate, providers must attest to the following at registration:

- You have checked for health care coverage eligibility and confirmed that the patient is uninsured. You have verified that the patient does not have coverage such as individual, employer-sponsored, Medicare or Medicaid coverage, and no other payer will reimburse you for COVID-19 testing and/or care for that patient
- You will accept defined program reimbursement as payment in full.
- You agree not to balance bill the patient.
- You agree to program terms and conditions and may be subject to post-reimbursement audit review.

What is covered?

Reimbursement will be made for: qualifying testing for COVID-19 and treatment services with a primary COVID-19 diagnosis, including the following:

- Specimen collection, diagnostic and antibody testing.
- Testing-related visits including in the following settings: office, urgent care or emergency room or via telehealth.
- Treatment, including office visit (including via telehealth), emergency room, inpatient, outpatient/observation, skilled nursing facility, long-term acute care (LTAC), acute inpatient rehab, home health, DME (e.g., oxygen, ventilator), emergency ground ambulance transportation, non-emergent patient transfers via ground ambulance, and FDA approved drugs as they become available for COVID-19 treatment and administered as part of an inpatient stay.
- FDA-approved vaccine, when available.
- For inpatient claims, date of admittance must be on or after February 4, 2020.

Program timeline

Eligible providers can begin enrolling in the program on April 27. HRSA and UnitedHealth Group (the administrative contractor) will provide technical assistance beginning on April 29. Providers can begin submitting claims on May 6 and can expect to begin receiving reimbursements by mid-May.

For More Information

More information about the HHS reimbursements can be accessed here and here. Providers can begin the reimbursement process here.

Other Notable CARES Act Health Care Provisions

Medicare Add-on for Inpatient Hospital COVID-19 Patients

The CARES Act increases Medicare reimbursement to care for a COVID-19 patient by 20 percent. This add-on payment recognizes the increased costs incurred by providers and will be applied for the duration of the COVID-19 emergency.