PRF Improper Payments/Overpayments

Link to Most Recent PRF FAQ (1/28/21)

BACKGROUND

Through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act (PPPCHE), the federal government has allocated $175 billion in payments to be distributed through the Provider Relief Fund (PRF). Qualified providers of health care, services, and support may receive Provider Relief Fund payments for healthcare-related expenses or lost revenue due to COVID-19. Separately, the COVID-19 Uninsured Program reimburses providers for testing and treating uninsured individuals with COVID-19.

Provider Relief Fund payments may be used to **cover lost revenue attributable to COVID-19 or health-related expenses** purchased to prevent, prepare for, and respond to coronavirus, including but not limited to:

- Supplies
- Equipment
- Workforce training
- Reporting COVID-19 test results to federal, state, or local governments
- Building or constructing temporary structures for COVID-19 patient care or non-COVID-19 patients in a separate area
- Acquiring additional resources, including facilities, supplies, or staffing to expand or preserve care delivery
- Developing and staffing emergency operation centers

Recipients of >$10,000 will be required to submit reports about the use of their Provider Relief Fund distribution.

REPAYMENT/RECOUPMENT

PRF Payments that are Greater than Expected or Received in Error

If HHS identifies a payment made in error, HHS will recoup the erroneous amount. If a provider receives a payment that is greater than expected and believes the payment was made in error, the provider should contact the **Provider Support Line at (866) 569-3522 (for TYY, dial 711)** and seek clarification.

The Provider Relief Fund and the Terms and Conditions ***require that recipients be able to demonstrate that lost revenues and increased expenses attributable to***

COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund.

A health care provider that believes it has received an overpayment from a targeted distribution may keep the overpayment if the health care provider expects it will have cumulative lost revenues and increased costs that are attributable to coronavirus during the COVID-19 public health emergency that exceed the intended calculated payment.

Provider Relief Fund payment amounts that have not been fully expended on the combination of healthcare expenses and lost revenues attributable to coronavirus by the end of the final reporting period, must be returned to HHS. HHS reserves the right to audit Relief Fund recipients in the future to ensure that this requirement is met and collect any Relief Fund amounts that were made in error or exceed lost revenue or increased expenses due to COVID-19. Failure to comply with the Terms and Conditions may be grounds for recoupment.

Time Period for Use of Funds

As explained in the notice of reporting requirements on the Provider Relief Fund website, funds must be expended no later than June 30, 2021. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately.

"Proper Use"

In its PRF FAQs, HHS says that the agency "expects 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."

"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." The referenced Terms and Conditions do not require rejection of Tranche #1 payments based on application of the "program service revenue" formula.

Recoupment

HHS has not yet detailed how recoupment or repayment will work. However, the Terms and Conditions associated with payment require that the Recipient be able to certify, among other requirements, that it was eligible to receive the funds (e.g., provides or provided after January 31, 2020, diagnoses, testing, or care for individuals

with possible or actual cases of COVID-19) and that the funds were used in accordance with allowable purposes (e.g., to prevent, prepare for, and respond to coronavirus).

Additionally, recipients must submit all required reports as determined by the Secretary. Non-compliance with any term or condition is grounds for the Secretary to direct recoupment of some or all of the payments made. HHS will have significant anti-fraud monitoring of the funds distributed, and the Office of Inspector General will provide oversight as required in the CARES Act to ensure that Federal dollars are used appropriately.

OTHER CONSIDERATIONS

Accrued Interest

For Provider Relief Fund payments that were held in an interest-bearing account, the provider must return the accrued interest associated with the amount being returned to HHS. However, if the funds were not held in an interest-bearing account, there is no obligation for the provider to return any additional amount other than the Provider Relief fund payment being returned to HHS.

Excess Return

The Provider Relief Fund will refund returned payments that are determined to be $500 or more in excess of the required returned amount.

Early Clawbacks for Overpayments

In Q2 2020, HHS distributed $50 billion from the CARES Act to providers adversely affected by lost revenue and increased costs from the pandemic. However, after the first tranche of $30 billion was distributed, HHS changed the calculation for how much each provider would receive and then retroactively applied it to both the original $30 billion and a new $20 billion allocation. For some providers that heavily rely on Medicare, the change raised concerns that their organization might have been overpaid under the first formula.

In a response to questions on potential clawbacks of the federal assistance, an HHS spokesperson said May 5, ***"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 [the] provider has received."***

The "terms and conditions" of those payment tranches require recipients to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been paid from other sources or that other sources are obligated to pay, "do not exceed total payments from the [CARES Act] Relief Fund."

The limitation on clawbacks identified by the spokesperson may be more favorable to providers than a more open-ended, earlier assertion by an HHS official that the department was prepared to claw back "any further overpayment amounts through CMS and our partnership with UHG [UnitedHealth Group]."

Audits

"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." ***Note that HHS has not further defined what receiving a relief payment "in error" means.***

"Reverse" False Claims Liability

If a health care provider receives a Provider Relief Fund payment to which it knows it is not at all entitled and chooses not to reject or return the payment, that health care provider may incur "reverse" false claims liability.

Any health care provider that knowingly conceals or knowingly and improperly avoids returning such an overpayment to the government risks violating the "reverse" false claims provision of the False Claims Act, 31 U.S.C. §§ 3729–3733 (FCA), and incurring civil penalties ranging from $11,665 to $23,331 per instance plus three times the government's damages.

Whistleblowers/Relators

The FCA permits the government and private citizens (i.e. whistleblowers) to pursue violators of the FCA. The FCA allows whistleblowers to file qui tam lawsuits by which the whistleblowers (called relators) can get a portion of the government's recovery from the case. Last fiscal year, the government recovered more than $3 billion from FCA enforcement cases, $2.6 billion of which related specifically to the health care industry.

Now that the Centers for Disease Control and Prevention (CDC) has listed on its website the recipients and amounts of HHS Provider Relief Fund payments, an increase in relators are inevitable, especially in these uncertain economic times.