Proskauer

A Guide to Compliance Considerations for Health Care Providers:

CARES Act, Payroll Protection, and Medicare Advance Payment Programs

Executive Summary

In response to widespread cash flow issues resulting from the COVID-19 public health emergency, Congress enacted two key pieces of legislation: the CARES Act and the Paycheck Protection Program and Health Care Enhancement Act ("PPPHCEA"). This guide details the compliance and oversight implications stemming from health care providers' receipt of COVID-19-related grants and loans through the various CARES Act and PPPHCEA funding programs.

The terms and conditions, attestations, and other requirements attached to the receipt of such funds are rife with ambiguity and impose substantial burdens on providers to ensure the proper application for funds, as well as compliant receipt, distribution, and use-tracking of such funds.

These requirements present potentially significant financial and reputational risk to recipients whose resources are already stretched thin in responding to COVID-19.

We dissect key avenues through which COVID-19-related funds dispersed under the aforementioned statutes could be recouped from recipients, or serve as the basis for other government enforcement actions, mainly under the False Claims Act.

We elaborate on the most significant areas of potential recipient liability, with a focus on detailed compliance tips that providers can employ to minimize the risk of such liability for the three main programs under which providers will receive funds:

(1) the Provider Relief Fund;
(2) the Paycheck Protection Program; and
(3) the Medicare Accelerated and Advance Payment Program.

The in-depth guide concludes with a list of concrete best practices for CARES Act and PPPHCEA related funding compliance.

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CARES Act & PPPHCEA Funding: Compliance Considerations for Providers

I. Overview

In response to widespread cash flow issues resulting from the COVID-19 public health emergency (the "PHE"), Congress enacted two key pieces of legislation: the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act" or "the Act") and the Paycheck Protection Program and Health Care Enhancement Act ("PPPHCEA"). Each made various funding sources[1] available to providers of all types that have been affected by COVID-19-related revenue shortfalls and expense increases. The potential forgiveness of loaned funds or retention of granted funds, and the propriety of receipt and use of such funds, depending on the relevant administering program, hinges on receiving providers taking prudent steps in complying with the Terms and Conditions attached to such funds.

Failure to adhere to the requirements and Terms and Conditions could expose recipients of loaned or granted funds to potential government enforcement and recoupment actions. Chief among these are potential government audits, investigations, and False Claims Act ("FCA") actions, in addition to the prospect of FCA *qui tam* whistleblower suits.

Given the unprecedented amounts of funds available through the various programs and the rapid nature of eligibility determinations, fund distributions, and programmatic roll out, the Department of Health and Human Services ("HHS"), including its Office of Inspector General ("OIG"), the Department of Treasury ("Treasury"), the U.S. Small Business Administration ("SBA"), and the Department of Justice ("DOJ") are likely to be particularly aggressive in auditing and investigating compliance with relevant requirements. Both the Secretary of the Treasury[2] and the Secretary of HHS (the "HHS Secretary") have stated their intent to conduct rigorous fraud and abuse oversight accordingly.[3] In a memo to all attorneys in the U.S. Attorney's Office, Attorney General William Barr said, "The pandemic is dangerous enough without wrongdoers seeking to profit from public panic and this sort of conduct cannot be tolerated."[4]

Furthermore, the CARES Act created and funded three new oversight bodies: (1) the Office of the Special Inspector General for Pandemic Recovery, created by the DOJ in coordination with other federal agencies and tasked with oversight of the Treasury Secretary's distribution of CARES Act aid through investigating and prosecuting COVID-19-related fraud schemes and supported by subpoena authority; (2)

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[1] This Article does not address the Main Street Lending Program, through which nonprofit providers may be able to receive loans. Please see Proskauer's Coronavirus Task Force's up-to-date alert ("Where is Main Street? – Fed Provides Guidance on the Main Street Lending Program") for guidance regarding the terms of receiving loans under the Main Street Lending Program, including compensation restrictions that should be considered in tandem with those discussed below in Section 2.b of Terms and Conditions: Restrictions on Use of PRF Funds. *See* https://www.proskauer.com/alert/where-is-main-streetfed-provides-guidance-on-the-main-street-lending-program.

[2] Secretary Mnuchin has announced audits of any recipients of more than $2 million in PPP loans (as defined below) by the SBA, which indicated that borrowers should expect additional guidance regarding such audits in the future.

[3] OIG must submit to the Senate and House Committees on Appropriations reports on interim CARES Act distributions every 60 days and a final audit report within three years of final payments made through the CARES Act. OIG has not yet released audit guidelines or interpretations of key concepts, such as what constitutes the use of funds for an appropriate purpose under the CARES Act. Where differences in recipients' and OIG's interpretations occur, liability could attach.

[4] https://www.justice.gov/ag/page/file/1258676/download.

the Pandemic Response Accountability Committee, a committee of inspectors general from relevant agencies and a new inspector general for pandemic recovery, tasked with general oversight of all spending and lending related to COVID-19, especially as it relates to fraud, waste, abuse, and mismanagement; and (3) the Congressional Oversight Commission, a joint committee of Congress that is tasked with overseeing all pandemic-related legislation and programs.

Of particular concern to recipient providers is the specter of FCA liability under 31 U.S.C. § 3729, et seq. The FCA provides a basis for civil, administrative, and even criminal penalties where violations are found. This includes the potential for treble damages for any person or entity that either:

> "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;"[5] or
>
> "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."[6]

The former type of false claims present exposure for grant or loan applicants who submit false information in order to obtain CARES Act and PPPHCEA aid in the first instance. The latter "reverse false claims," termed as such because instead of submitting false claims, a recipient improperly retains government funds, pose liability for those who receive loans, forgiveness, and grants made through the CARES Act and PPPHCEA but fail to return funds to the government where obligated to do so by the Terms and Conditions.

The FCA also includes *qui tam* provisions,[7] which enable actions to be brought on behalf of whistleblowing "relators" who have independent knowledge of inappropriate receipt or use of government funds and who can collect between 15 and 30 percent of any damages awards resulting from successful enforcement actions – a strong financial incentive for relators to initiate *qui tam* actions.

FCA liability and other enforcement action may result if funds are accepted, used, and tracked improperly. To avoid exposure and liability, recipients should pay particular attention to the following program-specific concerns and institute best practices accordingly.

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[5] 31 U.S.C. § 3729(a)(1)(B).

[6] 31 U.S.C. § 3729(a)(1)(G).

[7] 31 U.S.C. § 3730 et seq.

II. Provider Relief Fund (PRF)

The CARES Act created the Public Health and Social Services Emergency Fund (the "Provider Relief Fund" or "PRF") to which it and the PPPHCEA allocated a combined total of $175 billion in grant money to be distributed to hospitals and other health care providers affected by the PHE.[8]

The CARES Act apportions $30 billion and $20 billion of the total PRF pool to two respective successive rounds of "General Distributions," and $12 billion of the pool to hospitals in "High Impact" areas (e.g. New York) through "Targeted Distributions."[9] There is also now a potential $15 billion available for certain providers who bill Medicaid or CHIP (either fee-for-service or managed care) and meet specific eligibility requirements to receive a Medicaid Targeted Distribution grants if they submit applications by July 20, 2020.[10]

Providers receiving PRF funds are required to conform to the distribution-specific Terms and Conditions and make attestations related thereto within 90 days for receipt of such funds.[11] The PRF distributions to providers are grants and do not need to be repaid if accepted by eligible providers and used in accordance with such Terms and Conditions. However, providers receiving PRF funds may be at risk for recoupment actions or FCA liability if they improperly receive PRF funds or use PRF funds in ways that breach the Terms and Conditions or conflict with the attestations made in receipt of such funds.

To limit exposure and comply with the relevant PRF requirements, providers receiving PRF funds should be cognizant of the following key issues in making attestations, and receiving and using such funds:

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[8] HHS has yet to clarify exactly how the additional $75 billion included in the PPPHCEA will be allocated.

[9] $2 billion of the $12 billion is earmarked for distribution based on hospitals' Medicare and Medicaid disproportionate share and uncompensated care payments. The CARES Act also allocated funds from the total pool to an FFCRA Relief Fund, an Uninsured Relief Fund, and a Rural Provider Relief Fund, which are beyond the scope of this article. General distributions to providers are allotted based on proportionate shares of Medicare fee-for-service reimbursements and delivered using CMS's automated clearinghouse account information on file for each eligible provider. High-impact-area providers should update their capacity and COVID-19 census data through their CDC National Healthcare Safety Network account. https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[10] The eligibility requirements to receive Medicaid Targeted Distributions include that the recipient "(1) must not have received payment from the $50 billion General Distribution; (2) must have directly billed Medicaid or CHIP for healthcare-related services during the period of January 1, 2018, to December 31, 2019, or (ii) own (on the application date) an included subsidiary that has billed Medicaid or CHIP for healthcare-related services during the period of January 1, 2018, to December 31, 2019; (3) must have either (i) filed a federal income tax return for fiscal years 2017, 2018 or 2019 or (ii) be an entity exempt from the requirement to file a federal income tax return and have no beneficial owner that is required to file a federal income tax return. (e.g. a state-owned hospital or healthcare clinic); (4) must have provided patient care after January 31, 2020; (5) must not have permanently ceased providing patient care directly, or indirectly through included subsidiaries; and (6) if the applicant is an individual, have gross receipts or sales from providing patient care reported on Form 1040, Schedule C, Line 1, excluding income reported on a W-2 as a (statutory) employee." https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. "Providers who began billing Medicaid/CHIP between January 1 and May 31, 2020 may be eligible for future allocations of the Provider Relief Fund," but are not eligible for the current Medicaid Targeted Distributions. *Id.* Note that dental providers are included in the eligible provider types, as are all other providers that bill Medicaid or CHIP through either a waiver or a state plan.

[11] Retention of payment for 90 days or more without contacting HHS regarding remittance of funds is deemed acceptance of the Terms and Conditions. The original period within which attestations were required to be made was 30 days, which was extended on May 7, 2020 to 45 days following receipt. https://www.hhs.gov/about/news/2020/05/07/hhs-extends-deadline-attestation-acceptance-terms-and-conditions-provider-relief-fund-payments-45-days.html. HHS thereafter extended the deadline for attestations an additional 45 days to 90 days from receipt of payment. *See* https://www.hhs.gov/about/news/2020/05/22/hhs-announces-45-day-compliance-deadline-extension-for-providers.html and https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

PRF Grant Eligibility Information Submitted to HHS

1. **Potential Exposure Related to Submission of Improper or Incorrect Information to HHS:** FCA liability can attach under 31 U.S.C. § 3729(a)(1)(B) or (G) if providers, including hospitals, submit to HHS incorrect, false, or misleading revenue information in order to obtain PRF grant funds and/or thereafter retain such funds without correcting their submissions.

a. *General Considerations for All Provider Submissions*: The initial $30 billion PRF rapid general distribution was proportionate to each receiving provider's 2019 Medicare fee-for-service payments (Medicare Parts A or B), whereas the subsequent $20 billion distribution was proportionate to the receiving provider's share of 2018 net patient revenue as submitted in complete Medicare cost reports or via the PRF General Distribution Portal. However, all providers receiving funds from the second wave of $20 billion in grants must have submitted to HHS additional revenue information for verification of eligibility by June 3, 2020.[12] Furthermore, hospitals in high impact areas must have applied for targeted grant funding by submitting the following information to HHS: 1) Tax Identification Number, 2) National Provider Identifier, 3) Total number of Intensive Care Unit beds as of April 10, 2020, and 4) Total number of admissions with a positive diagnosis for COVID-19 from January 1, 2020 to April 10, 2020.[13]

The Terms and Conditions attached to each grant now mandate that the recipient certifies that "all information (including admission data)" provided in relation to the grant is now and in the future (if requested by the HHS Secretary or Inspector General) "true, accurate and complete, to the best of its knowledge." In direct reference to potential enforcement actions, the Terms and Conditions further provide that:

> "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."[14]

Recipient providers and hospitals should be especially wary of whistleblowing relators and future government investigations that may uncover and/or disclose improprieties in data submissions related to obtaining PRF grants.

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[12] Such information includes: "1) a provider's "Gross Receipts or Sales" or "Program Service Revenue" as submitted on its federal income tax return; 2) the provider's estimated revenue losses in March 2020 and April 2020 due to COVID; 3) a copy of the provider's most recently filed federal income tax return; 4) a listing of the TINs any of the provider's subsidiary organizations that have received relief funds but that DO NOT file separate tax returns." https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf. For additional information on payment methodology, *see* https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[13] Providers are instructed to continually update their capacity and COVID-19 census data to ensure timely payment. Payments for High Impact Area recipients are made at the TIN level, so hospitals with more than one facility (four walls) under the same TIN "must report the number of COVID-19 positive inpatient admissions occurring within each facility" through the end of June 10, 2020. https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[14] *See* each Terms and Conditions document located at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/terms-conditions/index.html.

b. *Implications for Parent Entities*: The above considerations may be heightened for larger parent entities that submit applications for PRF funds on behalf of their subsidiary providers. Such parent entities must collect additional information and adhere to specific submission requirements in order for their PRF grant submissions to be correct and retention of any PRF grant funds distributed to be compliant. For example, a parent entity may not have a Tax Identification Number ("TIN") used to bill Medicare ("Billing TINs") but may submit tax returns for the entire organization, whereas its subsidiaries may have such Billing TINs but do not submit independent tax returns.[15] HHS instructs that parent entities in such cases must list the subsidiaries' Billing TINs (as opposed to the parent's own *Filing* TIN) in its submission, along with the sum of all associated gross sales or receipts of its Medicare billing subsidiaries that rendered health care services after January 31, 2020 to "possible or actual" COVID-19 patients.[16] If a parent entity is a vertically integrated organization with non-health care business lines and revenue streams, only subsidiaries rendering such COVID-19-related health care services may be reported. In other cases, a parent entity may have a Billing TIN that covers multiple business lines, only some of which bill Medicare but all of which have lost revenues attributable to COVID-19. HHS instructs such parent entities to report lost revenues from all business lines that actively care for patients with or prevent the spread of COVID-19. HHS also instructs in its FAQs that for some of the above situations, parent entities should also submit cover pages describing the specifics of its submission when uploading their tax returns.[17]

While parents can receive PRF grant funds on behalf of subsidiary organizations who do not independently file tax returns and receive PRF grant distributions, and may distribute such funds at their discretion (in accordance with the Terms and Conditions associated with each distribution, as discussed below), the initial submission required to receive the funds presents a complex web of documentation requirements for parent entities to navigate. Given the nuances of PRF submissions and the various updates HHS has made and continues to make to its FAQ guidance over time, parent entities may have submitted incomplete or incorrect information prior to attesting to the Terms and Conditions of the PRF grant distribution. Such errors, even if inadvertent, may raise compliance concerns for parent entities related to their initial eligibility for PRF grants and their ongoing documentation, reporting, and adherence to the Terms and Conditions of PRF grant distributions.

Compliance Tip #1: To limit exposure, providers who received funds through either the general or targeted PRF distributions should carefully review and, if the amounts received are large enough, retain a third party accounting firm to review, the accuracy of information submitted to HHS and notify HHS immediately of any necessary corrections that should be made. This may require returning funds received, depending on the severity of the submission error.

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[15] Such subsidiaries may have Billing TINs but not Filing TINs because they are disregarded for tax purposes or consolidated as part of the parent's financials, but still bill Medicare and other payors using their own TIN.

[16] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. For a discussion of "possible or actual" COVID-19 patients, see Terms and Conditions: Restrictions on Use of PRF Funds, Section 1(c).

[17] The content required to be included in such cover pages is set forth in the PRF FAQs for various scenarios. Entities should refer to the the FAQs to determine whether such a scenario applies to the entity's circumstances, and if so, what documentation and information must be included on its cover page. *See* https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

c. *Implications for Provider Transactions and Changes of Control*: Similar to parent entities, provider organizations that are or have been involved in transactions or changes of control since 2018 must adhere to specific submission requirements to be and remain compliant with the PRF grant Terms and Conditions.

Many issues that may arise, and which HHS addressed in its FAQs, relate to situations in which control of a provider's Billing TIN changes following a transaction. Two principles of eligibility continue to dictate which providers can accept and retain PRF General Distribution funds (or, for parent entities, on behalf of which subsidiary providers they can accept PRF funds): (1) the provider's TIN must have been used to bill Medicare fee-for-service in 2019, and (2) the provider's TIN was used to bill for diagnoses, testing, or care the provider rendered to individuals with possible or actual cases of COVID-19 on or after January 31, 2020 (this is true even if the provider has since ceased operations or changed ownership). Therefore, assessing compliance with the PRF Terms and Conditions requires following the control of a provider's Billing TIN.

If a provider did not render care to possible or actual COVID-19 patients on or after January 31, 2020, or if its practice or facility changed ownership in 2019[18] and is no longer providing services on or after January 31, 2020, the provider is ineligible for PRF grant funds because "it cannot attest that it was providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020."[19] In essence, the provider's TIN was not used to bill Medicare fee-for-service in the required eligibility time periods.

HHS states that if the current provider organization owner ("Buyer") has "purchased a TIN" from past owners ("Sellers") in 2019, the previous owner cannot accept PRF grant funds and subsequently transfer such funds to the new owner.[20] HHS appears to be signaling that if, as a result of a transaction or change of control that occurred prior to January 31, 2020, a Seller's TIN is no longer operational and the Buyer uses a new TIN, the Buyer cannot meet the above eligibility requirements and would not be able to accept PRF grants. This could occur where the transaction takes the form of an asset transfer. Similarly, a Buyer that "purchased" a previous owner's TIN before January 31, 2020 cannot accept PRF grant funds on behalf of the previous owner, but it may be eligible for other types of distributions. If an organization eligible for PRF grant funds sold an eligible provider that was included in the organization's most recent tax return gross receipts or sales figures, the Seller organization can still accept grant distributions associated with the now-sold provider. Conversely, for transactions that occurred prior to January 31, 2020 and result in the Seller's TIN remaining operational post-transaction, which may be the case in stock transfer transactions (or mergers in which the Seller entity is the surviving entity, as discussed below), the Buyer would still be eligible for PRF grant distributions if it meets the eligibility requirements.

HHS has also addressed circumstances where a prospective Seller received PRF grant funds prior to the completion of a transaction or change of control occurring after January 31, 2020. HHS instructs that where the sale is an acquisition of stock or membership interests, the Seller that received the PRF grant funds may continue to use the funds regardless of the new owner if the Seller provided care to actual or possible COVID-19 patients on or after January 31, 2020. However, where the sale is a purchase of some or all of the PRF recipient's (Seller's) assets, including where the transaction is the liquidation of a bankrupt recipient, only the original recipient may use the funds for eligible expenses and lost revenues, returning any leftover funds to HHS.[21] In such cases, PRF funds would not be transferred to the Buyer, but the Buyer may be eligible for other future PRF distributions.

Relatedly, where two provider entities have merged between January 1, 2018 and January 31, 2020, only the surviving entity should accept PRF grant funds, assuming it billed Medicare fee-for-service in 2019 and rendered care to possible or actual COVID-19 patients on or after January 31, 2020.[22] In such cases, HHS instructs the surviving entity to submit its adjusted gross receipts if they exceed those shown in the survining entity's most recent tax return filing by 20% in order to properly account for the nonsurviving entity. However, until an ongoing merger is complete, the prospective Buyer should *not* include in its PRF submission the gross receipts of the practice it intends to purchase. Entities with ongoing mergers, acquisitions, or changes of control should submit information that reflects the organization that exists at the time of application.[23]

Given the above guidance, providers submitting information to obtain PRF grants must be particularly careful about which TINs they list in their submissions to HHS, the dates for which those TINs were active, and when the TINs were acquired. Submissions including information of not-yet-acquired providers or providers who were acquired prior to January 31, 2020 could subject the recipient to oversight scrutiny and potential FCA actions for improper retention of government funds.

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[18] The FAQs refer to changes of control or sales that occurred "in 2019," seemingly (and perhaps unintentionally) omitting transactions that took place between December 31, 2019 and January 30, 2020 from its conception of transactions that may render the surviving entity ineligible for PRF General Distribution grants. In light of this discrepancy, the guiding principles for PRF eligibility should remain whether (1) the provider's TIN was used to bill Medicare fee-for-service in 2019, and (2) the provider's TIN was used to bill for diagnoses, testing, or care the provider rendered to individuals with possible or actual cases of COVID-19 on or after January 31, 2020.

[19] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[20] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[21] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[22] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. However, if the surviving entity did not bill Medicare fee-for-service in 2019, it is not eligible for PRF General Distributions, even if it acquired an entity that did so.

[23] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

Terms and Conditions: Restrictions on Use of PRF Funds

1. **Potential Exposure for Improper Use of PRF Grants:** Providers risk FCA liability or recoupment action if they violate the use restrictions contained in each PRF grant's Terms and Conditions. Providers may only use PRF grant funds to "prevent, prepare for, and respond to coronavirus" or to reimburse for "health care related expenses or lost revenues that are attributable to coronavirus."[24] Additionally, recipients cannot use PRF grant funds to reimburse expenses or losses incurred from or obligated to be reimbursed by other sources, such as to satisfy other outstanding debt obligations, or for prohibited activities, such as lobbying, embryonic research, gun control advocacy, contracting with entities that have unpaid Federal tax liabilities, or abortion services (or coverage thereof).[25]

   Notably, the Terms and Conditions specifically apply various whistleblower protections to the improper use of PRF grant funds. Accordingly, providers receiving PRF funds are responsible for diligently tracking how such funds are used. The following issues are likely to be of particular interest to recipients in tracking the use of funds to ensure compliance with the Terms and Conditions and limit FCA exposure:

   a. *Reimbursing Health Care-Related Expenses or Lost Revenue*: HHS has updated its guidance to offer additional context as to what constitutes a "health care related expense" and how to estimate lost revenues attributable to COVID-19. The HHS FAQs state that permissible expenses beyond the statutory language[26] "cover a range of items and services" whose purchase satisfies the requirements that such expenses "prevent, prepare for, and respond to coronavirus," including:

      - "supplies used to provide healthcare services for possible or actual COVID-19 patients;
      - equipment used to provide healthcare services for possible or actual COVID-19 patients;
      - workforce training;
      - developing and staffing emergency operation centers;
      - reporting COVID-19 test results to federal, state, or local governments;
      - building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide healthcare services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and

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[24] *See* each Terms and Conditions document located at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/terms-conditions/index.html.

[25] For a full list of prohibited activities, *see* each Terms and Conditions document located at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/terms-conditions/index.html.

[26] The statute provides some context of what constitutes a health care-related expense, noting that funds can be used "for building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity" if not reimbursable by "other sources."

- acquiring additional resources, including facilities, equipment, supplies, healthcare practices, staffing, and technology to expand or preserve care delivery."[27]

Such expenses *could also* include anything above usual and customary expenses incurred in preventing, preparing for, and responding to COVID-19, such as reasonable hazard or incentive pay for staff, the use of contractors, agency and outside staff, and additional cleaning, housekeeping, laundry, food, and other operational costs. PRF funds *could* also be used for infrastructure projects related to the recipient's COVID-19 preparations and response that not listed in the statute, such as to either accelerate the build out of, or institute from scratch, broader telehealth programs to expand patients' access to care during COVID-19, including access from patients' homes. However, it is unclear to what extent the permitted uses allow for larger infrastructure projects, such as modernizing or building new permanent structures and capacities. Any such projects would have to be linked to the recipient's prevention of, preparation for, or response to COVID-19 – the nexus for which remains subject to interpretation.

The HHS FAQs also instruct that providers must use a "reasonable method" to estimate lost revenue resulting from COVID-19, such as by comparing budgeted revenue or last year's revenue with this year's actual revenue for the period in question. Such calculations may include value-based payments, such as quality measures achievement payments."[28] While HHS has released limited guidance on the boundaries of what constitutes a "reasonable method," whatever method the provider uses and any extrapolations made therefrom should be supported by retrievable and verifiable data.[29]

HHS has recently elaborated on the use of PRF funds used to reimburse "lost revenues that are attributable to coronavirus," explaining that PRF funds can be used to "cover any cost that the lost revenue otherwise would have covered, so long as that cost prevents, prepares for, or responds to coronavirus."[30] HHS' stated rationale for the use of such funds is to maintain a recipient's healthcare delivery capacity, giving examples of such consistent uses as: (i) making payroll, (ii) paying employee health insurance, (iii) paying rent or mortgage payments, and (iv) paying equipment leases and licensing fees. Notably, these suggested uses all relate to the day-to-day operational costs needed to keep a recipient provider's "lights on" (i.e. maintain healthcare delivery capacity).[31]

HHS explicitly notes that PRF funds received are not subject to creditors' claims, and providers may only transfer PRF funds to creditors to satisfy claims "to the extent that such claims constitute eligible health care related expenses and lost revenues attributable to coronavirus."[32] Based upon the foregoing, it appears that PRF funds used either for capital

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[27] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[28] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. HHS also instructs that "[p]atients' out-of-pocket costs are considered part of the revenue received from a payer, therefore, should be reported in the commercial payer amount or whichever category is applicable, not separated out into "other" field." *Id.*

[29] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[30] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[31] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[32] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

purposes beyond the scope mentioned above or to pay principal on pre-existing debt that the recipient would not otherwise be able to pay in the ordinary course would each be highly suspect, except to the extent that the capital expenditure or debt incurred directly related to preventing, preparing for, or responding to coronavirus. In the event that a recipient provider owes principal debt and simultaneously uses PRF grant funds to reimburse for lost revenues, the reimbursements made from PRF grants should be backed out of any calculation of excess cash flow used to pay the principal.

HHS states that providers need not have already incurred COVID-19-related expenses and lost revenues in excess of the PRF grant received in order to be compliant with the PRF Terms and Conditions. Rather, PRF funds may continue to be used for permissible expenses and lost revenue reimbursements throughout the duration of the PHE, and should the recipient have leftover PRF grant funds that cannot be used for permissible expenses and losses after the PHE concludes, then HHS expects (and will release instructions guiding) providers to return such excess funds.[33] However, this updated guidance also instructs that in the event of an overpayment of PRF Targeted Distribution or General Distribution grant funds to a recipient, the provider should not retain the funds and instead should have returned the entire granted sum and submit the appropriate revenue documentation by June 3, 2020 in order to receive a corrected PRF grant amount thereafter.[34] It remains unclear which procedures a recipient provider should follow in the event of a PRF grant overpayment as compared to budgeted or projected lost revenues and expenses attributable to COVID-19, and to what extent the difference between anticipated expenses and lost revenues, on the one hand, and PRF funds received, on the other, would dictate the course of action. This confusing guidance could lead to provider recipients retaining PRF funds that, under one interpretation of the FAQs, should have been affirmatively returned prior to June 3, 2020, and subsequent improper retention of which could form the basis for FCA liability.

Related issues include how recipients store PRF grant funds, whether excess funds should be retained or returned given the uncertain end date of the COVID-19 PHE, and how recipients should treat interest accrued on PRF grant funds or on the excess funds retained. The FAQs make no mention of the types of accounts into which recipients can deposit granted PRF funds, leaving open to interpretation whether PRF grant funds can be funneled into investment mechanisms other than simple low interest bearing accounts. In light of the repayment obligations mentioned above, the requirement for recipients to maintain accurate and readily retrievable documentation of the storage and use of all funds, and the requirement that recipients submit corroborating documentation and reports to HHS on a quarterly basis, any improper uses of PRF funds (including improper storage and investment of PRF funds) may be flagged by oversight authorities. To avoid such potential scrutiny and any FCA liability, investigations, or enforcement actions that may follow, the safest course of action would be to store PRF grant funds in a segregated readily accessible cash account with no downside risk.

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[33] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[34] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

A lack of definite end date to the PHE exacerbates the uncertainty over how to store PRF funds and at what point excess funds must be returned to HHS. Assuming that recipients can retain excess PRF funds until the PHE is declared over, the safest option for recipients is to continue storing the excess funds as they have the funds from the initial grant amount. Additionally, to date, the government has not stated whether investment returns or interest on such PRF grant funds will be treated as part of the grant or allowed as other income to the grantee, or if such returns or interest will be treated as funds in which the government retains a primary interest. Accordingly, until HHS offers clarification, recipients can minimize the possibility of FCA liability by treating interest accrued on initial and excess PRF grant funds as government funds for which the recipient is the trustee until such funds are applied to acceptable COVID-related purposes.

Compliance Tip #2: Providers receiving PRF funds should deposit such funds into readily accessible cash accounts with no downside risk and treat interest earned thereon as funds in which the government retains a primary interest, until directed otherwise by HHS. Recipients should diligently track grant funds from the moment of receipt and document a nexus between COVID-19, the expense or loss of revenue, and the use of PRF funds to ensure that no such funds are directed to non-COVID-19-related (i.e. non-permitted) uses. Providers should also consider tracking expenses by payor, provider type and service line, as this information may become necessary in the management and distribution of PRF funds given forthcoming compliance and oversight activity.

Providers should consider using special accounting techniques, including using separate bank accounts or special separate general ledgers for COVID-19-related grants and expenses. Additionally, if providers have pre-existing debt obligations that become due during the PHE, PRF funds used to reimburse for lost revenues attributable to COVID-19 should be backed out of the calculation of funds available for principal debt payments.

Relatedly, providers should not use PRF grant funds to reimburse for expenses that are reimbursable from "other sources." If an expense is covered by another source, such by liability or business interruption insurance coverage, or by another CARES Act or PPPHCEA program (including, but not limited to, the PPP or AAPP, as discussed below), PRF funds may not be used in replication of the other source. For example, the CARES Act also appropriated $200 million to the Federal Communications Commission to support and fully fund eligible providers' telehealth infrastructure.[35] Providers using PRF grant funds to scale telehealth infrastructure may face allegations of "double dipping" if also receiving FCC-allocated funds for the same purpose.

[35] https://www.fcc.gov/covid-19-telehealth-program

Compliance Tip #3: Providers who receive funds from both the PRF and the FCC, and other providers who similarly receive funds from multiple sources to cover like expenses, should meticulously document which funding stream is used to pay for each aspect of the relevant expense to avoid concerns over "double dipping" and subsequent liability that may attach. Providers can employ accounting practices, such as those mentioned in Compliance Tip #2, to segregate and track funding streams.

b. *PRF Funds Used to Pay Salaries above the Executive Level II Cap*: Recipients are prohibited by the PRF Terms and Conditions from using PRF grant funds to pay the salary of an individual in excess of the Executive Level II cap of $197,300. However, employees, providers and executives taking pay cuts due to COVID-19 might earn usual salaries in excess of the cap, leading to uncertainty over how much such individuals can be paid using PRF grant funds without violating the Terms and Conditions and exposing the recipient to FCA liability.

While HHS has released minimal further guidance on paying salaries using PRF funds, the Executive Level II cap does not appear to be an annual salary cap for the affected individual. Rather, 48 C.F.R. 352.231–70 and pre-COVID-19 HHS guidance documents related to salary rate limitations instruct that an individual can receive payments up to the cap from each grant under multiple grants. The cap only limits the portion of an individual's salary that can be paid from one grant ($197,300 per grant).[36] Notably, none of HHS, HHS OIG, or PRAC have opined on the propriety of recipients using PRF grant funds to make bonus or hazard payments to employees who worked through the PHE. Absent further guidance from the relevant authorities and assuming that such a use is permissible under the PRF Terms and Conditions, recipients that wish to use PRF grant funds to offer employees bonuses or hazard pay as incentives for working during the PHE should include such payments as wages (i.e. salary) subject to the pro rata Executive Level II cap. Thus, if a recipient is using PRF funds to make both payroll and bonus payments, the total amount of PRF grant funds used to pay an individual must fall below the pro rata cap in order for the use to be compliant.

As a result of the foregoing and in light of the scrutiny that will be placed on PRF grant uses, such funds should be used to pay compensation only as a last possible use, and if so used, the portion of salary paid through the granted funds should not exceed the pro rata cap of $197,300 divided by the period of time during which the relevant individual's salary was affected by the PHE.

[36] "The limitation only applies to the rate of pay charged to Provider Relief Fund payments and other HHS awards. An organization receiving Provider Relief Funds may pay an individual's salary amount in excess of the salary cap with non-federal funds." https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

Compliance Tip #4: To help ensure compliance with the PRF Terms and Conditions, recipients should be extremely careful in compensating providers and executives, in whole or in part, using grant funds and should ensure that if funds are used in such a manner, that payments from the PRF grant do not exceed $197,300 divided by the likely lost revenue period. Any PRF grant payments in excess of the pro rata cap amount used to cover salaries are likely to be subject to increased scrutiny and are more likely to be targets of enforcement actions in the future.

c. *Exposure for Breaching Terms and Conditions Related to Balance Billing*: One of the more significant undefined terms in each of the PRF grant Terms and Conditions is the restriction on billing "presumptive or actual" COVID-19 patients in excess of what the patient would ordinarily pay in-network. Providers who accept PRF grant funds must attest that they bill such patients only the amount that can be charged in-network.[37] HHS had originally used the language "possible or actual" COVID-19 patients, which it interpreted to mean *any* patients that eligible providers treated after January 31, 2020.

HHS recently clarified that "not every possible case of COVID-19 is a presumptive case of COVID 19… A presumptive case of COVID-19 is a case where a patient's medical record documentation supports a diagnosis of COVID-19, even if the patient does not have a positive in vitro diagnostic test result in his or her medical record."[38] This appears to assume that any patient seeking treatment for a recognized symptom of COVID-19 or, who at the time of treatment showed evidence of a potential positive diagnosis of COVID-19, would be considered a "presumptive" COVID-19 patient. While it appears that medical record documentation of treatment and therapies related to COVID-19 are included in the guidance's formulation of identifying a "presumptive" case of COVID-19, it is unclear if treatment unrelated to COVID-19 signs and symptoms for patients who are or become antibody positive prior to billing will be similarly included. Additionally, it is not yet clear what period of claims are subject to the balance billing requirement (i.e. whether this applies only to patients seen after the CARES Act effective date, or to patients seen dating back to January 31, 2020).

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[37] HHS specifically notes in its FAQs that this requirement applies both to skilled nursing facilities whose patients have insurance and to providers independently contracted by hospitals to provide services. https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[38] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. The FAQs goe on to clarify that "most health insurers have publicly stated their commitment to reimbursing out-of-network providers that treat health plan members for COVID-19-related care at the insurer's prevailing in-network rate. But if the health insurer is not willing to do so, the out-of-network provider may seek to collect from the patient out-of-pocket expenses, including deductibles, copayments, or balance billing, in an amount that is no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider." *Id.*

Compliance Tip #5: PRF grant recipients should carefully separate patient accounts related to its or its employed providers' treatment of presumptive COVID-19 patients during the PHE. Segregation of such bills should extend back to January 31, 2020 as is reasonably possible. Recipients might consider reviewing or auditing bills rendered during that period to help ensure compliance with the certification and the prompt return of payables collected in error. Recipients should also pay close attention to updated HHS guidance that further elaborates on who constitutes a "presumptive or actual" COVID-19 patient, as a narrower definition would limit the number of bills subject to the certification's requirements.

2. **Potential Exposure for Failing to Timely and Accurately Submit Required Reports:** PRF grant fund recipients risk recoupment action and FCA exposure if they submit delayed or incorrect data reports that are required quarterly by the Terms and Conditions. Recipients of $150,000 or more from any COVID-19-related act[39] must submit to the HHS Secretary and the Pandemic Response Accountability Committee a (calendar) quarterly report containing various data elements.[40] The first report was initially scheduled to be due within 10 days of June 30, 2020.[41] However, in one of its many revisions to the FAQs, HHS instructed that it is "posting the names of payment recipients and their payment amounts on its public website."[42] It then implies that until HHS releases further guidance regarding the form and type of documentation required for such quarterly reports, its posting of the names and payment amounts of recipients suffices for CARES Act reporting purposes (i.e. the quarterly reporting condition).[43] Concerningly, this guidance does not *clearly and explicitly* relieve recipients of the required responsibility to submit quarterly reports until HHS releases additional guidance on the form and content of such reports, leaving recipients in limbo as to when they are required to begin submitting their own quarterly reports. Additionally, given the operational and financial stress under which recipients are operating during the PHE, recipients' internal data collection and documentation practices may receive relatively less attention than normal and updates to HHS guidance regarding quarterly reports may slip under recipients' radars. However, since the quarterly reports are required by the Terms and Conditions, recipients' breach thereof by failure to accurately and timely submit such reports could expose recipients to FCA liability.

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[39] The Coronavirus Aid, Relief, and Economics Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities,

[40] Such data include, in relevant part: "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; 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…." https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[41] *See* each Terms and Conditions document located at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/terms-conditions/index.html.

[42] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[43] See Appendix A of OMB Memo M-20-21 [Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)]." https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. Future HHS guidance regarding the type of documentation required for future reports will be posted at https://www.hhs.gov/provider-relief/index.html. The Terms and Conditions also require the submission of any other reports requested by the Secretary that are necessary to ensure compliance.

Compliance Tip #6: To minimize exposure, recipients of PRF grant funds and of funds from other CARES Act programs should regularly update monitoring systems with information on new funding streams, overlapping uses, and distributions to downstream subcontractors. These steps will enable recipients to aggregate information for accurate and timely report submission to the relevant oversight authorities. Recipients should see Compliance Tips #2 and #3 for related best practices.

3. **Potential Recoupment or FCA Exposure for Not Adhering to Document Retention Requirements:** Recipients also risk FCA exposure for failing to appropriately retain documents and records regarding costs and financial management that substantiate reimbursements made through PRF grant funds, as required by the Terms and Conditions.[44] These concerns undergird the aforementioned risks, as recipients should carefully track and document the flow and use of PRF grant funds to help ensure compliance with the Terms and Conditions.

Compliance Tip #7: PRF grant recipients should institute comprehensive COVID-19 documentation programs that remain beyond the end of the PHE, as the various oversight authorities will conduct future audits of PRF grant recipients, and an inability to provide accurate corroborating information could lead to more formal enforcement actions, recoupments, or civil, administrative, or criminal penalties.

Attestations

1. **Potential Exposure for Inaccurately or Untimely Completing Attestations:** Recipients risk FCA exposure for failing to accurately submit attestations within 90 days of receiving PRF grant funds,[45] as the attestation states that "commitment to full compliance with all Terms and Conditions is material to the HHS Secretary's decision to disburse these funds to you." This reference alludes to FCA liability for recipients that fail to timely attest to the receipt of funds subject to such Terms and Conditions, even if the recipient does not intend to retain the funds distributed.[46] HHS has clarified that failure to so attest within the 90-day period following receipt of PRF grant funds is deemed an attestation to the Terms and Conditions and will be treated as such for the purposes of oversight and auditing.[47] HHS

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[44] As noted in the Terms and Conditions, recipients should keep documentation of records and costs as specified and described in 45 C.F.R. § 75.302 and 45 C.F.R. § 75.361 through 75.365.

[45] *See* https://www.hhs.gov/about/news/2020/05/07/hhs-extends-deadline-attestation-acceptance-terms-and-conditions-provider-relief-fund-payments-45-days.html; https://www.hhs.gov/about/news/2020/05/22/hhs-announces-45-day-compliance-deadline-extension-for-providers.html; and https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[46] HHS announced in a recent FAQ that if a provider wishes to return granted PRF funds, "the provider would need to contact their financial institution and ask the institution to refuse the received Automated Clearinghouse (ACH) credit by initiating an ACH return using the ACH return code of 'R23 - Credit Entry Refused by Receiver.' If a provider received the money via ACH they must return the money via ACH. If a provider was paid via paper check, after rejecting the payment in the attestation portal, the provider should destroy the check if not deposited or mail a paper check to UnitedHealth Group with notification of their request to return the funds." https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf.

[47] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf & https://www.hhs.gov/about/news/2020/05/22/hhs-announces-45-day-compliance-deadline-extension-for-providers.html.

guidance also directs providers how to appropriately deal with over- and under-payments from the PRF grants:

> "If a provider believes it was overpaid or may have received a payment in error, it should reject the entire General Distribution payment and submit the appropriate revenue documents through the General Distribution portal to facilitate HHS determining their correct payment. If a provider believes they are underpaid, they should accept the payment and submit their revenues in the provider portal to determine their correct payment."[48]

Each facility or recipient of PRF grant funds must complete a separate attestation, and each round of PRF grant distribution requires a new attestation (i.e. recipients must separately attest to receipt of funds and satisfaction of all Terms and Conditions for each distribution, including the first and second rounds of general distributions, in addition to the targeted distributions).[49] Failure to do so, or retention of funds beyond the 90-day window following distribution, when the recipient is ineligible to receive funds or has used funds in ways that contradict the Terms and Conditions, subjects the recipient to future FCA liability and recoupment of retained funds. To help ensure compliance, recipients should see Compliance Tips 2 through 7.

III. Paycheck Protection Program (PPP)

The CARES Act authorized $349 billion to fund the Paycheck Protection Program (the "PPP"), a small business loan program administered by the SBA and Treasury to help businesses impacted by the PHE maintain operations, most importantly through retention of employees. Congress allocated an additional $310 billion in PPP funds as part of the PPHCEA. For a comprehensive, up-to-date summary of the PPP, including in-depth discussions of the various Interim Final Rules issued by the SBA and Treasury (the "PPP Rules") and other guidance documents, please see "Paycheck Protection Program – Where Are We Now? An Up-To-Date Guide to the Paycheck Protection Program" here: https://www.proskauer.com/alert/paycheck-protection-program-where-are-we-now-an-up-to-date-guide-to-the-paycheck-protection-program.

Providers submitted a Paycheck Protection Program Borrower Application Form ("Form 2483") in order to receive loan proceeds through the PPP. Form 2483 includes a number of certifications and authorizations, including certifications that the provider is eligible to receive a PPP loan and that the proceeds from a PPP loan will be used in accordance with the PPP Rules. In addition to the criminal penalties specifically identified in Form 2483, providers receiving PPP loans may be subject to FCA liability if they (1) knowingly make a false statement to obtain the PPP loan or (2) knowingly use the funds for an unauthorized purpose.

Providers can mitigate FCA liability and remain in compliance with the PPP Rules by considering the following issues related to Form 2483 and providers' use of the PPP loan proceeds:

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[48] https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf. Notably, if a recipient makes an attestation and accepts PRF funds, but later wishes to retract the attestation and reject the funds, they should immediately call the provider support line at (866) 569-3522. *Id*.

[49] In the case of recipient entities or facilities, the attestation must be made by someone with proper authority to sign on behalf of the entity, such as a CEO or CFO. Note that "HHS plans to make publicly available the names of payment recipients and the amounts received, for all providers who attest to receipt of a payment and acceptance of the Terms and Conditions. By accepting funds, the recipient consents to the Department of Health and Human Services publicly disclosing the payments that recipient has received from the Relief Fund." Further, the Terms and Conditions note that they apply directly to the recipient, and indirectly to all subrecipients and contractors.

Potential FCA Liability Related to Submission of Improper Information to the SBA

Form 2483 includes a specific certification that "the information provided in [the Form 2483] application and the information provided in all supporting documents and forms is true and accurate in all material respects" and that the recipient understands that "knowingly making a false statement to obtain a guaranteed loan from SBA is punishable under the law."

Given the speed at which guidance has been issued by the SBA and Treasury since the enactment of the CARES Act on March 27, 2020, many questions that providers may have had regarding borrower eligibility have been addressed and clarified since providers submitted Form 2483 in early April. For example, the SBA has issued answers to multiple Frequently Asked Questions to guide borrowers in determining whether a PPP loan request is "necessary" as required by law; providers must "tak[e] into account their current business activity and their ability to access other sources of liquidity sufficient to support their ongoing operations in a manner that is not significantly detrimental to the business."[50] As this clarification could change a provider's analysis as to whether it is eligible to receive a PPP loan, and since the determination as to whether the PPP loan is necessary is set forth as a specific certification in the PPP application, a knowing failure to correct false information submitted in the provider's application to receive funds from the government could result in a reverse false claim under FCA liability under 31 U.S.C. § 3729(a)(1)(G). A provider that certified in early April that the loan request was "necessary to support the ongoing operations" of the provider may have done so without much reflection beyond the fact that without the loan, it would need to furlough employees or take other cost-cutting measures; the provider should revisit the necessity certification in light of the additional guidance and confirm that it still meets the eligibility requirement and has not made a false certification. Given that the FAQ responses related to the "necessity" certification are still unclear as to the definitions of "liquidity" or "significantly detrimental," this certification may need to be revisited again in the future as additional clarifications are issued. Providers should implement the practices set forth in Compliance Tip #1 (notifying the SBA instead of HHS) in order to protect themselves against FCA liability related to eligibility certifications.

Potential FCA Liability Related to Misuse of PPP Loan Proceeds

With regard to provider use of PPP loan proceeds, the PPP Rules specify that the loan amounts can be used to, in addition to covering payroll costs, maintain employee benefits, mortgage interest (not principal), rent and utility payments, make interest payments on pre-COVID-19 debt obligations and refinance any Economic Injury Disaster Loans taken out between January 31 and April 3, 2020. Given that there is an explicit certification in the PPP loan application stating that the borrower will use the funds for these purposes, and knowing use of the funds for unauthorized purposes may constitute fraud, recipient providers should be extremely wary of FCA liability related to misuse of PPP loan proceeds. Providers should take extra precautions to carefully track the use of the PPP loan funds so that the they can show that expenses totaling the full amount of the PPP loan have been allocated to these costs. In addition, the PPP Rules require that at least 60% of the loan proceeds are used to cover payroll costs, so providers should carefully review the definition of payroll costs found in 2.f of the PPP Rules to ensure that their books support the 60% requirement.

We have additional resources discussing the definition of "payroll costs" and other clarifications on PPP loan uses here: https://www.proskauer.com/uploads/paycheck-protection-program-where-are-we-

[50] https://www.sba.gov/document/support--faq-lenders-borrowers.

now?utm_source=web&utm_medium=CTA&utm_campaign=PPP. Providers should implement the practices set forth in Compliance Tips #2 and #3 in order to protect themselves against FCA liability related to misuse of PPP loan proceeds.

IV. Medicare Accelerated and Advance Payment Program (AAPP)

The CARES Act modified the eligibility criteria during the PHE for Medicare Part A providers and Medicare Part B suppliers seeking to receive accelerated and advance payments from Medicare through the Accelerated and Advance Payment Program (the "AAPP"). To participate in the AAPP, the provider/supplier in question must (1) have billed Medicare within the 180 days immediately preceding the signature date of the application to the AAPP, (2) not be in bankruptcy, (3) not be under active medical review or program integrity investigation, and (4) not have any outstanding delinquent Medicare overpayments. Providers/suppliers seeking accelerated and advanced Medicare payments must certify in their application to the Medicare Administrative Contractor ("MAC") servicing their region that the provider/supplier (1) has no plans to file for bankruptcy, is not currently in bankruptcy, nor has it retained bankruptcy counsel, (2) has no plans to cease doing business, and (3) is not under fraud investigation. Much like with requests for funds from the PRF and loans through the PPP, providers/suppliers should take special care to confirm eligibility requirements, as making a false certification to the MAC could result in FCA liability. Compliance Tip #1 is crucial to protect providers/suppliers against FCA liability related to eligibility certifications.

V. Best Practices

General Practices to Implement

Recipients of any of the government funds discussed here should consider taking the following measures to help ensure compliance with requirements for receipt of such funds and avoid FCA exposure as enforcement actions ramp up in the coming months:

1. Stay informed of any government clarifications, guidance documents, and new regulations to ensure that any inaccuracies in information previously submitted are identified and corrected immediately.
2. Employ special accounting techniques for COVID-19-related funds and expenses, including:
    a. Documenting a relevant nexus between COVID-19, lost revenue or expenses, and each use of CARES Act and PPPHCEA funds (especially salary/payroll of retained employees);
    b. Clear tracking and detailed descriptions of COVID-19 expenses and losses with as close to real-time adjustments and updates as possible;
    c. Separating incoming funding streams, including by using distinct bank accounts or special general ledgers, to avoid "double dipping" and document overlapping uses;
    d. Tracking lost revenue and expenses by payor and provider type;
    e. Being pro-active in self-auditing finances and revising policies and procedures to account for new requirements; and
    f. Implementing internal controls, including "hard stop" protocols, which must be satisfied prior to internal release of COVID-19-related grant funds.

3. Thoroughly vet all subcontractors to whom COVID-19-related funds are distributed for compliance with applicable laws, regulations, Terms and Conditions, certifications, and attestations.
4. Educate both decision-makers and supporting staff on the relevant steps necessary to ensure organizational compliance, including recurring status checks and regular updates related to COVID-19 compliance.
5. Regularly consult and document advice received from counsel and accounting firms to corroborate internal practices and lend credence to compliance measures taken.
6. Report to the board of directors or managing members regularly on the receipt and use of COVID-19 funds, compliance progress, and potential risks.
7. Integrate the above COVID-19 fund segregation, tracking, documentation, and reporting as a general part of regular and ongoing organizational compliance duties and personnel reporting structures.

Best Practices to Aid in PRF Compliance

In addition to the generally-applicable best practices above, recipients of PRF Funds should implement the following additional measures to help ensure compliance with PRF Terms and Conditions and avoid FCA exposure related to PRF Funds:

1. Separate all bills that have been or will be charged to patients seen during the PHE (after January 31, 2020), and review such bills for compliance with attestations and certifications regarding balance billing practices. This may include rendering a preliminary internal determination of whether any such patient is likely to be considered, based on clinical indicators, a "presumptive or actual" COVID-19 patient.
2. Employ heightened record-keeping and support for staff whose salaries exceed $197,300, and consider reviewing salary inputs for such staff, as applicable, to ensure that inputs from PRF grants are in line with the pro rata cap.
3. Diligently track the number of jobs created or retained by project or activity supported by the use of PRF grants and other COVID-19-related funds, in addition to other relevant metrics required to be tracked by recipients of grants over $150,000. This may include dedicating specific personnel to oversee compliance of certain projects supported by COVID-19-related grants.

VI. Conclusion

As oversight activities ramp up across the various bodies tasked with ensuring that CARES Act funds are allocated and used appropriately, providers will need to be flexible in responding to government inquiries while continuing to prudently manage their internal operations. As with the other Federal programs implemented in connection with the CARES Act, it is reasonable to expect that the contours of the PRF, PPP, and AAPP will each continue to evolve, especially as such oversight is conducted. Proskauer will continue to monitor legislation, oversight actions, and institutional practices related to these programs, along with associated regulations and guidance, and will provide detailed updates and analysis as developments unfold.

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Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. We will continue to evaluate the CARES Act, related rules and regulations and any subsequent legislation to provide our clients guidance in real time. Please visit our Coronavirus Resource Center at https://coronavirus.proskauer.com/ for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

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