CITY OF LEAGUE CITY
GRANT APPLICATION PRE-APPROVAL FORM

Grant Name	CARES Act Provider Relief Fund		
Directorate/Department Applying for Grant		Proposed Grant Manager	
Fire Directorate - EMS Department		Gregory Kunkel	
Awarding Grant Agency Name		Total Project Amount	
U.S. Department of Health & Human Services		$40,758.27	
General Purpose of the Grant			
Automatic distribution by HHS to provide relief to providers who bill Medicare fee-for-service for projected loss related to COVID-19 Pandemic - amount based on provider's share of Medicare fee-for-service reimbursements in 2019.			
Items the Grant Will Pay For			
Incurred revenue loss related to COVID-19 pandemic for March 2020 and April 2020. Amount is reflected in EMS Service Fee Account 0100-43640, dated 04/17/2020.			

Requires Council Approval?	Yes ✓	No	If yes, Proposed Agenda date?	06/23/2020	
Amount or % Covered by Grant	100%		Amount or % Matched by City	0%	
Grant Time/Performance Period	N/A		Application Deadline	N/A	
Estimated Annual Fiscal Impact:	Year One		Year Two	Year Three	
Revenue Generated					
Grant Funds to be Received	$40,758.27				
City Match	0				
Net Fiscal Impact					
In future CIP?	Yes	No ✓	If yes, what year?		
Year One Currently Budgeted?	Yes		No ✓		*(Choose Yes or No)*

If no, how do you intend to fund City's match?

N/A

Attach Supporting Grant Documentation for Approval

Approval Order	Signature	Date
Grant Manager		6-3-20
Department Head		6-3-20
Director		6-4-2020
Grant Administrator	DocuSigned by: Kayla Davis	06-04-2020
Assistant City Mgr.	DocuSigned by: EA8B8E0CF61F473...	6/5/2020
Budget Manager	DocuSigned by: AE0F56AED359401...	6/7/2020
Finance	DocuSigned by: C9D64E0246DA404...	6/10/2020
City Manager	DocuSigned by: AA44FE3917BC441...	6/10/2020
City Manager	Approved X	Denied	***Please Check One***

Explanation or comments related to City Manager's decision.

HHS has announced the possibility of future distributions to provide additional relief of continued incurred revenue loss as related to the COVID-19 Pandemic.

HHS to Begin Immediate Delivery of Initial $30 Billion of CARES Act Provider Relief Funding

Today, the Department of Health and Human Services (HHS) is beginning the delivery of the initial $30 billion in relief funding to providers in support of the national response to COVID-19 as part of the distribution of the $100 billion provider relief fund provided for in the Coronavirus Aid, Relief, and Economic Security (CARES) Act recently passed by Congress and signed by President Trump.

The $100 billion of funding will be used to support healthcare-related expenses or lost revenue attributable to coronavirus and to ensure uninsured Americans can get the testing and treatment they need without receiving a surprise bill from a provider. The initial $30 billion in immediate relief funds will begin being delivered to providers today.

Recognizing the importance of delivering the provider relief funds in a fast, fair, and transparent manner, this initial broad-based distribution of the relief funds will go to hospitals and providers across the United States that are enrolled in Medicare. Facilities and providers are allotted a portion of the $30 billion based on their share of 2019 Medicare fee-for-service (FFS) reimbursements. These are payments, not loans, to healthcare providers, and will not need to be repaid.

HHS and the Administration are working rapidly on additional targeted distributions to providers that will focus on providers in areas particularly impacted by the COVID-19 outbreak, rural providers, and providers of services with lower shares of Medicare FFS reimbursement or who predominantly serve the Medicaid population. This supplemental funding will also be used to reimburse providers for COVID-19 care for uninsured Americans.

HHS is partnering with UnitedHealth Group (UHG) to deliver the initial $30 billion distribution to providers as quickly as possible. Providers will be paid via Automated Clearing House account information on file with UHG, UnitedHealthcare, or Optum Bank, or used for reimbursements from the Centers for Medicare & Medicaid Services (CMS). 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 30 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 from hhs.gov/providerrelief.

UnitedHealth Group will donate all fees for the administration of the CARES Act provider relief fund.

Visit hhs.gov/providerrelief for additional information.

CARES Act Provider Relief Fund: General Information

$50 Billion General Distribution

$50 billion is allocated proportional to providers' share of 2018 net patient revenue. The allocation methodology is designed to provide relief to providers, who bill Medicare fee-for-service, with at least 2% of that provider's net patient revenue regardless of the provider's payer mix. Payments are determined based on the lesser of 2% of a provider's 2018 (or most recent complete tax year) net patient revenue or the sum of incurred losses for March and April.

Total Amount	Date distributed	Distribution
$30 billion	April 10 ($26 billion) April 17 ($4 billion)	Automatic based on provider's share of Medicare fee-for-service reimbursements in 2019
$20 billion	April 24 (portal access begun)	Based on CMS cost reports or incurred losses

Information about the Initial $30 Billion Distribution

On April 10, 2020, HHS immediately distributed $30 billion to eligible providers throughout the American healthcare system.

All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution.

- All relief payments are made to the billing organization according to its Taxpayer Identification Number (TIN).
- Payments to practices that are part of larger medical groups will be sent to the group's central billing office.

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.

Payments from the initial $30 billion are based on the provider's share of total Medicare fee-for-service (FFS) reimbursements in 2019.

- To estimate a payment amount, divide the provider's 2019 Medicare FFS (not including Medicare Advantage) payments received by the total 2019 FFS Medicare payments, which were approximately $484 billion, and multiply that ratio by $30,000,000,000. Providers can obtain their 2019 Medicare FFS billings from their organization's revenue management system.

Example

A community hospital billed Medicare FFS $121 million in 2019. To determine how much they would receive, use this equation:

(Provider's 2019 Medicare FFS Amount) / (Total 2019 Medicare Payments) x ($30,000,000,000)

$121,000,000/$484,000,000,000 x $30,000,000,000 = $7,500,000

HHS has partnered with UnitedHealth Group (UHG) to provide rapid payment to providers eligible for the distribution of the initial $30 billion in funds.

- Providers are paid via Automated Clearing House account information on file with UHG or the Centers for Medicare & Medicaid Services (CMS).
- The automatic payments 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.

Visit the For Providers page for information about the attestation process to accept or reject the funds.

- Providers must sign an attestation confirming receipt of the funds and agreeing to the terms and conditions of payment within 45 days of receiving the payment.
- Not returning the payment within 45 days of receipt will be viewed as acceptance of the Terms and Conditions.

$50 Billion Targeted Allocations

$50 billion is allocated for targeted distribution to providers in areas particularly impacted by the COVID-19 outbreak, rural providers, providers of services with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population, and providers requesting reimbursement for the treatment of uninsured Americans. The fast and transparent dispersal of funds gives relief to those providers who are struggling to keep their doors open.

$12 Billion High-Impact Distribution

HHS is distributing $12 billion to 395 hospitals who provided inpatient care for 100 or more COVID-19 patients through April 10, 2020, $2 billion of which will be distributed to these hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments.

- These 395 hospitals accounted for 71 percent of COVID-19 inpatient admissions reported to HHS from nearly 6,000 hospitals around the country. The distribution uses a simple formula to determine what each hospital receives: hospitals are paid a fixed amount per COVID-19 inpatient admission, with an additional amount taking into account their Medicare and Medicaid disproportionate share and uncompensated care payments.

$10 billion high-impact distribution to hospitals

Inpatient admissions are a primary driver of costs related to COVID-19. A portion of the Provider Relief Fund is being distributed to hospitals that have treated a large number of COVID inpatient admissions.

In response to an HHS request for information, 5,598 hospitals submitted the number of COVID-19 inpatient admissions they encountered through April 10, 2020. 184,037 COVID-19 inpatient admissions were reported.

From this data, HHS identified those facilities with 100 or more COVID-19 admissions. These facilities encountered 129,911 admissions, or over 70% of the total number of COVID-19 inpatient admissions reported. The number of admissions encountered by these hospitals was the used to determine the allocation of Relief Funds across the pool of eligible recipients. Each recipient received funding equal to $76,975 per admission.

Note: Payments to these facilities on this basis is not intended to reimburse the facilities for the specific cost of these admissions. Rather, COVID-19 admissions is being used as a proxy for the extent to which each facility experienced lost revenue and increased expenses associated with directly treating a substantial number of COVID-19 inpatient admission.

$2 billion high-impact distribution to facilities

HHS recognizes that not all facilities are equally prepared to withstand the impacts of the coronavirus. Facilities that serve large Medicare or uninsured populations often do not have the same level of financial resources as other facilities. In recognition of this fact, HHS distributed $2 billion in additional funding to these facilities in proportion to each facility's share of Medicare Disproportionate Share funding.

$10 Billion Rural Distribution

HHS is distributing $10 billion to rural hospitals, including rural acute care general hospitals and Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Community Health Centers located in rural areas.

- Hospitals and RHCs will each receive a minimum base payment plus a percent of their annual expenses. This expense-based method accounts for operating cost and lost revenue incurred by rural hospitals for both inpatient and outpatient services. The base payment will account for RHCs with no reported Medicare claims, such as pediatric RHCs, and CHCs lacking expense data, by ensuring that all clinical, non-hospital sites receive a minimum level of support no less than $100,000, with additional payment based on operating expenses.
- Rural acute care general hospitals and CAHs will receive a minimum level of support of no less than $1,000,000, with additional payment based on operating expenses.
- Eligible providers will receive the funds via direct deposit, based on the physical address of the facilities as reported to the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), regardless of their affiliation with organizations based in urban areas.

This funding recognizes that rural hospitals, health clinics, and health centers function with lower operating margins than urban and suburban providers and thus are at greater risk of closure as a result of reduced volumes attributable to the coronavirus. Targeted distributions to rural hospitals, health clinics, and health centers were made according to the following methodology.

Recipients fall into three categories:

- Rural acute care general hospitals and Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Community Health Center sites located in rural areas

Rural acute care hospitals and Critical Access Hospitals (CAHs):

The methodology provides hospitals with supplemental funds based on a graduated base amount plus an additional amount to account for a portion of their usual operating costs and the volume of care they regularly provide, according to the following formula. The most recent, publicly available Medicare hospital cost reports were used to identify operating costs:

- Per Hospital $ Allocation = Graduated Base payment + 1.97%* of the hospital's operating expenses

The graduated base payment is calculated as:

- 50% of the first $2 million of expenses (payment of up to $1,000,000)
- 40% of the next $2 million of expenses (payment of up to $800,000)
- 30% of the next $2 million of expenses (payment of up to $600,000)
- 20% of the next $2 million of expenses (payment of up to $400,000)
- 10% of the next $2 million of expenses (payment of up to $200,000)

Rural hospitals with annual operating expenses greater than $10,000,000 receive a base payment of $3,000,000.

Rural hospitals with no operating expense data receive a base payment of $1,000,000.

The total calculated amount was then multiplied by 1.03253231** to determine the actual payment per rural provider.

*The actual value used in the formula was 1.967728428%.

Rural Health Clinics (RHCs):

Provider-Based RHCs: RHCs connected with rural hospitals have their allocations included with their hospital's allocation, and the hospital is responsible for allocating dollars to support its RHC services.

Independent RHCs: A base amount plus a percentage of total operating costs were calculated for independent RHCs not associated with a hospital using RHC Cost Report data according to the following formula:

- Per Independent RHC $ Allocation = $100,000 per clinic site + 3.6% of the RHC's operating expenses

Community Health Centers:

Health Centers in rural areas: The allocation for health centers in rural areas was a flat payment amount per health center site of $100,000. Funds are distributed to each FQHC organization based on the number of individual rural clinic sites it operates.

- Per FQHC $ Allocation = $100,000 per rural clinic site

The total calculated amount for RHCs and health centers was then multiplied by 1.03253231** to determine the actual payment per rural provider.

**This adjustment was applied to ensure that the total value of distributions equaled $10 billion.

Providers eligible for the targeted Rural Health Relief Fund distribution must be located in a geography that meets the following rural definition:

1. All non-Metro counties.
2. All Census Tracts[1] within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the

identification of rural Census Tracts in Metropolitan counties.
3. 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.
4. For independent Rural Health Clinics: the authorizing statute applies the Census Bureau definition, which defines a Rural Health Clinic as being located outside of an Urbanized Area as defined by the U.S. Census Bureau.
5. For Critical Access Hospitals: CAHs have a unique safety net role and statutory charge per Section 1820 of the Social Security Act. That statute initially gave state governors the authority to designate necessary provider CAHs, a number of which did not make a distinction between rural and urban designations.

RUCA Codes

(Code Definitions: Version 2.0)

1. Metropolitan area core: primary flow within an Urbanized Area (UA)
2. Metropolitan area high commuting: primary flow 30% or more to a UA
3. Metropolitan area low commuting: primary flow 10% to 30% to a UA
4. Micropolitan* area core: primary flow within an Urban Cluster (UC) of 10,000 through 49,999 (large UC)
5. Micropolitan* high commuting: primary flow 30% or more to a large UC
6. Micropolitan* low commuting: primary flow 10% to 30% to a large UC
7. Small town core: primary flow within an Urban Cluster of 2,500 through 9,999 (small UC)
8. Small town high commuting: primary flow 30% or more to a small UC
9. Small town low commuting: primary flow 10% through 29% to a small UC
10. Rural areas: primary flow to a tract outside a UA or UC (including self)

Allocation for Skilled Nursing Facilities

HHS is distributing $4.9 billion to skilled nursing facilities (SNFs) to help them combat the devastating effects of this pandemic.

Allocation for Uninsured Patients

A portion of the funds will be distributed to healthcare providers who have provided treatment for uninsured COVID-19 patients on or after February 4, 2020. Providers can request claims reimbursement and will be reimbursed at Medicare rates, subject to available funding.

To request reimbursements, visit the COVID-19 Uninsured Program Portal.

Allocation for Indian Health Service

HHS is distributing $500 million to Indian Health Service facilities, distributed on the basis of operating expenses. This funding complements other funding provided to expand IHS capacity for telehealth and testing.

Additional Allocations

Separate funding will be distributed to other providers, including dentists and providers that solely take Medicaid.

Patient Protections

We are working to remove financial obstacles that might prevent people from getting the testing and treatment they need from COVID-19.

Protecting uninsured patients

Every health care provider who has provided for COVID-related treatment of uninsured patients on or after February 4, 2020, may request claims reimbursement and will be reimbursed at Medicare rates, subject to available funding.

Insurance protections

Private insurers must waive an insurance plan member's cost-sharing payments for COVID-19 testing.

- Some private insurers, including Humana, Cigna, UnitedHealth Group, and the Blue Cross Blue Shield system, have agreed to waive cost-sharing payments for COVID-19 treatment related for insured patients.

Providers/recipients must not seek collection of out-of-pocket payments from a presumptive or actual 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.

No surprise billing

Recipients/providers must not to seek collection of out-of-pocket payments from a presumptive or actual 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.

Recipients/providers must abstain from "balance billing" any COVID-related treatment/any uninsured patient for whom the provider seeks reimbursement for COVID-19-related treatment.

Preventing fraud and misuse of the funds

Recipients/providers must submit documents sufficient to ensure that these funds were used for healthcare-related expenses or lost revenue attributable to the coronavirus.

Content created by Assistant Secretary for Public Affairs (ASPA)
Content last reviewed on June 1, 2020

FAQs – HHS CARES Act Provider Relief Funding

Frequently Asked Questions (FAQs) related to HHS CARES Act Provider Relief Funding

By Brian S. Werfel, Esq.

In March 27, 2020, President Trump signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). As part of that Act, Congress allocated $100 billion to the creation of a "CARES Act Provider Relief Fund," which will be used to support hospitals and other healthcare providers on the front lines of the nation's coronavirus response. These funds will be used to fund healthcare-related expenses or to offset lost revenue attributable to COVID-10. These funds will also be used to ensure that uninsured Americans have access to testing a treatment for COVID-19. Collectively, this funding is referred to as the "CARES Act Provider Relief Fund."

On April 9, 2020, the Department of Health and Human Services (HHS) began the disbursement of the first $30 billion of this provider relief funding. This disbursement was made to all healthcare providers and suppliers that were enrolled in the Medicare Program, and who received Medicare Fee-for-Service reimbursements during Calendar Year 2019. For most ambulance providers and suppliers, these relief funds were automatically deposited into their bank accounts.

In this Frequently Asked Question (FAQ), the AAA will address some of the more common questions that have arisen with respect to the Cares Act Provider Relief Funds.

Question #1: My organization received relief funds through an ACH Transfer. Is there anything our organization needs to do?

Answer #1: Yes. Within thirty (30) days of receiving the payment, you must sign an attestation confirming your receipt of the provider relief funds. As part of that attestation, you must also agree to accept certain Terms and Conditions. The attestation can be signed electronically by clicking here.

Question #2: Am I required to accept these funds? What happens if I am not willing to accept the Terms and Conditions imposed on the receipt of these funds?

Answer #2: You are not obligated to accept the provider relief funds. The purpose of these funds was to provide healthcare providers and suppliers with an immediate cash infusion in order to assist them in paying for COVID-related expenses and/or to offset lost revenues attributable to the COVID-19 pandemic.

If you are not willing to abide by the Terms and Conditions associated with these funds, you must contact HHS within thirty (30) days of receipt of payment, and then return the full amount of the funds to HHS as instructed. The CARES Act Provider Relief Fund Payment Attestation Portal provides instructions on the steps involved in rejecting the funds. **Please note that your failure to contact HHS within 30 days to arrange for the return of these funds will be deemed to be an acceptance of the Terms and Conditions.**

Question #3: Our organization has elected to retain the provider relief funds. Are there any major restrictions on how we can use these funds?

Answer #3: Yes. In the Terms and Conditions, HHS has indicated that you must certify that the funds will only be used to prevent, prepare for, and respond to coronavirus. You are also required to certify that the funding will only be used for health-care related expenses and/or to offset lost revenues that are attributable to coronavirus.

You are specifically required to certify that you will not use the relief funding to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

While the language in the Terms and Conditions are somewhat ambiguous, the AAA interprets this to mean that you must certify that your organization's operations have been impacted, in some way, by the national response to the coronavirus. The AAA further interprets this language as requiring that, on net, the coronavirus pandemic has had an adverse impact on either your operations (in terms of added costs) or your revenues (in terms of decreased revenues). At the present time, the AAA believes that most, if not all, of our members that are currently providing services in response to the coronavirus pandemic will meet this standard.

Note: one situation where a provider may not be eligible for provider relief funding would be a situation where the provider ceased operations prior to January 31, 2020. For example, a provider that ceased operations on December 31, 2019. Because the ambulance provider was paid for Medicare FFS services furnished in 2019, it may receive provider relief funding. However, if the organization's operations ceased prior to the onset of the current state of emergency, it would not be able to meet the requirement that it provided diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. In this situation, the ambulance provider would likely be obligated to reject the provider relief funding.

Question #4: Are there any other restrictions on our use of provider relief funding?

Answer #4: Yes. In addition to the restrictions discussed in Answer #3 above, you are also restricted from using the provider relief funding for any of the following purposes:

1. The provider relief funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II (approximately $189,600);
2. The provider relief funds may not be used, in whole or in part, to advocate or promote gun control;
3. The provider relief funds may not be used, in whole or in part, for lobbying activities;
4. The provider relief funds may not be used to fund abortions (subject to certain exceptions);
5. The provider relief funds may not be used for embryo research;
6. The provider relief funds may not be used for the promotion of the legalization of controlled substances;
7. The provider relief funds may not be used to maintain or establish a computer network, unless such network blocks the viewing, downloading, and exchanging of pornography;
8. The provider relief funds may not be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors;
9. The provider relief funds may not be used to purchase sterile needles or syringes for hypodermic injections of illegal drugs.

Question #5: How will HHS verify that the provider relief funding is being used for an appropriate purpose?

Answer #5: HHS will require all recipients of provider relief funding to submit reports "*as the Secretary determines are needed to ensure compliance with the conditions imposed.*" HHS indicated that it will provide future program instructions to recipients that specifies the form and content of these reports. Recipients will also be required to maintain appropriate records and cost documentation to substantiate how provider relief funds were spent, and to provide copies of such records to HHS upon request.

In addition, ambulance providers and suppliers that receive, in the aggregate, more than $150,000 in funds under the CARES Act, the Coronavirus

Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act, and any other legislation that makes appropriations for coronavirus response and related activities will be required to submit a report within 10 days of the end of each calendar quarter. These reports must specify: (1) the total amount of funds received from HHS under each of these pieces of legislation, (2) the amount of funds received that was spent or obligated to be spend, and (3) a detailed list of all projects or activities for which large covered funds were expended or obligated.

Question #6: We understand that one of the conditions associated with the provider relief funding is that we agree not to balance bill patients. Is our understanding correct?

Answer #6: The Terms and Conditions do contain provisions that would likely place restrictions on your ability to balance-bill patients.

In order to understand these restrictions, it is probably helpful to understand the underlying purpose of the restriction. The actual language from the Terms and Conditions reads as follows:

"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 presumptive 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."

As the language makes clear, HHS was not focused primarily on the practice of balance-billing. Rather, HHS' concern was that many healthcare providers would have capacity restraints. As a result, patients may be restricted in their ability to receive care from their normal providers (who are presumably in-network with the patient's insurer). HHS' intent was to ensure that the patient does not suffer any adverse financial consequences as a result of seeking care for presumptive or actual cases of COVID-19. It accomplishes this goal by requiring the recipient of provider relief funds to agree not to collect from the patient out-of-pocket expenses that are greater than what the patient would have incurred has the care been provided by an in-network provider.

This is being interpreted as a ban on "balance-billing" because most commercial insurers require their contracted providers to accept the plan's allowed amount as payment-in-full, i.e., to agree to only bill the patient for applicable copayments and deductibles.

Ambulance providers and suppliers should keep in mind that this will not impact the payment of claims from: (1) Medicare, Medicaid or other state and federal health care programs that already require you to accept the program's allowed amount as payment-in-full, (2) commercial insurers with which the organization currently contracts, and (3) the uninsured. In other words, this requirement only impacts payments from commercial insurers with which the organization currently does not contract.

At this point in time, it is expected that non-contracted commercial insurers will process your claim and make a determination as to whether the claim is related to the treatment and care of a presumptive or actual case of COVID-19. If the plan determines that the services you furnished were COVID-related, they will likely pay you the in-network rate they have established with contracted providers in your services area. The plan will likely then issue a remittance notice that indicates that you may not bill the patient for any balance over the insurer's payment. **Note:** many of the larger commercial insurers have indicated that they will waive the copayments and deductibles due from patients for COVID-related claims. If the plan waives the copayment and deductibles, they will pay these amounts to you as part of their payment of the claim. If they do not waive the copayment and deductible, you will be permitted to seek to collect these amounts from the patient. If the plan determines that the services you furnished were not COVID-related, they will continue to pay your claims using their normal claims processing, and you would be permitted to balance bill the patient to the extent otherwise permitted under state and local law.

There is still a good deal of confusion related to this aspect of the CARES Act Provider Relief Funding. It is expected that HHS will be issuing further clarification in the days to come. The AAA will update this FAQ to reflect any updated guidance from HHS.

Smith, Nicole

From: Legal Request
Sent: Tuesday, May 5, 2020 11:20 AM
To: Smith, Nicole
Subject: Re: [Request ID :530] FW: CARES ACT Provider Relief Fund: Action Required (City of League City)

Hello Nicole,

Thanks for the info.

~Michelle