



Apr 10, 2020

Categories:

[Coronavirus Response Team](#)

[Health Law Matters](#)

Authors:

[Thomas D. Anthony](#)

[Chad N. Eckhardt](#)

Free Money, Pretty Much: Medicare Providers to Automatically Receive \$30 Billion in Relief Funds From CARES Act

The CARES Act signed into law on March 27, 2020, provides [\\$100 billion dollars](#) in “Provider Relief Funds” to Medicare-enrolled hospitals and other healthcare providers fighting the COVID-19 outbreak. Of the \$100 billion, \$30 billion will be distributed immediately by direct deposit to eligible providers. All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution. All payments will be made to the billing organization according to its taxpayer identification number. These are not loans expected to be repaid; however, there are some strings attached to keeping the funds, as further detailed below.

How Much Will Each Provider Receive?

A provider can estimate the payment amount they are to receive by dividing their 2019 Medicare FFS (not including Medicare Advantage) payments received by \$484,000,000,000 and then multiplying that ratio by \$30,000,000,000.

The Department of Health and Human Services (HHS) provides the following example: if a community hospital billed Medicare FFS \$121 million in 2019, it would receive \$7,500,000 ($\$121,000,000 / \$484,000,000,000 \times \$30,000,000,000 = \$7,500,000$).

The Centers for Medicare and Medicaid Services (CMS) has contracted with UnitedHealth Group to disburse the funds. Providers will want to pay attention to electronic deposits from OptumBank with the payment description of “HHSPAYMENT” to confirm its receipt of these relief funds. Within 30 days of receiving the payment, providers must sign an attestation confirming receipt of the funds and must indicate whether they are willing and able to

satisfy the terms and conditions of retaining the funds, which conditions are described below. The portal for signing the attestation will be open the week of April 13, 2020, and will be linked on this [page](#). If a provider is unable or unwilling to satisfy the conditions, it must contact HHS and return the funds within that thirty (30) day period.

What Strings Are Attached to Keeping the Funds?

Since the Provider Relief Funds are not required to be repaid, nearly every organization will want to keep the money. It is important, however, for each recipient to be sure it is eligible to do so and is comfortable with the following key [terms and conditions](#) associated with keeping the funds:

1. Must Care for COVID-19 Patients. The provider must currently provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.
2. Limit Patient Portion to In-Network Amounts. The provider must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.
3. Use Funds for COVID-19 Purposes. The provider must only use the funds to (a) prevent, prepare for, and respond to COVID-19, or (b) reimburse the provider only for healthcare-related expenses or lost revenues that are attributable to COVID-19 and not reimbursed from other sources.
4. Submission of Quarterly Reports. Not later than 10 days after the end of each calendar quarter, any provider receiving the funds that is an entity receiving more than \$150,000 total in funds pursuant to other “[Federal Acts](#)” primarily making appropriations for the coronavirus response, must submit a report containing the following information:
 - The total amount of funds received from HHS under the other Federal Acts;

- The amount of funds received that were expended or obligated for each project or activity; and
- A detailed list of all projects or activities for which large covered funds were expended or obligated, including: the name and description of the project or activity, and the estimated number of jobs created or retained by the project or activity, where applicable; and detailed information on any level of sub-contracts or subgrants awarded by the provider or its subcontractors or subgrantees.

5. Active Billing Privileges. The provider must not be excluded from participation in any federal healthcare program, including Medicare or Medicaid, nor have its Medicare billing privileges revoked.

6. Record-Keeping. The provider must retain appropriate records and documentation of costs to submit additional reports as may be required by the Secretary of HHS to ensure compliance with conditions that are imposed on the funding.

For more information on this funding, please reach out to the authors of this article. You can also visit our [Health Law Matters blog](#) for more insight into legal issues impacting the health care industry.

To provide guidance and support to clients as this global public-health crisis unfolds, Frost Brown Todd has created a [Coronavirus Response Team](#). Our attorneys are on hand to answer your questions and provide guidance on how to proactively prepare for and manage any coronavirus-related threats to your business operations and workforce.

© 2026 FBT Gibbons LLP. May be considered attorney advertising in some jurisdictions.