What Health Systems Need to Know About COVID-19 Relief Funding

By Bobbi Brown, MBA, Senior Vice President, Health Catalyst
Dan Orenstein, JD, Senior Vice President, General Counsel, and Secretary

According to Kaiser Health News, almost half of U.S. adults report a member of their household has postponed healthcare during the pandemic. For healthcare organizations, the deferral of routine and non-emergent care has meant steep declines in volumes, and therefore revenue, across the healthcare setting, from regular primary-care and specialist visits to emergency and surgical care.

Congress has responded to the healthcare industry's financial strain with $100 billion in relief for hospitals and other healthcare providers as part of a $3 trillion COVID-19 stimulus package. While this aid clearly addresses a financial need, the rules and regulations around using the funds are less straightforward. Terms and conditions around qualifying expenditures, risks, and compliance requirements haven't been well defined, leaving health systems without a clear path forward.

Prevent, Prepare, Respond

There are many sources of funding support from federal agencies (e.g., the CDC, HHS, U.S. Treasury, and more), which distribute the funds in many ways. Funding covers both short and long-term relief.

For providers to use COVID-19 stimulus funds to keep organizations financially viable and able to serve their communities, financial leaders need to understand where they can apply each type of loan or grant and how to stay within legal compliance. Effectively leveraging these stimulus funds early will help organizations resume effective, profitable operations and prepare for healthcare's post-pandemic

landscape, while properly documenting the use of the relief will help providers stay within compliance.

New Laws Aim to Promote Healthcare Economic Recovery

The following laws passed between March and June 2020 aim to help healthcare organizations recover financially from COVID-19-related drops in volume and best respond to the emergency and the new healthcare landscape.

The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020

Congress launched relief efforts with a March 6, 2020, bill for $8.3 billion, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (H.R. 6074). This bill provides money for the Department of Health and Human Services (HHS), the Department of State, and the Small Business Administration. Funding covers vaccines and other medicines; grants for local, state, and tribal public health agencies; loans for affected small businesses; and evacuations and emergency preparedness activities at U.S. embassies and other State Department facilities. H.R. 6074 also allowed HHS to waive restrictions for telehealth (e.g., extending telehealth benefits to all Medicare beneficiaries).

Families First Coronavirus Response Act

Congress passed the Families First Coronavirus Response Act (FFCRA), or H.R. 6201, on March 18, 2020, for $3.5 billion. The bill focuses on COVID-19 testing (reimbursing cost for uninsured individuals), unemployment, and sick leave. It also offers tax credits for sick and family leave, increased the Federal Medical Assistance Percentage (FMAP) for Medicaid by 6.2 percent, and expanded food assistance through the Supplemental Nutrition Assistance Program (SNAP).

The CARES Act Provider Relief Fund

The Coronavirus Aid, Relief, and Economic Security Act (H.R. 748), better known as the CARES Act, passed on March 27, 2020. At $2.2 trillion (the largest relief package to date), the CARES Act focuses on providing emergency assistance and healthcare response for individuals, families, and businesses affected by the 2020 coronavirus pandemic. The funds apply to individual unemployment, small and large businesses, public health, and education and served as a safety net for state and local governments.

For the healthcare industry, the CARES Act offers a $100 billion Provider Relief Fund, with $10 billion earmarked for rural grants, $.4 billion for Indian Health Services, and $29.6 billion for skilled nursing facilities (SNFs), future hot spots, and the uninsured. Of this funding, $50 billion has been distributed in a “General Distribution” to cover healthcare-related expenses or coronavirus-related loss of revenue. To be eligible for the General Distribution, a provider must have billed Medicare fee-for-service in 2019 and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.

Distributions under the Provider Relief Fund have also been made to hospitals that experienced a high impact from COVID-19, rural providers, and others ("Targeted Distributions").

The Provider Relief Fund General Distribution funding is a grant, not a loan; meaning recipients don't have to repay it. The $50 billion was distributed in two rounds:

- $30 billion sent to provider accounts on April 10, 2020.
- A $20 billion distribution, beginning on April 26, 2020.

As a grant, Provider Relief recipients must sign in and attest to terms and conditions within 90 days of receiving payment. According to public distribution data, for the $30 billion round, 318,168 providers have attested/received an allocation as of the end of May 2020. The Provider Relief Fund bases distribution on provider share of total Medicare fee-for-service reimbursements in 2019, and recipients must not be currently excluded from participation in Medicare. Providers can use payment only to prevent, prepare for, and respond to coronavirus and as reimbursement for healthcare-related expenses or lost revenue. Providers agree to accept payment and not to send unexpected bills ("surprise" billing) to insured patients with COVID-19. Providers cannot collect cost sharing above what a patient would pay for in-network care.

Providers receiving more than $150,000 must submit reports no later than ten days after the end of the quarter. Reporting includes the amount of funds received and expended, a detailed list of actions, projects, jobs created or retained, and subcontracts, and an agreement to cooperate in audits. HHS has delayed report submission for the June 30 time period. The agency will release additional guidance in the following months.

The Provider Relief Fund includes a COVID-19 High-Impact Allocation of $12 billion, intended for testing, staffing, and lost revenue. High-impact dollars went to 395 hospitals with the highest proportion (70 percent) of COVID-19 inpatient cases, and the fund also has provisions for rural facilities, skilled nursing facilities, and health centers.

The Paycheck Protection Program and Health Care Enhancement Act

Signed on April 24, 2020, for $484 billion, the Paycheck Protection Program (PPP) and Health Care Enhancement Act is a continuation of the CARES Act. It establishes set-asides or carveouts (for rural and Indian Health Services), clarifies eligibility for relief, and changes allocations for hospitals around net revenue and hardest-hit areas.

Congress continued economic stimulus with the Paycheck Protection Program Flexibility Act of 2020 (H.R. 7010), which passed on June 3, 2020. This bill extends PPP coverage from 8 to 24 weeks and maturity from two to five years, reduces minimum spend on payroll from 75 percent to 60 percent, and establishes new safe harbors for forgiveness.

More Provider Support

In addition to grants and loans, providers have more ways to access COVID1-19-related funding:

- Under COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured, health systems can file for reimbursement for COVID-19 testing and services to uninsured for services after February 4, 2020.
- CMS suspended the Accelerated and Advance Payment Program for re-evaluation in April 2020, but the loan aimed to accelerate health system cash flow, with for COVID-19 expenses, lost revenue, personal protective equipment, other supplies, construction, and capacity surge.
- Providers can also get money through the billing process, as Medicare has suspended planned lower payments and will increase 20 percent of the MS-DRG payment planning for patients with COVID-19.
- Physicians and small providers (i.e., small businesses) with fewer than 500 employees can apply for funding via the PPP.
- Under the Federal Communications Commission, the COVID-19 Telehealth Program provides $200 million in funding to help healthcare providers offer connected care services to patients at their homes or mobile locations.
- State and local governments and private nonprofit groups can apply for assistance for public health emergency management activities for prevention and response to COVID-19 through the Federal Emergency Management Agency (FEMA).
- Waivers are not a direct source of funding. However, during an emergency, they put aside some of the regular compliance requirements for provider reimbursement. Examples include increasing hospital capacity (temporary sites), removing barriers for hiring and retaining professionals, and expanded telehealth services.

Compliance: Using Provider Relief Fund Dollars

HHS has stated that under the General Distribution ($50 billion) of the Provider Relief Fund, it views every patient as a possible case of COVID-19, creating a broad definition of potential patients. This expands the scope possible qualifying expenses from the statutory language. More explanation and more resources, however, are emerging to help providers navigate the terms and conditions of the stimulus (e.g., the Provider Relief Fund FAQ).

The General Distribution calculates distribution based on the lesser of 2 percent of a provider's 2018 net patient revenue or the sum of incurred losses for March and April 2020. For the Targeted Distributions, each grant/loan has its own payment methodology (e.g., rural hospitals have a base payment plus a percentage of operating expenses and so forth and high-impact stimulus is based on a fixed amount per admission).

The key HHS term regarding appropriate use of Provider Relief Funds has two parts, operating on the principle that any patient is a possible coronavirus patient:

1. The funds have to be used to prevent, prepare for, and respond to coronavirus (i.e., direct expenses for COVID-19 or probable COVID-19 patients).
2. The funds will reimburse only for healthcare-related expenses or lost revenues attributable to coronavirus (requiring providers to demonstrate and document lost revenues during the COVID-19 emergency period).

The Fine Print: Statutory Language and Provider Relief Fund FAQ

As health systems enter the post-emergency period, many are wondering what they can spend the money on. This is where it helps to dig into some of the statutory language and FAQ guidance.

The statutory language has not provided that clarity that health care organizations need. HHS has provided more clarity in its FAQs on what healthcare-related expenses are appropriate expenses for use of the funds.

The term "healthcare-related expenses attributable to coronavirus" is broad and may cover a range of items. The FAQ provides that qualifying expenses include the following:

- Supplies and equipment used to provide healthcare to possible or actual COVID-19 patients.
- Workforce training.
- Reporting COVID-19 test results to federal, state, or local governments.
- Acquiring additional resources, including facilities, equipment supplies, healthcare practices, staffing, and technology to extend or preserve care delivery.
- The above are examples as well as other documented healthcare expenses incurred to prevent, prepare for, and respond to coronavirus qualify as healthcare-related expenses attributable to coronavirus.

Lost Revenue

Providers can also use the Provider Relief Fund to cover any costs that lost revenue otherwise would have included—within the qualification of preventing or preparing for the response to coronavirus. These costs do not need to be specific to providing care for possible or actual coronavirus patients.

Qualifying lost-revenue expenses include the following, without limitation:

- Employee or contractor payroll.
- Employee health insurance.
- Rent or mortgage payments.
- Equipment lease payments.
- Electronic health record licensing fees.

The above are examples provided in the FAQs, however a range of other operational expenses would also be qualifying under the lost revenue category.

The lost revenue category is not subject to some of the limitations of the direct healthcare reimbursement provision, meaning it covers a wider range of operational expenses. Organizations need to demonstrate the amount of lost revenue and must be able to track their expenses.

Additional terms and conditions of note include using funds to reimburse healthcare expenses (i.e., a payer of last-resort provision). Providers can't have another payer reimbursing them for those same expenses. There is a no balance billing provision, which applies to COVID-19 patients. There are also political limitations that prohibit the use of the money for executive pay, gun control, advocacy, lobbying, and more.

Compliance with the Provider Relief Fund Terms and Conditions

Health systems must use Provider Relief funding per the statutory requirements and the terms and conditions from HHS. Requirements include attesting to the terms and conditions and regularly reporting (tracking the expenses) and preparing for audits.

Healthcare organizations may find themselves in one of three situations regarding compliance:

1. Comfortable, with good staff to support compliance.
2. In need of some help (e.g., external consultants and advisors).
3. Concerned about returning the funds due to a lack of understanding and guidance.

HHS intends for relief funds to help, not penalize providers (i.e., keep them out of the third category above). There will be audits and accountability, but there is also a lot of flexibility built into compliance. The Provider Relief Fund FAQs provide more guidance on the Provider Relief Fund terms and conditions.

Attestation and Reporting

For attestation and reporting, the fund's recipient must confirm agreement with the terms and conditions by written attestation. This deadline (which may change again) is 90 days. For example, for funds received on April 10, the deadline was extended to July 11, and for funds received April 24, the deadline was extended to July 23. In terms of reporting, providers receiving more than $150,000 must provide quarterly reports for all the projects and activities for which they used the funds. Quarterly reports must include the following:

- The total amount of funds received.
- Amount of expenditures.
- A detailed list of all the projects and activities.
- Estimated number of jobs created, only if applicable.
- Detailed information on subgrants and subcontracts awarded.

Policy Changes: What's Coming and What's Needed

From a data and analytics perspective, one of the critical opportunities COVID-19 has exposed is the need to share data better—making available aggregated and de-identified information to public health authorities, research organizations, and academic medical centers. The crisis has made existing barriers stark, as they've prevented disclosure of de-identified and limited dataset information that could be vital in pandemic management and recovery. The HHS Office for Civil Rights (OCR) has waived certain HIPAA provisions, but researchers and providers need greater access to information to make an impact.

The Provider Relief Fund and other relief dollars became available rapidly. In the next round of legislation, there may be a more-targeted, grant-based process for funds distribution, as well as infrastructure for public health development, data infrastructure development, and reporting surveillance, both for health and hospital systems, as well as for localities and states. As some of those funds have already come through to states and localities for further distribution, it's worth questioning whether the existing systems the CDC, states, and other federal agencies have in place are sufficient. The infrastructure to quickly aggregate and report data in an emergency is generally lacking.

As part of the infrastructure, the national patient identifier is controversial. It was frozen in Congress two years after HIPAA was enacted in 1996 but is re-emerging in 2020. Nothing could have put the choice between more privacy restrictions and saving lives more starkly than the COVID-19 emergency—both on the policy side, as well as the provider side. Privacy advocates may now realize better data infrastructure will help them find their patients across a longitudinal care journey and use that information in an emergency and for non-emergency public health purposes.

Legislation over the next year or two will likely involve further expansion of data sharing, at least during an emergency, and for public health oversight purposes. These provisions will be important to respond to future waves of COVID-19 or other public health emergencies and stand to improve public health response and oversight over time.

Preparing for an Extensive, Dynamic Process

With no known endpoint to COVID-19's impact on healthcare delivery, healthcare organizations must prepare for an ongoing economic recovery process. If the many new bills and policy changes of March through June 2020 are any indications, the industry can count on continued refinement of existing acts, possible additional stimulus dollars, infrastructure for public health development, and changes in policy to remove barriers to data sharing both during a public health emergency as well as in the new normal. As the funds from the various COVID-19 packages are subject to audit and review for several years, providers must continue to document the usage of the funds for the foreseeable future. Further clarification from HHS on qualifying use of the funds and on reporting requirements is likely.

Also, based on the impact of COVID-19 on older Americans and the highest risk for those with chronic conditions as well as disparities in health outcomes for racial and ethnic minority groups and low-income populations, the CMS is asking for a renewed commitment to value-based care.

About The Authors

Bobbi Brown is the Vice President of Financial Engagement for Health Catalyst. Ms. Brown started her healthcare career at Intermountain Healthcare supporting clinical integration efforts before moving to Sutter Health and, later, Kaiser Permanente, where she served as Vice President of Financial Planning and Performance. Ms. Brown holds an MBA from the Thunderbird School of Global Management as well as a BA in Spanish and Education from Misericordia University. She regularly writes and teaches on finance-related healthcare topics.

Prior to joining Health Catalyst Dan Orenstein was at athenahealth, Inc. (NASDAQ: ATHN) for 10 years, the last 7 as General Counsel and Secretary. Prior to that, Dan practiced in the areas of corporate, intellectual property, and healthcare law with law firms in Boston and Washington, D.C. He has written and presented on health care law and IT topics throughout his career. He also served as a leader of the American Health Lawyers Association's Health IT practice group.