Methodology for a Quickly-Prepared Application to the CARES Act $100 Billion Public Health and Social Services Emergency Fund

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The Coronavirus Aid, Relief and Economic Security ("CARES") Act provides $2 trillion in funding, including numerous programs and provisions targeted at health care providers. This paper focuses on the Public Health and Social Services Emergency Fund. CMS has yet to provide guidance regarding the application process, but as soon as those guidelines are available, we expect a frenzy of activity as thousands of providers apply, since the funds are limited as is CMS' capacity to review and process those applications. Hence, **we recommend that providers assemble documentation in a logical fashion immediately, so that they can "simply" fill-out the forthcoming application once it is released**. Given the uncertainty regarding what CMS will require and in what format, flexibility is essential.

This paper focuses on health systems (hospital(s) with employed physicians), although its observations and recommendations likely apply to other providers.

Background: The Emergency Fund

The CARES Act added **$100 billion** to the Public Health and Social Services Emergency Fund. This fund will be used to reimburse providers for **expenses** and **lost revenues attributable to COVID-19**. Suppliers or providers who are eligible to receive funds include those enrolled in Medicare or Medicaid, and public, for-profit, and non-profit entities that provide testing, diagnoses or care for individuals with possible or confirmed cases of COVID-19.

The Act's language is quite limited. Below are the relevant portions, with key phrases in bold:

> *"$100,000,000,000 to remain available until expended, to prevent, prepare for, and respond to the coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related* ***expenses or lost revenues that are attributable to coronavirus****: Provided, That these funds may* ***not be used*** *to reimburse expenses or losses that have been* ***reimbursed from other sources*** *or that other sources are obligated to reimburse." (Page 750, Lines 4-13)*
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> *"Funds appropriated under this paragraph in this Act shall be* ***available 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.*** *" (Page 751, Lines 5-11)*
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> *"Recipients of payments under this paragraph* ***shall submit reports and maintain documentation*** *as the Secretary determines are needed to ensure compliance with conditions that are imposed for such payments" (Page 750, Lines 13-17)*

Observations and Assumptions:

1. **Expenses related to COVID-19** will be eligible for a grant, excluding those expenses already reimbursed by other sources.
2. Unless a health system has an extremely robust activity-based costing system already configured for a pandemic emergency, *it will be impossible to accurately and completely identify, quantify, and document all incremental non-reimbursed expenses of COVID-19.*
3. Hence "expenses related to COVID-19" should be subdivided into logical categories, and efforts to identify, quantify, and document expenses should be prioritized and conducted based on the ease of documentation and likely magnitude.
4. Expense examination should be holistic, systemic, and logical. Given the complexity of the typical health system, this will require creativity for any grant application in the near term.
5. **Loss of revenue** is likely of greater financial impact than COVID-19 expenses (as many hospitals' procedural margins exceed their operating incomes) and quantifying the financial impact of lost revenue is relatively straight-forward.
6. Due to the grave likelihood that the COVID-19 crisis will drive health operations and financial performance (and sustainability) for the remainder of 2020, health system financial leaders should simultaneously implement tracking systems to document all COVID-19 related decisions (starting with those made by the Hospital Incident Command System (HICS)) actions and then monitor the resulting financial implications on an ongoing basis.
7. The $100 billion fund will be insufficient, and the needs are great, so providers should be prepared to submit a well-grounded application as soon as CMS promulgates the guidelines, to be included in the first "batch" of approvals/payments.
8. As the Act does not limit a provider to one application and the societal need will likely last for many months (and exceed the $100 billion funding), we hope that future legislation will provide more funding. Hence, a provider's initial application is unlikely to be its last.

Overall, we have **Two Recommendations for Immediate Action:**

1. **Be prepared to submit a grant application on 24 hours' notice, by April 10**. Thereafter, the information needed for an application should be updated/improved on a daily/weekly basis. Not only will this increase the magnitude of the applicable amount, but routine measurement is also necessary for ongoing management of these unplanned expenditures
2. **Implement systemic tracking of the financial implications of dealing with COVID-19.** This starts with installing a tracking system to document all COVID-19 related decisions in the Hospital Incident Command System and then monitoring the resulting financial implications, but it also likely includes augmenting the chart of accounts so all resource usage at the departmental and patient-level can be tracked via regular financial systems.

The remainder of this paper addresses: How to immediately develop a comprehensive, fact-based application, starting with a systematic framework for identifying the impact of COVID-19, followed by our initial recommendations on how to prepare the first application to the Fund.

A mutually exclusive, collectively exhaustive framework for Expenses and Lost Revenues:

1. **Operating expenses** by expense type (labor, supplies) and direct/indirect:
    a. Direct patient care for which no reimbursement is expected, such as free testing for the community
    b. Increased direct patient care expenses for all/most patients that is not reimbursable, including:
        i. Supplies: PPE, increased testing costs, other supplies
        ii. Direct labor: incremental costs due to lower nursing ratios, overtime/agency cost, etc.
        iii. Excess LOS (on inpatient case rate activity) due to inability to discharge effectively (e.g., constraints placed by SNFs on transfers)

        To the extent that supplemental Medicare (and other) reimbursement covers higher costs on patients diagnosed with COVID-19, those expenses should be excluded
    c. Caregiver, support staff, contract staff and consultants, and managerial time related to COVID-19 but not direct patient care:
        i. Training (all staff, including physicians and APPs)
        ii. Managerial time, such as operating the Incident Command Center. This will require determining and documenting an allocation of (mostly) salaried staff
        iii. Patient screening at facility entrances
        iv. Increased security and housekeeping costs
    d. For non-patient care departments (e.g., revenue cycle):
        i. One-time costs related to changes of operations (e.g., working from home)
        ii. The direct cost of lost productivity (that is, if productivity drops 20% (based on documentation), then 20% of labor costs could be considered an expense due to COVID-19)
    e. Employee benefits:
        i. Employee Health Benefits: increase in medical claims
        ii. Increased sick leave and other paid leave
    f. Other non-labor costs:
        i. Supplies
        ii. Insurance: Business-related; medical malpractice
        iii. Facility-related

2. **Capital expenditures** (both already incurred and expected future) related to COVID-19 (e.g., construction of temporary structures, retrofitting structures, surge capacity) should be relatively straight-forward, as there's typically a financial approval process for un-budgeted CapEx:
    a. Retrofitting structures. For example, one client modified their air handling equipment to expand their negative-pressure rooms from 2 ICU rooms to the full 45-bed ICU/CCU
    b. Construction of temporary structures (if capitalized; otherwise, these should be considered a covered expense)
    c. Investments in "surge capacity".

3. **Lost revenues**. For health systems, this includes hospital services and physicians who are either employed or under professional services arrangements:
    a. Reduction in all procedural care. This includes:
        i. Surgeries (inpatient and outpatient)
        ii. Cardiac diagnostics and procedures
        iii. Physician office-based procedures
        iv. Other diagnostic procedures (imaging, sleep, lab, etc.)
        v. Therapeutic procedures (PT/OT/SP; cancer treatment)
    b. Reduction in medical care
        i. ED visits (non-COVID-19)
        ii. OBS cases (non-COVID-19)
        iii. Medical admissions (non-COVID-19)
        iv. Physician/Extender care (Office visits and in-hospital care)
    c. Greater write-offs on:
        i. Accounts receivable as of Sunday, March 15, 2020 (when CMS promulgated its recommendation to "limit all non-essential planned surgeries and procedures")
        ii. All reimbursable care provided after March 15, 2020

Recommended approach to Prepare an Application for the Emergency Fund:

1. As guidance has not yet been written to describe exactly how to quantify the above, it would make sense to model various scenarios/variables (e.g., how to define "allowable expenses" or calculate "net revenue"; how to project volume changes (e.g., year-over-year versus trend; seasonality; actual versus budget); how to project go-forward projections).

2. Treat the application development process as "an SAT of great importance but with a minute's notice of the unknown end time":
    a. Assemble a cross-functional team, with a logical assignment of the above framework's components:
        i. HICS Finance member — All COVID-specific initiatives ("top down view")
        ii. Operational managers: — Direct patient care; COVID-specific initiative
        iii. Practice leaders: — Shift of providers to non-traditional roles
        iv. HR managers: — Institution-wide staff-related items
        v. Managed care staff: — Revenue loss due to volume
        vi. Revenue Cycle staff: — Increased write-offs
    b. Have the above staff identify COVID-19-related effects and relevant volume statistics
    c. Have Finance:
        i. Catalogue COVID-19-related expenditures that they recognize and can document the magnitude (both one-time and ongoing), such as all unbudgeted capital and operating expenditures
        ii. Develop financial implications, with sources documented, for the activities and volume statistics identified by the team
    d. Pull these facts into one database and draft the "version 1" application

3. Have senior team members (including physicians and Board members) review the application for holes, and address them

4. Implement a process and responsibilities for ongoing updates and enhancements to the database and application

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