Financial Resources to Assist Hospitals & Health Systems Previous Updates

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Updates from August 12 – 17:

1. HHS was expected to release details regarding Provider Relief Fund data collection requirements for providers that received more than $10,000 on August 17, but this has been delayed. HHS has posted a notice stating that providers will still receive instructions and a data template well in advance to the reporting system's availability on October 1. [1]
2. HHS announced an additional $1.4 billion in Provider Relief Fund distribution allocated to almost 80 free-standing children's hospitals nationwide. These 80 children hospitals will receive 2.5 percent of their net revenue from patient care, and these funds will begin being distributed the week of August 17. [2,3]
3. CMS issued guidance for Critical Access Hospitals (CAHs) to not subtract Paycheck Protection Program loans from their salary and wage expense, as these loans will not be included when calculating CAHs' expense-related Medicare payments. [4]

Updates from August 4 – 11:

1. HHS has provided guidance for providers that received funding from the CARES Act Provider Relief Fund stating they must expend the entire amount received by July 31, 2021, which is the same date that reports must be submitted to HHS on the funds' utilization. Chad Mulvany with HFMA suggested that all funds should be spent by June 30, 2021 to be able to fully report on the expenses and lost revenue. [5]
2. On August 7, HHS announced $5 billion in CARES Act Provider Relief Fund distributions to nursing homes. The distribution will provide $2.5 billion in upfront funding to support increased testing, staffing, and PPE needs. There will also be funding available for those establishing COVID isolation facilities. The remaining $2.5 billion will be linked to nursing home performance. Evaluation of performance will consider the prevalence of the virus in the nursing home's local geography and the nursing home's ability within this context to minimize COVID spread and COVID-related fatalities among its residents. [6]
3. Trump signed an executive order to expand telehealth to assist healthcare in rural areas. CMS plans to issue a proposed Physician Fee Schedule rule that will secure regulatory flexibilities enacted during the public health emergency to reimburse for telehealth visits. Examples of these CMS reimbursable telehealth visits are emergency room visits, nurse consultations, and speech and occupational therapy. [7]

Updates from June 27 – August 3:

1. The president announced a 90-day extension of the public health emergency. There are many waivers and temporary authorities that will continue under this extension, including expansive use of telehealth services and higher Medicare payments. [8]
2. HHS extended the application period to August 28, 2020 for: [9]

    a. Certain Medicare providers who experienced challenges in the Phase 1 Medicare General Distribution
    b. Phase 2 of the General Distribution to Medicaid, Medicaid Managed Care, Children's Health Insurance Program (CHIP) and dental providers
3. If providers or practices changed ownership in 2020, the original owner may have received the Provider Relief payments. The prior owners are required to return the funds to HHS and the new owners will be given the opportunity to apply for provider relief funding through August 28, 2020. [9]

Updates from June 20 – July 26:

1. HHS announced the timing for future reporting for providers that received $10,000 or more from the Provider Relief Fund. HRSA will have Question and Answer Sessions via Webinar prior to the submission deadline. The reporting system will become available to providers October 1, 2020, and below are the time requirements. [10]
    a. All recipients must report within 45 days of the end of calendar year 2020 on their expenditures through the period ending December 31, 2020.
    b. Recipients who have expended funds in full prior to December 31, 2020 may submit a single final report at any time during the window that begins October 1, 2020, but no later than February 15, 2021.
    c. Recipients with funds unexpended after December 31, 2020, must submit a second and final report no later than July 31, 2021.
    d. Detailed Provider Relief Funding reporting instructions and a data collection template with the necessary data elements will be available through the HRSA website by August 17, 2020.
2. On July 20, HHS began to distribute the previously announced additional $10 billion in federal funding to over 1,000 COVID-19 hotspot hospitals. These payments will be $50,000 per COVID-19 admission. Hospitals will qualify for this funding if their admissions between January 1 and June 20 meet the following requirements:
    1. More than 161 COVID-19 admissions
    2. At least one COVID-19 admission per day
    3. Higher than the national average ratio of COVID-19 admissions per bed

    If the hospital has previously received a hotspot payment, this new round of funding will be reduced by the funding they already received. [11,12]
3. HHS has extended the deadline to apply for the $15 billion distribution to August 3 for Medicaid and CHIP providers and dentists. [13]

Updates from June 13 – July 19:

1. Hospitals have been requested to send daily COVID-19 reports directly to HHS instead of the CDC effective immediately. HHS has requested hospitals to prioritize specific data fields in COVID-19 daily reporting starting July 15 to track the agency's distribution of Remdesivir.
    a. Previous day's new adult admissions for confirmed COVID-19
    b. Previous day's new adult admissions for suspected COVID-19

c. Total adults hospitalized for COVID - suspected and confirmed
d. Total hospitalized for COVID - confirmed only
e. Total adults in ICU with COVID - suspected and confirmed
f. Total adults in ICU with COVID - confirmed
g. Remdesivir doses

While HHS has currently prioritized the collection of the data fields above, the agency notes that it intends to use all data fields from hospital daily reporting for various resource allocations. HHS has requested hospitals to begin reporting all data fields included in HHS's "COVID-19 Guidance for Hospital Reporting and FAQs For Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting" no later than July 22. [14,15]

2. The Federal Reserve Board approved two new loan options for their Main Street Lending Program to provide support to a broad set of nonprofit organizations that were in sound financial condition prior to the pandemic. These two new options lower the minimum employment requirement from 50 employees to 10, eased the limit on donation-based funding, the maximum loan amount has increased from $200 million to $300 million, and several financial eligibility criteria were adjusted to include additional nonprofit operating models. [16]

<u>Updates from June 6 – July 12:</u>

1. HHS announced additional funding allocated for safety net hospitals, certain rural providers and other providers from small metropolitan areas, and dentists on July 10. [17]
    a. HHS has announced additional allocation of $3 billion to safety net hospitals. HHS is expanding the qualifications for payment to allow certain acute care hospitals to be eligible for funding if they meet the revised profitability threshold of less than of 3% averaged consecutively over two or more of the last five CMS cost report filings. HHS expects to distribute over $3 billion across 215 acute care facilities, which will bring the total payments for safety net hospitals from the Provider Relief Fund to $12.8 billion for 959 facilities.
    b. HHS also announced an additional $1 billion to certain rural hospitals, urban hospitals with certain rural Medicare designations, and hospitals in small metropolitan areas. HHS is altering the current payment formula to include certain special rural Medicare designation hospitals in urban areas as well as others who provide care in smaller non-rural communities. By expanding the payment, some suburban hospitals that are not considered rural but serve rural populations and operate with smaller profit margins and limited resources than larger hospitals are now eligible for funding. HHS estimates that this Provider Relief revision will equal over $1 billion distributed to 500 of these newly eligible hospitals with payments ranging from $100,000 to $4,500,000 for rural designated providers and $100,000 to $2,000,000 for the other providers.
    c. HHS opened the provider portal to allow dentists to apply for provider relief funding, but no funding amount was announced.

2. The FCC has approved the final set of COVID-19 telehealth program applications, which totaled 539 applications approved and $200 million in funding. [18]
3. In August, hospitals that took advantage of the Medicare Advanced Payment Program will need to begin to repay their loans. While the hospitals have 12 months to repay the advances, any remaining balance will have an interest rate of 10%. Hospitals can choose to withhold Medicare payments as a way to repay the advances. Hospitals are urging Congress to extend the loan repayment term, as most hospitals are still well below their pre-COVID volumes and revenue. [19]

<u>Updates from June 22 – July 5:</u>

1. Medicaid and CHIP providers must submit their gross revenues from patient care for CY 2017, or 2018 or 2019 by July 20, 2020 to be eligible to receive CARES Act funding Medicaid/CHIP targeted distribution. [20]
2. HHS clarified in their FAQ document what to include in the lost revenue calculation and the attributable time frame for allowable expenses or lost revenue. [21,22]
    a. "Lost revenue estimates should be based on budget-to-actual or year-over-year, and should include revenue from all sources that can be attributed to COVID-19. This may include value-based payments, such as quality measure achievement payments."
    b. "HHS expects that providers will only use Provider Relief Fund payments for as long as they have eligible expenses or lost revenue. If, at the conclusion of the pandemic, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds."
3. On June 25, the FCC announced they are no longer accepting new applications. [23]

<u>Updates from June 10 – June 21:</u>

1. The Terms and Conditions for all Provider Relief Fund payments require recipients who receive at least $150,000 from the general and targeted payments distributions to submit quarterly reports to HHS and the Pandemic Response Accountability Committee. HHS released more clarity on these reports stating that providers will not need to submit separate quarterly reports to the HHS and the Pandemic Response Accountability Committee. [24]
    a. HHS will create a report with all information required from recipients to comply with the Terms and Conditions.
    b. HHS is posting the names of payment recipients and their payment amounts, once the providers attest to receiving the payment and agree to the Terms and Conditions, on its public website Tracking Accountability in Government Grants System (TAGGS). HHS is also working with the Department of Treasury to post the aggregate total of each recipient's attested to Provider Relief Fund payments on USAspending.gov.

    c. The Terms and Conditions for all Provider Relief Fund payments also includes a requirement for recipients to submit any reports requested by the Secretary. HHS will be requiring recipients to submit future reports on the use of its funding received. HHS will notify recipients of the content and due date(s) of these reports in the coming weeks.
2. As of June 10, the FCC has awarded more than half their available funding, $105 million of $200 million, which was allocated by the CARES Act for 305 nonprofit and public health providers to construct and expand their telehealth infrastructure. For providers to receive this funding, they are required to submit additional documentation including an invoice for the costs of eligible services, devices, and other expenses. [25]
3. Small Business Administration released an updated loan forgiveness application for the Paycheck Protection Program, which reflects the provisions of the recently enacted PPP Flexibility Act. The SBA also released an "EZ" version of the application for borrowers who: are self-employed and have no employees; did not reduce employees' salaries or wages by more than 25% and did not reduce employees or employee hours; or experienced reduced business activity due to COVID-19-related health directives and did not reduce employees' salaries or wages by more than 25%. Both applications allow borrowers to use the initial eight-week covered period for loans or the extended 24-week covered period. [26,27]
4. With patient demand for telehealth services, hospitals and congress are supporting the permanent expansion of telehealth services. These expanded services includes allowing access to telehealth services for patients in their homes and other locations, allowing RHCs and FQHCs to serve as distant sites that can provide telehealth services, making all healthcare professionals eligible to bill Medicare for telehealth services, allowing hospitals to bill the Outpatient Prospective Payment System or other applicable payment systems for remote services, and allowing providers to deliver Medicare telehealth services through cellphones. [28]

<u>Updates from June 1 – June 9:</u>

1. HHS announced on June 9 that $35 billion of the allocated funding from the $175 billion CARES Act will be distributed to eligible Medicaid and CHIP providers, safety net hospitals, and COVID hot-spots. [29]
    a. $15 billion will be sent to Medicaid providers that did not receive funding from the CARES initial $50 billion general distribution and have directly billed their state Medicaid/CHIP programs or Medicaid managed care plans for healthcare-related services between January 1, 2018 to May 31, 2020. Providers eligible for this funding are pediatricians, obstetrician-gynecologists, dentists, opioid treatment, and behavioral health providers, assisted living facilities, and other home and community-based services providers.
    b. $10 billion will be distributed to safety-net hospitals. These hospitals must have a Medicare disproportionate payment percentage of 20.2% or greater, average uncompensated care per bed of $25,000 or more, and profitability of 3% or less

on the most recent CMS cost report. The minimum distribution is $5 million, and the maximum is $50 million.

   c. An additional $10 billion will be distributed to hospitals in COVID-19 hot-spots. On June 8, HHS requested an updated data submission regarding COVID-19 positive inpatient admissions. The previous $12 billion distribution was sent to 395 hospitals that treated at least 100 COVID-19 patients by April 10. The new distribution may have a different patient threshold, and data submissions are due June 15. Funds from the prior hot-spot allocation will be factored into the second round of grants, but providers who did received funding may still be eligible for additional funds.

2. The HHS is providing an additional $250 million to aid health systems' response to the COVID-19 pandemic. Of the $250 million from CARES Act funding being distributed, $125 million will be distributed through cooperative agreements with hospital associations. The other $125 million will be distributed through the Hospital Preparedness Program's cooperative agreements with 62 state and local public health departments. The funds are to support hospitals' and other health care entities' efforts to train workforce, expand telemedicine and the use of virtual health care, procure supplies and equipment, and coordinate effectively across regional, state and local health care facilities to respond to COVID-19. [30]
3. The Senate passed the Paycheck Protection Program Flexibility Act 417-1 this week and now awaits President's approval. This Act gives small business borrowers 24 weeks instead of eight weeks to spend the PPP funds, allows them to delay paying payroll taxes, and would only require them to spend 60% of the loan expenses on payroll costs instead of 75% as stipulated in the CARES Act. [31]
4. The Fed lowered the minimum loan amount to $250,000 and raised the maximum loan limit to $200 million under its Federal Reserve Main Street Lending Program. The loan terms have been extended to five years from four years and will allow businesses to defer principal payments for the first two years of the loan, instead of only the first year. [32]
5. CMS acts to limit losses for participants in value-based payment programs during COVID-19. [33,34]
   a. Changes for BPCI-A include:
      i. Allowing elimination of upside and downside risk by excluding 2020 clinical episodes from reconciliation
      ii. Allowing those choosing to remain in two-sided risk to exclude COVID-19 patient care from reconciliation
   b. For PCF, the agency will delay the start of the performance period for the serious illness component until April 1, 2021. The PCF-only component will still start on Jan. 1, 2021.
   c. Changes for NGACO include:
      i. Reducing 2020 downside risk by reducing shared losses by the proportion of months that comprise the PHE
      ii. Capping NGACOs' gross savings upside potential at 5%
      iii. Removing episodes of care for treatment of COVID-19

iv. Using retrospective regional trends, rather than prospective, for 2020
v. Removing the financial guarantee requirement for 2020
vi. Extending the 2019 quality-measure reporting deadline from March 31 to April 30, 2020
vii. Cancelling 2019 quality audits
viii. Extending the program through December 2021

d. Changes for Medicare ACO Track 1+ model include:
    1. Removing episodes of care for treatment of COVID-19
    2. Applying the MSSP extreme and uncontrollable circumstances policy to 2020 financial reconciliation
    3. Extending the 2019 quality-measure reporting deadline from March 31 to April 30, 2020
    4. Applying the extreme and uncontrollable circumstances policy to 2019 and 2020 reporting
    5. Allowing participants to extend their agreement for one year, through December 2021
e. Changes for the global and professional tracks of the DC model include:
    1. Delaying the start of the first performance period for the first cohort to April 1, 2021
    2. Creating a 2021 application cycle for a second cohort to launch Jan. 1, 2022
    3. Adjusting quality benchmarks, if necessary, to reflect the change in duration of the 2021 performance period due to the later start

<u>Updates from May 25 – 31:</u>

1. HHS announced a second extension for providers who received payments from the Provider Relief Fund to accept the Terms and Conditions for Provider Relief Fund payments. Providers now have 90 days from the date they received a payment to accept HHS Terms and Conditions or return the funds. [35]
2. HHS posted details on the calculation for the Public Health and Social Services Emergency Fund for RHCs distribution. [36]
    a. Hospital allocation was a graduated base payment plus 1.97% of the hospital's operating expenses. The graduated base payment was calculated as:
        i. 50% of the first $2 million of expenses (up to $1,000,000)
        ii. 40% of the next $2 million of expenses (up to $800,000)
        iii. 30% of the next $2 million of expenses (up to $600,000)
        iv. 20% of the next $2 million of expenses (up to $400,000)
        v. 10% of the next $2 million of expenses (up to $200,000)
        vi. Rural hospitals with annual operating expenses greater than $10,000,000 receive a base payment of $3,000,000.
        vii. Rural hospitals with no operating expense data receive a base payment of 1,000,000.

viii. RHCs associated with rural hospitals had their allocations included with their hospital's payment, and the hospital is responsible for distributing this funding to support theirs RHCs. For independent RHCs, their allocation was $100,000 per clinic site plus 3.6% of the RHC's operating expenses.

b. FQHC allocation was a flat rate of $100,000 per rural clinic site.
c. The total calculated amount for RHCs and health centers was then multiplied by 1.03253231 to determine the actual payment per rural provider to ensure the total amount distributed was $10 billion.

3. Tribal healthcare providers have been allocated $500 million from the CARES Act Provider Relief $175 billion in funding. [37]
    a. Tribal hospitals will receive a $2.81 million base payment plus three percent of their total operating expenses
    b. Tribal clinics and programs will receive a $187,000 base payment plus five percent of the estimated service population multiplied by the average cost per user
    c. Tribal urban programs will receive a $181,000 base payment plus six percent of the estimated service population multiplied by the average cost per user
4. On May 28, HHS awarded $15 million to 52 Tribes, Tribal organizations, urban Indian health organizations, and other health services providers to prepare, prevent, and respond to COVID-19 in rural tribal communities as part of the CARES ACT allocated funding for Indian Health Services. HHS distributed funding based on their needs and capacity to implement COVID-19 related activities in their rural communities. Tribes could request up to $300K in funding for these activities through the Rural Tribal COVID-19 Response (RTCR) program. [38]
5. The House of Representatives passed the Paycheck Flexibility Act to allow more leeway for small business loans. The Act extends the loan period from 8 to 24 weeks through Dec. 31, 2020, as well as the period for repayment (if required). It also allows borrowers to use up to 40% (previously 25%) of the loan on non-payroll expenses. The Act provides different scenarios under which borrowers may be eligible for forgiveness, even if they are unable to retain the same amount of full-time equivalent employees. It also allows PPP loan borrowers who seek forgiveness of the loan to qualify for deferred payment of the employer's portion of certain payroll taxes. [39]

<u>Updates from May 18 – 24:</u>

1. $100 billion in grants (added to $175 billion previously appropriated) for hospitals and other healthcare providers. Congress is expected to enact another major coronavirus law with hospital provisions by early July. Additional grants totaling $100 billion — and directions on who should get them — were included in the House-passed version. [40]
2. By June 3, providers must accept the Terms and Conditions and submit their revenue information to receive (or keep if already received a second allotment) additional payment from the Provider Relief Fund $50 billion General Distribution. [41]
3. Hospitals are not eligible for additional General Distribution funds if their first-round payment was 2% or more of net patient revenue. HHS clarified only providers that

received a previous payment from the General Distribution are eligible for the ongoing second round of funding. [42]

4. HHS has disbursed 336 grants totaling $12 billion to 395 hospitals and health systems that provided inpatient care for 100 or more COVID-19 patients through April 10. [43]
5. On May 20, $225 million was distributed to over 4,500 RHCs to support COVID-19 testing efforts and expand access to testing in rural communities. "The funding may be used for a wide range COVID-19 testing and related expenses including planning for implementation of a COVID-19 testing program, procuring supplies to provide testing, training providers and staff on COVID-19 testing procedures, and reporting data to HHS on COVID-19 testing activities," said HRSA Administrator Tom Engels. "Funds may also be used for building or construction of temporary structures, leasing of properties, and retrofitting facilities as necessary to support COVID-19 response." [44]
6. HHS announced nearly $4.9 billion in allocated funding for SNFs affected by COVID-19. Each SNF will receive a fixed distribution of $50,000, plus an additional $2,500 per bed. All SNFs with six or more certified beds are eligible. [45]
7. On May 13, HRSA awarded $15 million to 159 organizations across five health workforce programs to increase telehealth capabilities in response to the COVID-19 pandemic, which was funded through the CARES Act signed on March 27. [46]
8. Paycheck Protection Program loan forgiveness application and guidance has been published. [47]

<u>Updates from May 11 – 17:</u>

1. $33 million has been distributed to providers through the FCC for telehealth program funding (authorized by the CARES Act). [48]

<u>Updates from May 4 – 10:</u>

1. HHS has extended the deadline for accepting the terms and conditions for Public Health and Social Services Emergency Fund payments to 45 days from when the provider receives payment. [49]
2. Details on the distribution of funding to support high impact areas of COVID-19 were released and funding will be released in the next few days. There are 395 hospitals that will receive a fixed amount per COVID-19 inpatient admission, with additional funding based on their Medicare and Medicaid disproportionate share and uncompensated care payments. [50]
3. As of May 6, providers who treated COVID-19 uninsured patients can submit claims for reimbursement at Medicare rates through an online portal on HHS's website. [51,52]

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