CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

# ADDITIONAL FEDERAL FUNDING OPPORTUNITIES FOR HOSPITALS

*Updated April 16, 2021*

*In addition to distributions from the Provider Relief Fund – established by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act – a number of direct funding opportunities are available to hospitals and health systems to support the response to the COVID-19 pandemic. These programs are described below. In addition, CHA has also prepared a federal funding infographic showing specific legislation, amount of funding allocated for health care providers, what the funding covers, and more.*

## Medicare Accelerated and Advance Payments

- **Program Suspension:** On April 26, CMS announced it would suspend the Medicare Accelerated and Advance Payments (MAAP) programs while reevaluating payments made, taking into account funding providers received from the Provider Relief Fund. **CMS now says that as of October 8, it will no longer accept applications for accelerated or advance payments relating to the COVID-19 public health emergency.**
- **Description**: Under an expanded option through the Medicare Hospital Accelerated and Advanced Payment programs, eligible providers may request payments that cover a period of up to six months. The payment is calculated based on Medicare inpatient, outpatient, and pass-through payment amounts. For details, please see CMS' fact sheet.
- **Eligible providers**: All Medicare providers including acute care hospitals, critical access hospitals (CAHs), children's hospitals, prospective payment system (PPS)-exempt cancer hospitals, and physicians. Specifically, facilities that:
    - Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/supplier's request form
    - Are not in bankruptcy
    - Are not under active medical review or program integrity investigation
    - Do not have any outstanding delinquent Medicare overpayments
- **Payment details**:
    - Providers can request up to 100% (up to 125% for CAHs) of what the hospital would otherwise have expected to receive based on historical payments. The Medicare administrative contractor (MAC) will determine the provider's maximum payment amount.

        - Inpatient prospective payment system (IPPS) hospitals, CAHs, children's hospitals, and PPS-exempt cancer hospitals can request up to six months of payments based on payments received from July 1 - December 31, 2019.
        - All other providers — including long-term care hospitals (LTCHs), inpatient rehabilitation facilities, and inpatient psychiatric facilities — can request up to two months of payments based on payments received from October 1 - December 31, 2019.
    - If the provider chooses not to request the maximum payment, the remainder may be requested at a later time within the declared public health emergency.
- **Repayment**: If a provider received an accelerated or advance payment, CMS will begin to recoup any outstanding balance from any payments due to the organization from Medicare claims. This began as soon as March 30, 2021, depending upon the one-year anniversary of when the provider received its MAAP payment.
- The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159), enacted on October 1, 2020, amended the repayment terms for all providers and suppliers who requested and received accelerated and advance payments during the COVID-19 Public Health Emergency. A provider or supplier may repay their accelerated or advance payment at any time by contacting their Medicare administrative contractor (MAC). If such payment is repaid in full, the repayment terms below will not apply. The updated repayment and recoupment terms are as follows:
    - Repayment will begin one year from the date the accelerated or advance payment was issued. When repayment begins, CMS will recoup portions of the accelerated for advanced payment against future Medicare payments by offsetting payment for submitted claims.
    - Beginning at one year from the date the payment was issued and continuing for 11 months, Medicare payments owed to providers and suppliers will be recouped at a rate of 25% of submitted claims.
    - After the 11 months end, Medicare payments owed to providers and suppliers will be recouped at a rate of 50% of submitted claims for another 6 months.
    - After the 6 months end (29 months after the date the accelerated or advance payment was issued), a letter for any remaining balance of the accelerated or advance payments will be issued.
        - If a letter requiring reimbursement is issued, providers and suppliers will have 30 days from the date of the letter to repay the balance in full. If payment is not received within 30 days, interest will accrue at the rate of 4% from the date the letter was issued and will be assessed for each full 30-day period that the balance remains unpaid.
        - Extended Repayment Schedule: Information related to Extended Repayment Schedules (ERS) will be included in these letters. ERS is a statutorily authorized debt installment payment schedule, which allows a provider or supplier experiencing financial hardship to pay debts over the course of three years. This can be extended to as many as five years, where certain extreme hardship criteria are met. Providers and suppliers

are able to request ERSs after demand letters are issued and should contact their MAC for information on how to request an ERS.
- Periodic Interim Payment (PIP) Providers: CMS clarifies that the timeline for repayments is the same for PIP and non-PIP providers. The recoupment process from bi-weekly PIP payments will begin after 12 months from the date the provider received their accelerated payment. Repayment will comport with the timeline described immediately above. Accelerated payments will not be included in the reconciliation and settlement of final cost reports.

## Medicare Payment Increase for COVID-19 Patients

- **Description**: Payment increase for Medicare patients with a positive COVID-19 diagnosis
- **Eligible providers**: Urban and rural IPPS hospitals
- **Payment details:** During the emergency period, the legislation provides a 20% add-on to the DRG rate for patients with COVID-19. CMS guidance states that discharges of an individual diagnosed with COVID-19 will be identified by the presence of the following International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes:
    - B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020
    - U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period
- Beginning on September 1, claims eligible for the 20 percent increase in the MS-DRG weighting factor will also be required to have a positive COVID-19 laboratory test documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with CDC guidelines. The test may be performed either during the hospital admission or prior to the hospital admission.
    - A viral test performed within 14 days of the hospital admission, including a test
    - performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.
- The add-on payment is effective for hospitals that submit an IPPS claim for discharges on or after January 27, 2020, or an LTCH claim for admissions on or after January 27, 2020. If CMS received the claim on April 20 or earlier, the claim will be reprocessed without additional action by the hospital. Claims received on or after April 21 will be processed in accordance with the CARES Act.
- **Application:** None

## State Hospital Association Grants to Hospitals

- **Description**: The Assistant Secretary for Preparedness Response is authorized to distribute grants to state hospital associations as a mechanism to distribute federal funds to hospitals quickly. In April, CHA was allocated $4.1 million to distribute to hospitals across the state. In July, CHA was approved for a second round of grant funding of $10.1 million that will be distributed to CHA member hospitals.
- **Eligible providers**: Hospitals and health care providers in each state
- **Eligible expenses**: Health care-related expenses or lost revenues not otherwise reimbursed and directly attributable to COVID-19. CHA has designed its grant program to cover the costs of personal protective equipment (PPE).
- **Application:** Hospitals do not need to apply for this grant. The first allocations, distributed in May, were sent to hospitals based on their number of licensed beds. The second distribution of $10.1 million was be distributed to CHA members on a per-bed basis, with additional funds provided to member hospitals most significantly impacted by COVID-19 positive patients. Funds should be distributed to member hospitals in mid-August.
- **Compliance:** In addition to returning electronic compliance documents, hospitals must submit documentation of PPE purchased in expenditure of the funds.

## Small Business Loans (for hospitals with fewer than 500 employees)

- **Description**: The Economic Aid Act (as incorporated into the Consolidated Appropriations Act of 2021) reauthorizes lending under the Paycheck Protection Program through March 31, 2021.
    - **Initial Draw**: Loan opportunities up to $10 million are available through the Small Business Administration's (SBA) Paycheck Protection Program. Loans may be awarded for up to the lesser of $10 million or 250% of average monthly payroll costs (excluding any compensation above an annual salary of $100,000).
    - **Second Draw**: Certain borrowers are eligible (see criteria below) for an additional, second draw loan. Second draw loans may not exceed the lesser of the product of the recipient's average monthly payroll costs for 2019 or for the one-year period before the PPP loan is made, multiplied by 2.5 and $2,000,000. Second draw PPP loans are generally subject to the same terms, conditions, and requirements as First Draw PPP loans.
    - Loans from either draw may be used to pay salaries, leave and health benefits, rent, utilities, interest on mortgages, interest on existing debt, covered operations expenditures, covered property damage costs, covered supplier costs, and covered worker protection expenditures (including the costs of certain PPE).
    - On January 6, 2021, the Department of the Treasury released an interim final rule incorporating changes from the Consolidated Appropriations Act (CAA) into previously released guidance and provides key details to loan terms. The table below summarizes key loan terms.

| Loan Term | Description |
|---|---|
| Interest Rate | 1%, non-compounding |
| Maturity Date: Before 6/5/20 | 2 years |
| Maturity Date: On/After 6/5/20 | 5 years |
| Payroll Cost Requirement | Borrowers must use at least 60% of the PPP loan for payroll costs to receive full forgiveness. |
| Payment Deferral | Payments are deferred 10 months after the end of the covered period for the borrower's loan forgiveness. |

- An December 9, 2020, FAQ document from Treasury is available here.
- Information on how to calculate maximum loan amounts is available here.
- The Consolidated Appropriations Act clarified that that most expenses funded by forgiven PPP loans are deductible for federal tax purposes.

- **Eligibility**:
  - **Initial Draw**: Small businesses and 501(c)(3) non-profit organizations, including hospitals, health systems, and health care providers with fewer than 500 employees (full time and part time). The Consolidated Appropriations Act (CAA) allows entities that have not yet received a PPP loan to apply for the original program, as modified by the CAA when it was passed in December.
  - **Second Draw**: Eligibility criteria for second draw loans are narrower than for initial PPP loans. Small businesses and 501(c)(3) non-profit organizations, including hospitals, health systems, and health care providers must meet the following criteria:
    - **Prior PPP Loan**: Received a PPP Loan and on or before the expected date on which the second draw loan is disbursed, has used, or will use such PPP loan
    - **Number of Employees:** Employs 300 or fewer employees
    - **Losses:** Suffered a reduction of at least 25% or more in gross receipts for a quarter in 2020 compared to the same quarter in 2019.
  - The Consolidated Appropriations Act generally prohibits new PPP loans for publicly traded companies, even if they were otherwise eligible.
  - Treasury has released guidance clarifying that public hospitals exempt from taxation under section 115 of the Internal Revenue Code who are otherwise eligible – however, do not have IRS determination letters recognizing them as described in section 501(c)(3) and exempt from tax under section 501(a) – will qualify as a 501(c)(3) for purposes of PPP if the hospital reasonably determines (in a written record maintained by the hospital) that it functions as an organization described in section 501(c)(3). An American Hospital Association special bulletin on the May 3 guidance is available here.

- On April 24, SBA issued an interim final rule clarifying certain provisions, including that public hospitals otherwise eligible that receive less than 50% of their funding from state or local government sources, exclusive of Medicaid, are eligible.
- Affiliation rules apply and are intended to determine, using the "totality of circumstances," whether an organization is operating as part of a larger organization and, therefore, not considered a small business. The January 2021 interim final rule provides guidance on affiliation rules.

- **Application information**:
  - Eligible applicants may apply to an SBA-approved lender.
  - Loans are available through March 31, 2021, or until funds are exhausted. The CAA included an additional $284 billion in funding after previous allocations were exhausted.
  - Applicants must submit SBA Form 2483. A list of participating lenders and additional information are available here (updated June 25).

## Federal Communications Commission (FCC) Telehealth Program

**Description:** The program was established by the CARES Act with a $200 million appropriation to help nonprofit and public health care providers deliver telehealth and connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic.

**Program Status:**
*Round 1*: During the initial round of funding, which closed in June 2020, the program provided $200 million in immediate support to eligible health care providers responding to the COVID-19 pandemic by committing to fully funding the telecommunications services, information services, and connected devices necessary to provide critical connected care services. A full list of Round 1 grant recipients is available on the FCC website.

*Round 2*: The Consolidated Appropriations Act appropriates an additional $249.95 million for a second round of funding for eligible providers.

**Round 2 Application:**
The FCC will begin accepting applications for Round 2 of the COVID-19 Telehealth Program on April 29, 2021. The application portal will be open for seven calendar days, closing on May 6, 2021. Eligible hospitals and other providers may apply here.

Funding per applicant is capped at $1 million. The FCC's grant review process will attempt to ensure that at least two applications with a lead health care provider from each state or territory receive funding. Round 1 applicants that did not receive funding will be required to submit an application to receive funding in Round 2. However, they will receive an increase in points that are not available to new applicants. Additionally, Round 1 applicants that received

less than $1 million may submit an application during the second round and receive funds up to the cap.

Round 2 application evaluation metrics will prioritize funding to: (1) eligible health care providers that will benefit most from telehealth funding; (2) as many eligible health care providers as possible; (3) Tribal, rural, and low-income communities; and (4) areas most impacted by the COVID-19 pandemic. The table below outlines the application metrics and their weighting.

**Round 2 Evaluation Metrics**

| Factor | Required Information | Available Points |
|---|---|---|
| **Hardest Hit Area** | Provide health care provider county | Up to 15 |
| **Low-Income Area** | Provide health care provider physical address and county | 15 |
| **Round 1 Unfunded Applicant** | Provide unique application number from Round 1 | 15 |
| **Tribal Community** | Provide physical address or supporting documentation to verify Indian Health Service or Tribal Affiliation | 15 |
| **Critical Access Hospital** | Proof of CAH certification | 10 |
| **FQHC/FQHC Look-Alike/DSH** | Proof of FQHC certification, or demonstrate qualification as a FQHC Look-Alike, or demonstrate qualification as a disproportionate share hospital | 10 |
| **Health care Provider Shortage Area** | Provide Healthcare Provider Shortage Area ID number or health care provider county | Up to 10 |
| **Round 2 New Applicant** | Certify, under penalty of perjury, that the applicant has not previously applied for program funding | 5 |
| **Rural County** | Must provide health care provider county | 5 |

Funding for Round 2 of the program will be awarded in two phases. The initial phase will award at least $150 million to the highest-scoring applicants. Once the initial group of awardees is identified, applications outside that group will be given a 10-day period to supplement their application. After that 10-day period, the remaining applications will be re-ranked and awarded the available funding.

The COVID-19 Telehealth Program will not directly pay a health care provider's service providers or vendors. Funding recipients must first pay the vendor or service provider for the costs of the eligible services and/or connected devices received before requesting reimbursement for those costs from the COVID-19 Telehealth Program. The FCC emphasizes that only items eligible under the CARES Act will be reimbursed. To that end, the FCC's OIG was

allocated funds to conduct compliance audits. Additional guidance on audit procedures will be made available at a later date.

Additional details about the application process are available here.

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Sources:
https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf
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