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Safety Net Hospitals in the Covid-19 Crisis: How Five Hospitals Have Fared Financially

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America's hospitals have been on the front lines of the COVID-19 pandemic, which has caused financial havoc in the industry. Safety net hospitals disproportionately care for those with low incomes and communities of color, the very groups hardest hit by the pandemic. Those hospitals typically treat a larger share of Medicaid and uninsured patients than other hospitals and thus often operate on thinner financial margins, making them especially vulnerable to the financial and other stresses caused by the pandemic.

In this brief, we describe how the pandemic has financially affected five safety net hospitals as of the summer of 2020, including the costs of preparing for and operating during the pandemic, the pandemic's impact on their revenues, the federal financial relief they have received, and implications for policy and practice. The five hospitals in our study are:

- Erie County Medical Center (ECMC) in Buffalo, New York;
- Henry Ford Hospital in Detroit, Michigan;
- Parkland Hospital in Dallas, Texas;
- Truman Medical Center in Kansas City, Missouri; and
- Vidant Medical Center in Greenville, North Carolina.

Data and Methods

We selected our study hospitals based on several factors, including diversity in facility size, ownership, system affiliations, and geography. We also considered whether the hospital was in a state that had adopted Medicaid expansion under the Affordable Care Act and sought input from industry observers.

Using a semistructured protocol, we conducted 75-minute interviews over Zoom with hospital leaders, including chief executive, financial, operating, and marketing officers. We conducted interviews between June and September 2020. Because the interviews took place over three months and the pandemic hit parts of the country at different times with varied intensity, hospitals were in different phases of responding to the pandemic (e.g., rebounding from a surge, in the middle of a peak, or gearing up for another wave). Hospital leaders provided data on study facilities during interviews or in follow-up emails afterward. We also relied on publicly available resources for hospital-specific information (e.g., the Centers for Disease Control and Prevention's Provider Relief Fund COVID-19 High-Impact Payments dataset and Good Jobs First's COVID Stimulus Watch database).

Study Results

Hospitals and Characteristics

Table 1 summarizes the five study hospitals' characteristics. The hospitals share common features: They are all Level I Trauma Centers and academic medical centers. Most are large facilities with more than 500 beds and located in urban areas. The hospitals also have similar payer mixes. Because they are safety net hospitals, Medicaid and uncompensated care for underinsured and uninsured patients account for at least 20 percent of each study hospital's payer mix.

In other ways, though, the hospitals vary. Three are private nonprofits (Henry Ford Hospital, Truman Medical Center, and Vidant Medical Center), whereas ECMC is a public benefit corporation and Parkland Hospital is a county-owned public facility. The facilities also vary in the size of the systems with which they are affiliated. Vidant Medical Center and Henry Ford Hospital are part of major health care systems that include several hospitals, multiple community clinics, and large physician groups. By contrast, ECMC and Parkland Hospital are the only hospitals in their systems, though both systems have community-based clinics and other associated facilities.

Table 1. Selected Characteristics of Five Study Hospitals, 2019–20

Study hospital	Type of ownership	Location	Number of beds	System facilities and services	2019 payer mix	Total COVID-19 patients
Erie County Medical Center (ECMC)	Public benefit corporation	Buffalo, NY	573	Part of the ECMC Corporation, which includes 1 hospital, 1 behavioral health center, 5 specialty care centers, and 1 long-term care facility	• Medicaid: 34.3% • Medicare: 17.7% • Commercial: 18.2% • Self-pay/uncompensated care: 12.8% • Other: 6.9%	71 as of April 10 206 as of June 10 253 as of August 31
Henry Ford Hospital	Private, nonprofit	Detroit, MI	877	Flagship hospital for the Henry Ford Health System, which includes 5 acute care hospitals (2,468 beds), 2 psychiatric hospitals, 1 specialty hospital, a medical group with about 1,900 employed physicians, and a health insurance plan	• Medicaid: 20.0% • Medicare: 46.0% • Commercial: 32.0% • Self-pay/uncompensated care:1.5% • Other: 0.5%	951 as of April 10 1,473 as of June 10 1,763 as of August 31
Parkland Hospital	Public	Dallas, TX	882	Hospital for the Parkland Health and Hospital System, which includes 1 hospital, 12 primary care clinics, 12 school-based clinics, 1 behavioral health center, 6 specialty care centers, 37 skilled nursing homes, and a managed-care plan	• Medicaid: 31.2% • Medicare: 17.6% • Commercial: 8.0% • Self-pay/uncompensated care: 39.0% • Other: 4.2%	251 as of April 10 1,727 as of June 10 6,944 as of August 31
Truman Medical Center	Private, nonprofit	Kansas City, MO	249	Part of the Truman Medical Centers, which includes 2 hospitals (359 beds), 1 behavioral health center, and 1 long-term care facility	• Medicaid: 34.1% • Medicare: 24.6% • Commercial: 18.7% • Self-pay/uncompensated care: 21.0% • Other: 1.6%	21 as of April 10 84 as of June 10 370 as of August 31
Vidant Medical Center	Private, nonprofit	Greenville, NC	974	Flagship hospital for Vidant Health, which includes 9 hospitals (1,708 beds), a medical group practice with about 550 physicians, and 9 specialty care centers	• Medicaid: 18.5% • Medicare: 48.7% • Commercial: 22.3% • Self-pay/uncompensated care: 7.1% • Other: 3.4%	32 as of April 10 222 as of June 10 699 as of August 31

Sources: About. Erie County Medical Center website. https://www.ecmc.edu/about-ecmc/; 2019 fact sheet. Henry Ford Health System website. https://www.henryford.com/newsroom/facts; About us. Parkland Hospital and Health System website. https://www.parklandhospital.com/about-us; Who we are. Truman Medical Center website. https://www.trumed.org/about-us/who-we-are/; About Vidant Health. Vidant Health website. https://www.vidanthealth.com/About-Vidant-Health.

Notes: Payer mix and COVID-19 patient counts, which may include inpatient, outpatient, and observation COVID-19 patients, were provided by study hospitals following our interviews. Other characteristics were retrieved from hospital websites or public records.

Hospitals' Preparation for and Early Operational Experiences with the Pandemic

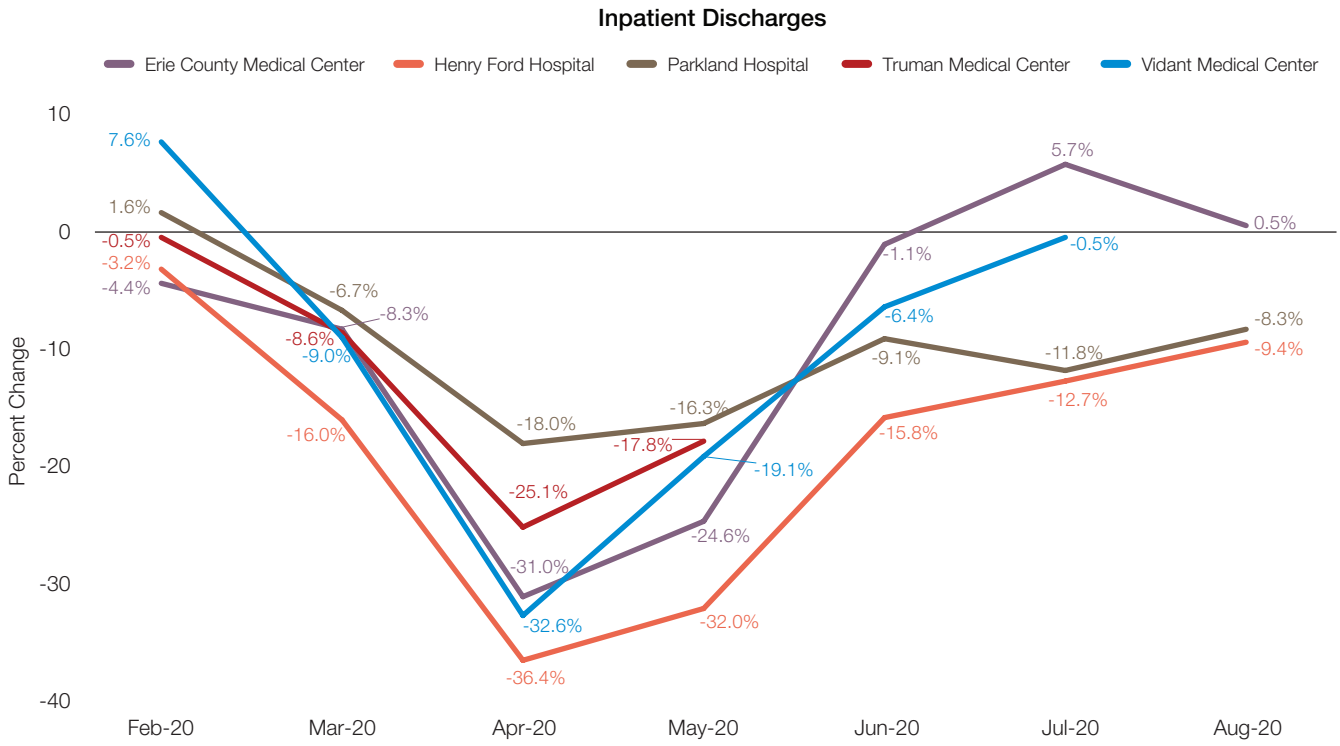
Like hospitals nationally,[1,2,3] the need to prepare for COVID-19 hit study hospitals hard and suddenly, posing dramatic financial and operational challenges as they worked to maintain their mission of serving disadvantaged populations, particularly those affected by the pandemic. However, hospital leaders believed these safety net hospitals' shared mission and each hospital's experience operating both in a crisis environment, as Level I Trauma Centers, and with tight margins helped them respond quickly and handle a surge of severely ill patients.

Though the study hospitals began preparing for the pandemic (e.g., establishing incident command centers, modifying visitor policies) and treated their first COVID-19 patient by mid-March, the timing of COVID-19 outbreaks in their communities varied. Henry Ford Hospital in Detroit, which was an early COVID-19 hot spot, very quickly had 90 percent of its hospital filled with COVID-19 patients. Conversely, Parkland Hospital was ready for a surge in March but the pandemic hit Dallas in mid-May. And as a health system with multiple hospitals, outbreaks struck communities served by Vidant Health at different times.

Regardless of the timing of the outbreak in its community, each study hospital emptied its beds and cancelled most clinic visits and elective surgeries in March, significantly reducing patient volumes and associated revenue. Simultaneously, they incurred significant additional costs from obtaining supplies and reconfiguring physical spaces and operations, staffing, and their service delivery. Though these additional costs varied across study hospitals, representatives from four hospitals reported such costs being in the tens of millions of dollars when they were interviewed. Executives said they were closely tracking expenses related to COVID-19, because they hope to be partially reimbursed with Federal Emergency Management Agency funds.[4]

Service cancellations and reduced patient volume. To make room for a surge of COVID-19 patients and preserve their volume of personal protective equipment (PPE), hospitals stopped all elective surgeries and outpatient visits. Four of the five systems operate in states that required facilities to halt elective procedures by mid- to late-March.[5] However, some hospital executives described having already stopped these procedures and services before state order or federal guidance.[6] Consequently, patient volumes, as measured by inpatient discharges, had dramatically fallen by April 2020 for all five hospitals (Figure 1).

Figure 1. Percent Change in Inpatient Discharges Compared with the Same Month in 2019, 2020

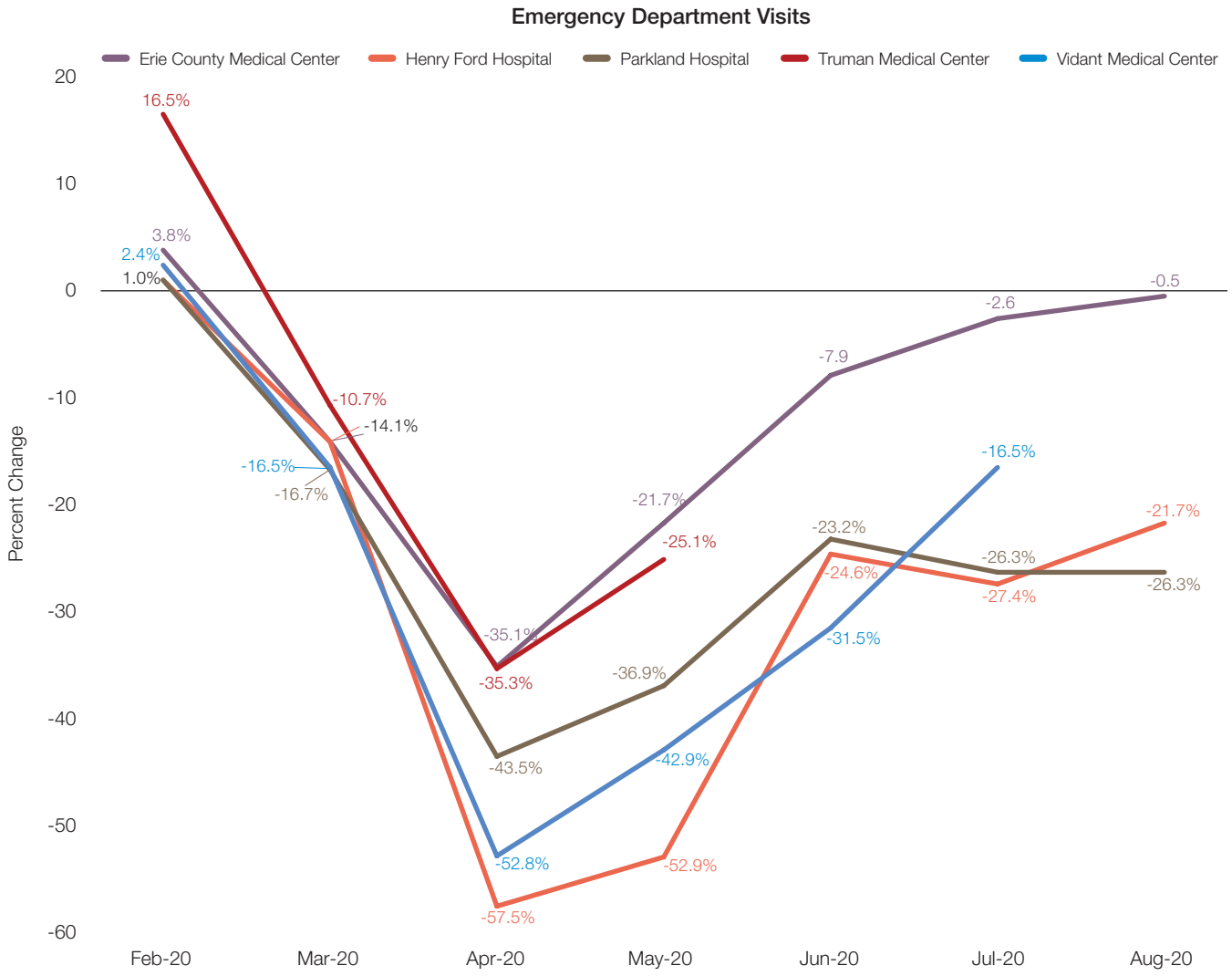


Source: Inpatient visits were reported by each study hospital following our interviews conducted between June and September 2020.

Because Detroit was one of the nation's first COVID-19 epicenters, the volume decrease was especially dramatic for Henry Ford Hospital, where inpatient discharges dropped nearly 40 percent in April 2020 relative to April 2019. Statistics for May were comparable. ECMC and Vidant Medical Center also experienced comparable reductions in inpatient discharges. Though not as steep, declines in patient discharges also occurred at Parkland Hospital and Truman Medical Center in both April and May. Signs of a rebound began in June, as state and local governments in three of the study states started easing some restrictions.[7] Even so, inpatient discharges were generally lower in August 2020 than in August 2019. "People are starting to come back now [in August]. It's not as robust as it was before," as one executive said. Moreover, for hospitals that had been expanding their operations, the pandemic's impact on volume is even greater when just compared with the previous year.

Unexpectedly, according to executives, hospitals also experienced sharp decreases in emergency room visits beginning in March 2020 (Figure 2), as did emergency rooms across the country.[8] One executive observed that people with serious medical needs (e.g., heart attacks) were "so scared of getting [COVID-19]" they stayed away from getting needed emergency care. In April and May, some study hospitals experienced more than a 40 percent decline in emergency room visits compared with the previous year. Though such visits have started to bounce back, they were still lower in August than

Figure 2. Percent Change in Emergency Department Visits Compared with the Same Month in 2019, 2020



Source: Emergency department visits were reported by each study hospital following our interviews conducted between June and September 2020.

they had been in August 2019. A couple executives mentioned hearing anecdotes from clinicians that the acuity of patients coming to the emergency room is much higher than before the pandemic. As one executive said, "So even though the volume is down, the people coming in are sicker." It could also be that unnecessary emergency room visits are down, and only the most acute individuals are going to the emergency room.

Additional cost of supplies. Securing adequate PPE, which is necessary for protecting patients and staff, was a major challenge and expense for all five hospitals. Leaders at each hospital detailed constraints of finding PPE supplies early in their responses to the pandemic. Three hospitals attributed the lack of PPE to a complete breakdown of the supply chain, where PPE was in such high demand that hospitals could not locate vendors. One hospital reported having paid surcharges upwards of 20 percent to secure PPE. Executives from another hospital also described paying significant add-ons for surgical masks: "[We are] paying 10 times what we [had been] paying. It was 65 cents apiece before, and now we're paying $6.50."

In addition to paying a surcharge for general medical supplies, hospital leaders also reported needing to acquire new equipment and materials to treat COVID-19 patients, including beds, lab equipment, and cleaning supplies. All five hospitals also established in-house testing facilities, equipped with the newly procured materials and capacity to test in the community. Hospital leaders said they primarily expanded testing capacity to conserve scarce PPE, because all suspected COVID-19 cases had to be isolated and required the dedicated staff treating them to be fully covered by PPE. Also motivating their decision to bring testing in-house, multiple hospital leaders mentioned needing more rapid results than the standard four to five days it could take if they used an outside lab for testing. Providing more rapid results helped hospitals limit unnecessary use of resources on patients who do not have COVID-19. Hospitals also developed testing capacity for their broader communities, such as drive-up and mobile testing sites, to better understand how the outbreak was progressing and to help prevent spread. In some cases, study hospitals became major testing sites for their regions; Parkland Hospital executives estimated that the system performed roughly 50 percent of testing in Dallas.

Reconfiguring floor plans and operations. In anticipation of a surge and, in one case, as required by state mandate,[9] all five hospitals increased bed capacity and reconfigured existing floor plans to treat COVID-19 patients. By establishing COVID-19 wards or designated areas, hospitals segmented their spaces to ensure patients with confirmed or suspected COVID-19 were isolated from unexposed staff and patients and conserved PPE by having dedicated staff working in those areas.

Staffing adjustments. As numerous services were temporarily suspended, several study hospitals retrained staff to help with essential services or assist with screening and testing. Coupled with the need to redeploy staff, hospitals simultaneously faced challenges ensuring an adequate supply of critical care nurses, respiratory therapists, and housekeeping and dietary staff. To handle some of these staffing issues, hospitals brought in outside nurses for short-term placement and offered overtime and hazard pay, among other strategies. One hospital executive estimated that, during six weeks this past spring, their hospital system incurred $13 million in additional staffing expenses.

To reduce expenses as service use plummeted, three of the hospitals temporarily furloughed staff who could not be redeployed to other parts of the system. In addition, two hospitals permanently laid off a small number of staff members. Other cost-cutting strategies included reducing staff pay and lowering hospital contributions to employee retirement plans. Leaders from two hospitals commented that, because of the length of the pandemic, they were forced to provide hazard pay and issue layoffs and furloughs simultaneously. At the time of our interviews, most of the staff's pay had been restored and most temporarily furloughed employees had returned to work, according to the hospitals' leaders.

The number of employees who had to quarantine because they or a family member had been exposed to the virus or contracted COVID-19 also exacerbated staffing challenges. One hospital reported that more than 2,000 of their own employees tested positive for COVID-19 at one point. In addition, hospital executives noted the need to address the emotional toll and burnout among hospital employees. These experiences can range from the anxiety of working with limited PPE and putting oneself and one's family at risk to the grief of continually caring for patients isolated from their families through severe illness and death. Executives from one hospital reported seeing increased staff retirement and turnover after the initial COVID-19 surge. Several of the hospitals have created special teams to support the emotional needs of employees. One hospital leader described this as ongoing work, saying, "These intangibles [costs] hang around forever because you have to spend time to make sure people feel safe and secure."

Changes to care delivery. In addition to preparing their facilities and staff for the pandemic, hospital leaders also reported investing resources to better meet medical and other needs of their patients and communities. Safety net hospital executives described the importance of working outside their walls on prevention, early detection, and social determinants of health to help control the spread of the virus in their areas and ensure hospitals have adequate staffing and PPE to address

community needs. These investments included community education and outreach, particularly for populations most at risk, such as communities of color and nursing home residents, and developing virtual models of care, including using telehealth and conducting multidisciplinary patient visits using a virtual team.

The study hospitals also built capacities to conduct education and community outreach to promote testing and other measures to prevent virus spread. This included efforts focused on communities particularly hard hit by the pandemic, such as partnering with churches to promote testing among African American and Latino communities. In one case, ECMC repurposed some of the money it received through its state Medicaid waiver to support a group of churches working with African American communities not only with COVID-19 tests but other health and community services. Hospitals also contacted area nursing homes to promote adequate testing, use of PPE, and cleaning.

Hospital leaders also all reported increasingly providing virtual care, such as through telehealth and email consultations. The Henry Ford Health System increased telehealth visits from 300 visits per week before the pandemic to nearly 10,000 per week in May 2020. Other hospital leaders also reported substantial increases in the use of telehealth. Interviewees did not describe significant technical challenges with increasing virtual care, citing the helpfulness of the Centers for Medicare & Medicaid Services' waiver allowing use of nonsecure portals.[10] Hospital executives did, however, have concerns about telehealth's financial sustainability, given that reimbursement is being addressed differently across payers. In addition to using telehealth for regular clinical care, one hospital implemented multidisciplinary rounding for COVID-19 inpatients, having the critical care doctor accompanied by a robot that displays the rest of the care team on a screen. This approach allowed the hospital to incorporate input from multiple providers (e.g., specialists, pharmacists, and social workers), providing more comprehensive and coordinated care while limiting staff exposure and the use of scarce PPE.

The Pandemic's Financial Impacts

Incurring additional expenses to prepare for the pandemic and performing only the most essential services to make space for COVID-19 patients had swift and considerable financial impacts on the study hospitals. Eliminating elective procedures hit especially hard, because these services are some of a hospital's most profitable revenue sources. They are also especially important for safety net hospitals; as one leader said, "[Safety net hospitals] don't produce a significant amount of margin on a regular basis. So those procedures that do produce margin, that are high paying, really impact the organization." Another executive said, "No doubt the largest [financial] impact is the lost revenue from postponing elective surgeries." For two hospitals, stopping elective procedures was particularly tough given that they were already operating with a negative margin in February 2020, just before state and local government guidance terminating these services took effect.[11]

Hospital revenue. The pandemic's impact on each study hospital's revenue was substantial (Figure 3). Mirroring the decline in service volume, revenues dropped for all hospitals in March 2020. For each hospital, the steepest decrease occurred in April; compared with revenue in April 2019, the declines ranged from 35 percent at Parkland Hospital to 48 percent at Henry Ford Hospital. Though revenues were down by more than a third, Parkland Hospital executives explained that the system's revenue decline "is probably less than systems that have more commercial insurance, because so many of [their] patients are unfunded [receive uncompensated care]" and added that the system has "a smaller amount to lose."

The impact of revenue loss quickly produced cash flow concerns for several of the hospitals. According to hospital executives, Truman Medical Center dropped down to five days' worth of cash on hand at one point. Not knowing when or if federal relief funds would be made available, hospitals relied on loan-based strategies to bolster their revenues. Two of the hospital systems got credit lines ranging from $50 million to $500 million. Three hospitals took advantage of the Centers for Medicare & Medicaid Services' expansion of the accelerated and advanced Medicare payment program.[12] Payments made under this program are loans providers pay back. Along similar lines, one hospital also partnered with several of their private payers and negotiated advance payments in which payers "kept [the hospital] at a sustainability payment," meaning that whatever the hospital's payments were per week before the pandemic, the payer was "going to pay [them] through the period." In addition, ECMC leaders said their cashflow benefitted from an effort in New York requiring payers to suspend all retroactive reviews and denials.[13]

Federal Provider Financial Relief

Some of the pandemic's financial effects on hospitals have been mitigated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act that, combined, provide $175 billion in emergency funding for hospitals and other health care providers.[14] Importantly, funding received through the CARES Act constitute grants providers do not have to repay. Providers, however, must certify that the CARES Act funding is used for health care–related expenses or lost revenues attributable to the pandemic. They also have to return funds exceeding their pandemic-related financial losses.

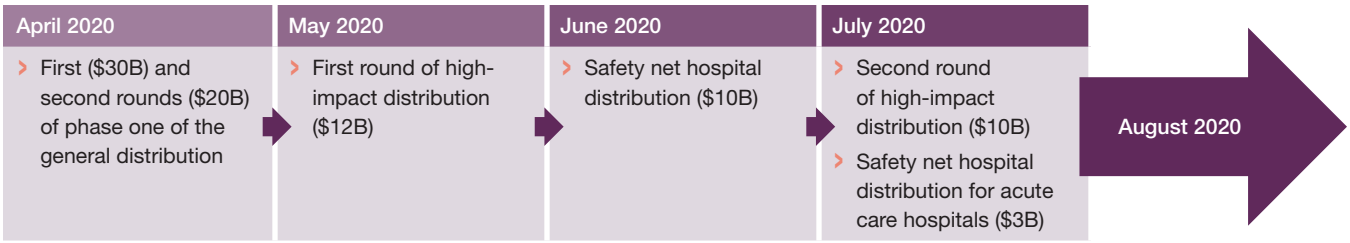
Figure 3. Percent Change in Revenue Compared with the Same Month in 2019, 2020

Source: Monthly revenue was reported by each study hospital following our interviews conducted between June and September 2020.

CARES funding received by study hospitals. As of September 1, 2020, each study hospital received money from the $50 billion in CARES Act funding paid in two waves through the general distribution allocation in April 2020 (Table 2).[15] Each also got funding from the distribution targeted at safety net hospitals, which was paid in three waves between June and August (Figure 4). Nationally, safety net hospitals received nearly $15 billion. In addition, all study facilities except Truman Medical Center received CARES Act funds targeted at hospitals in COVID-19 hot spots. Between the two rounds of hot spot funding, $22 billion in COVID-19 high-impact funds have been distributed. The first round, released May 2020, paid $75,000 per COVID-19 patient; the second round, released July 2020, repriced such cases at $50,000. Given that Detroit was an early COVID-19 hot spot, Henry Ford Hospital received high-impact funds in both rounds; ECMC, Parkland Hospital, and Vidant Medical Center received such funds in the second round.[16]

Universally, hospital executives expressed deep appreciation for the money they received through the CARES Act Provider Relief Fund. As one executive said when the first round of the general distribution funds was released April 10, "I knew we were going to see the other side and [knew] that we would come out ok." Several leaders were also grateful for how quickly the Centers for Medicare & Medicaid Services distributed the money.

Figure 4. Timeline of Selected Provider Relief Funds Authorized Under the CARES Act, General Distribution and Targeted Allocations, April–August 2020



Source: CARES Act Provider Relief Fund: General information. U.S. Department of Health and Human Services website. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html. Updated October 28, 2020.

Table 2. Selected COVID-19 Financial Relief Received by Study Hospitals, April–August 2020

Millions of dollars

Study Hospital	General Distribution (Rounds One and Two)	Targeted Distributions	
		Allocations for safety net hospitals	Allocations for high-impact areas*
Erie County Medical Center	$11.5	$28.2	$10.3 (received second round)
Henry Ford Hospital	$57.8	$50.0	$79.7 (received first and second rounds)
Parkland Hospital	$22.8	$50.0	$26.7 (received second round)
Truman Medical Center	$12.4	$38.0	
Vidant Medical Center	$23.9	$2.0	$11.4 (received second round)

Source: Provider relief funds received as reported by each study hospital following our interviews conducted between June and September 2020.

Notes: Truman Medical Center did not receive high-impact funding.

* High-impact funds were verified using the CDC's high-impact tracker. See Provider Relief Fund COVID-19 high-impact payments. Centers for Disease Control and Prevention website. https://data.cdc.gov/Administrative/Provider-Relief-Fund-COVID-19-High-Impact-Payments/b58h-s9zx. Updated October 30, 2020. Accessed November 5, 2020.

The extent to which CARES Act funding has filled financial gaps. How much federal financial relief has offset revenue losses related to the pandemic varied across the study hospitals. One hospital fully expects to report a negative margin this year, with one executive saying, "We're going to have losses this year. And we're a mission organization, and you can only cut so far without affecting the mission and critical services." On the other hand, another hospital leader reported that "CARES money is basically covering [their] revenue losses" for this year. Still others worried about having to possibly return CARES Act funding because of future changes in allocation formulas and limitations on how systems can use the funding across their facilities.

Hospital leaders' differing perspectives on the distribution of CARES Act grants. Executives had strong views about how the U.S. Department of Health and Human Services (HHS) had so far distributed CARES Act funds, largely echoing the national controversy on the topic.[17] Consistent with earlier reports, several hospital leaders felt the formula used to allocate the first $50 billion through the general distribution disadvantaged their hospitals. Between the two general distribution waves, funds were released in proportion to a provider's share of 2018 net patient revenue. But, safety net hospitals generally have lower patient revenue than other hospitals: Many of their patients are enrolled in Medicaid or uninsured, and Medicaid programs tend to pay providers at lower reimbursement levels than private insurance or Medicare. And providers receive little to no reimbursement for treating uninsured patients. As one executive said, "We're mostly [a] low-charge and low-reimbursement hospital; the general disbursement aid didn't even cover one payroll period for us." Another leader said, "The first round just didn't feel good, doing it off whatever your income was." Leaders also pointed out that, by basing general distribution on net patient revenue, the aid did not "reach those [providers] that need it the most and have the highest [COVID-19] impact."

Since the general distribution, however, HHS has made more targeted allocations to help providers disproportionately affected by the pandemic. Particularly important to several of the study facilities was the safety net hospital targeted allocation. To receive this funding, however, hospitals had to meet certain criteria. The first wave required that a hospital meet a threshold percentage of Medicare disproportionate payments and uncompensated care and have a profit margin of 3 percent or less in its most recent Centers for Medicare & Medicaid Services Medicare cost report.[18]

All of the hospitals received funding from the first wave of safety net hospital aid except Parkland Hospital. The hospital received a backlog of several Medicaid supplemental payments in 2018 (when it last filed a Medicare cost report with the Centers for Medicare and Medicaid Services), which drove their margin to about 8 percent, though it had low or negative margins, according to one executive, in the four previous years. Parkland Hospital was not the only safety net hospital excluded from the first wave.[19] Later, HHS issued a second safety net hospital allocation, adding flexibility to the profit margin criterion.[20] Parkland Hospital qualified for $50 million in this second round.

Hospital leaders appreciated getting the safety net funds; one executive observed that HHS "actually recognized who [they] we were with…that [safety net] formula." At the same time, others were somewhat less sanguine; one executive said the general distribution was based "just on how much money [hospitals] generally get," and added, "when you get to the safety nets, there are these conditions…'We want to pay you, but not too much.'"

The COVID-19 high-impact fund similarly had specific qualifying criteria, which some executives felt disadvantaged their hospitals. In May 2020, HHS distributed $10 billion to hospitals that had provided inpatient care to at least 100 COVID-19 patients between January 1 and April 10, 2020. Of the study hospitals, only Henry Ford Hospital got funds from the first wave of this money. ECMC and Parkland Hospital came close to qualifying but did not reach the required patient threshold; Parkland Hospital had treated 99 COVID-19 inpatients by the deadline. Though HHS released a second round of $10 billion in high-impact funds in June, some executives were disheartened by what they viewed as an arbitrary patient threshold and deadline for qualifying for the funds.

Henry Ford Hospital executives felt that because Detroit was an early COVID-19 hot spot, their system experienced unique financial and emotional costs. Other hospitals had to shut down electives, but as one Henry Ford executive said,

> *"Early hot spot markets like ours had virtually no history in the treatment of [COVID-19] patients to rely on. As a result, the human and financial resource stress was deep and long-lasting. We led the way in innovation around care practices, PPE preservation, and family and patient communication strategies. These early discoveries took enormous resources and provided huge learnings for markets that got hit later and were able to adopt and utilize these tactics."*

Henry Ford executives worried, however, that if HHS releases more high-impact funds and again reprices the cost of a COVID-19 case, their system could have to return some of its funding. As one leader said, "it's kind of back to business as usual" for other hospitals, but "there is no usual for the hot spot communities." Henry Ford executives hoped policymakers will remember this as the debate about CARES Act funding continues.

Though for a different reason, Vidant Health executives worried that they, too, may have to return some CARES Act funding. As they explained, CARES Act funding is paid at the facility level rather than system level. This has posed problems for the Vidant Health system because it received funding through targeted allocations, where lost revenue due to COVID-19 must be declared at the facility level. Eight hospitals in Vidant's system received CARES Act funding from the rural hospital allocation, but, as one executive explained, "Our rural hospitals have gotten the majority of the [CARES Act] money. They don't have the majority of the lost revenue." But across the Vidant Health system, it has sustained enough lost revenue to keep the rural hospital allocation. "That gets frustrating when you're looking at it as a system level, but [HHS] looked [at facilities] as standalone," said one Vidant executive.

CARES Act increase in the federal Medicaid matching rate. In addition to offering financial relief to providers, the CARES Act also provides a temporary 6.2 percentage-point increase to states' Federal Medical Assistance Percentage for Medicaid to help states weather the pandemic.[21] Parkland executives highlighted that the bump "helped them tremendously," saving the hospital about $30 million through December 2020. Parkland Hospital provides the state funding for several Medicaid payments (e.g., Medicaid disproportionate share payments), but with the increased federal matching rate, Parkland Hospital needs to fund a smaller share of such payments.

Implications for Policy and Practice

Our study provides a snapshot of the considerable investments safety net hospitals have made to prepare for and operate during the pandemic. It also depicts the dramatic financial impact the pandemic has had on these hospitals as of September 2020. The crisis has "shined a light on health disparities," as one executive put it, underscoring the importance of maintaining the financial health of safety net hospitals serving populations hardest hit by the pandemic.

The varying and unpredictable timing of COVID-19 outbreaks by locality, combined with the lack of information on whether, when, and how much financial relief was coming, made it particularly difficult for hospitals to plan. These unknowns imposed additional costs as executives had to make decisions and major operational adjustments quickly. Also adding to costs, these preparations were taking place in a health care system not designed to sustain a medical surge with such staying power as COVID-19. Moreover, many costs associated with the pandemic are hard to fully capture, such as hospitals' need to address their staff's significant emotional toll and burnout experienced from working on the pandemic's front lines. Given safety net hospitals were already operating with thin margins before the pandemic, these additional costs are even more difficult for them to absorb.

Undoubtedly, CARES Act funding helped mitigate the study hospitals' financial losses. However, like safety net hospitals nationally, they received much of their financial relief later than non–safety net hospitals because of how the funding was allocated early on. In addition, it is unclear whether more funding will be made available to safety net hospitals from the CARES Act Provider Relief Fund, or whether more money will be allocated if there is another COVID-19 wave. While acknowledging policymakers' delicate balancing act in allocating relief funds, study hospital leaders universally recommended future distributions focus on where need is greatest.

The pandemic's ripple effects on hospitals will be important to monitor, especially for safety net providers. The economic impact of the pandemic on local property values and state budgets will particularly affect safety net hospitals given that property taxes and Medicaid payments are critical revenue sources for them. In addition, with millions of Americans losing their employer-sponsored health insurance coverage because of the COVID-19 recession,[22] many will enroll in Medicaid or go without insurance. Beyond these challenges, the potential overturn of the Affordable Care Act by the Supreme Court could lead to coverage losses for millions of Americans.[23] These coverage shifts will put yet further financial strain on all hospitals, especially safety net hospitals.

To survive, safety net hospitals must balance needing to maintain both readiness for more COVID-19 surges and their regular lines of business. In addition, hospitals will have to reduce future expenses to stabilize their finances, which two study hospitals said they had already done.[24] This is a tall order for all hospitals but even more so for safety net hospitals, given that they care for disadvantaged populations and rely heavily on public funding, which may be more limited in the future. It will be important to both track how safety net hospitals meet these challenges and to ensure they receive needed financial relief and other support as they serve the communities most affected by the pandemic.

References

1 Hospitals prepare for influx of patients with coronavirus. American Hospital Association website. https://www.aha.org/aha-center-health-innovation-market-scan/2020-03-17-hospitals-prepare-influx-patients-coronavirus. Accessed November 5, 2020.

2 Updates and resources on novel coronavirus (COVID-19). American Hospital Association website. https://www.aha.org/2020-01-22-updates-and-resources-novel-coronavirus-2019-cov. Accessed November 5, 2020.

3 Centers for Disease Control and Prevention. *Comprehensive Hospital Preparedness Checklist for Coronavirus Disease 2019 (COVID-19)*. Atlanta: Centers for Disease Control and Prevention; 2020. https://www.cdc.gov/coronavirus/2019-ncov/downloads/HCW_Checklist_508.pdf. Accessed November 5, 2020.

4 If not covered under previous federal appropriations provided by HHS or the Centers for Disease Control and Prevention, hospitals can apply for emergency funding for activities related to the management, control, and reduction of the virus, as well as emergency medical care and medical sheltering. See Eligible emergency protective measures. Federal Emergency Management Agency website. https://www.fema.gov/fact-sheet/eligible-emergency-protective-measures. Published March 24, 2020. Accessed November 5, 2020.

5 Four of the five states in which the hospitals operate suspended elective surgeries: Michigan (executive order in effect March 21), New York (governor announcement in effect March 25), North Carolina (HHS guidance in effect March 23), and Texas (executive order in effect March 22). As of this writing Missouri has not halted these procedures. See COVID-19: Executive orders by state on dental, medical, and surgical procedures. American College of Surgeons website. https://www.facs.org/Covid-19/legislative-regulatory/executive-orders. Updated June 8, 2020. Accessed November 5, 2020.

6 On March 18, 2020, the Centers for Medicare & Medicaid Services recommended health care providers stop nonessential medical, surgical, and dental procedures using a tiered approach to preserve resources. See Centers for Medicare & Medicaid Services. *Non-Emergent, Elective Medical Services, and Treatment Recommendations*. Baltimore: Centers for Medicare & Medicaid Services; 2020. https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf. Accessed November 5, 2020.

7 Three of the four states where the hospitals operate had suspended elective surgeries and later resumed operations: Michigan (executive order rescinded May 28), New York (select counties permitted to resume elective surgeries beginning April 29 and largely restored statewide by the end of June), and North Carolina (HHS issued new guidance resuming elective surgeries on May 1). Texas amended its executive order on July 9, which, as of this writing, still imposes restrictions on elective surgeries in facilities in designated counties. As of this writing, Missouri had not halted these procedures. See State resumption of elective surgery orders, guidance, and resources. American College of Surgeons website. https://www.facs.org/Covid-19/legislative-regulatory/state-resumption. Published June 5, 2020. Accessed November 5, 2020.

8 Lange SJ, Ritchey MD, Goodman AB, et al. Potential indirect effects of the COVID-19 pandemic on use of emergency departments for acute life-threatening conditions – United States, January–May 2020. *Morbidity and Mortality Weekly Report* 2020;69:795–800. http://dx.doi.org/10.15585/mmwr.mm6925e2external icon. Published June 26, 2020. Accessed November 5, 2020.

9 On March 21, 2020, Governor Cuomo announced New York hospitals were required to increase bed capacity by at least 50 percent. See Office of New York Governor Andrew Cuomo. *Amid Ongoing COVID-19 Pandemic, Governor Cuomo Accepts Recommendation of Army Corps of Engineers for Four Temporary Hospital Sites in New York*. New York: Office of Governor Andrew Cuomo; 2020. https://www.governor.ny.gov/news/video-audio-photos-rush-transcript-amid-ongoing-Covid-19-pandemic-governor-cuomo-accepts. Accessed November 5, 2020.

10 On March 17, 2020, the Office for Civil Rights announced that Health Insurance Portability and Accountability Act provisions would be waived to accommodate providers' use of telehealth remote communications during the pandemic. See U.S. Department of Health and Human Services, Office for Civil Rights. *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*. Washington: U.S. Department of Health and Human Services; 2020. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html. Accessed November 5, 2020.

11 Based on information from study hospitals about their operating margins provided following our interviews conducted between June and September 2020.

12 Centers for Medicare & Medicaid Services. *Trump Administration Provides Financial Relief for Medicare Providers*. Baltimore: Centers for Medicare & Medicaid Services; 2020. https://www.cms.gov/newsroom/press-releases/trump-administration-provides-financial-relief-medicare-providers. Accessed November 5, 2020.

13 New York State Department of Financial Services. *Insurance Circular Letter Number 8: Coronavirus, Utilization Review Requirements, and Payments to Participating Hospitals*. New York: Department of Financial Services; 2020. https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_s01_cl2020_08. Accessed November 5, 2020.

14 Summary of the Paycheck Protection Program and Health Care Enhancement Act (COVID 3.5). American Medical Association website. https://www.ama-assn.org/delivering-care/public-health/summary-paycheck-protection-program-and-health-care-enhancement-act. Updated April 24, 2020. Accessed November 5, 2020.

15 The information in the table is as of September 1, 2020. Since that time, HHS has released more CARES Act funds to providers, including the study hospitals. Specifically, HHS most recently made additional funds available for eligible providers through rounds two ($18 billion) and three ($20 billion) of the general distribution. See U.S. Department of Health and Human Services. *CARES Act Provider Relief Fund: General Information*. Washington: U.S. Department of Health and Human Services; 2020. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html. Accessed November 5, 2020.

16 Though not shown in Table 2, the systems the study hospitals are affiliated with received other CARES Act funding. Parkland Health and Hospital System and Vidant Health system received CARES Act funding targeted to nursing facilities. Vidant Health also received CARES Act funding targeted toward rural providers; eight of Vidant's nine hospitals qualified for this funding. Our study hospital, Vidant Medical Center, did not receive any rural provider CARES funds, however.

17 Coughlin TA, Ramos C, Blavin F, Zuckerman S. (2020). *Federal COVID-19 Provider Relief Funds: Following the Money*. Urban Institute. https://www.urban.org/urban-wire/federal-Covid-19-provider-relief-funds-following-money.

18 Children's hospitals did not have to meet the Medicare disproportionate payment percentage criterion.

19 Werner E, Harris S, Goldstein A. Hospital relief money slow to reach places that need it most, lawmakers and industry groups say. *Washington Post*. April 16, 2020. https://www.washingtonpost.com/us-policy/2020/04/16/bailout-money-hospitals-slow-get-out-missing-some-places-that-need-it-most-lawmakers-industry-groups-say/. Accessed November 5, 2020.

20 Specifically, rather than the profit margin criterion being less than 3 percent for a hospital's most recent filing year, the amendment required that a hospital's profit margin be less than 3 percent, on average, over two or more consecutive years of the last five reporting years.

21 Centers for Medicare & Medicaid Services. *Families First Coronavirus Response Act – Increased FMAP FAQs*. Baltimore: Centers for Medicare & Medicaid Services; 2020. https://www.medicaid.gov/state-resource-center/downloads/Covid-19-section-6008-faqs.pdf. Accessed November 5, 2020.

22 Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 recession extended into the summer of 2020, more than 3 million adults lost employer-sponsored health insurance coverage and 2 million became uninsured. Urban Institute. 2020. https://www.urban.org/research/publication/Covid-19-recession-extended-summer-2020-more-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured. Published September 18, 2020. Accessed November 5, 2020.

23 Blumberg LJ, Simpson M, Buettgens M, Banthin J, Holahan J. The potential effects of a Supreme Court decision to overturn the Affordable Care Act: Updated estimates. Urban Institute. 2020. https://www.urban.org/research/publication/potential-effects-supreme-court-decision-overturn-affordable-care-act-updated-estimates. Published October 15, 2020. Accessed November 5, 2020.

24 Accordingly, Henry Ford Hospital reduced its planned capital spending by $150 million for 2020, and Truman Medical Center terminated discussions with local partners to finance a new building for the local university medical school.

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