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The US COVID-19 Provider Relief Fund - Adventures and Lessons Learned in Healthcare Financing during a Global Pandemic

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ABSTRACT

The 2020 Provider Relief Fund, established by the U.S. Department of Health and Human Services, provided critical financial support to healthcare providers during the COVID-19 pandemic. This fund helped to stabilize the U.S. health economy by offsetting lost revenue and increased costs incurred by healthcare organizations. By ensuring continued operational funding, the relief measures allowed providers to maintain essential services despite the pandemic's disruptions. This financial aid was vital in preventing further strain on the U.S. healthcare infrastructure during an unprecedented global crisis. This paper is an interview with Stephen T. Parente, the health policy architect of the initial $100 Billion COVID Provider Relief Fund.

Introduction

The 2020 Provider Relief Fund, established by the U.S. Department of Health and Human Services, provided critical financial support to healthcare providers during the COVID-19 pandemic[1]. This fund helped to stabilize the U.S. health economy by offsetting lost revenue and increased costs incurred by healthcare organizations. To date over $135 billion has been distributed[2]. This paper is an interview by Anna Grossbach with Stephen T. Parente, the health policy architect[3] of the initial $100 Billion COVID Provider Relief Fund.

AG: Tell us about how you were approached to undertake this effort while working part time in the White House on the Council of Economic Advisors early March 2020.

SP: As I was working part time at the White House and Full Time at the University, I got a random call right before a weekend in the evening from HHS folks I had worked with before. They asked, "hey, what are you doing this Sunday"? This was an odd request, because one asks themselves, would I really work on a Sunday? I was silent for a few moments but then they said "would you mind coming over for a few hours to talk about this new thing that we have? I don't know if you noticed we've gotten a hundred billion dollars to distribute for Covid relief for the provider community. It'd be great to have a health economist help us think through how we should distribute this money. So, I went over to HHS HQ on a Sunday, and what I thought would be a 3-hour meeting turned into a 3-month policy adventure.

Designing the Policy- Roadblocks and the Coincidence Breakthrough

AG: With this policy adventure, you had to disperse all this money very quickly to the provider community, which was shut down because of the covid pandemic. We know that hospitals really don't have a lot of margin, need to make payroll and are very important to local economies. What were the key things that you were thinking about initially in terms of the American and or international healthcare financing systems that helped you design this approach? Were there any learnings or revisions that you had to do after that initial approach?

SP: There was an incredible team at very high levels of HHS that sat down to identify key principles as we outlined out an initial approach. The main principles that we identified were "fair, fast, simple, and transparent." We also knew that we had a few key differences from other international healthcare financing and delivery systems as well as our own unique situation with the March 2020 shutdowns. There was a tremendous urgency because we recognized that most of American healthcare runs on payments from insurance companies as compared to global budgeting models used in the National Health Service (NHS) or other European countries. If no procedures were occurring, no one was getting paid. As you mentioned, hospitals run very lean with 8-9 days cash on hand. We also recognized that those hospitals were caring for COVID patients at the same time. We also knew that private insurers financed American healthcare delivery; even Medicare runs through private transaction brokers. We wanted to find a fair way and a mechanism to keep normal payments flowing because we wanted to minimize the 2-week shutdowns impact. Of course, we thought it would only be a 2-week shut down.

The first approach we pursued was via the Treasury and IRS who could use the 2019 tax earnings of those listed as medical providers. They weren't willing to share that with us.

When we went back to the drawing board, we recognized that another option was the National Medicare Program which was administered via command and control through the center of Medicare and Medicaid services. That meeting was probably the most disappointing conversation I've ever had in my public policy life. We were told that the soonest they could even design a plan to our specification was 6 weeks and that execution would occur in another month.

Coincidence ended up providing the final approach. Some of us had professional connections with a

private insurance company, United Health Group (UHG). Through conversations with them about these roadblocks, it became obvious OptumBank, a division of UHG could administer the money with corporate Tax IDs in about a week. CMS gave us some information but with bank and routing numbers, we were able to complete the disbursement basically overnight. In comparison, there was not a paycheck protection program at the time. It was established later via the Treasury Department. We executed the same thing for providers in partnership with an insurance company.

Comparative Financing and Outcomes, Policy

AG: We talked about comparative financing related to administering funds. How do you think lockdown pandemic financing impacted different countries' outcomes in terms of provider support, continuing to keep the systems running and other outcomes? Any policy commentary related to what you experienced?

SP: The biggest difference I understood was that staff were worked harder outside of the United States because there was less availability of 'surplus' labor. In the United States, especially in the nurse and nurse practitioner workforce, there was capacity to be surged because different nurses worked part time or less FTE appointments, especially because travel positions were paying such high wages for nurses. With our specific approach administered via OptumBank, we could send multiple rounds to harder hit areas like Seattle and New York and tailor funding to specific kinds of providers.

Policy wise, we in effect proved that the Federal Government could pay for everyone in the system. Of course, this isn't standard practice but it worked for a short-term crisis. We also were able to deliver this money in a very short period which doesn't happen in global budget administration. Hospitals were able to use the money at their discretion which is superior to typically very time-intensive bureaucratic battles one district authority at a time which occurs in the UK, France and Germany.

AG: How did this experience shape your perspective on the ongoing conversation in America to provide Universal Healthcare as a right and, increasingly, in European markets where there are essentially 2-tiered systems created by more people going to private insurance to skip queues for basic access?

SP: The main takeaways were related to our focus on private economy. We saw the impact of aligned incentives that got everyone on the same page and direction in an emergency. We saw everyone pull out stops to surge and create more capacity, data and medical supplies.

We had the money to allocate it through Congress much faster than most other European countries could. We also had the flexibility to allow managers to allocate funds as they saw appropriate. For example, kidney dialysis centers returned funds to us immediately because they never shut down and didn't need the money. In central budgets, I wonder if individual managers in universal budget models would have banked the money for the future because they weren't certain when other money might arrive.

Hindsight Insights and Looking to the Future

AG: What do you think this funding saved the United States and broader healthcare system from? Who do you think got the most benefit? Any unanticipated losers?

SP: As we discussed earlier, at the time, the biggest concern was hospitals. The flexibility that the funding provided allowed for the system to keep going although it had to survive on the revenue from loss-leading services (i.e. non-procedural services). For them, it enabled it to do is avoid the costs and issues that closing and reopening would have caused. There were stores and assembly lines that had to shut down and then be re-opened.

Hospitals couldn't do that because of care needs to continue in a pandemic and there are vast amounts of equipment that need to be kept at really high standards of operation. I would humbly say that we

were able to save American healthcare delivery with this funding because it's a system that cannot fail.

I will also double down on that our wealth and administration approach allowed us to surge stronger than other areas.

We do know that some hospitals (especially rural) were likely saved from shutting down. We received correspondence back through UHG from the payment team that conveyed how this money saved them from shutting down and allowed them to re-consider how they should operate as an institution.

Conclusion

AG: What are your key "Hindsight is 20/20" (no pun intended) insights?

SP: I put them into two buckets. The first bucket is about the provider program which happened before the paycheck protection program. The second is about how we respond to crisis. We still do not have standardized, accessible and centralized tracking systems to understand what is happening. Our Electronic Health Systems are not interoperable and are incredibly expensive. Although we gained access to clearinghouses to use claims for disease tracking, we weren't even allowed to talk about that publicly. This impeded our response, which could have been more informed, targeted and thoughtful. We also didn't get to engage in relationships with larger hospital systems who likely had a very high-level executive determining where funds went. Some sort of phone tree and then future audit process would be ideal in such a situation. The biggest concern is that we are not thinking ahead to the next crisis except for a few people in the CDC. Appointees at HHS could consider doing this work. We also have realized how our resources allowed us to surge our funds and equipment while others weren't able to do so. The International Monetary Fund or World Bank could consider having a plan to surge resources in international crises such as what we just experienced in the COVID pandemic. Finally, I think one of the biggest lessons learned from the pandemic is that shutting everything down is not the best way to go. We literally triggered our own global collapse and put our economy at risk for hyperinflation.

Conflict of Interest:

None.

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References:

1. HHS Provider Relief Fund. https://taggs.hhs.gov/Coronavirus/Providers Accessed September 10, 2024.

2. Government Accounting Office. COVID-19 Provider Relief Fund: HRSA Continues to Recover Remaining Payments Due from Providers. https://www.gao.gov/products/gao-23-106083 Accessed September 10, 2024.

3. Trump team's use of big insurer to dispense recovery funds comes under scrutiny. Politico. April 18, 2020. https://www.politico.com/news/2020/04/18/unitedhealth-trump-coronavirus-recovery-funds-193716. Accessed September 10, 2024.

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