



Charles N. Kahn III
President and CEO

March 30, 2020

The Honorable Alex Azar
Secretary
The U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH commends you for your recognition of the urgency of the novel coronavirus (COVID-19) pandemic and your expeditious efforts thus far to work with hospitals and find ways to address the impact of the current public health emergency on our nation's hospitals. On Friday, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), Pub. L. No. 116-136, into law. Among other things, the CARES Act appropriates \$100 billion dollars to the Public Health and Social Services Emergency Fund (PHSSEF) for hospitals and other providers to address "health care related expenses or lost revenues that are attributable to coronavirus." These funds provide a critical means for addressing the significant financial impact of COVID-19 on hospitals, and we strongly urge you to move quickly to make prospective PHSSEF payments using a streamlined process that minimizes operational burdens and uncertainty for hospitals and health systems.

Principles for Distributing PHSSEF Funding to Support Hospitals and Health Systems

The FAH believes that the PHSSEF payment process should be guided by principles that aim to balance the necessity and inherent value of a rapid response with the importance of an equitable, proportionate, and controlled process. These are as follows:

- ***Substantial Majority Allocated to Hospitals.*** Although COVID-19 is inflicting widespread financial losses among health care providers, America’s hospitals are undeniably on the front-lines of this pandemic and experiencing substantial, two-sided financial harm. The financial harm to hospitals results from substantial revenue losses (as high as 60 percent) as non-emergent clinical activity declines or virtually disappears at the same time that hospital expenditures for pandemic preparedness and response activities and direct patient care skyrocket. As a result, many hospitals will struggle to financially weather the pandemic. At the same time, maintaining hospital capacity through the course of the pandemic is of critical importance. Therefore, PHSSEF funds should be allocated in a manner that appropriately prioritizes the financial health of our front-line hospitals.
- ***Recovery of Lost Revenue in Addition to Expenses.*** As explained further below, the COVID-19 pandemic is causing significant financial strain as hospitals lose revenue from non-emergent clinical services that may typically account for 30 to 60 percent of a hospital’s revenue base at the same time that they incur significant, unexpected capital and labor expenses associated with COVID-19 preparedness and care. The CARES Act explicitly and appropriately provides for reimbursing providers for “lost revenue” attributed to COVID-19 in addition to expenses attributed to the pandemic. The FAH strongly urges you to consider both lost revenue and health care related expenses when making PHSSEF payments to providers and to prioritize payment for hospitals’ and health systems’ lost revenue. Although provider expenditures to confront COVID-19 are significant, the burden of these expenses is substantially magnified by the sustained and in some cases permanent reduction in hospital and health system revenue associated with the loss of non-emergent care. Addressing hospitals’ and health systems’ lost revenue in as expeditious of a manner as possible should therefore be a top priority as PHSSEF funds are distributed.
- ***Prospective Payments.*** The CARES Act provides the Secretary with the flexibility to issue final, prospective payments for lost revenue and expenses, and the FAH urges you to do so by making payments on a prospective basis, ensuring predictable, expeditious provider payments. Retrospective payments would lag behind COVID-19 expenses and losses, reducing the benefit to providers, and a pre-payment strategy would involve a costly reconciliation process at a time when providers lack operational capacity for recoupments and reconciliations.
- ***Streamlined Application Process for Health Systems or Individual Providers.*** Providers’ resources have been stretched thin as this public health emergency has unfolded, and the FAH therefore requests that the application process be as streamlined as possible. The CARES Act requires that the provider’s application include “a statement justifying the need of the provider for the payment” along with a valid tax identification number. These statutory requirements can be met with a simple, streamlined process that gathers the lost revenue (discussed further below) and incurred expense data, and an attestation sufficient for a prospective payment. In addition, the operational burden associated with the application can be minimized by recognizing health systems as

“eligible health care providers,”¹ enabling each health system to submit a single application in lieu of applying on behalf of each individual hospital or provider.

- ***Accounting for the Special Circumstances of Heavily Impacted Regions and Rural Providers.*** The FAH supports appropriate payment adjustments based on circumstances that magnify the financial risks of the COVID-19 pandemic for certain hospitals. First and foremost, the FAH supports a ***COVID-19 Severity Adjustment*** that prioritizes funding for hospitals in areas that are disproportionately impacted by COVID-19 and at risk of exceeding surge capacity. In addition, the FAH urges you to take into account the particular circumstances of ***rural providers, especially Medicare Dependent and Sole Community Hospitals***, many of which will serve as the only available COVID-19 treatment center in a community and for miles around. Rural providers are experiencing acute, short-term cash needs, and, without adequate and expeditious financial support, many rural hospitals in particular will struggle to survive economically during the pandemic.
- ***Eligible Health Care Providers: Provider Types.*** Where PHSSEF payment is not available on a health system-wide basis for a provider, the term “eligible health care provider” should be read to encompass general acute care hospitals, long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRF), and critical access hospitals (CAH) as well as behavioral health providers that have sustained losses due to COVID-19, including inpatient psychiatric facilities (IPFs). Non-hospital providers such as ambulatory surgery centers and residential treatment centers are other institutional settings that must have appropriate access to the PHSSEF as they are integral to patient care and essential to the health system’s ability to respond to the emergency. The financial impacts of COVID-19 reach all health care facilities to varying degrees, from critical care to post-acute and behavioral health providers.

Background: The Financial Impact of COVID-19 on Hospitals and Health Systems

Although the COVID-19 pandemic is still in a relatively early stage in much of the United States, it has already had a significant economic impact on hospitals and health systems nationwide, and we fully expect that this impact will continue to escalate. At present, the financial impact on hospitals largely derives from three sources: (1) the disruption to non-emergent clinical service, (2) the expenses incurred preparing for and responding to the pandemic, and (3) the actual expense of treating COVID-19 patients. Although the financial impacts are evolving as the pandemic unfolds, the first two categories of financial impacts have

¹ The CARES Act defines “eligible health care providers” to include, in addition to Medicare-enrolled provider and suppliers, other “for-profit entities and not-for-profit entities. . . as the Secretary may specify, . . . that provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19.” Health systems are on the front lines of responding to the COVID-19 pandemic and treating patients, and allowing health systems to apply for payment on a system-wide basis in lieu of submitting applications on behalf of each of its affiliated provider entities would serve Congress’s aim of an efficient, emergency response.

already had a profound impact on hospitals, dramatically depressing revenue at the same time that hospitals are incurring substantial preparation and response costs.

Disruption of Non-Emergent Clinical Services. Hospitals and health systems are experiencing significant disruption of their business due to COVID-19 with declines in scheduled inpatient procedures, outpatient surgeries, diagnostic procedures, and emergency room activity. As the scope of the pandemic has expanded, health systems have followed government mandates, guidance, and recommendations by delaying and cancelling elective procedures where clinically appropriate in order to minimize community spread while also reserving both system capacity and equipment (including personal protective equipment and ventilators) where possible for COVID-19 cases. Patients have also been reluctant to come to health care facilities, or in some cases removing themselves before their full course of care and rehabilitation is complete, cancelling procedures, and foregoing even emergency room visits. Hospitals rely on these services not just to sustain a stable revenue base, but to help offset the cost to provide other essential health care services to the community. In fact, non-emergent services may equate to 30 to 60 percent of a hospital's revenue base, and some projections suggest that a hospital could see 75 to 100 percent of these services eliminated during the pandemic.² These revenue losses alone will have a significant financial impact, and many hospitals will struggle to survive economically as the pandemic progresses.

Pandemic Response and Preparedness Costs. Hospitals are incurring significant capital and labor costs associated with preparedness and pandemic response activities. These capital costs include the acquisition of critical supplies and ventilators at increasing costs amid escalating shortages, as well as altering the hospital's physical environment to expand critical care capacity, manage points of entry, and otherwise prepare for a surge in COVID-19 cases. These capital costs are incurred alongside significant labor costs as hospitals work to supplement front-line caregivers in order to adequately staff critical care areas and relieve over-burdened workers and workers who are quarantined after suspected exposure to COVID-19.

Direct Care Costs for COVID-19 Patients. Our members' experiences to date indicate that COVID-19 hospital patients are significantly compromised, with approximately half requiring intensive care, often with prolonged ventilation. The length of stay for COVID-19 patients is double or triple that of the typical hospital inpatient, and the daily resources consumed for these cases are significant. Even with the critically needed temporary sequester relief and increased Medicare payment for COVID-19 discharges under the CARES Act (limited only to acute care hospitals), it appears that the high costs of COVID-19 cases will not be fully met by increased Medicare reimbursement. Moreover, early experience indicates that a higher percentage of COVID-19 patients are uninsured and underinsured as compared to the typical inpatient payer mix, which will result in additional uncompensated care for hospitals during the pandemic.

² This loss of revenue is not generally offset by savings in operational costs because hospitals have a high labor, high fixed cost structure. Hospitals are critical, typically the largest employers in their communities, and most hospitals nationwide have made commitments to their staff involving continued payment programs to minimize job loss in the communities they serve.

Framework to Address Lost Revenue and Extraordinary Expenses Attributable to COVID-19

In order to account for the lost revenue and extraordinary expenses attributable to COVID-19 for purposes of PHSSEF payments without overwhelming providers or the Department of Health and Human Services (the Department) with operational burdens, the FAH recommends three phases of prospective payments, with each payment based on provider attestations. These three phases are as follows:

Phase I: Immediate Relief. The first phase of PHSSEF payments should be made available as expeditiously as possible, targeting those hospitals that have already experienced significant disruption in their business and incurred expenses both to treat patients who present with COVID-19 symptoms and prepare for a surge in such patients. Eligible hospitals and health systems during Phase I would be those that have experienced a disruption of non-emergent clinical activity in March 2020 in excess of 20 percent and have COVID-19 related expenses. The payment amount during this phase would be 20 percent of the hospital's average monthly revenue in 2019 (*e.g.*, a hospital with \$600 million in 2019 revenue would receive a Phase I payment of \$10 million). The application for this phase would consist of an attestation of 2019 revenue as well as an attestation that March 2020 revenue for non-emergent clinical activity declined by at least 20 percent. This approach would assure that immediate payments would be available to those providers that were hit earliest by the COVID-19 pandemic, and approximately 20 to 25 percent of the PHSSEF lost revenue payments would be made in this phase.

Phase II: Accounting for March and April Impacts. The second phase of PHSSEF payments for lost revenue would occur in late-June 2020, based on hospital revenues in March, April, and May 2020. This phase would target a larger pool of hospitals, recognizing the more widespread impacts of COVID-19 in late-March, April, and May 2020, and payments would be offset by Phase I payments received by eligible providers. Each provider would compare its March, April, and May 2020 revenue against revenue generated for the same period in 2019, and the difference between these amounts would be considered the COVID-19 revenue impact for these months. Hospitals would also demonstrate COVID-19 related expenses. Applications for Phase II funding would be due by June 20, 2020 and would consist of an attestation as to the COVID-19 revenue impact for March, April, and May 2020 as well as extraordinary expenses. If the aggregate COVID-19 revenue impact reduced by Phase I payments to applicant providers, exceeded the amount designated for Phase II payments for lost revenue, the Department would calculate and apply an appropriate payment factor. Each provider would then receive payment in the amount of its attested COVID-19 revenue impact for March, April, and May multiplied by any payment factor set by the Department, and reduced by the amount of Phase I payments. Approximately 50 percent of the PHSSEF lost revenue payments would be made in Phase II.

Phase III: Final Impacts. The third and final phase would distribute the remaining PHSSEF payments and would take place in or around October 2020. This phase would proceed in a similar manner to Phase II, except that the COVID-19 revenue loss would be calculated over a seven-month period (March to September 2020), compared against the same period in the prior year (March to September 2019). The Phase III payment would be reduced by the amount of Phase I and II payments. Depending on the trajectory of the pandemic and recovery, the

COVID-19 revenue loss for this period may exceed remaining funds, in which case the Department would calculate an appropriate payment allocation factor and distribute the resulting payment amounts in October or early November 2020.

The foregoing framework for lost revenue payments and extraordinary expenses would require some adjustment for particular circumstances. For example, new hospitals could receive payments based on industry average COVID-19 revenue losses for facilities with comparable bed size. In addition, the relative amount of COVID-19 related expenses and the degree to which a hospital is located in a so-called “hotspot” would need to be taken in account. With modest adjustments to account for such circumstances, this framework would provide a fairly simple method for capturing and addressing hospitals and health systems’ approximate lost revenue and expenses attributable to COVID-19.

If you have any questions, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Nig", with a horizontal line underneath.