AMERICA'S ESSENTIAL HOSPITALS

March 20, 2020

Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Azar:

America's Essential Hospitals is encouraged by the actions of the Trump administration, including the Department of Health and Human Services (HHS), to mitigate the novel coronavirus (COVID-19) outbreak. These actions will help hospitals meet the immediate needs of their communities as they prepare for and respond to COVID-19 cases. However, as the pandemic evolves, we urge the agency to consider additional actions to support essential hospitals, which are on the front lines of the nation's response to the outbreak.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Our more than 300 member hospitals fill a vital role in their communities. They provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care while operating on margins one-fifth that of other hospitals—1.6 percent on average compared with 7.8 percent for all hospitals nationwide.[1]

As essential hospitals, our members serve as community cornerstones of care, providing specialized inpatient, outpatient, and emergency services—such as trauma, burn, and inpatient psychiatric care—that often are unavailable elsewhere in their communities. In the 10 largest U.S. cities, our members operate 31 percent of all level I trauma centers, 39 percent of all burn-care beds, and 6,200 psychiatric care beds.[2] Members of America's Essential Hospitals play a vital role in providing ambulatory care to their communities—operating a median of nine ambulatory care locations per hospital.[3]

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[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2017 Annual Member Characteristics Survey*. America's Essential Hospitals. April 2019. https://essentialdata.info. Accessed March 17, 2020.
[2] Ibid.
[3] Ibid.

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In addition, essential hospitals' diverse patient mix and commitment to serving all people, regardless of income or insurance status, pose unique challenges. A disproportionate number of their patients face sociodemographic challenges to accessing health care, including poverty, homelessness, language barriers, and low health literacy. Ten million people in essential hospital communities have limited access to healthy food, and nearly 24 million live below the poverty line.[4] Essential hospitals are uniquely situated to target these social determinants of health and are committed to serving these vulnerable patients. These circumstances, however, compound essential hospitals' challenges and strain their limited resources.

Essential hospitals are taking extraordinary steps to respond to COVID-19. Many of these necessary steps come with a significant price tag and disruptions to daily operations. They include:

- constructing temporary spaces on their campuses to diagnose and treat COVID-19 patients;
- canceling planned surgical cases to increase capacity for COVID-19 cases and to ration surgical supplies, forgoing a critical revenue source for hospitals that rely on government payers;
- shutting down clinical units due to lack of available staff;
- purchasing laptops to ensure employees can work remotely when appropriate and to maintain hospital operations;
- hiring contract workers to fill front-line positions when caregivers are quarantined after COVID-19 exposure;
- ensuring adequate stock of personal protective equipment (PPE) and other supplies to protect those treating COVID-19 cases;
- accommodating staff child care needs resulting from school closures by establishing onsite child care facilities and subsidizing child care services; and
- accounting for large numbers of patient cancellations for outpatient appointments and planned procedures resulting from social distancing practices.

This is an unprecedented and challenging time for our nation, as we are faced with a public health emergency of unknown scope and duration. Essential hospitals, at the center of the nation's safety net, face this challenge with short supplies of available cash. Costs continue to rise while revenues decrease. To succeed in mitigating the spread of the COVID-19 outbreak, essential hospitals need **rapid** financial relief and support.

We call for decisive federal action to ensure essential hospitals can respond to this urgent public health threat. We urge HHS, as the lead agency for the administration's response to the outbreak, to take the following actions to support essential hospitals as they respond to the COVID-19 outbreak:

- **Ensure a stable Medicaid program.** Medicaid plays a critical role in the nation's response to COVID-19, most notably by ensuring that millions of Americans have access to necessary diagnostic testing and treatment. We call on federal policymakers to ensure adequate Medicaid funding is available to maintain access and safeguard provider payment during this pandemic. Now is not the time to implement significant cuts or

[4] Ibid.

changes to Medicaid funding at the federal or state level. Instead, we urge the following actions:

- The Centers for Medicare & Medicaid Services (CMS) must withdraw the damaging Medicaid Fiscal Accountability Regulation (MFAR), which will hamstring states' ability to respond to public health threats. The MFAR creates a cloud of uncertainty over the COVID-19 response. If finalized, it would worsen the crisis by undermining the stability of the nation's safety net.
- States should have additional flexibility to target funding to essential hospitals for COVID-19–related testing, services, and treatment. We urge the agency to enable states to increase current supplemental payments by at least 50 percent and to take the following actions:
  - CMS should create template, emergency Medicaid Section 1115 demonstration waivers that suspend budget neutrality requirements to increase hospital-specific disproportionate share hospital (DSH) limits. This will allow hospitals to receive relief through additional DSH payments.
  - CMS should temporarily raise current upper payment limits through expedited rulemaking to allow hospitals to receive new hospital supplemental payments targeted at a COVID-19 response. Alternatively, the limits could be raised in an emergency Section 1115 waiver template.
  - CMS should issue emergency rulemaking to temporarily lift the direct pay prohibition. This will allow states to make targeted pass-through payments under Medicaid managed care plan contracts to providers affected by the outbreak.
- CMS must fast track all approval processes necessary for states to access and target additional Medicaid funds.
- HHS should urge Congress to further increase the Federal Medical Assistance Percentage, while requiring states to maintain current Medicaid eligibility criteria.
- HHS should urge Congress to stop the impending Medicaid DSH reductions from taking effect for at least two years. Additionally, HHS must work with Congress to temporarily increase Medicaid DSH state allotments. Congress previously acted to raise Medicaid DSH state allotments for two years, during the last economic downturn. Increasing DSH allotments by 3 percent now will give states more resources that can be targeted to hospitals on the front lines of the outbreak.

- **Eliminate barriers to Medicaid coverage and access to care.** CMS should encourage all state and territorial Medicaid officials to use state plan and emergency Medicaid Section 1115 waiver authority to implement presumptive eligibility to expedite enrollment for patients who are currently eligible for Medicaid coverage but not enrolled. Additionally, CMS should encourage officials to suspend cost-sharing and premium policies for COVID-19 diagnosis and treatment in the fee-for-service and managed care delivery systems. This will encourage and enable immediate access to care for all Medicaid-eligible patients.

- **Targeted funding and coverage for the uninsured.** HHS should provide additional funds to hospitals to cover costs incurred from treating the uninsured. HHS also should encourage states to temporarily cover under Medicaid specific populations that otherwise are not eligible. This action is critical to ensure patients do not forgo diagnosis and treatment for COVID-19 out of concern for cost or lack of health insurance coverage. We encourage the agency to consider the following:
    - CMS should allow states to re-establish or create time-limited, Medicaid-funded uncompensated care pools through Section 1115 waivers to cover the costs of treating the uninsured.
    - The economic effect of COVID-19 might increase the number of uninsured in the short term. CMS should work with states to use emergency Section 1115 waivers to extend temporary Medicaid coverage to uninsured populations that otherwise are not eligible and that need COVID-19–related testing or care.
    - To ensure hospitals have adequate resources to respond to the emergency, HHS should work with Congress to establish a federal program to directly reimburse providers for costs associated with caring for the uninsured. While federal law now provides a reimbursement mechanism for testing and testing-related services, this mechanism must expand to include treatment costs. We suggest the agency use Section 1011 of the Medicare Modernization Act of 2003 as a potential model.

- **Encourage the use of telehealth services and other supportive technologies.** In accordance with social distancing strategies, essential hospitals are expanding telehealth services to ensure patients are treated in appropriate care settings. We encourage HHS to consider the following to loosen restrictions on telehealth services and technology:
    - CMS must fast track approvals for state plans that detail Medicaid fee-for-service payment methodologies for telehealth services.
    - HHS should work with Congress to expand the "qualified provider" definition for receiving telehealth reimbursement under HHS' waiver authority as defined in the supplemental appropriations bill. HHS can achieve this by removing the requirement that providers must have an established relationship with a patient (that is, billed Medicare for a service for that patient) in the past three years. This requirement is unnecessarily constraining in a time of crisis, when patients—even those who do not have an established relationship with an essential hospital—are turning to them for care. In many cases, a provider did treat the patient in the past three years, but the patient was on a source of coverage other than Medicare, and only recently transitioned to Medicare. Lifting the three-year requirement will better allow essential hospitals to expand access to more patients in their response to the COVID-19 pandemic. While we appreciate HHS' guidance noting that it will not enforce the three-year rule, we still encourage the agency to work with Congress to remove the legislative requirement.

- **Protect access to the 340B Drug Discount Program. We call on HHS to preserve essential hospitals' access to lifesaving drugs through the 340B Drug Pricing Program.** Congress created the 340B program to allow covered entities to "stretch scarce Federal resources as far as possible, reaching more eligible patients and providing

more comprehensive services."[5] During the COVID-19 public health emergency, access to these discounted drugs and the savings that the discounts enable is more critical than ever. We urge HHS to take the following steps to protect essential hospitals as they adapt to treat communities reeling from COVID-19:

- CMS must restore full Medicare Part B reimbursement to 340B hospitals. Since 2018, CMS has paid 340B hospitals 77.5 percent of average sales price (ASP) for Medicare Part B drugs. This is nearly 30 percent lower than the payment rate for non-340B hospitals. Reductions in Medicare payment rates to 340B hospitals significantly eroded the program's value. These policies are most damaging to essential hospitals, given their high levels of uncompensated care, narrow margins, and large proportion of patients with Medicare and Medicaid coverage. A federal district court already has ruled that these cuts are unlawful, and, while a decision on appeal is pending, CMS must immediately pull back on these cuts during this national crisis. The cuts to 340B hospitals significantly gut the program's benefit and have caused hospitals to pull back on the services they offer to patients or to make staffing cuts. Now is not the time for unnecessary and unlawful reimbursement cuts to hospitals that are on the front line of the COVID-19 response. CMS must immediately use its regulatory authority to restore payment to 106 percent of ASP.
- CMS should immediately withdraw its proposed survey of 340B hospitals' acquisition costs, set to take effect March 23. Besides having tenuous legal justification, this survey will be extremely burdensome for hospitals and require additional resources in the form of dedicated personnel, staff training, and changes to hospital workflows. Essential hospitals cannot afford to divert their limited resources toward this survey during this challenging time for their communities.
- 340B eligibility changes during the COVID-19 response must be disregarded. Depending on the classification of the hospital (e.g., disproportionate share hospital, sole community hospital, rural referral center) 340B hospitals are required to satisfy a minimum Medicare DSH percentage. If a hospital drops below the required threshold, it must notify the Health Resources and Services Administration (HRSA), and it would no longer be eligible for the 340B program. It is likely that, during the response to the COVID-19 emergency, hospitals will see a change in the types of patients and their insurance sources. A hospital with a DSH adjustment percentage close to the eligibility threshold could fall below the threshold temporarily, due to changing payer mix. To ease this unintended consequence of treating COVID-19 patients, HRSA should disregard any changes in DSH adjustment percentage that arise as a result of a hospital's response to the COVID-19 crisis.
- HRSA should allow entities and child sites that can demonstrate eligibility for the 340B program to immediately register and begin participating in the 340B program so that they can receive lifesaving drugs at discounted prices.
- HRSA should confirm that drugs prescribed during a telehealth visit are eligible for 340B discounts. Providers are expanding access to patients across their immediate service areas and beyond through telehealth, both generally and in response to additional flexibility provided by HHS for the COVID-19 crisis. As

[5] H.R. Rep. No. 102-384, pt. 2 (1992).

providers adopt telecommunications technology, HRSA should clarify that the use of a telehealth visit has no bearing on a covered entity's ability to purchase a drug with a 340B discount as long as the purchase complies with other 340B requirements. In other words, the patient's physical location should have no bearing on a 340B covered entity's ability to prescribe a drug and receive a 340B discount, insofar as all other requirements are met. This clarification will provide assurance to providers who are meeting the needs of their community through telehealth visits.

- **Ensure access to care in patients' communities.** Essential hospitals offer comprehensive, coordinated care across large ambulatory networks to bring vital services to patients where they live and work. Our members' networks of hospital-based clinics include onsite features, such as radiology, laboratory, and pharmacy services. These networks are a vital part of essential hospitals' response strategy as they strive to expand access to testing and treatment for COVID-19 patients while keeping patients outside their hospital walls, when possible. Many essential hospitals have off-campus clinics in federally designated areas with provider shortages, including health professional shortage areas and medically underserved areas. CMS can ensure continued access to these ambulatory networks by restoring full payment under the Outpatient Prospective Payment System (OPPS) for off-campus provider-based departments that are excepted under Section 603 of the Bipartisan Budget Act of 2015. CMS already has restored payment for 2019, pursuant to a court order, and should immediately restore the full OPPS payment rate for 2020. These clinics face severe cuts due to CMS' policy, and their closure would restrict access to care for communities in which access to health care providers is already limited.

- **Continue to identify and issue needed blanket Section 1135 waivers.** We applaud HHS for its swift action in granting several blanket Section 1135 waivers to states aimed at removing regulatory barriers in Medicare, Medicaid, and the Children's Health Insurance Program as states and providers respond to the COVID-19 outbreak. States and health care providers are now applying for more targeted Section 1135 waivers. We encourage HHS to identify commonalities among these requests and issue subsequent blanket waivers to further remove barriers for all states.

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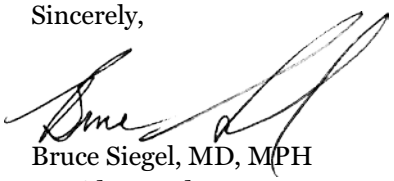
We appreciate the opportunity to share the priority needs of essential hospitals during this extraordinary time and look forward to continued engagement and partnership to successfully mitigate the COVID-19 outbreak. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,



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