April 13, 2020

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| The Honorable Mitch McConnell<br>Majority Leader<br>United States Senate | The Honorable Nancy Pelosi<br>Speaker<br>United States House of Representatives |
| The Honorable Charles Schumer<br>Minority Leader<br>United States Senate | The Honorable Kevin McCarthy<br>Minority Leader<br>United States House of Representatives |

Dear Majority Leader McConnell, Speaker Pelosi, Minority Leader Schumer, and Minority Leader McCarthy:

America's Essential Hospitals applauds your leadership in recognizing the critical and immediate needs of hospitals serving on the front lines of the COVID-19 public health emergency. We are grateful for Congress' quick action to develop and pass legislation to initiate the federal government's response to this pandemic. The three emergency supplemental bills signed by the president—the Coronavirus Preparedness and Response Supplemental Appropriations Act; Families First Coronavirus Response Act; and Coronavirus Aid, Relief, and Economic Security (CARES) Act—include supportive measures designed to help hospitals manage the sudden and costly disruptions to daily operations due to the COVID-19 pandemic. However, as the impact of the coronavirus continues to unfold, more federal assistance is needed to ensure mission-driven hospitals are adequately prepared and equipped to serve patients and the broader community.

This public health crisis will bring unprecedented hardships to essential hospitals and the disadvantaged people and communities they serve. Even at this still early stage, we know COVID-19 poses a disproportionate risk to racial and ethnic minorities, those with underlying conditions, and the other complex patients who constitute a significant share of the populations essential hospitals serve. This virus will wreak havoc in communities where poverty, homelessness, food insecurity, and other disparities in health and health care persist, leaving millions without the means and opportunity to achieve social distance and avoid infection.

These communities rely on essential hospitals, where three-quarters of patients are uninsured or covered by Medicaid or Medicare. True to their safety-net mission, essential hospitals meet this demand and, in doing so, sustain more than 17 percent of the nation's uncompensated care while representing 5 percent of all hospitals.[1] Even in better times—and we are far from better times—

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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 April 9, 2020.

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essential hospitals operate barely in the black and with cash reserves typically measured in days rather than weeks or months. They operate with an average margin of 1.6 percent, just one-fifth that of other U.S. hospitals[2] and offering no cushion for the crushing financial blow COVID-19 will deliver. So, as this virus spreads, it puts essential hospitals and their communities in an increasingly tenuous and precarious position.

Compounding this are the preparation and response efforts associated with COVID-19, which significantly increase essential hospitals' costs. This includes expenses associated with building out alternative care sites to accommodate patient surge and the higher costs of competing for scarce personal protective equipment (PPE) and other vital supplies. At the same time, our member hospitals have experienced an abrupt drop in revenue due in part to the shift away from elective procedures and other ancillary services to free up capacity for a surge in COVID-19 patients, preserve limited PPE supplies, and minimize the chances of spreading the virus. While these actions are necessary, given the circumstances, they have resulted in severe cash flow concerns, with some of our members struggling to make payroll.

As Congress works to develop the next emergency supplemental legislation, we urge lawmakers to take these steps to ease the financial pressures on essential hospitals:

1. **Increase the amount of emergency funding available and target funds toward hospitals with the greatest need for support.** We are pleased the bipartisan CARES Act allotted $100 billion in emergency funding to hospitals and providers. However, we are deeply concerned that allocating the first $30 billion of this aid based solely on Medicare fee-for-service revenue, regardless of need, clearly disadvantages essential hospitals and other providers with below-average Medicare volumes and disproportionately high Medicaid and low-income volumes. In fact, some of the hospitals caring for the largest influx of COVID-19 patients in hotspots will get minimal funding in the first tranche of emergency fund payments. These hospitals need rapid financial relief and support to successfully mitigate the spread of the outbreak, test all patients in need, and provide appropriate treatment.

   We urge Congress to provide additional dollars to the emergency fund and ensure payments are disbursed using a targeted methodology that prioritizes hospitals, through a weighting process or other means, that serve a disproportionate share of Medicaid and low-income patient populations and vulnerable communities. We recommend using a combination of metrics, such as deemed disproportionate share hospital (DSH) designation (to identify hospitals that primarily serve Medicaid and low-income patients); the DSH patient percentage (to identify hospitals that serve a disproportionate share of low-income patients to qualify for a Medicare DSH adjustment); and the uncompensated care payment factor (to measure a hospital's uncompensated care burden).

2. **Medicaid policy changes:** Essential hospitals see more patients covered by Medicaid and disproportionately rely on Medicaid supplemental payments, relative to other hospitals. Lawmakers should leverage the program to grant additional financial relief for hospitals struggling with low cash reserves. We call on Congress to:

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[2] Ibid.

- block the Centers for Medicare & Medicaid Services (CMS) from finalizing its shortsighted and damaging Medicaid Fiscal Accountability Regulation (MFAR);
- create access to advanced Medicaid payments for providers, similar to the Medicare Accelerated Payment Program;
- temporarily increase Medicaid DSH state allotments by at least 3 percent;
- direct CMS to create temporary, emergency Medicaid Section 1115 demonstration waivers and expedite rulemaking to increase upper payment limits and hospital-specific Medicaid DSH limits, which will allow hospitals to receive new supplemental payments and additional Medicaid DSH funds targeted for COVID-19-related treatment, services, and testing;
- require CMS to fast track all approval processes necessary for states to access additional funding;
- expand the enhanced Federal Medical Assistance Percentage (FMAP) and maintenance of effort requirements established by the Families First Coronavirus Response Act to the Medicaid expansion population; require states to use the additional federal funds to increase provider reimbursements; and extend the enhanced FMAP until six months after the public health emergency has been lifted to help states recover from high rates of unemployment resulting from the pandemic response;
- ensure states can use emergency Medicaid coverage for immigrants who need COVID-19 testing or treatment and do not otherwise qualify for Medicaid; and
- extend through 2021 section 1115 Medicaid waivers scheduled to expire on or before December 31, 2020.

3. **340B Drug Pricing Program:** The 340B program is key to the patchwork of federal supports essential hospitals rely on to fulfill their safety-net mission. Our members will lean on 340B discounts to maximize their limited resources during this pandemic. Congress can preserve hospitals' access to affordable, lifesaving drugs during the pandemic by:
    - allowing hospitals to maintain 340B eligibility notwithstanding changes in payer mix during the pandemic. For some essential hospitals, the disruptions caused by COVID-19 could result in temporary swings in their DSH adjustment percentage, jeopardizing their eligibility for the 340B program. We urge Congress to ensure, for the duration of the COVID-19 emergency, that covered entities can maintain 340B eligibility if their payer mix changes.
    - ensuring access to 340B-discounted drugs for patients treated through telehealth. Providers are increasingly turning to telehealth to expand their reach to patients facing barriers to access, including lack of transportation. Congress can clarify that 340B discounts are available to covered entities on covered outpatient drugs without regard to the patient's physical location—that is, whether the provider treats the patient in-person or through telehealth.

4. **Medicare:** We commend lawmakers for increasing Medicare provider reimbursements during this current pandemic. We respectfully ask Congress to take additional steps by:
    - augmenting the expansion of the Medicare Accelerated and Advance Payment Program included in the CARES Act to forgive payments received to help providers meet payroll and purchase PPE and to reduce the interest rate on repayment of funds;

- providing additional telehealth flexibility during the COVID-19 emergency to allow hospitals serving as a distant site to bill Medicare a facility fee for patients seen in a telehealth setting. Health care facilities serving as a distant site do not normally receive a facility fee. However, as hospitals are compelled to shift typically in-person services to telehealth settings to prioritize their COVID-19 patients and avoid exposing other patients, they are forgoing substantial revenue by not receiving a facility fee for these services. Providing a facility fee for the duration of the COVID-19 emergency will protect hospitals from significant financial losses associated with declining in-person visits; and
- holding teaching hospitals harmless for a temporary increase in beds by excluding these beds from affecting a hospital's indirect medical education (IME) payments. IME payments are calculated using a hospital's intern- and resident-to-bed (IRB) ratio, and a temporary increase in beds could result in a decrease in the IRB ratio. Congress can protect teaching hospitals responding to the COVID-19 crisis by excluding these beds from the IRB ratio calculation.

5. **Payroll tax credits:** The Families First Coronavirus Response Act creates a payroll tax credit for employers to offset the costs of providing paid sick and family medical leave to employees, due to COVID-19. However, government entities, including public hospitals, are excluded from taking advantage of the tax credit. We call on Congress to address this unintended consequence by extending the tax credit to public hospitals.

6. **Demographic data collection:** We urge lawmakers to work with the Department of Health and Human Services (HHS) to promote the collection and analysis of COVID-19 testing, hospitalization, and mortality data by race, ethnicity, and preferred spoken and written language of patients; and to provide funding for these activities. These data are critical to understanding the unique challenges and disparities patients face and will help policymakers direct funding and resources toward providers committed to serving all patients during this crisis.

We also urge lawmakers to recognize the selfless and courageous work of caregivers at essential hospitals and emergency personnel who are the front lines of treating and caring for COVID-19 patients. They serve daily in the face of this deadly pandemic, placing their patients and work above all else. The next COVID-19 supplemental legislation should include hazard pay for these caregivers and emergency personnel as an acknowledgment of their service.

We appreciate the opportunity to share the critical needs of essential hospitals during the current public health emergency. If you have questions, please contact Vice President of Legislative Affairs Carlos Jackson at (202) 585-0112 or cjackson@essentialhospitals.org.

Sincerely,

/s/

Bruce Siegel, MD, MPH
President and CEO