



AMERICA'S ESSENTIAL HOSPITALS

July 6, 2020

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

Dear Secretary Azar:

America's Essential Hospitals appreciates the leadership of the Department of Health and Human Services (HHS) as the nation responds to the COVID-19 pandemic. We also appreciate the agency's work to determine provider allocations from the \$175 billion Provider Relief Fund, authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act. We are especially encouraged by HHS' recognition of hospitals that serve vulnerable patients and communities and the relief they need through the \$10 billion safety-net allocation. This allocation was an important step in meeting the funding needs of some essential hospitals. However, we remain concerned that the methodology used to identify hospitals serving a safety-net role leaves behind many essential hospitals, which operate with limited resources and serve on the front lines of this public health emergency. **We urge HHS to fill this gap using a refined methodology in a second round of funding to ensure all hospitals filling a safety-net role receive critical relief dollars.**

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 two-thirds of their patients are uninsured or covered by Medicare or Medicaid. Essential hospitals provide state-of-the-art, patient-centered care while operating on margins one-fifth that of other hospitals—2.5 percent on average compared with 7.6 percent for all hospitals nationwide.¹

These tight operating margins result in minimal reserves and low cash on hand, with many essential hospitals struggling to make payroll. These hospitals continue to make significant investments to respond to the COVID-19 pandemic—including increasing capacity through alternative care sites, competing with other providers for personal protective equipment and other critical supplies, and ensuring staff capacity. Hospitals have made these investments while

¹ Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2018 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2020. <https://essentialdata.info>. Accessed June 12, 2020.

facing a drop in revenue due in part to decreasing the number of planned and elective procedures and other ancillary services to stand ready for COVID-19 patients. As the pandemic continues, hospitals' volume of non-COVID-19 services has not yet returned to prepandemic levels; many hospitals do not believe this will change until the end of the year. As a result, essential hospitals face an uncertain financial future and many other challenges as they continue to respond to this public health emergency.

Compounding these challenges are essential hospitals' complex patient mix and commitment to serving all people, regardless of income or insurance status. A disproportionate number of essential hospitals' patients face sociodemographic challenges to accessing care, including homelessness, language barriers, and low health literacy. Approximately 10 million people in essential hospital communities have limited access to healthy food and nearly 24 million live below the poverty line.²

The COVID-19 pandemic has hit the patients and communities served by essential hospitals particularly hard, especially racial and ethnic minorities. Sociodemographic factors greatly influence patient health status, putting essential hospitals' patients most at risk as COVID-19 appears detrimental for those with underlying risk factors. As outbreaks continue, essential hospitals serving these vulnerable patient populations find themselves in an increasingly precarious position of responding to the pandemic with strained resources.

Essential hospitals also are critical to their state and local economies, which continue to be severely impacted by pandemic response efforts. Before the COVID-19 outbreak, members of America's Essential Hospitals contributed a monthly average of over \$45 billion to their state and local economies. Due to the impact of incurred expenses and lost revenue to respond to the pandemic, essential hospitals are contributing at least 30 percent less economic activity to their state and localities—an average decrease of more than \$13 billion a month.³ This economic activity is critical to the fiscal health of states and localities and further underscores the importance of essential hospitals to the communities they serve.

While the association appreciates HHS for recognizing the critical role of these hospitals in the nation's response to the pandemic through the recently announced safety-net allocation, we remain concerned that many essential hospitals were excluded from this distribution. To be eligible for payment under the safety-net allocation, a hospital must meet three specific metrics:

- a Medicare disproportionate share hospital (DSH) patient percentage of 20.2 percent or more; **AND**
- minimum average uncompensated care of \$25,000 per bed; **AND**
- a maximum profit margin of 3 percent, as reported to the Centers for Medicare & Medicaid Services on the 2018 Medicare cost report.⁴

² Ibid.

³ America's Essential Hospitals analysis of 2018 Medicare Cost Report data and Bureau of Economic Analysis RIMS II multipliers.

⁴ Press Release: HHS Announces Enhanced Provider Portal, Relief Fund Payments for Safety Net Hospitals, Medicaid & CHIP Providers. Department of Health and Human Services. June 9, 2020. <https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicare-chip-providers.html>. Accessed June 2020.

Having to meet all three metrics results in a stringent eligibility standard further compounded by using only one year of data, which results in examining a hospital's patient mix and fiscal situation at a particular point in time. This approach does not reflect natural fluctuations of a hospital's patient population and finances year-to-year, nor does it reflect variations in health care delivery systems and hospital financing among and within states. By disregarding yearly fluctuations and operational nuances, this approach ultimately excludes many of the hospitals this allocation seeks to target.

America's Essential Hospitals conducted an internal analysis of the safety-net allocation and identified many hospitals that would be eligible for this distribution but for their 2018 profit margin, as defined by HHS for this allocation. By only examining one year of data, HHS' eligibility criteria for this allocation does not fully capture the variations of hospital financing that directly impact hospital margins. For example, a hospital might have an atypically high profit margin one year due to receiving federal or state reimbursement for services provided in previous years. This results in fluctuating margins that, at times, overstate the fiscal health of a facility. Further, many essential hospitals receive support from their communities through voter-approved bonds. Through these bonds, the community invests significant resources for a hospital to modernize existing and establish new, needed infrastructure. Dollars from these bonds cannot be used to support a hospital's operations, but bond-related income is included in the calculation of its profit margin, resulting in a distortion of a hospital's margin. Last, teaching hospitals might have seemingly healthier margins due to an inextricable link between their finances and their affiliated medical school, when in reality margins of teaching hospital often are quite slim. Because of these types of nuances and fluctuations in profit margins, many deserving hospitals likely are excluded from the safety-net allocation. These hospitals still face fiscal challenges and have scarce resources on hand, all while filling a safety-net role in their communities.

In addition, our internal analysis estimates only about a third of deemed DSH hospitals might be eligible for the safety-net allocation. Defined by statute, the deemed DSH designation is used to identify hospitals with high Medicaid and low-income utilization rates.⁵ Deemed DSH hospitals are a critical element of the nation's response to COVID-19 and, by definition, are the very hospitals that HHS stated the safety-net allocation targets.⁶

Given these outstanding considerations, we urge HHS to fill the gaps created by the safety-net allocation by ensuring all hospitals serving Medicaid and low-income patients receive targeted relief dollars. Through a second safety-net distribution, HHS must direct payments to:

- **all hospitals that meet the statutory definition for a deemed DSH hospital;**
- **hospitals that meet two of the three metrics HHS used to identify eligible safety-net hospitals; or**
- **are essential hospitals that serve vulnerable communities and complex patients, and that have limited resources and are still in need of relief.**

⁵ 42 U.S.C. § 1396r-4(b)

⁶ Press Release: HHS Announces Enhanced Provider Portal, Relief Fund Payments for Safety Net Hospitals, Medicaid & CHIP Providers. Department of Health and Human Services. June 9, 2020. <https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html>. Accessed June 2020.

HHS must fill the gaps from the safety-net allocation without reconciling or recouping any payments from hospitals included in the initial distribution. Rather, a second safety-net allocation foremost must target additional relief funds to hospitals that did not receive payment from the first safety-net allocation and that meet the criteria above. This approach ensures essential hospitals—with limited resources that continue to serve on the front lines of the pandemic—excluded from the first allocation will receive needed relief dollars.

HHS has recognized the need to refine previous Provider Relief Fund allocations. The initial general allocation distribution largely omitted providers with little to no Medicare fee-for-service patient revenue. The agency acknowledged this and issued subsequent general allocation payments that, ultimately, resulted in the general allocation distribution based on a provider's net patient revenue.⁷ In addition, HHS targeted dollars to hospitals in areas with severe COVID-19 outbreak—defined as having more than 100 inpatient admissions through April 10—in a high-impact allocation. The agency correctly understood that many hospitals saw peak admissions after the arbitrary cut-off date. Now, the agency is in the process of collecting admission data through June 10 for a second high-impact allocation for hospitals.⁸

We remain concerned that many essential hospitals' provider relief payments are not commensurate with their increased expenses and lost revenue from responding to the pandemic. HHS' methodology for distributing the general allocation clearly disadvantaged essential hospitals, which provide care to a disproportionately high number of Medicaid and low-income patients. Care for these patients is reimbursed at lower payment rates compared with Medicare and commercial reimbursements, resulting in these hospitals receiving substantially lower patient revenues. Because of this, they did not get a fair share of the \$50 billion relative to their need. Now, many of these hospitals find themselves excluded from the safety-net allocation, leaving them in dire need of rapid relief.

It is imperative that HHS ensures the Provider Relief Fund is targeted to all hospitals serving the vulnerable patient populations, including those most at risk of contracting and facing serious complications from COVID-19. **HHS must direct a portion of the remaining dollars in the Provider Relief Fund to ensure hospitals filling a safety-net role—critical to the nation's response to the pandemic—receive the resources they need to keep their doors open. We urge HHS fill gaps within the safety-net allocation to account for all essential hospitals serving Medicaid and low-income patient populations omitted from the initial distribution.**

We look forward to continued engagement and partnership to 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.

⁷ *CARES Act Provider Relief Fund: General Information*. Department of Health and Human Services. <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html>. Accessed June 2020.

⁸ Press Release: HHS Announces Enhanced Provider Portal, Relief Fund Payments for Safety Net Hospitals, Medicaid & CHIP Providers. Department of Health and Human Services. June 9, 2020. <https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html>. Accessed June 2020.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO