AMERICA'S ESSENTIAL HOSPITALS

October 7, 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 Department of Health and Human Services' (HHS') work to determine provider allocations from the $175 billion Provider Relief Fund (PRF), authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act. As the nation responds to the COVID-19 pandemic, support from the PRF is critical to providers incurring increased expenses and lost revenue. Support, to date, has partially mitigated the financial losses of essential hospitals, but September 19 HHS guidance on the use and reporting of these funds threatens the ability of some providers to retain this support.

America's Essential Hospitals is concerned about HHS' recent post-payment notice of reporting requirements and the consequences it could have for essential hospitals treating vulnerable patients and leading COVID-19 response in their communities. **We urge HHS to withdraw this notice and ensure any new guidance is consistent with previous guidance issued by the agency through its FAQs.**

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-third 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. Essential hospitals continue to make significant investments in responding to the COVID-19 pandemic, including increasing capacity through

[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 October 2, 2020.

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alternative care sites, competing with other providers for personal protective equipment and other critical supplies, and ensuring staff capacity. These investments are made in the face of declining 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 and new hot spots emerge, hospitals' volume of services unrelated to COVID-19 have not yet returned to pre-pandemic levels. As a result, essential hospitals face an uncertain financial future and many other challenges as they continue to respond to this public health emergency.

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.

Due to these strained resources and the need for continued support for expected future outbreaks of COVID-19, it will be critical that essential hospitals can use PRF funds to bolster their response to the pandemic. As HHS shifts its focus from disbursing PRF funds to accounting for the use of these funds, it is imperative that the agency provide clear guidance to hospitals that does not disfavor facilities hardest hit by the pandemic. We are concerned HHS' recently released post-payment reporting notice could require some providers to return PRF funds due to no fault of their own, but rather to new arbitrary changes in guidance from the agency. For hospitals with narrow, often negative, operating margins, the recoupment of funds because of changing guidance would have a devastating impact on operations and would destabilize their COVID-19 response.

The September 19 notice issued by HHS was inconsistent with previous guidance, which is particularly troublesome because a provider's decision to accept or reject PRF funds would have been based on their understanding of the terms and conditions at the time. When all previous PRF distributions were made, providers interpreted their obligations based on the language of the terms and conditions, as well as the associated FAQs that HHS published. In its new guidance, HHS not only provided more detail on the data elements required but also made substantive changes to definitions that have payment and reporting implications for providers.

Most glaringly, HHS redefined "lost revenues" in its September 19 guidance. Previously, HHS stated providers could use "any reasonable method" to estimate lost revenues, including either the difference between budgeted revenue and actual revenue, or the difference in revenues compared with 2019.[2] In fact, this definition of lost revenues is still used in the FAQs posted on HHS' PRF website as of October 2, clearly indicating that either of these definitions of lost revenues is an acceptable way for providers to account for the impact of COVID-19. In the new guidance, HHS severely restricts the definition of lost revenue by removing a comparison of budgeted to actual revenue in 2020 as an acceptable interpretation of lost revenue. Some providers could have expected higher revenues in 2020 compared with 2019 because of new service lines, clinics, or other expansions. However, the onset of the pandemic would have wiped

[2] HHS Cares Act Provider Relief Fund FAQs. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html. Accessed October 2, 2020.

out those expectations. Therefore, HHS should revert to its existing definition of lost revenues as published in its FAQs.

Additionally, HHS now uses net operating income from patient care (which is calculated as net charges from patient care minus expenses) as the definition of lost revenues. This is a curious reversal that defies logic and contradicts existing definitions of lost revenues used by health care providers and accountants. HHS already accounts for health care expenses attributable to COVID-19 as a separate data element, so it is unclear why the agency has chosen to subtract expenses from revenues in calculating lost revenues for the purposes of PRF accounting. The terms and conditions of the PRF state payments only are to be used for "health care–related expenses or lost revenues that are attributable to coronavirus"—they do not mention hospital income. Including expenses in the definition of lost revenues would penalize hospitals that reduced their expenses in 2020 compared with 2019 in anticipation of the expected financial hit from COVID-19.

Finally, elements of HHS' guidance are burdensome, confusing, and inconsistent, which will result in unreliable and nonuniform data reported by hospitals. For one, HHS requires reporting at the taxpayer identification number (TIN) level, which is not feasible for providers that have many subsidiaries. Some financial data points, such as expenses related to COVID-19, are reported at the parent TIN level and are difficult to break out at the subsidiary TIN level. For example, a large health system that purchased personal protective equipment and distributed it across its various subsidiaries, such as multiple hospitals and clinics in its system, might not assign these expenses across each subsidiary in its accounting records. Moreover, HHS explicitly asks that certain data elements be reported by quarter (such as lost revenues) but does not mention this is the case for expenses, so it is unclear if expenses are to be reported for the whole year or on a quarterly basis. HHS also does not ask for expenses in 2021 but does request revenues in 2021. Providers who continue to invest in COVID-19 supplies and equipment likely will continue to incur expenses in 2021 to which they should be able to apply PRF funds.

The inconsistency in the guidance and the change in the definition of lost revenues not only mean HHS could recoup money but also will cause a high level of uncertainty for hospitals for which fiscal years already ended; these hospitals already may have completed financial statements and undergoing audits. These hospitals are in the untenable position of not knowing whether they will be able to retain their PRF payments or will have to return them due to the conflicting nature of the guidance.

For these reasons, we urge HHS to withdraw its September 19 guidance. The agency should work with providers to ensure future guidance is consistent with its long-held positions on lost revenues and expenses and does not have an adverse impact on providers on the front lines of the nation's COVID-19 response.

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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.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO