AMERICA'S ESSENTIAL HOSPITALS

February 17, 2021

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

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

Thank you for your continued diligence and commitment to addressing the COVID-19 pandemic. Our members appreciate your responsiveness to the real and imminent strain COVID-19 places on the individuals they care for and employ. Although the various COVID-19 relief laws Congress passed last year provided timely relief to essential hospitals, these front-line providers need more support to weather this persistent pandemic.

Our more than 300 member hospitals and health systems are central to the nation's health care safety net. Three-quarters of their patients are uninsured or covered by Medicaid or Medicare. Racial and ethnic minorities comprised more than half of discharges in 2018. Essential hospitals anchor communities across the country, from large urban centers to broad rural regions. They are sources of lifesaving care, jobs, and vital public health services that improve collective social, economic, and environmental circumstances. In communities served by essential hospitals, 23.3 million people live below the federal poverty line, 9.7 million have limited access to nutritious food, and 360,000 experience homelessness.[1]

Our mission-driven hospitals remain on the front lines of this crisis, from distributing vaccines to helping make the COVID-19 response more equitable, particularly for underrepresented people and underserved communities. Hospitals still experience many of the same challenges they have faced over the past 11 months—sporadic access to personal protective equipment (PPE), a shrinking workforce, and financial strain due to lost revenue and increasing expenses related to COVID-19. Essential hospitals, which operate on margins one-third that of other

[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 February 4, 2021.


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hospitals, feel these challenges acutely.[2] More relief is needed, especially as new strains of the virus and other public health challenges create more uncertainty for the pandemic's trajectory.

As lawmakers continue to develop and negotiate future COVID-19 relief legislation, America's Essential Hospitals urges Congress to build upon its important work and address the following priorities in any legislative package:

## COVID-19 Relief Priorities

Last year, Congress considered several helpful measures to support health care providers on the front lines of the COVID-19 crisis that ultimately did not become law. We remain hopeful many of these policy provisions will gain traction in forthcoming legislation, further building upon Congress' invaluable commitments thus far.

1. Replenish the Provider Relief Fund (PRF) with additional dollars and prioritize essential hospitals in future disbursements.

COVID-19 cases have continued to spread, driving hospitalizations across the nation. Currently, essential hospitals face significant capacity concerns, scarce personal protective equipment (PPE) and supplies, and staffing shortages. In many communities, they now are at the forefront of the COVID-19 vaccine rollout to health care workers and the general public simultaneously. Our hospitals have been challenged managing the influx of patients requiring COVID-19 treatment, following up with recovered or recovering patients in an outpatient setting, and maintaining testing locations for their communities. The vaccine rollout has added a significant burden to our hospitals' staff, and the unpredictability of vaccine supply has hampered vaccination efforts. For example, essential hospitals have been forced to cancel or move some vaccination appointments due to unpredictable shipments and logistics. Essential hospitals are cognizant of the need to ensure vaccines reach marginalized people in communities hit the hardest by the pandemic. These are the same communities in which residents are more likely to forego vaccination due to a lack of trust in the health care system rooted in a history of mistreatment and discrimination.

Moreover, as the virus mutates, new COVID variants present increasing challenges and demonstrate the pandemic and corresponding public health emergency are far from over. Essential hospitals bear much of the brunt of COVID-19 as they serve the patients and communities hardest hit by the pandemic, in terms of both economic and health outcomes. More federal help is needed, especially for providers serving large numbers of Medicaid and uninsured patients and in underserved areas.

The PRF is a critical resource these hospitals rely on to help offset losses from canceled procedures and the rapid scaling up of infrastructure to meet the unprecedented demand. We thank Congress for its work last year to establish and provide financial resources to the PRF. **America's Essential Hospitals urges Congress to replenish the PRF with $35 billion and prioritize funding to hospitals that are most in need.** This level of funding received bipartisan support as part of several COVID-19 relief proposals, and the concept was most recently adopted by a vote of 99-1 as an amendment to the Senate's budget resolution.

2. Augment Medicaid funding to increase DSH allotments and further expand the Medicaid Federal Medical Assistance Percentage (FMAP).

[2] *Ibid.*

The Medicaid program plays a critical role in blunting the economic impact of the COVID-19 public health crisis, serving as a lifeline for individuals and families who have lost access to employer-provided health coverage. To help state Medicaid programs pay for increased health care and coverage costs associated with COVID-19, the *Families First Coronavirus Response Act* (FFCRA) temporarily increased the Medicaid FMAP by 6.2 percent. The enhanced FMAP covered a greater portion of state Medicaid expenditures, allowing states to reduce their Medicaid spending. However, the FFCRA did not make a corresponding adjustment to Medicaid disproportionate share hospital (DSH) allotments to reflect the increased FMAP. Consequently, this will reduce the total amount states can spend on DSH. This unintentional omission could lead some states to cut Medicaid DSH payments to hospitals to stay within their state DSH allotments.

**America's Essential Hospitals urges Congress to pass a technical correction by temporarily increasing state DSH allotments to correspond with any enhanced FMAP.** This action would ensure essential hospitals receive the same level of DSH payments expected in the absence of COVID-19.

**We also ask Congress to increase the enhanced FMAP in the FFCRA to 12 percentage points to reflect the uncertain duration of the public health emergency.**

3. Aid essential hospitals disproportionately harmed by the change to the Medicaid shortfall definition.

Section 203 of the *Consolidated Appropriations Act, 2021* altered the definition of Medicaid shortfall. Specifically, the new law modified the uncompensated care adjustment for DSH payments to count only costs and payments for patients for whom Medicaid is the primary payer or who are uninsured. It provides an exemption to hospitals that, in the most recent cost reporting year, are in the 97th percentile of hospitals for the number of inpatient days for Medicare patients also eligible for supplemental security income (SSI) benefits or the percentage of total inpatient days for Medicare patients also eligible for SSI. For these hospitals, the limit is the greater of the DSH cap calculation provided under this bill or under the law as in effect on January 1, 2020.

Unfortunately, the exclusion criteria for the new definition are quite restrictive. Essential hospitals that see high numbers of Medicare patients might be disproportionately and substantially penalized by the new Medicaid shortfall definition. Congress has acted many times on a bipartisan basis to stop cuts to Medicaid DSH payments. **America's Essential Hospitals urges Congress to mitigate the impact of this provision by expanding the pool of hospitals eligible to choose either the DSH cap calculation established in section 203 or the formula enforced on January 1, 2020.**

4. Extend the Medicare sequester moratorium through the public health emergency.

Congress wisely understood the need for immediate resources to support health care providers and included a Medicare sequester moratorium in *Coronavirus Aid, Relief, and Economic Security (CARES) Act*. Congress reaffirmed this by extending the moratorium for three months through March 31, 2021, in the *Consolidated Appropriations Act, 2021*. Our nation will continue to fight COVID-19 long past the first quarter of this year. Now is not the time for providers to face a 2 percent cut to their current Medicare payments.

**We urge Congress to tie the temporary sequester moratorium to the end of the public health emergency to provide stability through the course of the pandemic.**

5. Provide additional relief to providers through the Medicare Accelerated and Advance Payment (AAP) programs.

Essential hospitals operate with margins about a third that of other hospitals; yet even with their limited means, they shoulder a disproportionate share of the nation's uncompensated care costs. Thin operating margins and limited financial capital coupled with the unprecedented burden of the COVID-19 pandemic compelled essential hospitals to take advantage of any and all opportunities for supplemental federal resources. The Medicare AAP program provided a critical and desperately needed financial lifeline that many of our hospitals took advantage of despite less-than-optimal terms and conditions. We are grateful for the assistance Congress has provided so far to extend repayment timelines and provide flexibility on AAP terms and conditions. However, more help is needed. The COVID-19 public health emergency is far from over and many hospitals will struggle significantly to begin repayment amid this ongoing pandemic. **We, therefore, ask Congress to delay the AAP repayment schedule and further lower the interest rate in recognition of the ongoing challenges essential hospitals continue to face.**

## Additional COVID-19 Relief

The aforementioned priorities are crucial to help essential hospitals sustain operations and meet the demands of the ongoing COVID-19 pandemic, especially as their roles expand with vaccine distribution and the rising threat of new and more contagious variants. Additional policy relief is necessary to recognize the unique way in which essential hospitals continue to respond to the pandemic as a function of their leadership and anchor roles in the communities they serve.

1. Protect 340B Drug Pricing Program eligibility during COVID-19.

The 340B program is indispensable for essential hospitals caring for vulnerable populations, as its discounts provide vital support for the health care safety net during the COVID-19 crisis. Disruptions to hospital operations caused by COVID-19 could result in temporary swings in the DSH adjustment percentage for some essential hospitals, putting their 340B status at risk. **We urge Congress to act to protect 340B eligibility for covered entities that experience changes to their payer mix for the duration of the COVID-19 public health emergency while still allowing new hospitals and clinics to join the program as soon as they become eligible.**

2. Protect health providers from liability lawsuits resulting from COVID-19 care provided in good faith.

The sudden onset of COVID-19 demanded an unprecedented response from health care providers, including essential hospitals on the front lines of the pandemic. Essential hospitals acted quickly to reorder daily operations, complying with government orders and public health guidance to suspend elective procedures, close nonessential units, shift personnel to front-line roles, and ensure caregivers had adequate PPE and supplies. However, these actions also heighten legal liability concerns for hospitals and their staff. Most recent, essential hospitals have answered the call to administer COVID-19 vaccines to the health care workforce and broader communities they serve. These vaccines have been authorized for use outside the Food

and Drug Administration's ordinary regulatory processes via an emergency use authorization. Essential hospitals and providers should not be saddled with questionable legal actions at this critical time, including instances when a patient does not return or refuses to return for a second dose of vaccine. **We urge Congress to provide a consistent level of protection against unwarranted liability for front-line providers responding in good faith to an unprecedented public health emergency.**

## Reimagining the Health Care Safety Net

COVID-19 has devastated communities served by essential hospitals. The pandemic has disproportionately impacted populations that have been disadvantaged by persistent health and socioeconomic disparities. Essential workers and racial and ethnic minorities have suffered COVID-19 infections, hospitalizations, and deaths at disproportionately high rates. These populations turn to essential hospitals in times of need.

Essential hospitals heavily rely on a patchwork of federal financial support and resources to sustain the health care safety net. Together, these programs and initiatives provide a foundation for essential hospitals to achieve their mission-driven mandates. Ensuring a reliable safety net, one that is ready to meet the moment in any crisis, means robustly protecting and bolstering the mechanisms and ideals that make the safety net function.

1. Protect the 340B Drug Pricing Program.

The 340B program works as Congress intended; it reflects the unique role of essential hospitals in caring for vulnerable populations, as well as their inherent financial challenges, by enabling hospitals to reach more patients and provide more comprehensive services at virtually no cost to taxpayers. The necessity of the 340B program is especially evident now, when essential hospitals' thin operating margins are further constrained by financial pressures related to COVID-19.

Bipartisan, bicameral prescription drug pricing legislation introduced last Congress contained provisions that would require Medicaid managed care plans to pay the actual acquisition cost (AAC) for drugs dispensed by providers or pharmacies, including 340B drugs dispensed by 340B covered entities and contract pharmacies. This policy would undermine a necessary benefit to 340B providers. America's Essential Hospitals supports reducing the prescription drug prices consumers pay and believes this can be achieved without jeopardizing vital 340B savings safety-net providers rely upon to meet their missions. **We urge Congress to keep the 340B program out of future drug pricing legislation.**

2. Improve health equity by mitigating health disparities and address structural racism.

The health and socioeconomic inequities that affect patients treated by essential hospitals manifest as chronic medical conditions, traumatic injuries, substance use, and mental health disorders, among other challenges. Consequently, these populations have been disproportionately harmed during public health emergencies, despite advances in population health over the past several decades.

The COVID-19 pandemic has shed light on such inequities, including disparate access to care and health outcomes experienced by racial and ethnic minorities. It underscores that a stable health care safety net is critical to supporting underserved communities.

*a. Recognize impacts of structural racism on health outcomes.*

Essential hospitals see firsthand the adverse health outcomes tied to structural racism that burden low-income populations and communities of color. We acknowledge that barriers to health arise from structural racism—the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color.[3] Our association is committed to addressing the root causes of socioeconomic factors that influence the health disparities so prevalent in communities anchored by essential hospitals.

Accordingly, America's Essential Hospitals advocates for meaningful policy solutions that will help our members execute their mission-driven, safety-net role and, in turn, benefit the individuals and communities they serve. Last year, we announced an initiative to combat structural racism as an urgent public health threat. This effort will culminate with the dissemination of actions essential hospitals can take to tackle disparities in health and social injustices that afflict their communities. **We urge Congress to engage with essential hospitals and advance policies that will help them address structural racism and improve health outcomes for underrepresented people and underserved populations.**

The Medicaid program is ripe for such a conversation. While Medicaid provides high-quality coverage to millions, it often reimburses hospitals substantially less than the cost of care. In the aggregate, Medicaid payments fell below costs in 2018, resulting in a $19.7 billion shortfall. This translated to hospitals receiving payment of only 89 cents for every dollar spent caring for Medicaid patients.[4] The history of low Medicaid base rates is part of the fabric of structural racism in our county—discriminating against the most vulnerable and undervaluing the provision of care to patients the program serves.

Adequate Medicaid payments would ensure people who rely on the program—a population disproportionately comprising racial and ethnic minorities—have equal access to care through providers who, themselves, are not disadvantaged due to below-cost rates. Improving payments could be achieved by various means, including increasing base payment rates, protecting supplemental payments, or providing new payment pathways, This, in turn, would help mitigate health disparities and improve health equity overall. **Congress should work with the Biden administration and states to ensure sufficient Medicaid rates.**

*b. Address social determinants of health.*

In addition to providing high-quality care, essential hospitals work to mitigate disparities to improve health outcomes and meet the social needs of their communities, especially in times of crisis. America's Essential Hospitals is encouraged by the volume of bills introduced in the last Congress to address social determinants of health. Improving health equity, often by addressing social determinants of health, is the cornerstone of the essential hospital mission.

Essential hospitals rely on the federal government to offer support and resources to carry out many of their patient-level initiatives focused on social determinants of health. **We ask**

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[3] Lawrence K and Keleher T. *Structural Racism.* For the Race and Public Policy Conference 2004. http://www.intergroupresources.com/rc/Definitions%20of%20Racism.pdf. Accessed February 17, 2021.
[4] Medicare-Medicaid Underpayment Fact Sheet. American Hospital Association. January 2020. https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf. Accessed January 22, 2021.

**Congress to develop permanent incentives, potentially through the Medicaid program, to support initiatives to eliminate health disparities.** A dedicated stream of support would help essential hospitals develop and maintain social determinants of health programming and policies that could transcend financial threats to the hospital, ultimately benefiting the communities they serve.

Further, in designing new incentives or payment systems, Congress should work with and encourage the Centers for Medicare & Medicaid Services (CMS) to give special recognition and financial support to providers who disproportionately deliver care to disadvantaged populations facing disparities in health and health care. Incentives across the health care delivery and payment system need to be aligned to promote equity of care and eliminate disparities.

**We encourage Congress to engage with stakeholders, including CMS and essential hospitals, to develop new, voluntary delivery models, within Medicare and Medicaid, that seek to address social determinants of health and improve the overall health of the nation.** We believe demonstrations should be used in a manner that drives improvement without unduly burdening essential hospitals.

c. *Combat disparities by improving maternal health outcomes.*

The unconscionable racial disparities in maternal health outcomes are a glaring example of the health inequities experienced by minority populations. Essential hospitals across the country initiate and sustain programs to help reduce maternal morbidity and mortality. To enhance this work, America's Essential Hospitals supports several bills and legislative initiatives to improve maternal health outcomes and eliminate maternal health disparities, including allowing states to extend continuous Medicaid coverage for 12 months postpartum. We look forward to continuing to work with lawmakers on legislative efforts to improve maternal health, providing perspectives from essential hospitals to meaningfully address this public health crisis. **We encourage Congress to build on bipartisan efforts from the last Congress and pass legislation to improve maternal health outcomes this year**.

3. Invest in rebuilding the safety net infrastructure.

Stories about front-line health care providers facing a COVID-19 surge with antiquated hospital facilities caught the attention of America. Media watchers saw how aging facilities can impede swift adjustments to facilities and equipment and impact staff morale. Moreover, the pandemic cemented the role of telehealth and health information technology in the health care delivery system, rendering the service indispensable but often unattainable for many providers and populations.

Essential hospitals, which operate on razor-thin margins, often rely on Congress to support their infrastructure needs, whether those relate to facilities and services or preparing for emergencies. Dedicated funding to hospitals to support infrastructure is necessary to help recover from the COVID-19 pandemic and ensure preparedness for future public health emergencies. Investing in infrastructure improvements now will help mitigate disparities in the short term by increasing capacity and resources while simultaneously ensuring preparedness in the event of a future outbreak.

a. *Provide new opportunities for capital investments.*

Capital investments in both built and technological infrastructure are paramount to ensuring essential hospitals can continue to provide high-quality care to their patients. The House-passed Moving Forward Act from the 116th Congress would have provided $10 billion in hospital infrastructure, prioritizing investments in cybersecurity protection and emergency preparedness. Congress also could make available new grants, loans, tax credits, or other means to assist essential hospitals in modernizing and updating aging infrastructure. **We urge Congress to engage with essential hospitals to identify the best mechanisms for achieving infrastructure improvements and accessing the necessary resources to do so.**

Further, **Congress should recognize the importance of stable funding to support essential hospital infrastructure in its annual appropriations process**. Recognizing the immense strain a public emergency places on hospitals with a safety net role, **Congress also should include temporary infrastructure funding in any emergency or temporary relief legislation aimed at combating public health emergencies**.

*b. Support investments in emergency preparedness.*

More can and should be done to prepare and support our nation's health care system and improve public health preparedness. The COVID-19 pandemic has disproportionately impacted essential hospitals and the communities they serve. Congress must prioritize the health care safety net before, during, and after a public health emergency. The populations and communities at risk can be identified in advance and investments should be directed accordingly.

Specifically, to meet the demands of the virus, it has been imperative that essential hospitals rapidly expand capacity, including on- and off-campus solutions. Examples of this work include converting hospital wards to intensive care units (ICUs), adding beds to on-campus space not previously designated for patient care, and erecting temporary structures on the premises. These efforts have, in some cases, resulted in dramatic growth of ICU capacity.

One New York essential hospital's ICU capacity increased from 29 to 111 beds, and other hospitals in the system grew at comparable rates. In addition, many of our hospitals collaborated with others to stand up field hospitals in a variety of off-campus locations, including gyms and convention centers, largely to serve patients who do not require ICU care. These expansions were critical to serving the needs of the public in hot-spot regions. Even with these innovative strategies in place, the surge of patients poses significant problems. For example, makeshift or temporary ICUs do not have anterooms, where health care workers can remove PPE within the isolation space.

4. Invest in the health care workforce.

Foreign-born nurses, physicians, and other providers represent a critical component of America's health care workforce. Foreign-born clinicians are unnecessarily subject to burdensome restrictions that prevent them from efficiently joining the health care workforce to help meet our nation's demand for care. **We urge Congress to advance proposals to reinforce our nation's foreign-born workforce.** Specifically, in the short term, we encourage lawmakers to expand immigrant employment visas for clinicians who provide care, conduct medical research, or participate in graduate medical education or training programs related to the diagnosis, treatment, and prevention of COVID-19.

Essential hospitals play a critical role in training the next generation of health care professionals; three-quarters of essential hospitals are teaching institutions, training on average 241 physicians a year—three times as many as other U.S. teaching hospitals.[5] Residents and fellows are a vital part of the provision of care to patients of teaching hospitals. They have taken on increased importance during the COVID-19 pandemic, when hospitals in hot spots experienced exponential surges in cases that strained their already taxed resources and staff. Nearly one-third of physicians in the United States are foreign-born.

Maintaining a strong physician training pipeline is critical. America's Essential Hospitals will continue to advocate for programs, such as the Conrad 30, that expand the workforce for foreign-born clinicians and future clinicians.

5. Make permanent the COVID-19 telehealth priorities.

A crucial goal of essential hospitals is to meet patients where they are and offer services that are accessible and tailored to their unique needs. This is especially important when serving diverse and vulnerable populations with specific needs, like those communities that our hospitals anchor. Telehealth is an important tool that allows essential hospitals to reach outside the walls of their buildings and out into the communities, where the patients they care for live and work. Telehealth is a safe and effective option for patients and allows our hospitals to operate more efficiently and stretch their scarce resources further. Beyond increasing access to primary care and routine health services, it also allows patients to sometimes receive more complex care in their preferred setting and avoid hospitalizations through new and cutting-edge hospital at home and remote patient monitoring programs.

Despite the devastation the pandemic has inflicted on our nation, the rapid advancement and expansion of telehealth has emerged as a bright spot during the COVID-19 public health emergency and has shown how nimbly health systems can respond to the unique needs of their communities if payment and policy incentives align. Multiple essential hospitals dramatically built out and scaled up their telehealth capabilities to help respond to the care needs of their communities despite the pandemic. These important avenues of care should not be tied just to this or future public health emergencies. Instead, Congress should build on the progress made in the telehealth space to better allow patients and providers to take advantage of this important tool.

Congress and CMS made several changes in 2020 to expand access and payment for telehealth services during the public health emergency, including temporarily lifting the geographic originating site restrictions and site-of-service restrictions and allowing the use of audio-only equipment for certain evaluation and management services. **America's Essential Hospitals supports legislation, including the Telehealth Modernization Act from the 116th Congress, that make these changes permanent and urges Congress to take up and pass such a measure this year.**

It is always vital that adequate emergency and trauma services are available, and hospital facility fees help to ensure these services remain accessible to all Americans. Though furnishing telehealth services to patients doesn't necessarily require the patient's physical presence within the brick and mortar of a hospital, these services nonetheless require significant hospital and staff resources. Hospitals incur substantial costs investing in telehealth technology and maintaining staff and equipment to ensure seamless operation of their platforms. CMS

[5] *Ibid.*

recognized this by allowing hospitals to bill an originating site facility fee for services provided through telehealth as long as the patient is a registered outpatient of the hospital, even if the patient receives the service from their home. **America's Essential Hospitals urges Congress to follow CMS' lead and pass legislation that codifies this important payment priority.**

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Thank you for your continued support of essential hospitals and the vulnerable communities we serve. As we embark upon a new Congress and new opportunities, we look forward to working with lawmakers in both chambers to ensure safety-net providers receive the support they need as the COVID-19 public health crisis continues.

If you have any questions, please contact Vice President of Legislative Affairs Carlos Jackson at 202-585-0112 or cjackson@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
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