February 26, 2021

Norris Cochran  
Acting Secretary  
U.S. Department of Health and Human Services  
200 Independence Ave. SW  
Washington, DC 20201

Dear Acting Secretary Cochran:

America’s Essential Hospitals appreciates the leadership of the Department of Health and Human Services (HHS) in confronting COVID-19 and tackling health inequities brought to the fore by the pandemic. We urge the swift allocation of the remaining funds in the $178 billion Provider Relief Fund (PRF), as they will be vital to helping essential hospitals respond to the pandemic and lead vaccination efforts in their communities. These hospitals continue to see higher expenses and deeper revenue losses due to their front-line work and need more support.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including underrepresented people and underserved communities. 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. The difficulties associated with these narrow margins have been compounded by the strain on hospital finances associated with responding to the pandemic. Essential hospitals continue to make substantial investments to maintain surge capacity and adequate staffing during record-high numbers of COVID-19–related hospitalizations following the winter holidays. The pressures of the pandemic have led to staff burnout and required essential hospitals to expend significant resources to recruit and retain external medical staff, which is a costly undertaking considering the competitive marketplace for health care workers during the pandemic. Essential hospitals were some of the first providers involved in vaccinating health care workers and the general public. Their vaccination-related efforts have included procuring adequate supplies of vaccines, setting up the appropriate vaccine storage capabilities, establishing mass vaccination sites and drive-through vaccination clinics, and hiring staff to administer vaccines. As the pandemic continues and

hospitals dedicate additional resources to vaccination efforts, essential hospitals face an uncertain financial future.

The COVID-19 pandemic hit the patients and communities served by essential hospitals particularly hard—especially people of color, which constitute more than half of essential hospitals’ discharges.\(^2\) We applaud the administration’s swift actions to address issues critical to a national pandemic response, including the establishment of a COVID-19 Health Equity Task Force. Sociodemographic factors greatly influence patient health status, making our member hospitals’ patients most at risk, as COVID-19 is detrimental for those with underlying health conditions. Sustained efforts by essential hospitals in vaccination rollout and education campaigns will be critical to ensuring the nation’s most underserved communities are vaccinated.

While we appreciate distributions made through the general and targeted PRF distributions to date, many essential hospitals received minimal funds from general distributions tied to Medicare or total revenues, and others were left out from targeted distributions altogether. As the remaining funds decrease and providers ramp up their vaccination efforts while maintaining their capacity to treat patients, we urge HHS to take these steps to ensure essential hospitals are equipped for their central role in the continued response to the pandemic:

- swiftly distribute remaining PRF funds;
- issue another targeted distribution to hospitals omitted from the first two safety-net distributions, with a refined methodology that will ensure hospitals committed to serving the most vulnerable remain financially viable; and
- ensure timely and transparent reporting and auditing processes that do not put providers in the untenable position of returning funds based on factors outside of their control.

We expand on these points in our comments below.

1. **HHS should swiftly allocate the remaining PRF funds.**

The year-end COVID-19 relief and appropriations bill allocated an additional $3 billion to the PRF, bringing the total pool to $178 billion. To date, according to the data provided on HHS’ PRF website, HHS has pledged $150.4 billion through the various general and targeted distributions, in addition to $3.5 billion through the Health Resources and Services Administration for testing and treatment of uninsured individuals. Of the $150.4 billion in pledged funds, HHS has yet to disburse more than $30 billion to providers, including funds from the second and third phases of the general distribution.\(^3\) Providers submitted applications and detailed financial information to confirm eligibility for these funds, but are awaiting receipt of the much-needed funds. **HHS should complete its disbursement of these remaining, already-allocated funds so providers can use them to cover the higher expenses and revenue losses associated with COVID-19.**

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\(^2\) Ibid.

Aside from the nearly $30 billion in funds HHS has pledged but not yet distributed, there are about $24 billion in unallocated funds remaining, of which 85 percent must be distributed through an application-based process, according to the year-end legislation. **We urge HHS to swiftly open the application process to direct these funds to providers in need.** Providers can use this money to cover critical activities, such as their vaccination initiatives and staffing, and to help maintain capacity for future COVID-19 surges. A portion of the remaining, non-application–based funds should be reserved for a targeted safety-net allocation to hospitals that were omitted from the first and second rounds of safety-net funding, further discussed below.

2. **HHS should issue a safety-net distribution to hospitals that serve those most in need and were excluded from the previous safety-net distributions.**

While we appreciate that HHS recognized in last year’s two safety-net allocations the critical role these hospitals play in the nation’s COVID-19 response, we remain concerned that many essential hospitals serving large numbers of underserved patients and under immense financial pressure were excluded from these allocations due to flaws in the allocation methodology. **We urge HHS to distribute funds through an additional safety-net distribution targeted at these excluded hospitals, using a revised version of its second safety-net methodology, with the addition of hospital deemed disproportionate share hospital (DSH) status as a metric.**

To have been eligible for the first safety-net allocation, a hospital had to meet three metrics: a Medicare DSH patient percentage (DPP) of at least 20.2 percent; a minimum average uncompensated care cost (UCC) 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. HHS modified the profit margin metric in the second safety-net distribution to use the average of two or more consecutive years of margin data from the past five years and modified the UCC metric to annualize the UCC data submitted in the hospital’s cost report. These tweaks represented incremental improvements over the methodology used for the first safety-net distribution but still are flawed in many ways.

Total margin data reported on cost reports does not reflect the true state of a hospital’s financial status and fails to capture the natural ebb and flow of a hospital’s finances or variations among and within states. While using two or more consecutive years of margin data was an improvement over using one year, the margin data HHS relies on is inherently flawed because it does not truly reflect hospital operations. The margin data on cost reports is unaudited data that is not used for Medicare or other reimbursement purposes, meaning it is not thoroughly reviewed for accuracy. There are many reasons a hospital’s total margins might not reflect the overall financial stability of that hospital. For example, a hospital might have an atypically high operating 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

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the calculation of its total margin—resulting in a distortion of a hospital’s margin. This approach to determining eligible hospitals disregards yearly fluctuations and operational nuances, ultimately excluding many of the hospitals this allocation seeks to target.

Although HHS’ use of two or more consecutive years of margin for the second safety-net distribution partially mitigates the issue with using one year of margin data, it still relies on unreliable data and fails to adequately account for year-over-year fluctuations that result from anomalies. Consider a hospital with margins of 3 percent in 2014 to 2016 cost reports and in its 2018 cost report, but with an uncharacteristically high margin of 8 percent in 2017 due to an anomaly for one of the reasons cited previously, such as delayed state reimbursement. HHS would calculate the average consecutive margin from 2017 and 2018 first, but the hospital’s average margin from these years would be 5.5 percent, thus not meeting the 3 percent threshold.

In addition to the shortcomings of margin data, the use of an all-or-nothing approach, in which a hospital must meet all three of the metrics, fails to capture the true safety-net status of a hospital. A hospital could have a high DPP and UCC per bed but just exceed the margin cut-off, thus rendering it ineligible for HHS’ previous safety-net distributions. However, the DPP and UCC per bed are indications the hospital serves a large number of low-income patients. It is unfortunate many essential hospitals were left out of the previous safety-net distributions due to these nuances, but they nonetheless continue to dedicate themselves to their communities and incur COVID-19–related revenue losses and expenses. **We urge HHS to swiftly issue another safety-net distribution to hospitals that did not receive funds from the first two safety-net distributions using this methodology:**

- a hospital meets two out of the three metrics HHS used for the second safety-net distribution (DPP greater than or equal to 20.2 percent, annualized UCC per bed of $25,000 or more, average consecutive margins of 3 percent or less); **OR**
- a hospital meets the deemed DSH designation as defined in the Medicaid statute.

Defined by statute, the deemed DSH designation is used to identify hospitals that have high Medicaid and low-income utilization rates. Deemed DSH hospitals have been a critical element of the nation’s response to COVID-19 and, by definition, are the very hospitals HHS stated the safety-net allocation targets. This methodology builds on HHS’ existing methodology but provides some flexibility to allow HHS to consider two of the three original metrics or the statutory deemed DSH designation, an indicator of a hospital’s commitment to low-income populations. Moreover, by using these metrics, HHS is using readily available and vetted data points that will allow it to swiftly deploy these funds. **Therefore, HHS should incorporate this updated methodology to ensure all hospitals with a safety-net role see relief for the costs of responding to the COVID-19 pandemic.**

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5 42 U.S.C. § 1396r–4(b)
3. **HHS should ensure future guidance on reporting and auditing of PRF funds is timely, clear, and consistent, and does not result in the recoupment of funds due to factors outside a provider's control.**

As HHS disburses the remainder of PRF funds and shifts its focus to accounting for the use of these funds, it is imperative the agency provides clear guidance to hospitals that does not disfavor facilities hardest hit by the pandemic. Essential hospitals are committed to the integrity of the reporting and auditing processes, but steps to date have caused significant confusion. Since a June frequently asked questions document establishing the reporting process, HHS has issued four versions of conflicting guidance on the process. Most recent, the January 15 guidance is a step in the right direction and addresses most of the deficiencies of the earlier versions of guidance from last fall. However, the constant changes in definitions and terms result in a high level of uncertainty for hospitals. Hospitals that accepted funds under their interpretation of one version of the guidance were concerned they might have to return funds when later versions of the guidance contradicted earlier definitions of key terms, such as lost revenue. This was particularly troublesome for hospitals that were completing statements or undergoing audits, and it placed them in the untenable position of not knowing whether they could retain their PRF payments or might have to return them due to the conflicting nature of the guidance. To avoid these issues going forward, we urge HHS to issue guidance well in advance of reporting deadlines and ensure it does not cause providers to return funds that were used in good faith to cover COVID-19 revenues losses and expenses.

**As HHS shifts to audits, we also urge the agency to be transparent and clear in its audit processes.** HHS should publish its audit protocols in advance to allow the hospital community more time and opportunity to respond to audits and address findings. HHS also should select hospitals for audits in an equitable and systematic way. HHS should minimize the burden associated with audits by minimizing documentation requests and giving hospitals ample time to respond. Last, HHS should ensure audit guidelines are clear so that they are conducted accurately and uniformly across hospitals that received PRF funds.

As the nation continues to face this unprecedented public health emergency, it is imperative HHS swiftly distribute the remaining PRF dollars, including with a targeted safety-net distribution to those hospitals that were omitted from the first two safety-net distributions. At the same time, the agency must implement a transparent process for reporting and auditing the receipt of these funds.

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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