



AMERICA'S ESSENTIAL HOSPITALS

June 15, 2021

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

Dear Secretary Becerra:

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. As providers continue to invest significant resources into COVID-19 prevention and response, and as they recover from the financial losses of the past 16 months, we urge HHS to take swift and decisive steps to allocate the remainder of the funds in the Provider Relief Fund (PRF). We also urge HHS to revise its guidance on the use of PRF funds to protect essential hospitals from having to return these vital funds. The disbursement of the remaining funds and the ability to use these funds for COVID-19-related lost revenue and expenses will ensure the continued operation of essential hospitals responding to the pandemic and leading vaccination efforts in their communities.

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 three-quarters 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—2.9 percent on average compared with 8.8 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 capacity for treating COVID-19 patients and leading vaccination efforts in their communities. 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

¹ Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. <https://essentialdata.info>. Accessed June 6, 2021.

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, who 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 establishing 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 to 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 of targeted distributions altogether. Today, many essential hospitals continue to struggle with COVID-19–related financial challenges. **We urge HHS to take these steps to ensure essential hospitals receive much-needed relief and are equipped for their central role in the continued response to the pandemic:**

- swiftly distribute remaining PRF funds;
- issue another targeted distribution to hospitals serving a safety net role, with a refined methodology that will ensure hospitals committed to serving the most vulnerable remain financially viable;
- issue guidance for the Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program that will align with ICD-10-CM coding guidance; and
- make revisions and clarifications in the PRF reporting guidance that will remove ambiguity and allow providers to continue to use funds to cover COVID-19–related lost revenue and expenses.

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 and by the Government Accountability Office, HHS has \$24 billion in unallocated funds remaining in the PRF. Also, according to the year-end bill, 85 percent of these unallocated funds must be distributed through an application-based process. **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 throughout the public health emergency. A portion of the remaining, non-application–based funds should be reserved for a third targeted safety net allocation to hospitals using a refined set of criteria, as discussed further below.

² Ibid.

2. HHS should issue a safety net distribution to hospitals that serve those most in need.

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 many essential hospitals serving large numbers of underserved patients and under immense financial pressure still have not recovered financially. These hospitals need additional funds to cover COVID-19 expenses and lost revenue. Others never received funding in the first place, due to flaws in the allocation methodology. **We urge HHS to distribute funds through an additional safety net distribution using a revised version of its second safety net methodology, with the addition of hospitals 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.³ 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 adjustments represented incremental improvements over the methodology used for the first safety net distribution but still are flawed in many ways, including the dependence on unreliable margin data, as we have detailed in previous letters to the administration.⁴

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.

Throughout the pandemic, members of America's Essential Hospitals have faced case surges that overwhelmed their capacity, shortages of supplies and personnel, and an uncertain financial future. Although cases are declining nationwide, essential hospitals must maintain capacity for potential future surges and are dedicating substantial resources to vaccine administration. That is, essential hospitals have not recuperated from the effects of the pandemic on their finances and still need additional resources.

We urge HHS to swiftly issue another safety net distribution to hospitals 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.

³ Press Release: HHS Announces Enhanced Provider Portal, Relief Fund Payments for Safety Net Hospitals, Medicaid & CHIP Providers. Department of Health and Human Services. <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 7, 2021.

⁴ Letter from Dr. Bruce Siegel to Acting Secretary Norris Cochran. February 26, 2021. <https://essentialhospitals.org/policy/association-asks-hhs-direct-additional-funds-essential-hospitals/>. Accessed June 7, 2021.

Defined by statute, the deemed DSH designation is used to identify hospitals that have high Medicaid and low-income utilization rates.⁵ 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.⁶ 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 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.**

3. HHS should align HRSA COVID-19 Uninsured Program rules with coding rules to allow providers to seek reimbursement for treatment of uninsured patients with COVID-19.

HHS has reserved a portion of PRF funds for HRSA to reimburse providers for testing, treating, and vaccinating individuals with COVID-19. **We urge HRSA to issue clarifying guidance that will allow providers to submit claims in accordance with Health Insurance Portability and Accountability Act (HIPAA) coding guidelines and be reimbursed for treatment of COVID-19 patients.**

Funding for treatment of COVID-19 patients is critical to essential hospitals, which treat disproportionate numbers of uninsured patients, resulting in high levels of uncompensated care. In the aggregate, essential hospitals provide nearly 17 percent of the nation's uncompensated care, with the average essential hospital providing \$56 million in uncompensated care—seven times as much uncompensated care as other hospitals.⁷ Given the already low margins of essential hospitals, it is important that they be able to receive reimbursement for the treatment of uninsured patients when such reimbursement is available. Unfortunately, due to unclear guidance from HRSA on eligibility for reimbursement resulting in potential compliance risks, many hospitals have been forgoing submitting claims for reimbursement, passing up millions of dollars in potential reimbursement.

HRSA has stated in FAQs on its website that for a claim to be eligible for reimbursement, COVID-19 must be the primary diagnosis listed on the claim, using ICD-10-CM code U07.1 for dates of service or discharges on or after April 1, 2020; and ICD-10-CM code B97.29 for services or discharges prior to this date. The only exception to this policy is for pregnant patients who are diagnosed with COVID-19, in which case the code for pregnancy will be primary on the claim. This policy that COVID-19 must be listed as the primary diagnosis is problematic in cases where a patient has COVID-19 and also is treated for sepsis or HIV. ICD-10 guidelines require providers to treat these conditions as the primary diagnosis on claims, which would mean providers submitting claims to HRSA with sepsis or HIV in the primary position and COVID-19 in the secondary position would not qualify for reimbursement under HRSA's policy.

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. <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 7, 2021.

⁷ Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey*. America's Essential Hospitals. May 2021. <https://essentialdata.info>. Accessed June 6, 2021.

In an FAQ on submitting claims for patients with sepsis and COVID-19, HRSA indicates that HRSA uninsured program claims are not subject to ICD-10 coding guidelines. This suggests that hospitals could submit claims to HRSA with COVID-19 as the primary diagnosis, even when sepsis is present on the claim as a secondary diagnosis. However, even if hospitals were to submit claims in this reverse order, this presents compliance risks, is burdensome for hospital coding staff, and has downstream consequences. Effectively, the requirement that hospitals reverse primary and secondary diagnoses for uninsured claims submitted to HRSA creates a two-tiered system. Hospitals seeking reimbursement for insured patients would submit claims to payers in accordance with ICD-10 rules, while for uninsured patients they would submit claims to HRSA with the diagnosis codes reversed. In addition to the operational complexity of maintaining this two-tiered coding system, this could put providers at risk of audit findings, can result in different diagnosis-related group (DRG) classifications and, thus, affect the setting of DRG-based payment, affect quality reporting programs, and affect hospital case mix.

To alleviate these concerns, HRSA should allow providers to submit claims in accordance with ICD-10 guidance and still be eligible for reimbursement when sepsis or HIV appear on the claim in the primary position. This would allow providers, as HIPAA-covered entities subject to coding rules, to be in compliance with coding guidelines while also permitting them to seek reimbursement for treating COVID-19 patients. Such a policy would align with the purpose of the COVID-19 Uninsured Program and also be consistent with HRSA's guidance. While not explicit, HRSA's guidance suggests that claims with a diagnosis of sepsis and COVID-19 are reimbursable through the COVID-19 Uninsured Program because the program is not governed by ICD-10 coding guidelines.⁸ **In the alternative, if HRSA maintains that COVID-19 must be listed as the primary diagnosis on claims, HRSA should issue guidance clearly stating that providers may reverse the position of sepsis and COVID-19, as well as HIV and COVID-19, on claims submitted to HRSA and be eligible for reimbursement.**

We also request that, once HRSA makes these clarifications, it allows hospitals to file claims dating back to April 1, 2020, notwithstanding the one-year filing window. Confusing requirements have resulted in providers forgoing claim submission. Once HRSA clarifies that providers may seek reimbursement for COVID-19 claims with sepsis or HIV, providers should be given the opportunity to submit those claims that they withheld due to ambiguity in HRSA's guidance to date.

4. HHS should revise the PRF reporting guidance so it does not disfavor hospitals hit hardest by the pandemic.

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 process, but steps to date have caused significant confusion. Since a June 2020 FAQ establishing the reporting process, HHS has issued five versions of conflicting guidance on the process. Most recent, the June 11 post-payment notice of reporting requirements is a step in the right direction and addresses some deficiencies of the earlier

⁸ See HRSA COVID-19 Uninsured Program FAQs on patients with sepsis and COVID-19, stating "The ICD-10-CM Official Coding Guidelines – Supplement for Coding encounters related to COVID-19 Coronavirus Outbreak do not apply to the HRSA Uninsured COVID 19 Program." <https://coviduninsuredclaim.linkhealth.com/frequently-asked-questions.html>. Accessed June 7, 2021.

versions of guidance. However, the June 11 guidance and the PRF FAQs related to reporting of funds still contain some ambiguity, resulting in uncertainty for hospitals on appropriate uses of the funds. **HHS can make the following changes to its guidance to ensure it does not cause providers to return funds that were used in good faith to cover COVID-19 revenues losses and expenses.**

- a. HHS should clarify whether targeted distribution payments can be transferred between a parent and subsidiary entity of an organization.

In the January 15 guidance, HHS clearly stated its policy that a parent organization may transfer targeted distribution payments made to one of its subsidiaries to other subsidiaries of the parent organization but did not state whether targeted payments could be transferred between a parent and its subsidiary. Subsequently, HHS in the June 11 guidance deleted the paragraph from earlier guidance that stated its position on the transfer of targeted distribution payments. Instead, the agency added a requirement that reporting entities report the amount of targeted distribution payments “transferred to/by a parent entity,” without further clarification on acceptable transfers of targeted funds. HHS should reconcile this discrepancy between the January and June versions of the guidance and clarify whether parent organizations can transfer targeted distributions between the parent organization and its subsidiaries. Allowing parent organizations to transfer the targeted distribution payments vertically within the organization will provide health systems with the discretion to make decisions based on the financial needs of their organization.

- b. HHS should provide additional guidance on acceptable alternative methodologies for reporting of lost revenue.

HHS provided three options for calculating lost revenue attributable to COVID-19: comparing the difference between actual patient revenue; comparing the difference between budgeted and actual patient care revenue; or using “any reasonable method of estimating revenue.” HHS provides few details on what constitutes an acceptable alternate methodology under this third category, other than stating that it must be “reasonable” and that a provider must include a description of its methodology, a description of why it is reasonable, and an explanation of how the lost revenues were attributable to COVID-19 and not another source. HHS also states that a provider using this methodology will be at increased risk of audit by HRSA.

Some providers, due to their specific financial circumstances, might be unable to use the first two methodologies for calculating lost revenue and will have to use the alternate methodology. The availability of the alternate methodology affords providers much-needed discretion to determine the impact of the pandemic on their operations. Due to finance variations by hospital and state, it is key that hospitals make judgments as how to best capture the impact of COVID-19 on their revenues. But hospitals that need to use the alternate methodology might be hesitant to do so because of the increased likelihood of audit. **To offer direction to providers, HHS should publish additional guidance on the alternate methodology, including examples of reasonable methods for calculating lost revenue, as well as examples of the justifications and supporting documentation that would be considered sufficient.**

- c. HHS should permit providers to compare 2020 and 2021 actual revenue to 2019 budgeted revenue for quarters in which the hospital did not have a budget approved prior to March 27, 2020.

HHS stated in the June 11 guidance that providers comparing budgeted revenue to actual revenue to calculate lost revenue must use budgeted patient care revenue from a budget that was established and approved prior to March 27, 2020. This interpretation poses a problem for hospitals that have fiscal years that do not coincide with the calendar year. Hospitals with a fiscal year that begins in October, for example, would be unlikely to have a budget for fiscal year 2021 (October 2020 to September 2021) that was approved prior to March 27, 2020. Therefore, these hospitals would be unable to compare 2020 actual revenue to 2020 budgeted revenue for the months of October to December 2020 due to the lack of a budget that was approved prior to March 27.

Hospitals will encounter a similar problem when calculating lost revenue in 2021. In the June 11 guidance, HHS deleted previous language stating which quarters a hospital should compare when calculating lost revenue for 2021. It is unclear whether a provider opting to use the budgeted-to-actual revenue comparison will compare 2021 actual to 2021 budgeted revenue, 2021 actual to 2020 budgeted revenue, or 2021 actual to 2019 budgeted revenue. In its January 15 guidance, CMS indicated a hospital would compare 2021 actual to 2020 budgeted revenue but has removed this language. While this method might be possible for the first and second quarters of 2021, for the same reasons as stated above, some hospitals calculating lost revenue for the third and fourth quarters of 2021 will be unable to compare 2021 actual revenue to budget revenue if they did not have a fiscal year 2021 budget approved before March 27, 2020.

HHS should accommodate these providers by allowing them to use 2019 budgeted revenues for the months for which they do not have a 2020 approved budget. These providers' 2019 budget would have been approved before March 27, 2020.

- d. HHS should clarify that providers may use PRF funds to cover base expenses, and not just incremental expenses, directly attributable to COVID-19, including the labor costs associated with providing care to COVID-19 patients.

Aside from the direct costs of treating COVID-19 patients, essential hospitals have invested significant resources into recruiting and maintain staff, including nurses. Due to the extremely high demand for clinicians, especially nurses, hospitals have had to resort to contract labor, paying retention bonuses, and increasing salaries. These are all costs that are directly attributable to the competitive labor market stemming from increased demand for health care workers during the pandemic, as well as staff burnout and other supply issues. **HHS should clarify that these types of costs for recruitment and retention of nurses and other staff are acceptable COVID-19–related expenses.**

Furthermore, HHS should clarify that expenses that were budgeted for non-COVID-19–related purposes but were then repurposed to respond to COVID-19 should be counted as qualifying expenses. For example, if a hospital had a nurse who provided care to non-COVID-19 patients prior to the pandemic but who was reassigned during the pandemic to treat COVID-19 patients, the allocable portion of that nurse's time should be treated as a COVID-19 expense, after being offset with any reimbursement from other payers or sources. This nurse likely would have faced reduced hours or furlough during the pandemic but was retained to treat COVID-19 patients—thus, their time is directly attributable to COVID-19. **HHS should clarify that these types of labor expenses are acceptable expenses.**

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. At the same time, the agency must extend the deadline for using PRF funds and revise the reporting guidance to allow providers to use these funds to respond to the pandemic.

We look forward to continued engagement and partnership in responding to COVID-19. 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

Cc: Diana Espinosa, HRSA Acting Administrator