AMERICA'S ESSENTIAL HOSPITALS

September 20, 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. With the highly contagious delta variant becoming the predominant strain of the Sars-CoV-2 virus, essential hospitals nationwide are facing dire staffing shortages and straining under the overwhelming demand the variant has created. While America's Essential Hospitals appreciates HHS' September 10 announcement of $25.5 billion in funds to providers, the methodology falls short of providing necessary support to the very providers the agency intends to help through this distribution—those committed to advancing equity and serving the most vulnerable communities. Allocating a proportion of the $25.5 billion in application-based funds to hospitals serving a safety net role—as well as releasing the remainder of the funds immediately, including through another targeted distribution—will ensure the continued operation of essential hospitals responding to the pandemic.

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]

We greatly appreciate HHS' intention to bolster providers who have endured demanding workloads, are under significant financial strain, and serve the nation's most vulnerable communities. These characteristics aptly describe essential hospitals. First, essential hospitals treat high numbers of the patients hit hardest by COVID-19—especially people of color, who constitute more than half of essential hospitals' discharges.[2] Our member hospitals serve a disproportionate number of people facing social risk factors and compounding health issues, putting our members' patients most at risk. Second, essential hospitals' tight operating margins

[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 September 13, 2021.
[2] Ibid.

essentialhospitals.org
AMERICA'S ESSENTIAL HOSPITALS
401 Ninth St NW Ste 900
Washington DC 20004
t: 202 585 0100
f: 202 585 0101
e: contact@essentialhospitals.org

result in minimal reserves and low cash on hand, with many struggling to make payroll and invest in necessary efforts to maintain capacity to treat surging COVID-19 cases and lead vaccination efforts. Finally, essential hospitals across the country continue to incur high costs in hiring and maintaining staff to respond to COVID-19, with many facing staffing shortages in the hundreds. The pressures of the pandemic have led to staff burnout and required our members to expend significant resources to recruit and retain external medical staff—a costly undertaking considering the competitive marketplace for health care workers during the pandemic. However, under HHS' stated methodology, these hospitals could receive minimal reimbursement to cover their expenses and lost revenues. It will be critical that HHS direct necessary resources to essential hospitals to ensure they can continue to operate in the face of these pressures.

America's Essential Hospitals has outlined in previous letters the need for the agency to release the remainder of the Provider Relief Fund (PRF) funds as soon as practicable, including through a targeted safety-net distribution that will provide immediate relief to these hospitals in a tenuous financial situation.[3] This targeted distribution will be critical, especially because the phase 4 distribution not only disfavors large providers but also omits lost revenues and expenses that hospitals incurred during the peak surge of the delta variant in the summer. Further, as HHS prepares to accept applications for the $25.5 billion in funds through the PRF and the American Rescue Plan Act (ARPA) fund for rural providers, it is imperative the agency provide sufficient funding through these two distributions to cover expenses of essential hospitals. **Before accepting applications for these new distributions, we urge HHS to take the steps outlined below to ensure essential hospitals receive much-needed relief and remain equipped for their central role in the continued response to the pandemic.**

1. **HHS should ensure that hospitals serving people of color and low-income populations receive funding adequate to cover their COVID-related expenses and losses.**

To "promote equity and support providers with the most need," HHS plans to disburse $17 billion in phase 4 PRF funds through an application-based distribution calculated using providers' lost revenues and expenses.[4] The agency states it will reimburse a higher percentage of lost revenue expenses for small providers compared with large providers, with large providers receiving a minimum payment amount. In addition to the payment based on lost revenues and expenses, providers will be eligible for a bonus amount based on the amount and type of services provided to Medicaid, Children's Health Insurance Program (CHIP), and Medicare beneficiaries. Unfortunately, focusing solely on small and medium providers omits the health systems and hospitals on the front lines of the pandemic, tackling COVID-19 and its disproportionate effects on their vulnerable patients. **We urge HHS to revise its methodology to ensure providers treating disproportionate numbers of people of color and low-income populations—regardless of size—receive a higher payment amount that will cover the steep rise in expenses and lost revenue they face as a result of the delta variant.**

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[3] America's Essential Hospitals Letter to HHS Secretary Xavier Becerra. August 24, 2021. https://essentialhospitals.org/wp-content/uploads/2021/08/FINAL-AEH-Letter-to-HHS-COVID-19-8-24-21.pdf. Accessed September 20, 2021; America's Essential Hospitals Letter to HRSA Associate Administrator Danita Hunter. July 27, 2021.

[4] Health Resources & Services Administration. Future Payments. https://www.hrsa.gov/provider-relief/future-payments. Accessed September 13, 2021.

More than a year has elapsed since the last distributions targeted at providers with a safety-net role, and many essential hospitals serving large numbers of underserved patients and under immense financial pressure still have not recovered financially. These providers are in dire need of additional funding, which will go a long way in bolstering their COVID-19 response and allowing them to continue vaccination efforts in underserved communities disproportionately affected by COVID-19. Essential hospitals' communities depend on them to advance health equity and provide comprehensive, coordinated care. These large providers are offering the cutting edge, high acuity care their patients need—care not regularly available at other community providers. By ensuring essential hospitals can continue to operate in the face of these ongoing financial pressures, HHS will further its goal of advancing health equity and protecting the nation's vulnerable communities.

In addition to ensuring that large providers serving low-income patients and people of color receive a payment that adequately covers their lost revenue and expenses, HHS should ensure the methodology for the bonus payment captures these providers. While the agency did not provide many details in its announcement, HHS has stated it will base bonus payment on the amount and type of Medicaid, CHIP, and Medicare services provided. **We urge the agency to provide more details on the methodology for bonus payments and ensure it captures a variety of providers serving people of color and low-income populations, such as Medicaid beneficiaries and uninsured patients.**

2. **HHS should be transparent in its methodology for calculating phase 4 payment amounts.**

HHS provided limited details in its announcement of its intention to distribute phase 4 payments. **To ensure accountability and transparency, HHS should clearly lay out its methodology for determining which providers are eligible for higher payments, as well as how it will determine the exact payment amount**. For example, while HHS intends to tailor the payments to small and medium providers, it does not define these provider types. As noted above, it is unclear what criteria HHS will use in its methodology for determining the phase 4 bonus payments. Considering issues related to contested phase 3 payment amounts, as highlighted by HHS in its announcement of a reconsideration process, it is critical to avoid similar issues for phase 4. HHS can ensure phase 4 payments are calculated accurately and equitably by publishing details of its methodology.

3. **HHS should issue the rural provider distribution consistent with Congress' intent in passing the ARPA.**

Similar to the phase 4 methodology, HHS' announcement provided scant details of the methodology for the distribution of $8.5 billion to rural providers. HHS states the ARPA rural distribution will be made to providers based on the amount and type of Medicare, Medicaid, and CHIP services provided to rural patients, which it defines as those in Federal Office of Rural Health Policy–defined rural areas. As HHS refines its methodology for the rural provider fund, it should do so consistent with the language of ARPA. To capture the scope of providers treating rural patients, the legislation broadly defined rural as meeting one of six criteria:

- a geographically rural provider—that is, not in a Metropolitan Statistical Area;
- a geographically urban hospital that has reclassified to rural for Medicare payment purposes;
- a provider in an area that serves rural patients, such as providers in a Metropolitan Statistical Area with a population of less than 500,000;

- a provider or supplier that furnishes home health, hospice, or long-term services and supports in an individual's home in a rural area;
- a rural health clinic; or
- any other rural provider or supplier as defined by the HHS secretary.

Many providers on this list serve rural patients but are not in a rural area. The HHS announcement directs providers to a Health Resources and Services Administration rural health grants eligibility tool to determine if the provider is eligible for the rural provider distribution. Not all provider types listed in ARPA would be considered rural using the rural health grants eligibility. **HHS should ensure that eligibility for the rural distribution includes all types of providers Congress determined needed support in appropriating the $8.5 billion through ARPA.**

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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, Acting Administrator, HRSA
Danita Hunter, Associate Administrator, HRSA