American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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Alex M. Azar
Secretary
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Secretary Azar and Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, **the American Hospital Association (AHA) asks the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) to directly and expediently distribute to rural and urban hospitals and health systems funds from the Public Health and Social Services Emergency Fund that were designated for providers in the Coronavirus Aid, Relief, and Economic Security (CARES) Act.**

The CARES Act increased funding for the Public Health and Social Services Emergency Fund by $100 billion in order to reimburse eligible health care providers for health care-related expenses or lost revenues that are attributable to COVID-19. Eligible providers are public entities, Medicare- or Medicaid-enrolled suppliers and providers, and other for-profit and non-profit entities as designated by the HHS Secretary. The law specified that funding be distributed on a rolling basis through "the most efficient payment systems practicable to provide emergency payment."

As you are aware, hospitals are in a crisis situation and time is of the essence. **Thus, we ask you distribute these funds directly to providers.** In past, relatively similar situations, Medicare Administrative Contractors (MACs) have been used to pay claims and distribute monies directly to providers for purposes other than Medicare payment (e.g., Section 1011). We believe that again using the MACs to process applications and make payments either to individual hospitals or to a health system for all of its hospitals is appropriate. Health systems are often best suited to manage the monies and prioritize needs within their system. **In addition, all types of hospitals, including rural and**

urban short-term acute-care, long-term care and critical access hospitals, as well as inpatient rehabilitation and inpatient psychiatric facilities, are incurring expenses related to COVID-19 as they work to treat patients and expand the capacity of the health care system. Thus, all types of hospitals must be eligible for funds.

We recognize that standing up a process for the MACs over time to directly distribute funds based on hospital applications is not an easy or quick task. **Therefore, we ask HHS and CMS to direct the MACs to immediately distribute funds to every hospital in the U.S. at the rate of $25,000 per bed, and $30,000 per bed for "hot spots."** This methodology is permissible under the CARES Act, which gives HHS and CMS the authority to make payments from the fund on a "prospective" and "prepayment" basis. Further, the MACs have the information necessary to calculate these per-hospital amounts. Based on the fact that there are approximately 924,000 hospital beds in the U.S., we estimate that this distribution of funds would total about $23 billion, not including the additional funding for hot spots. Such hot spots could be identified by number of coronavirus deaths, rate of increase in diagnoses or another method. Funds distributed in the manner above could be "reconciled" at a later date using hospital applications that delineate their exact need for funds. Depending on the time required to stand-up a MAC process, additional waves of funds may need to be distributed in this way – they could follow the original distribution formula stated above or have additional adjustments depending on need.

Regarding the types of costs and lost revenue eligible for funds, we believe those in the following categories should be among the eligible under the law.

- Expenses Related to Surge Capacity for Coronavirus, Including:
    - Construction or retrofitting of infrastructure to create capacity, such as additional triage and treatment areas and command centers.
    - Acquisition of equipment and supplies such as beds, ventilators, diagnostic testing supplies, personal protective equipment, pharmaceuticals and safety equipment, even if the acquired equipment and supplies are not deployed
    - Costs for setting up drive through testing and additional screening for every patient at the entrances to hospitals and outpatient facilities.
    - Acquisition of additional technology such as telehealth equipment, command center technology and software.
    - Relocation of existing equipment/supplies/infrastructure to other parts of a system or the country, and the cost of leasing distribution and storage space.
    - Additional security for hospitals and for temporary medical facilities.
    - Triage activities to manage the surge.

- Expenses Related to Ensuring an Adequate Workforce for Coronavirus, Including:
    - Overtime and emergency pay for existing employees, including to create additional standby capacity.
    - Salaries, benefits, overtime, emergency pay and other expenses for new/re-hired/temporary/contract employees, including those hired to create additional stand-by capacity.
    - Paid leave for quarantined or furloughed staff.
    - Housing costs for quarantined staff needing to self-isolate.
    - Hotel/housing costs for staff to enable longer work hours (e.g. through shorter commutes).
    - Additional administrative expenses associated with planning, coordinating and staffing the pandemic response.

- Lost Revenue Attributable to Coronavirus, Including:
    - Lost hospital revenue due to administrative directive to cancel elective procedures.
    - Lost physician/other practitioner revenue due to administrative directive to cancel elective procedures.

- Other Health-care Expenses Related to Coronavirus, Including:
    - Managing and treating persons under investigation (PUIs) who may or may not turn out to be COVID-19 positive.
    - Where needed, distributing one-time 30-day supplies of prescriptions for acute conditions or to replace maintenance prescriptions.
    - If necessary, mortuary services.
    - Purchase or lease of temporary generators for facilities that provide essential community services.
    - Hotel/housing costs for discharged patients who require isolation, but cannot do so at home.
    - Hotel/housing/boarding costs for discharged patients for whom placement is not (yet) possible (e.g., nursing homes refuse placement).
    - Interest charged on Medicare “accelerated” or other payments.
    - Interest charged on any loans taken out due to the emergency.
    - Costs associated with monitoring non-hospitalized patients.

Communities rely on America’s hospitals and health systems to be there for them in times of emergencies. Whether that emergency develops in the form of a natural disaster, like a hurricane or tornado, or as a virus, like COVID-19, hospitals and health systems and the front-line providers who work in them are prepared to fulfill their commitment to their patients. While our members continue to do everything they can to address COVID-19 cases, quickly making these funds available would help them

continue to put the health and safety of patients and personnel first, and in many cases, may actually ensure they are able to keep their doors open.

We appreciate your leadership and the ongoing work of the White House Coronavirus Task Force. We look forward to continuing to work with you during this critical time to protect the health of our nation.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer