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

November 9, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

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) again urges **you to *fully* reinstate the COVID-19 Provider Relief Fund (PRF) reporting requirements outlined in the June 19 frequently asked question that defined both expenses and lost revenues attributable to COVID-19. These requirements should *fully* replace those outlined in the Department of Health and Human Services' (HHS) October 22 notice. We also urge you to allow hospital systems to move targeted distributions within their system to follow COVID-19 patients and the hospitals that are incurring the expenses and lost revenues directly attributable to the virus.**

Communities rely on America's hospitals and health systems to be there for them in times of emergency. The PRF funds have helped hospitals and health systems to continue to put the health and safety of patients and personnel first, and in many cases, ensure they are able to keep their doors open. However, several of HHS' policies regarding use of these funds, which we discuss below, run counter to this goal.

First, the Coronavirus Aid, Relief, and Economic Security (CARES) Act and subsequent legislation provided funds to reimburse eligible health care providers for health care-related expenses or lost revenues attributable to COVID-19. The law specified that recipients of this fund must submit reports and maintain documentation to ensure compliance with payment. As such, on June 19, HHS released an FAQ stating that hospitals could "use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if [hospitals had prepared a budget] without taking into account the impact of

COVID-19, the estimated lost revenue could be the difference between … budgeted revenue and actual revenue."

However, on September 19, HHS issued a new definition of lost revenue that was extremely problematic for hospitals. On October 22, the Department revised this definition by partially restoring its original June definition, but *did not* restore the ability of hospitals to use a budgeted-to-actual comparison when calculating lost revenues. It also did not restore the ability of hospitals to calculate lost revenue on a monthly, rather than annual basis. These two flexibilities are critical so that hospitals are not penalized for year-over-year changes that allow them to better serve their communities. For example, before the pandemic hit many of our members worked to recruit new physicians and/or establish new health care services, which are vital to best serving their patients, particularly in rural and vulnerable communities. Yet, hospitals and health systems would be penalized for this work without the ability to use a budgeted-to-actual comparison.

In addition, we are concerned that HHS' allowed lost revenue calculations do not adequately take into account the ever-changing health care environment, particularly with regard to the Medicaid program. Specifically, it is not unusual to see significant fluctuations in year-over-year state Medicaid payments, which can relate to activity for historical years and/or are not consistently received on a year-over-year basis. Yet, hospitals would be penalized in many cases for these fluctuations – which occur for a variety of reasons – under HHS' methodology. For example, several state Medicaid programs have made substantial payments to hospitals this year to settle years-old legal disputes over the construction of the program. Revenue calculations for 2020 should not take into account reimbursement for care delivered years ago and that should have been paid for years ago. In addition, several states began new Medicaid "directed payment programs," which are designed to more adequately reimburse providers for their costs, or made significant rate adjustments. Fluctuations in supplemental payments and other Medicaid financing mechanisms also occur regularly.

HHS also recently stated that providers can claim only the value of depreciation for COVID-19-related capital purchases with useful lives of more than 12 months. This is problematic, particularly since many of these purchases were large, and/or may not be fully complete by the June 30, 2021, reporting deadline. This means that hospitals may not be able to claim anything, or only a nominal amount, under the reporting requirements. Yet, they acquired this equipment exclusively to prevent, prepare for and respond to COVID-19. As such, we urge HHS to allow hospitals to claim their total purchase price as an allowable use of PRF payments, as was their understanding given the Department's June guidance.

Finally, as we have previously communicated, we continue to urge HHS to allow hospital systems to move targeted distributions to follow their patients treated for COVID-19 to hospitals within the system that are incurring the expenses and lost revenues directly attributable to the virus. Specifically, HHS has distributed each

payment from the PRF to hospital systems or individual hospitals on the basis of a unique taxpayer identification number (TIN). For hospital systems whose corporate structure is composed of multiple hospitals under the control of a common parent and a single TIN, payments from both the general and the targeted distributions can be moved among those hospitals in proportion to their allowable expenses or lost revenues. By contrast, for hospital systems that operate under multiple TINs because of their corporate structure, targeted distribution payments cannot currently be moved among hospitals within the system to follow the patient or in proportion to the allowable COVID-19-related expenses or lost revenues.

To better care for patients and more effectively manage scarce resources, many hospital systems will move a COVID-19 patient who needs intensive care from a smaller rural hospital to a larger hospital within their system where resources and experience caring for these patients are concentrated. Whether the funds from the PRF can be shared among the hospitals that incurred the expenses relating to care for the patient and the lost revenue that resulted from concentrating services in another location depends entirely on whether the rural and larger hospitals operate under the same TIN. We do not believe this is what Congress intended.

Absent changes to the policies above, many hospitals, including many rural hospitals and those serving high numbers of low-income, elderly and severely ill patients, particularly in vulnerable communities, remain in the position of unfairly having to return substantial PRF funds to HHS. Below are but a few of the estimates our members have provided of how much they would need to return under the agency's requirements as of November 6:

- Large academic medical center (AMC)-based system in the Southeast: return $83 million out of $219 million (38%);
- Large AMC-based system in the Southeast: return $93 million out of $128 million (73%);
- Large multi-state system in the West: return $320 million out of $1 billion (32%);
- Large multi-state system in the East: return $316 million out of $1.15 billion (28%);
- Hospital serving high numbers of Medicaid and uninsured patients in the East: return $41 million out of $63 million (65%);
- Mid-sized regional hospital in the mid-Atlantic: return $14 million out of $19 million (74%);
- Small rural hospital in the Midwest: return $11 million out of $15 million (73%);
- Small rural hospital in the Midwest: return $3.5 million out of $3.5 million (100%); and
- Small rural hospital in the Upper Midwest: return $3 million out of $4.5 million (67%).

If you'd like more information regarding these estimates, we are happy to discuss them further.

We urge you to address the concerns discussed above, fully reinstate the June reporting requirements and allow hospital systems to move targeted distributions within the system to follow COVID-19 patients. Hospital systems throughout the nation are relying on PRF distributions as Congress intended so that they can better withstand the staggering losses caused by this unprecedented public health crisis and continue to serve the patients and communities who depend on them. Retaining these funds as entitled under HHS' June guidance will help them continue to serve their patients and communities.

The AHA stands ready to work with HHS to resolve these issues. Please feel free to contact me or have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer