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President and CEO

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The Honorable Lamar Alexander  
Chairman  
U.S. Senate Committee on Health, Education, Labor and Pensions  
Washington, DC 20510

Dear Senator Alexander:

The Federation of American Hospitals (FAH) is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH and our member hospitals deeply appreciate your efforts in releasing the white paper "Preparing for the Next Pandemic" with recommendations to address future pandemics based on lessons learned from COVID-19 and previous experiences in pandemic planning. We recognize that COVID-19 has required our member hospitals, and their health care practitioners and staff across the hospital system, to exercise their preparedness and response capabilities at an unprecedented scale, and that the industry needs to leverage lessons learned to ensure greater capabilities and response strategies for future outbreaks. In considering actions to prepare for the next pandemic, we would like to provide some initial recommendations for consideration based on the experiences of our member hospitals and look forward to continuing this important dialogue.

### **Hospital Eligibility Criteria During Emergencies**

All hospitals, regardless of tax-paying status, are on the front lines in caring for patients when emergencies strike, enduring the same financial hardships and challenges that must be overcome to protect our health care workforce while ensuring we have the resources necessary to care for our patients. Viruses and other emergencies do not distinguish between patients and the communities we serve or between the tax-paying status of their closest hospital. Unfortunately, in some instances, tax-paying hospitals have been excluded from participating in federal programs that play pivotal roles in enabling emergency response and expanding access to care during states of emergency. This lack of parity unjustly penalizes patients living in communities across the United States that are served by tax-paying hospitals.

The FAH appreciated Congress' recognition of this need across all hospitals by ensuring that tax-paying hospitals are eligible for several forms of emergency funding, including the Provider Relief Funds and the Medicare Accelerated and Advance Payment Programs, in H.R. 748, *The Coronavirus Aid, Relief, and Economic Security (CARES) Act*.

Despite FAH member eligibility for these programs, however, there remain examples of exclusions applied to tax-paying hospitals. For instance, the Federal Communications Commission (FCC) defines the eligibility criteria for its newly established COVID-19 Telehealth Program in such a way that tax-paying hospitals are ineligible for participation. Telehealth serves a critical role during pandemics, especially when access to in-person care is limited by stay-at-home orders and FAH member hospitals are often the sole provider of comprehensive medical care in their communities, especially in rural America.

Moreover, the eligibility criteria used by the Federal Emergency Management Agency (FEMA) (as determined by the Stafford Act) excludes tax-paying hospitals from directly receiving financial assistance during declared emergencies. This exclusion leaves approximately 20 percent of hospitals nationally unable to obtain direct funding for certain covered resources that are critical for responding to pandemics and other emergencies.

***For these reasons, all hospitals, regardless of tax-paying status, should be eligible for the same necessary assistance as public or private non-profit hospitals during declared emergencies.***

## **Disease Surveillance**

During the COVID-19 Public Health Emergency (PHE), despite the strain to the health system, efforts to rapidly rally, share data, and collaborate among hospital associations and health systems quickly coalesced. These types of collaborations have proved invaluable in detecting, identifying, modeling, and tracking infectious disease, yet substantial barriers inhibit their successful engagement by limiting information sharing, inhibiting trust with regard to safeguards to intellectual property and data use, and limiting the resources that can be leveraged. We ask that Congress consider the following provisions to facilitate information sharing and increase support to enable these collaboratives to succeed and strengthen our nations' surveillance activities.

### *Facilitate Information Sharing*

Disease surveillance relies on the voluntary sharing of information among multiple organizations, including academic, private, federal, state, and local partners. A reliable data sharing mechanism and appropriate protections need to be in place in order to protect an individual's data and foster the necessary trust between partners that render collaborations successful. ***The FAH urges Congress to support continued efforts to advance and improve information exchange throughout the health care system, including the establishment of a systematic process to rapidly deploy agreements among academic, health, federal, state, and local entities during a PHE that ensure privacy and protection of data.***

## *Increase Federal Funding*

In June 2019, the President signed into law *The Pandemic and All-Hazards Preparedness and Advancing Innovation Act* (PAHPAIA). This vital legislation reauthorizes and revises public health emergency preparedness and response programs through FY 2023.

Planning to once again re-authorize this legislation may seem like a task for the distant future. However, the sudden emergence of COVID-19 has taught us a painful lesson. As such, the FAH urges Congress to maintain an ongoing, bipartisan dialogue and assessment regarding the needs of these programs. ***Beginning now, the FAH urges Congress and the Administration to collaborate with health care leaders in crafting the next iteration of this legislation, and in particular, ensure that the Hospital Preparedness Program (HPP) is fully funded at a sufficient level as recommended by the hospital community with greater funding allocated directly to hospitals and health systems.***

We are encouraged that Chairman Alexander, along with other bipartisan members of the House and Senate, recognize that our public health infrastructure cannot afford any future delay, partisanship, or gamesmanship in preparing for the next pandemic.

In addition, the nation needs additional regulation and funding that will ensure support of domestic manufacturing of essential medical counter measures (MCM). For instance, the Biomedical Advanced Research and Development Authority (BARDA) can have a great impact in addressing the national health care security threat we face from over-reliance on non-domestic research, development and manufacturing. ***The FAH urges the Administration to direct greater support and commitment to domestic manufacturing through BARDA awards that include a domestic focus in the manufacturing of essential MCMs.***

## **Public Health Data Systems Modernization Act**

***The FAH supports the recommendation that Congress should pass the Public Health Data Systems Modernization Act, included in the Lower Health Care Costs Act, to modernize our nation's bio surveillance systems.*** In particular, the FAH supports the requirement that the Department of Health and Human Services (HHS) award grants to state, local, Tribal, and territorial public health departments for the expansion and modernization of public health data systems. The capacity for public health departments to capture the data required to support the success of pandemic response, let alone health care value initiatives, remains limited. As the health care delivery system increases its focus on the collection and use of social determinants of health, the implementation of community-based programs, and the integration of social and medical services, we increasingly rely on public health departments to capture data that can be used for research and integration with the medical system. For example, certain local public health data systems, such as Prescription Drug Monitoring Programs (PDMPs), must be modernized and integrated so that they can yield reliable, comprehensive results and be leveraged to combat the opioid epidemic. Currently, public health departments face pressing demands to contend with legacy technology while data needs grow at an accelerated pace.

The FAH applauds awarding grants for the simplification of reporting by health care providers and the enhancement of interoperability of current public health data systems. Hospitals often bear substantial administrative burden and cost when publicly reporting data. The simplification of reporting and enhancement of interoperability will support provider burden reduction.

In addition to improving interoperability of these systems, it is critical that public health departments consider information privacy and security, as well as infrastructure around data exchange, as they develop new information technology (IT) strategies.

### **Redesign the Stockpile Model to Align with National Supply Chain**

The Strategic National Stockpile (SNS) was established for procurement of MCMs and to serve as a repository of drugs, supplies, and devices necessary to respond to a public health threat. Policymakers should make sure the SNS has appropriate resources and funding to fulfill its role as a stopgap in emergencies.

However, long-term solutions also need to be considered to improve the efficiency and effectiveness of the SNS. The SNS fell short in responding to the unprecedented national demand posed by a national threat of the magnitude of COVID-19. ***The FAH urges Congress to conduct an evaluation that includes a root cause analysis of points of failure of the SNS under the threat of COVID-19 followed by a study focused on identifying what the proper authority, models of governance, capacity and scope of SNS need to be so as to inform a much needed re-vamping of the SNS. The FAH further urges that this evaluation engage a private sector council representing the functional components of industry that make up the operational components.*** The private sector council should include leaders from end to end of the supply chain distribution enterprise, from raw materials manufacturers to health system emergency managers, so as to inform on improvements that would allow the SNS to be more efficient to the needs posed by a national threat of the magnitude of COVID-19. The private sector council should further be leveraged during the operation of the SNS to continually inform the capabilities and align the response of the SNS towards greater operational effectiveness.

The mission of the SNS has evolved over time and needs to continue to evolve from past models of static stockpiling on shelves into more nimble frameworks and data sharing partnerships. It is critical that the SNS actively engage in the nation's circulation of supplies as part of the national supply chain in line with appropriate manufacturing ramp up and streamlined distribution to where supplies are needed most. In this vein, the stocking of the SNS should also be mindful of medical supply availability in the supply chain and avoid competing with hospital acquisition of supplies needed to provide patient care. ***We urge increased public-private collaborations, such as the Dynamic Ventilator Reserve partnership, and increased communication among Group Purchasing Organizations (GPO), SNS, HHS, FEMA, Food and Drug Administration (FDA), hospitals, health systems and other providers to help ensure a coordinated and comprehensive response during emergencies.***

Additionally, as part of the deployment strategy, consideration should be given to the impact of delivering products whose format require extensive health care training to utilize. In these cases, the efficiency of stockpiled deployment of products to health care organizations is hampered by the need to retrain health care workers on a new product format that differs from that which was previously used in the facility. Possible solutions include allotting for extra inventory within hospitals that would ensure an approximately 2 percent buffer of supplies for use in case of emergency. This buffer would circulate through the supply chain periodically to ensure no material losses as a result of lapsed expiration dates and ensure a continually refreshed supply of materials and devices that are in line with local provider training policies. Another possible solution would be to create "regional caches" through coalitions that dictate a common set of standards for a specific

region. These standards would be determined by local stakeholders who are connected to the health care organizations that would be served by these caches in the case of emergencies. When implementing these regional caches, care must be taken to ensure that using alternatives does not put organizations at risk for non-compliance with regionals dictates.

When determining the demand for personal protective equipment (PPE), care should be taken to account for the safety of all providers including Emergency Medical Services (EMS), other first line responders, and long-term care facilities. During the beginning of the COVID-19 pandemic, these providers were over-looked and faced substantial shortages.

### **Address the Impending National Physician Workforce Shortage**

*The FAH urges Congress to expand Medicare’s support for physician training to ensure all Americans have access to the care they deserve.* Demand for physicians continues to grow faster than supply, leading to projected shortfalls by 2030 of both primary and specialty care physicians. America’s medical schools, teaching hospitals, and their physician partners are doing their part by investing in physician and health care provider training and leading innovations in new care delivery models that are more efficient and include better use of technologies that improve patient access to care, and should include a curriculum for disaster readiness and response. Even with these efforts, however, shortages and access challenges will persist unless we expand the physician workforce. If we fail to build a robust physician workforce, the nation’s most vulnerable populations, such as those in rural and underserved areas, will be among the hardest hit. During a pandemic, a sufficient physician workforce is critical to successfully managing the surge in demand. As the frequency and intensity of large-scale disasters and regional emergencies continues to increase, it is essential that we invest in the development of our future clinical leaders by appropriately educating and training them toward the future of health care emergency operations readiness and response.

### **Design a National Reserve Corps**

Reserve corps fulfill a critical task filling in resource gaps during emergencies. The Medical Reserve Corps (MRC) supports local responses but is not designed to serve as a national-level reserve corps that can support the full United States during a pandemic. A national medical reserve requires a large pool of professionals with the capacity to be physically deployed throughout the country in response to shifting outbreaks. *We urge the investment in and expansion of the capabilities of a national reserve corps as a component of secondary workforce that rapidly allows individuals with former licenses (that lapsed in good standing) to provide support where it is needed most, funds the ready reserve officer program of the U.S. Public Health Service, and expands the recruitment and hiring of additional providers as intermittent federal employees. Providers that should be considered as part of the reserve corps include disaster medical assistance teams (DMAT) teams, nurses, medics, and respiratory therapists, otherwise employed throughout the health system, to be rapidly deployed nationwide to deal with surges.*

### **Allow for Clinical Judgement in Care Delivery Curtailment Considerations During a Pandemic**

Preparedness for a pandemic includes a national response that is nimble and responsive. Any national or local directives for change in the way health care systems respond should be implemented carefully and avoid over reliance on incomplete data. *Appropriate stakeholder input*

*should be considered as well to prevent unnecessarily restrictive directives that can adversely affect patient access to care.* For instance, in early March, government officials recommended that hospitals immediately stop performing “elective” surgeries without clear agreement on how hospitals and other health care providers classify various levels of necessary care. As pandemics develop, curtailment of the least critical or time-sensitive hospital services may be necessary, but must be nuanced to meet the needs of all severely ill patients. Broad cancellation or delay of non-emergent care has the potential to rapidly worsen a patient’s condition and can even be life threatening. This is particularly pertinent to children who are in an active phase of growth and development, as well as individuals with chronic conditions. The resulting decline in an individual’s overall health could increase their vulnerability to COVID-19.

A blanket directive to cancel elective and non-urgent procedures usurps the proper role of physicians caring for patients and their families, while collaborating closely with the hospital, to determine what is in the patient’s best interests. Instead, elective and non-urgent procedures, both those in an operating room and in other areas where the procedure can be safely performed, should be based on a case-by-case evaluation of many factors such as current and projected COVID-19 cases in the facility and in the surrounding area, supply of PPE, staffing availability and bed availability, urgency of the procedure, patient factors, and clinical judgement.

### **Social Determinants of Health**

Social risk factor data is a necessary component for driving patient care and ensuring health equity across the health system. The collection of these data, however, requires HHS to develop an informed framework that identifies the necessary information that must be collected in collaboration with appropriate stakeholders, the definition of data standards for capture of data in electronic health records (EHRs) and approaches for using this data to inform care delivery and adjust measures in value-based programs.

### **Strengthen and Diversify the Supply Chain and Domestic Manufacturing of Critical Supplies**

Supply chain resiliency depends on timely information, access to raw materials, manufactured supplies, and secured distribution channels. The FDA currently depends on voluntary reporting from manufacturers and health care organizations to identify shortages. Enabling access to timely information prior to emergencies enables the FDA and other supply chain stakeholders to identify potential shortages prior to an actual shortage and to identify back up supplies and mitigation efforts to respond with efforts to stem the occurrence of the shortage. The CARES Act strengthened reporting requirements for manufacturers, including information on shortages of active pharmaceutical ingredients (API). *We urge Congress to support policy solutions that enable the FDA and other authorities to have greater visibility into the source and location of manufacturing medical products in advance of emergencies by requiring manufacturers to provide this information.*

In addition, overreliance on particular geographic locations, more critically non-domestic locations, can lead to disruptions of the supply chain. We support increasing supply chain diversification by leveraging the global nature of the supply chain to build redundancies, while maintaining critical domestic capabilities. Both domestic and global manufacturing and sourcing capabilities are necessary to ensure multiple suppliers and facilitate scale up of production as necessary.

## **Expand FDA Drug Shortage List and Monitor Inventory Levels**

The FAH is committed to preventing and mitigating drug shortages and ensuring continued patient access to essential medications. We encourage the FDA to expand its list of drug shortages to include drugs experiencing national and regional shortages. We urge Congress to provide the FDA with access to critical data by requiring manufacturers to disclose data on inventory levels for essential medications that would enable the FDA to gauge capacity levels nation-wide and recommend ramp up of production when necessary.

## **Enable Automatic Waivers by Making Permanent HHS Temporary Waiver Authority**

The national impact of COVID-19 necessitated the development and issuance of additional waivers – above and beyond the standard “blanket” waivers – from the federal government to give health care providers the flexibilities needed to combat this pandemic. As we learn from the lessons of COVID-19, we urge Congress to request that HHS work with stakeholders to identify these additional waivers that should be included as “blanket” waivers in response to future PHEs. Doing so will help ensure that health care providers do not waste precious time, energy and resources identifying, requisitioning, and waiting for the waivers to be put in place.

## **Retain Appropriate Telehealth Changes and Expand Policy**

The way care is delivered via telehealth has changed substantially as a result of COVID-19, stay-at-home orders, and waivers from the Centers for Medicare & Medicaid Services (CMS). Many of these changes should remain after this pandemic is over because they expand access to services and support care delivery during the ongoing pandemic and beyond. We look forward to working with Congress and the Administration to develop an approach that maximizes patient access to care with evolving treatment modalities.

We thank you for your leadership in addressing the COVID-19 pandemic and your commitment to supporting America’s health care providers during this critical time and beyond. We look forward to continuing to work with you and the Senate HELP Committee to best prepare the nation’s health care infrastructure for future pandemics. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

